REPRESENTATIVE FOR
CHILDREN AND YOUTH

2007 Progress Report on the Implementation of the Recommendations of the BC Children and Youth Review

("Hughes Review")

November 26, 2007

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Ron Cantelon, Chair
Leonard Krog, Deputy Chair
Select Standing Committee on Children and Youth

I have the pleasure to submit for your consideration the 2007 Progress Report on Implementation of Recommendations in the Hughes Review. This is the first of what I sincerely hope will be a short series of annual reports from my Office on the implementation of the 62 recommendations of the April 2006 BC Children and Youth Review (the 'Hughes Review'), conducted by the Honourable Ted Hughes OC, QC, LL.D. (Hon.).

You will recall that all of Mr. Hughes' recommendations received the support of both Government and Opposition when they were made. My report covers the actual, on-the-ground implementation of these recommendations in the 18 months following the release of the Hughes Review.

I wish to make three preliminary points.

First, I had intended to bring this report forward earlier this year, closer to the first anniversary of the release of the Review. That proved unduly optimistic for several reasons, but this delay has allowed us to assess more of the actual record.

Second, I had hoped that this report, and this presentation, could have been made jointly with the senior management team of the Ministry of Children and Family Development (MCFD). Regrettably this has not proven possible. I was prepared, and I remain prepared, to share the opportunity with MCFD officials to showcase in these pages and with the Committee the work that they have put into the implementation of the recommendations of the Children and Youth Review. This invitation will remain open, and will apply to next year's report on this subject.

And thirdly and very importantly, I wish to emphasize that I share Mr. Hughes' view of the strong and compassionate people doing such essential work for our children. The Hughes Review was very supportive of frontline Ministry child protection workers, applauding their "toughness, warmth, intelligence, compassion, decisiveness and determination." He also called for additional resources to be earmarked for their recruitment, retention and training.

In my first year as Representative for Children and Youth, I have been deeply impressed and encouraged by the commitment of frontline social workers and many others in the child and family serving sector to nurture the resilience of our most vulnerable children and youth. My report is not critical of them or their work.

In preparing this 2007 Progress Report on the Implementation of the Recommendations of the Hughes Review, I have addressed each recommendation separately and have sought to determine the extent to which it has been implemented. I have found that this ranges from "no progress" or "limited progress" to "completely implemented". Wherever possible, I have used multiple sources of evidence to arrive at my conclusions, although in some cases I found no evidence one way or the other. It is accordingly possible that progress in some areas is not fully captured in these pages because the necessary documentation was not made available to me.

My report confirms that substantial progress has been made over the past 18 months on the implementation of certain of the Hughes recommendations, that some tangible progress is evident on others, but that too many recommendations have yet to receive the attention that they warrant. I discuss this in detail in two companion documents.

In short, I must give the performance of the Government a mixed review.

Assessment Overview of Hughes Recommendations

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Insufficient information provided
62	15	3	11	8	22	3
	18		19		22	3

My Office is just the latest external agency to be created. Predecessors include the Child and Family Review Board, the Child and Youth Advocate, the Children's Commission, and the Child and Youth Officer. As well, there have been two formal reviews – the Gove Inquiry into Child Protection, and the Hughes Review.

Recommendations made by these agencies have not always been acted on in full and with dispatch. This history must add to our renewed determination to act now on the Hughes recommendations. The Hughes Review is the best report of its kind that I have seen, and I have seen many. When it was released last year, it was enthusiastically received throughout the province and for a moment, united Government and Opposition in Victoria. It played a pivotal role in my decision to take on the position of BC's first Representative for Children and Youth.

I am pleased to note that the Hughes Review contained a key recommendation on which good progress has been made – the establishment of an inter-agency forum or council to help coordinate the work of some of the public bodies sharing responsibility for child welfare in British Columbia. This includes MCFD, the Coroners Service, the Public Health Officer, the Ombudsman, the Public Guardian and Trustee, and my Office. The new Children's Forum

has met four times and is working productively on issues of common concern. The positive response to this recommendation by all these agencies illustrates the kind of action I have been looking for on all the recommendations.

While progress has been encouraging in some areas, I must report that I have found too little evidence within MCFD of a coordinated effort to implement numerous Hughes recommendations where its leadership has been required. When progress on recommendations warrant only notations of "planning is underway" or "limited progress found", this is deeply concerning given that these recommendations were made and accepted more than 18 months ago.

I am concerned by the lack of sustained action on the agenda that Mr. Hughes provided, which had a clear linkage to the 'Five Great Goals for British Columbia' established by the Government. As well, the Opposition was supportive of the Hughes review and recommendations. There was a significant infusion of new money in Budget 2006 earmarked for the implementation of the Hughes recommendations and enhancements to child protection and family support services. There was an opportunity, which the Government took, to provide fresh leadership to MCFD. In April 2006, the path ahead seemed very clear.

Based on the work underpinning this report, I make two recommendations:

1. That Government clarify the connection between the MCFD draft *Good Practice Action Plan*, and the commitment to the full implementation of the Hughes Review; and

2. That Government reiterate publicly its continuing support for the recommendations of the Hughes Review, and that the Minister of Children and Family Development work with greater urgency to implement the Hughes recommendations that need and deserve priority attention by his officials.

I elaborate further in this Report on those recommendations from the Hughes Review that I believe are of the most pressing importance.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

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Executive Summary

Hughes Recommendations of Pressing Importance

As I prepared this detailed 2007 Progress Report for the Select Standing Committee on Children and Youth, it became obvious to me that many of Mr. Hughes' most important recommendations have not yet been implemented by MCFD.

The "Final Draft" of MCFD's *Good Practice Action Plan* (July 3, 2007) superficially refers to the recommendations of the Hughes Review in relation to its planned initiatives. It appears that these references were inserted and provided to my Office only after we inquired as to how earlier versions of the *Good Practice Action Plan* reflected ministry attention to Hughes' recommendations. The matter remains uncertain to me.

On Sept. 4, 2007, while discussing the draft Plan, the MCFD Deputy Minister reported to the Select Standing Committee on Children and Youth that "I do want to make the point that it is not a response to the Hughes recommendations or the Hughes report." The draft *Good Practice Action Plan* states that all planned ministry "actions and activities will change over the next four years." It is difficult to evaluate a draft plan which even when adopted will change.

> *In the best interests of our province's most precious assets – children, youth and families – I call upon the Government to move towards substantial compliance with what is proposed in this document ... I believe that a blueprint will be found here to allow for full repair of a system that has in recent times been battered on stormy seas.*
>
> Hon. Ted Hughes,
> Hughes Review

The July 3, 2007 draft *Good Practice Action Plan* is highly abstract, avoids making specific commitments where they should be made, and remains only "a draft plan" to which further amendments must be anticipated. On key areas there may be no real action for years, even if the broad principles and objectives in the plan are laudable ones. Improving the lives of vulnerable children and youth must be seen and not only planned.

I want to specifically comment on the implementation of some of the most important recommendations of the Hughes Review that require – but have not yet received – leadership by MCFD.

I will begin with those which address the situation of vulnerable Aboriginal children and youth, and then move to recommendations relating to five themes which I identified in June 2007 for Members of the Select Standing Committee on Children and Youth.

Aboriginal Children and Youth

I would like to comment first about the Hughes Review recommendations that address the organization and provision of services to vulnerable Aboriginal children and youth in the province. In any given month, one in ten is not living with his or her parents. One in seven will have contact with the child welfare system during childhood and adolescence. The recent trends are not favourable. The urgency of action and the necessity of well-designed strategies call for our closest attention.

> *Aboriginal people alone truly understand their communities and the needs of their children and families. It makes sense that their own wisdom and understanding should guide the way to any change in the governance structure of the child welfare system that serves them, in partnership with the support and experience of the Ministry.*
>
> Hughes Review Highlights Document

Mr. Hughes did not bring forward a specific model for organizing and operating child welfare services for Aboriginal children and families in his Review. Rather, he said that this is a matter for Aboriginal people to determine for themselves. He also called on the federal government to play a facilitative role.

I understand that recent discussions between the Ministry for Children and Family Development and Aboriginal leaders on the regional Aboriginal Authorities have not yet resulted in an agreement on a new working model of governance. There may need to be a reconciliation of strongly differing viewpoints, and all such work can take time and test patience. I would only ask that we find the time it takes to reach a workable and innovative set of arrangements for safeguarding vulnerable Aboriginal children and youth. I am of course ready to help the parties in any way I can.

The durable consensus essential to moving forward has not yet been reached, perhaps because governance models under discussion are not clearly linked to community and self-government rights and processes, or do not appropriately build on the experience of delegated agencies. Moreover, very little work has been done to link any discussion of governance models or options to specific improvements in the lives of the most vulnerable Aboriginal children. Indeed, clear expectations are lacking in that regard. This latter point is one that cannot be emphasized enough: while Aboriginal people must drive new approaches, there is no evidence that they wish to do so without expectations of excellence, performance management, and proper capacity or resources. Delegated child welfare agencies have been consistent in their identification of the need for equitable support.

Delegating or crafting legislation to pass to Aboriginal peoples a child welfare system or an interim authority structure that lacks clear performance measures, prevention resources, modern information technology, and capacity to secure better outcomes for children is not adequate. This may result in few – if any – improvements in the lives of these children and youth. While recent discussions are positive, there is not enough agreement or planning

to meet these important conditions for an effective and responsive system for Aboriginal children and youth.

I recognize how significant the federal government role is in these discussions, and the share of responsibility and accountability that it must rightly accept to address disparities for Aboriginal children and youth. Mr. Hughes wrote of the impact of the demise of the Kelowna Accord. The Accord has not been revived and this has an ongoing impact on the efforts to close the gaps for Aboriginal children, and to promote social and family stability and prosperity.

For the FNCFS Program to achieve its objective of 'contributing to a more secure and stable family environment for children on reserve', it seems appropriate that it too should move towards a stronger emphasis on prevention, and its prevention approach should be directed broadly to communities as well as to children and families that have come to the attention of child and family service agencies."

Indian and Northern Affairs Canada – Evaluation of the First Nations Child and Family Services Program (2007)

There is a unique fiduciary relationship with the federal government and First Nations as a matter of constitutional law in Canada, but particularly for these vulnerable First Nations' children, the inadequate support, assistance and care for their well-being is a blight on our national conscience and international reputation. I cannot let this opportunity pass to say that in my advocacy role as Representative during this first year, I have observed a distinct dereliction of duty toward Aboriginal children with disabilities for whom adequate social supports are crucial to meeting their developmental needs. I see no real efforts to build those essential supports for their safety, education and well-being by the federal government, and profound struggles on this front with the provincial service delivery model. I have seen the harmful impact on the lives of children caught between jurisdictions.

"Jordan's Principle"

Jordan was a First Nations child born with complex medical needs. During his short life, federal and provincial governments argued over who would pay for his at-home care.

Sadly, because of the discord, Jordan passed away far from his family home.

In honor of Jordan, all provincial, territorial and federal governments are being called on by over 600 leading organizations to adopt a child-first principle to resolving jurisdictional disputes over care of First Nations children.

Under "Jordan's Principle", when a dispute arises between two government parties regarding payment for services for a Status Indian child, the government of first contact must pay for the services without delay or disruption.

The gaps in the system in jurisdictional disputes over who supports First Nations children in need must be urgently resolved. "Jordan's Principle" is widely advocated as the preferred approach to support a child caught in a jurisdictional dispute. The principle supports the provincial system assuming responsibility for the needs of the child.

I recognize that within government valuable planning work is taking place by the Ministry of Health under the aegis of the First Nations Health Plan to close the health status gaps between Aboriginal British Columbians and the majority community. Further, the Ministry of Education is working to close gaps apparent in K-12 education through Aboriginal Education Enhancement Agreements now in place with 35 school districts. Both of these ministries have anchored their strategies in data indicators regarding Aboriginal health and education gaps, and allied performance measures, so that changes in service delivery can be evaluated to determine if they are effective and responsive in closing those gaps. I commend both ministries for these efforts, and recognize the pragmatic and dedicated push by First Nations and Métis leaders for excellence. There is much wisdom in their work for the unfinished business of child welfare.

Five Key Themes

At the meeting of the Select Standing Committee on June 28, 2007, I identified five key themes taken from the Hughes Review to which I now return:

1. *The development of a strong, centralized quality assurance program with effective standards, practices, policies and effective monitoring, auditing and reporting by MCFD.*
2. *The development of an effective complaint resolution process that is timely, accessible and simple; that takes a problem-solving, non-confrontational approach; and is publicly reported.*
3. *The development of an effective, accountable, internal child critical injury and death review process.*
4. *The information-sharing provisions regarding sharing relevant information on vulnerable children and youth with public agencies, and addressing any statutory barriers to disclosing information among MCFD program areas.*
5. *The project of linking and collecting data from other public bodies for the purposes of decision making about individual children and youth, particularly those most vulnerable.*

Quality Assurance and Monitoring

Mr. Hughes spoke favourably about the promise of decentralization, and its potential to bring about a closer match between the needs of children and the availability of programs and services at the community level.

While Mr. Hughes supported a more decentralized and integrated MCFD, he cautioned against the rapid and far-reaching transfer of child welfare authorities and resources without a considered framework of standards and performance expectations to guide the process. Indeed, he wrote "...that responsibilities be transferred to regions and to Aboriginal authorities once they have demonstrated their ability to meet key performance targets."

> *Government has a responsibility to be accountable to the public for its performance in protecting and serving children and youth. The Ministry needs a regular, coordinated program of public reporting on its activities and the results achieved for children in care and children at risk.*
>
> Hughes Review
> Highlights Document

I know that individuals, families, communities, agencies, regions, and entire ministries seek and welcome the resources they require to do their work, while trying to minimize the strings, conditions, and oversight arrangements that may accompany their provision by funders. This desire for autonomy is very well known in child welfare and in countless other settings.

To be sure, oversight can entail a degree of unwanted and unnecessary micro-management of operational matters and burdensome reporting requirements. It can stifle innovation and creativity where these would pay significant dividends in the achievement of fundamental goals and objectives. I recognize this, and my staff recognize this as well.

However, the Hughes Review affirmed that in a more decentralized child welfare system, effective quality assurance and monitoring arrangements may become, if anything, more important than they were under a more traditional, hierarchical model.

We all know, by and large, what we want to achieve in child welfare. This has been codified in the *Child, Family and Community Service Act* which places improved child safety and well-being at its heart. We know as well that there are many paths to improved child safety and well-being, and that no single path can or should be followed in all settings. Sensitivity to context is an important value as we contemplate the diversity of British Columbia's cities, towns, and rural and Aboriginal communities.

Simply put, effective programs and services for vulnerable children and youth, their families and communities, can and will look a bit different from place to place. But because of this

diversity there arises a need to ensure that, beneath all the variation, they are effective and efficient in their operation. We will continually need to know, and to demonstrate to others, that our programs are helping those for whom they exist.

Performance measures and quality assurance practices are indispensable.

> *The report supports the move to decentralization, but only if important guidelines are respected. The move to decentralize services and authorities to the regions, and eventually to Aboriginal governance authorities, poses many challenges. It is recommended government commit itself to decentralization, which means supporting it with adequate resources, time, a dedicated team, and budget stabilization.*
>
> Hughes Review Highlights Document

Mr. Hughes was amply aware of this need. He wrote that resources and authorities *should not* be transferred from the centre to regions, or from government to Crown Agencies, without clear performance expectations and the standards under which the work transferred will be carried out. Arrangements to ensure that these expectations are met take a number of forms: from practice standards to guide the work of individual practitioners; to guidelines covering financial and human resource management; to operational audits to show that guidance and standards are being met; to case reviews to uncover the hard lessons of difficult and sometimes tragic cases; to performance measures to establish targets and show progress toward their achievement; to external evaluations to determine whether programs and services are genuinely effective in their operation by meeting the objectives set for them.

Taken together, these arrangements comprise a quality assurance system that would help MCFD stay on track and encourage public confidence in the child serving system.

It has become particularly apparent to me that many of Mr. Hughes' specific recommendations that would provide this foundation for monitoring MCFD's progress, enhancing public accountability for its results, and assisting in the process of its decentralization are among those not yet acted on.

These include:

- creating a robust quality assurance system spanning the local office to ministry headquarters;
- conducting external evaluations of kith-and-kin and other out-of-care options, family group conferencing, mediation, and family development responses following diversion of certain child protection investigations;
- developing a list of performance measures covering key elements of the safety and well-being of vulnerable children;
- building the capacity to carry out aggregate analyses of audits and case reviews and to act on their results; and
- nurturing a body of research and analysis based on linked British Columbia data to guide ministry decision makers at all levels as to what, with real confidence, can be identified as a "best practice".

While it is true that some of these recommendations require a good deal of time to carry out, it is also true that effective organizations find the time to do work of this kind. Valuable time has been lost over the past 18 months in these concrete areas.

Complaint Resolution Process

I have not found in the draft *Good Practice Action Plan*, or elsewhere, evidence of the "urgency" Mr. Hughes wished to stimulate on the finalization of MCFD's complaint resolution process.

Nor have we determined that the Aboriginal agencies have been supported or are able to date to establish complaint-handling mechanisms, as they are obliged to do as a condition of delegation, in the absence of ministry leadership or apparent interest. My Advocacy staff report that this is a continuing issue for them as they try to help all parties in over 1,000 individual advocacy cases where their help has been sought.

What I am looking for is easily described, and is set out in the Hughes Review. We are looking for a process that assists in the timely resolution of complaints, is easy to access, is non-confrontational, and is respectful of the parties while having a strong child focus.

Among the numerous benefits of a functioning complaints resolution process is that it serves as a good source of data on how MCFD decisions and activities are being received by those whom they affect. To provide benefits of this kind, the provincial office needs to be able to aggregate and analyze local office and regional reports of complaints, to prepare roll-ups,

and take note of trends and changes over time. In turn, such knowledge should inform improved public reporting on this important area.

Given the continuing importance of this issue, and my concern for the current state of complaint resolution practices, I have invited the Ombudsman, and she has accepted, to join me in a comprehensive review and evaluation of complaint resolution processes within MCFD, the delegated agencies, and Community Living BC.

Review of Critical Injuries and Deaths

> The primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice... A secondary purpose ... is one of public accountability... government has a responsibility to account to the public as to whether it met its responsibilities to that child.
>
> Hon. Ted Hughes,
> Hughes Review

The Hughes Review stressed the importance of building internal ministry capacity to conduct case reviews to a high professional standard. It called for more integrated reviews, and a common model to be used across different program areas; it urged that realistic timelines for completing reviews be set, met and reported out.

It asked that the authority to conduct reviews be more plainly set out in law, providing a role for both regional and provincial office directors. It called for new authorities to permit the sharing of sensitive information gathered during reviews and, thereafter, with participating individuals and agencies.

Too little evidence has been made available for me to conclude that tangible progress has been made on most of these recommendations after 18 months.

Information Sharing

The Hughes Review devoted a good deal of attention to this subject, and made several recommendations on this issue, because the importance of information sharing had previously been highlighted again and again in audits, case reviews, inquests, and discussions with agencies and stakeholders in the child serving system. The need for clearer guidance on when to share sensitive information – and when not to – arises, most poignantly, in individual cases at the local level, those that can culminate in case reviews and coroners service inquests as discussed above. But Mr. Hughes noted that the same need extends to everyday relations within and among program areas of MCFD, and between MCFD and partner agencies, where restrictions to the freer flow of information were said to exist.

He asked that the statutes that govern access and privacy matters within MCFD be reviewed "to ensure that there are no statutory barriers to disclosure of information among program areas," and to ensure that ministry privacy policies are "current, accurate and easily useable by employees."

Although we have requested that MCFD provide documentation that would confirm that it is acting on these recommendations, we have not yet received sufficient information to allow us to determine that progress has been made on them since April, 2006.

However, I am pleased to report that the legislation under which I operate contains provisions that enable me to access and use the information I require to carry out my responsibilities.

Using Linked Administrative Data to Support Decisions

British Columbia has a better capacity to link administrative data on the well-being of children in care than most other jurisdictions in North America, and perhaps the world. These data have so far underpinned the publication of two joint studies between the Provincial Health Officer and myself on health and education outcomes, and will support the planned publication of two more studies in the future. One of these will describe the experiences of children in care in the youth justice and corrections systems, and the other will assess their dependence, as they approach adulthood, on income assistance.

We are proud of these studies, and yet we also know that they simply set the table for much more work to increase desired outcomes and decrease those that are harmful and destructive. I understand that work is underway to respond to the findings of the education joint report on the part of the Ministries of Children and Family Development and Education.

Two of Mr. Hughes' specific recommendations on linked administrative data concern access by my Office, and I am pleased that the necessary legislative provisions have been enacted to permit further work along the lines of the two joint studies prepared to date with the Provincial Health Officer.

Perhaps the key recommendation made by Mr. Hughes in this area is that the better data he called for be "used as a tool to support operations and management decision making, and program evaluation and policy development." In other words, MCFD, my Office, and our partners must learn to take maximum advantage of the potential benefits of linked data in a range of settings. This is essential to ensure that our array of policies, programs and services is fully aligned with our knowledge about what has worked, and what has not, for vulnerable children and youth.

I have been unable to determine that work of this kind is proceeding with the priority it merits within MCFD and the Government generally. I do note that the child and family service sector, largely contracted through MCFD, has pushed for this linking and integration of data for overall service delivery enhancement.

Concluding Note

The Hughes recommendations are not complex. Some welcome progress has been made, but too much seems to have been set aside.

A more detailed analysis of all the Hughes Review recommendations follows. The work of my Office in the near future will focus on the six areas of priority identified here. I will report again next year and, if needed, the year after in follow-up reports on the implementation of the Hughes Review recommendations.

2007 Progress Report on the Implementation of the Recommendations of the BC Children and Youth Review ("Hughes Review")

Introduction

This 2007 Progress Report is an 18-month update on the implementation status of the April 2006 *BC Children and Youth Review: An Independent Review of BC's Child Protection System*, known as the "Hughes Review." This Progress Report also identifies specific priority areas the Representative will review in greater detail to monitor change and improvements being made to support BC's most vulnerable children.

The Hughes Review indicated that significant change was necessary to improve the well-being of vulnerable children in the province. Its recommendations were widely endorsed by both Government and the Opposition.

The recommendations are consistent with one of Government's five great goals: *"To build the best system of support in Canada for persons with disabilities, those with special needs, children at risk and seniors."* They also support the principles and provisions of the *Child, Family and Community Services Act* (CFCSA), which is the legislative framework for services to the province's most vulnerable children and youth.

The 2006 Budget allocated $100 million to provide additional services to children, including government's response to the recommendations of the various external reviews of the child protection system, such as the Hughes Review.

Following this commitment, a Transition Steering Committee was appointed to oversee implementation of the recommendations. It included the Deputies from the ministries of Attorney General, Children and Family Development, and Solicitor General.

The Steering Committee issued its final report in May 2007. The report stated that 36 of the 62 Hughes Review recommendations had been completed, with the remainder in progress.

This 2007 Progress Report provides a more specific assessment, using a range of categories of activity.

Under our assessment, only 15 recommendations are considered complete or fully operational, 3 are substantially implemented, and 19 have implementation or planning underway. In the remaining 25, there is limited or no progress, or insufficient information to assess.

The Approach and Access to Information

The Representative for Children and Youth is committed to working cooperatively and collaboratively with all partners in the child and family serving system. In the context of this Progress Report, the collaborative activities that were planned involved working with the ministries of Children and Family Development (MCFD), Aboriginal Relations and Reconciliation (MARR), and Public Safety and Solicitor General (PSSG) to:

- seek input on the reporting format and the methodology,
- gather information and evidence to support assessments, and
- share assessments and a draft report in advance of publicly reporting out.

Although a collaborative process – including a joint reporting approach – was initiated, there was only modest success in engaging MCFD.

MCFD's draft *Good Practice Action Plan* identifies programs, services, policies and processes which are intended to undergo internal review by MCFD over the course of the next 8 to 10 months. Further, it indicates that full implementation of any changes resulting from internal review may take up to another two years. The draft *Good Practice Action Plan* is described by MCFD as "a guideline or a living document which will be adapted." The document appears to be a preliminary planning document, with no evidence of certainty or commitment that the activities identified for review and change will be carried out. As well, it does not provide sufficient detail in many areas to clearly understand what MCFD is intending to do.

To bolster information in the draft *Good Practice Action Plan,* we sought supporting documentation or additional sources of information. Unfortunately, few supporting documents were provided by MCFD. Reluctantly, we have relied on the draft *Good Practice Action Plan.*

Furthermore, there are three recommendations (#15, 19 and 60) which do not have an assessment due to a lack of information provided in the areas of: support to Aboriginal agencies, staff training, decentralization and information sharing/disclosure.

The Methodology

The methodology used in the 2007 Progress Report is in keeping with the "follow-up" approach used in the audit profession. It was developed after reviewing a number of follow-up models in different jurisdictions including BC, Ontario, Canada and the U.S. It is a high-level scan to simply indicate how much activity has occurred to implement each recommendation. It was not designed to be an in-depth review of how effectively each recommendation is being implemented. This latter type of review is significantly more time- and resource-intensive, and is being reserved for those high-priority areas where concerns remain over the lack of progress being made.

To assess the implementation status of each recommendation, primary sources of information were public documents and legislation, such as the *Representative for Children and Youth Act* and MCFD's *2006/07 Annual Service Plan Report*. We have also taken into consideration the May 2007 Final Report of the Transition Steering Committee, and other subsequent ministry documents provided. The information used to support our assessments was evaluated based on relevance, reliability, completeness and validity. As a general rule, verbal or written summary statements alone were not considered conclusive and needed to be supported with source evidence. At least two corroboratory sources of information were required to support an assessment.

Each recommendation has been assessed on a five-point scale. An additional category – "Insufficient information provided" – has been included to address instances when it was not possible to make an assessment due to a lack of information provided.

Rating Scale for Assessing Progress

Rating	Definition
Limited or no progress	No documentation is available to indicate that work is being done towards implementing the recommendation. Generating informal or general draft plans is regarded as limited progress.
Planning underway	Specific plans for implementing the recommendations are being developed, and appropriate resources and a reasonable timetable for implementing the plans have been addressed.
Implementation underway	Activities beyond the planning underway process are occurring, such as hiring staff or putting in place the structures necessary to fully implement the recommendation.
Substantial implementation	Significant results have been achieved in implementing the recommendation. Full implementation is imminent.
Complete or fully operational	All actions required to satisfactorily implement the letter, spirit or intent of the recommendation are completed. Structures and processes are operating as recommended and implemented fully in all intended areas of the organization.
Insufficient information provided	Verbal or written summary statements alone.

Assessment Overview

The recommendations have been assessed to determine how much progress has been made in the last 18 months. Of the 62 recommendations, 18 are complete or substantially implemented, and the remaining 44 are either in the early stages of implementation, have seen limited or no progress, or could not be assessed due to lack of information.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Insufficient information provided
62	15	3	11	8	22	3
	18		19		22	3

In general, the recommendations that are complete relate to oversight or higher level management functions, such as:

- *Legislative Committee:* establishing the Select Standing Committee on Children and Youth,
- *Independent Officer:* appointing the Representative for Children and Youth and establishing her Office, and
- *Coroners Service:* supporting the role of the Coroners Service in reviewing child deaths.

Many of the remaining recommendations not yet implemented relate to directly improving outcomes for children and youth, and are matters of pressing importance, such as:

- *Aboriginal Children and Youth:* safeguarding vulnerable Aboriginal children and youth by providing effective services and appropriate service delivery models to improve their outcomes.
- *Quality Assurance and Monitoring:* ensuring appropriate mechanisms are in place to oversee and evaluate the quality of services being delivered, such as external evaluation or case reviews.
- *Complaints Resolution:* putting in place a timely, accessible and simple way for complaints to be heard and effectively resolved so that children can get the help they need.
- *Critical Injuries and Deaths:* establishing effective processes and building capacity to better examine previous cases in order to prevent future child injuries and deaths.
- *Information Sharing:* the need for the different ministries/agencies involved in the lives and welfare of children to better share information and work together in a coordinated fashion to improve the overall health and well-being of children.

- *Performance Measurement and Linked Data:* using data and evidence-based approaches to evaluate services and look towards multi-dimensional outcomes for children in areas such as health, education and safety.

There are also two areas related to the role of the Representative that merit note:

- *Child in the Home of a Relative Program:* including this program as both a designated and reviewable service under the *Representative for Children and Youth Act* would fulfill the intent of the Hughes Review for oversight of programs for vulnerable children.
- *Transparency and Disclosure:* a minor legislative amendment is required to allow the Representative to inform the public of a review or investigation into a critical injury or death of a child, when it is determined to be in the public interest to do so, balancing privacy and public accountability.

Keeping Aboriginal Children Safe and Well

(Recommendations 12–15, 17)

Aboriginal children and youth are significantly over-represented in British Columbia's child welfare system.

	Children in Care	Kith and Kin	Child in the Home of a Relative (CIHR)
Total # of children	9,192[1]	125[1]	4,791[2]
# of Aboriginal children	4,677[1]	70[1]	1,916[2]
% Aboriginal	**51%**	**56%**	**40%**

- In some places in the province such as the North, up to 76 per cent of children in care are Aboriginal.
- Currently, more than one out of ten of B.C. Aboriginal children are in care, in the home of a relative or living under a kith and kin agreement.
- There is another large group of First Nations children not reflected in the above table, who are placed through the federally funded Guardianship Financial Assistance program, which mirrors the CIHR program on reserves.

[1] Oct. 2007 MCFD data
[2] Sept. 2007 MEIA data

The Hughes Review emphasized that the well-being of Aboriginal children and youth cannot be properly addressed in isolation from the political, social and economic environment that affects them, their families and their communities.

Recommendation 12	
That the provincial and federal governments, in collaboration with Aboriginal communities, begin work towards fulfillment of the commitments of the Kelowna Accord by assessing the health, economic and social needs of Aboriginal communities, including urban, off-reserve populations.	planning underway

Most of the activities associated with this recommendation are under development. The Ministry of Aboriginal Relations and Reconciliation indicates that progress will be made towards the goals outlined in the Kelowna Accord through the Transformative Change Accord Implementation Plan (draft dated June 10, 2007), prepared by the province in collaboration with the First Nations Leadership Council.

The Implementation Plan specifies actions that will be taken and performance measures that will show whether the socio-economic gap between Aboriginal and non-Aboriginal people is closing. While the Implementation Plan is still in draft form, specific components are moving ahead. For example in June 2007, the Tripartite First Nations Health Plan was signed by B.C.'s First Nations Leadership Council and the federal and provincial governments to support the 29 Accord actions intended to close the health-status gaps between First Nations and non-First Nations in the province.

Regarding educational gaps, Aboriginal Education Enhancement Agreements are in place in 35 B.C. school districts. In April this year, the Ministry of Advanced Education announced an Aboriginal Post-Secondary Education Strategy and Action Plan to work towards the Implementation Plan's post-secondary commitments.

Recommendation 13	
That the provincial government actively collaborate with Aboriginal people to develop a common vision for governance of the Aboriginal child welfare system; and whatever Aboriginal child welfare model evolves from that process must be the subject of active and widespread community consultation before its enactment.	implementation underway

Implementation of this recommendation is underway, although there is some question as to whether implementation is going smoothly or if a durable consensus has been reached. For example, the First Nations Child and Family Service Agencies Directors Forum, representing 13 of 24 Aboriginal delegated child and family service agencies, has written to express concern with the consultation processes, and does not support the proposed *Aboriginal Authorities Act* under development at MCFD. The ministry is moving ahead despite this, with a Crown agency model. Whether the model receives community support is unknown at this point.

Recommendation 13 speaks to the governance models that will emerge in B.C. for Aboriginal child welfare. The currently proposed model would have five Aboriginal authorities governing the delivery of child welfare services in the province. By March 2008, MCFD expects to have coordinated the development of a comprehensive plan for self-governance of delegated service agencies to support this model.

MCFD has also indicated that it will consult with Aboriginal communities and work to achieve agreement by December 2008 on the governance models to be implemented. For example, the Letters of Expectation that govern the Vancouver Island Aboriginal Transition Authority state that their work "will use an inclusive planning underway process with thorough and appropriate consultation" with individual First Nations and delegated agencies. The Fraser Region Interim Aboriginal Authority is mandated to consult with delegated agencies, First Nations, Métis and urban Aboriginal people in planning underway for Aboriginal governance of child welfare in that region.

As this work is carried out, it will be important to ensure that the governance model put into place is strongly linked to improving outcomes for Aboriginal children.

Recommendation 14	
That the provincial government work with Canada to clarify their respective funding responsibilities, remove jurisdictional obstacles facing Aboriginal child welfare agencies, and replace Directive 20-1[3] with a new approach that is more supportive of measures that protect the integrity of the family.	limited or no progress

[3] Directive 20-1 is the federal Department of Indian and Northern Affairs policy for administering funds for child welfare services to First Nations child and family service providers. The Directive has likely contributed to greater numbers of First Nations children being taken into care, rather than being served through alternative care options or early intervention and prevention models, because it provides more funding for in-care options.

MCFD indicates that it expects to develop a new model for federal funding, in collaboration with First Nations leadership, Indian and Northern Affairs Canada and service agencies. Verbal updates place implementation of this item in 2009. No specific discussion papers have been prepared so we could not analyze the extent of work to date. MCFD has also committed to analyzing, costing and considering provincial funding to provide additional services to on-reserve Aboriginal people until adequate federal funding is secured. However, no information has been provided to indicate that concrete action is underway.

A report being prepared by the Auditor General on the management of Aboriginal child protection services in B.C. is expected to provide further information in relation to the current situation.

Recommendation 15	
That the provincial and federal governments provide Aboriginal agencies with: modern information technology and help them acquire appropriate office management systems and skills; the same training opportunities as are offered to Ministry staff, as well as specialized training directed at their particular needs; and support during a crisis from an emergency response team.	insufficient information provided

Recommendation 15 has not been assessed due to lack of information. While the Caring for First Nations Children Society (CFNCS) is funded by MCFD to provide required training for social workers employed by Aboriginal delegated service agencies, it is difficult to tell from available information whether this recommendation has been adequately addressed. Training through CFNCS is said to address practice standards and competencies for delivering culturally appropriate child welfare services. MCFD has generally committed to supporting Aboriginal agencies in their recruitment and retention of staff and in developing capacity.

In addition, while the Final Report of the Transition Steering Committee indicates that funding for information systems is being pursued in concert with improvements to Directive 20-1 funding, there was no additional information provided. Nor has sufficient information been provided to indicate that the recommended emergency response team, or an effective alternative to support Aboriginal delegated agencies, is now in place.

Recommendation 17	
That the Ministry of Children and Family Development find ways to recruit and retain more Aboriginal people for service in the Ministry, at all levels, but particularly among social workers who deal directly with children and families.	implementation underway

This is a challenging recommendation to implement and while there has been some progress made, ongoing efforts are still needed. MCFD's 2006/2007 Annual Service Plan Report indicates that between January 2006 and January 2007, the number of Aboriginal staff in MCFD increased by 46 staff, from 119 to 165. However, to put this figure into context, that represents less than 5 per cent of MCFD's staff[4]. Among the Aboriginal staff hired in 2006 were three Directors and an Assistant Deputy Minister, which represents an important step for leadership and mentoring.

MCFD has undertaken recruitment outreach activities, and introduced the Aboriginal Child Protection Recruitment Project in February 2007. The Project is a partnership with Carrier Sekani Family Services and the University of Northern BC to recruit and train ten Aboriginal child protection workers to serve in their home northern communities. MCFD has also expressed an intention to continue to support Aboriginal agencies in their recruitment and retention of staff, and their capacity development.

Ministry Decentralization

(Recommendations 18–22)

The Hughes Review supported the idea of community-level service delivery and regional governance. However, this support for decentralization was qualified by a number of critical conditions including: partnership, commitment, resources, capacity and quality assurance.

While decentralization of the child welfare system is a complex, multi-year project, the current model has been underway since the government's core services review in 2001. Given the length of time it has taken and the limited progress made on decentralization, the Representative will continue to monitor decentralization, as well as governance generally, including how MCFD is structured.

[4] Total MCFD FTEs are 4,286 according to *"Budget Estimates, Fiscal Year Ending March 31, 2008".*

Recommendation 18	
That the Ministry and community representatives jointly develop a plan for decentralization, beginning with a set of principles that will guide the process, a clear statement of expected results, and a course of action to achieve those results.	limited or no progress

Recommendation 19	
That government commit itself to decentralization, which means supporting it with adequate resources, time, a dedicated team, and budget stability.	insufficient information provided

Recommendation 20	
That responsibilities be transferred to regions and to Aboriginal authorities once they have demonstrated their ability to meet key performance targets.	planning underway

As indicated under Recommendation 13, there is Aboriginal governance planning underway. Through delegation agreements with MCFD, 24 Aboriginal delegated agencies with various levels of delegated responsibility are responsible for administration of all or parts of the *Child, Family and Community Service Act* (CFCSA).

On the non-Aboriginal side, it was reported that a regional support secretariat had been created, and that the Regional Executive Directors are now part of the MCFD leadership committee. However, this is not sufficient information to permit an assessment of the commitment and resources dedicated to decentralization, which is the subject of Recommendation 19.

Recommendation 18 is assessed at "limited or no progress", as MCFD has created only preliminary plans for decentralization (called "regionalization") over the next 18 months.

Recommendation 20 indicates that a transfer of responsibility should occur only when capacity has been assessed as adequate, but to date, governance responsibilities have not yet been fully transferred. Therefore, a "planning underway" assessment has been given. Two Aboriginal planning committees have achieved the status of interim authority under the *Community Services Interim Authorities Act.* The Vancouver Island Aboriginal Transition Authority and the Fraser Region Interim Aboriginal Authority have signed Letters of Expectations setting out performance expectations that will be monitored.

Recommendation 21	
That the Ministry retain at its headquarters, the authority it needs to set and ensure compliance with provincial standards and to meet its responsibility for public accountability.	limited or no progress

MCFD indicates it maintains the authority to monitor compliance with provincial standards. The Transition Steering Committee reported that a restructured leadership team and the creation of the Provincial Office as the central agency coordinating policy, service delivery and evaluation reflects MCFD's commitment to implementing Recommendation 21. However, MCFD has also indicated that this function will not be in place until December 2008. As well, many additional items that are necessary to fulfill Recommendation 21 appear to be in the preliminary underway stage, for example, the review and revision of financial and administrative policies and procedures, and the development of a quality assurance framework for finance and administration.

Given the importance of this recommendation, and the key role of the Provincial Office, especially in relation to decentralization, the Representative will closely monitor whether MCFD has maintained an adequate policy-setting, quality assurance and monitoring role that protects the safety and well-being of children and youth.

Recommendation 22	
The Ministry should examine its management structure to find ways to realign roles and responsibilities in ways that will clarify lines of authority and facilitate collaboration across program areas and between regions and the central office.	limited or no progress

Recommendation 22 is assessed as "limited or no progress", given the information available from MCFD. MCFD indicates that it will review and possibly realign the roles of provincial and regional directors of child welfare, the delegation policy, and the relationship between the provincial office, regional directors and regional executive directors, as well as Aboriginal services and agencies by December 2008.

In addition, there are draft plans to restructure the Provincial Office to facilitate collaboration between program areas in the regions and head office with target dates of March and December 2008. The details here are scant and the preconditions of partnership, commitment, resources, capacity and quality assurance are not yet evident.

Quality Assurance and Accountability

(Recommendations 22–28)

The Hughes Review assigned great importance to the quality assurance and accountability role of the central agency in a decentralized system. The recommendations here speak to the importance of understanding outcomes for children, how government programs/services affect these outcomes, and the need to report on improvements being made to service delivery and for the lives of vulnerable children and youth.

The area of quality assurance and accountability is one that we will be focusing on as part of the Representative for Children and Youth's monitoring role. The lack of progress on these recommendations is of particular concern given their links to promoting better outcomes for children. They are crucial to public accountability.

Recommendation 23	
The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time.	limited or no progress

Recommendation 24	
The Ministry should continue its work with other B.C. ministries to establish common measures and linked data sets.	implementation underway

Recommendation 25	
Once collected and analyzed, data must be used as a tool to support operation and management decision making, and program evaluation and policy development.	limited or no progress

The performance measurement framework proposed through these three recommendations is a critical component of an effective and publicly accountable system. "Limited or no progress" for Recommendations 23 and 25 is indicated through MCFD's draft plans for the development of an integrated quality assurance system by December 2008.

In relation to Recommendation 24, MCFD is continuing to work with the Ministries of Education, Health, and Employment and Income Assistance and other agencies to establish

common measures and data sets. We have been provided related working documents that indicate inter-ministry efforts are underway, e.g. to report publicly on the educational outcomes of children in care. In arriving at an assessment of Recommendation 24, the two inter-ministry performance measures contained in MCFD's *2006/2007 Annual Service Plan Report* have also been considered.

Recommendation 26	
The Ministry must devote sufficient resources to develop and maintain a strong central quality assurance function at headquarters, in the regions, and in Aboriginal agencies. In consultation with the regions and Aboriginal agencies, headquarters must set provincial standards; provide training, support and expertise; and monitor results.	limited or no progress

Recommendation 27	
The Ministry needs to develop its capacity to do aggregate analysis of recommendations from case reviews and regional practice audits.	implementation underway

Given that an integrated quality assurance system has not yet been developed, Recommendation 26 is assessed at "limited or no progress".

Recommendation 27, however, is assessed as "implementation underway", in recognition that MCFD has begun conducting aggregated analysis and is publicly reporting annual child fatality case review summary reports, as well as both individual and provincial summary case practice audit reports. An Integrated Practice Analysis Tracking system was also launched in June 2006, with the capacity to do statistical aggregate analysis of both case reviews and practice audits, though it is not yet fully operational.

Recommendation 28	
The Ministry needs a regular, coordinated program of reporting on its activities and results achieved for children in care and children at risk.	limited or no progress

While the previous recommendations discuss activities that address aspects of this recommendation, many of those activities are in the "limited or no progress" category. There is significantly more work necessary to address Recommendation 28 to ensure that reporting is outcomes-focused, multi-dimensional and useful.

Ministry Complaints Processes

(Recommendations 29 and 30)

The Hughes Review identified complaints resolution as a critical component of quality assurance. When properly integrated into the quality assurance function, complaint resolution information can help MCFD in planning underway for service improvements. The Review also recognized that in the life of a child, the timely and effective resolution of complaints have practical implications, like obtaining consent in time to go on a school field trip, or earlier certainty about a foster home placement.

Given the direct link to the Representative's advocacy function and the lack of progress made on these recommendations, the Representative has invited the Ombudsman to undertake a thorough joint review of MCFD and delegated agencies' complaints processes, including those in place at Community Living BC. The Representative and the Ombudsman will report in 2008 on whether these processes are timely, accessible and simple, and will be engaging with MCFD, CLBC and delegated agencies early in the process.

Recommendation 29	
That the Ministry finalize, with a new sense of urgency, its complaint resolution process, ensuring that the process is timely, accessible, and simple; that it takes a problem-solving, rather than confrontational approach; and that it is respectful and responsive to the complainant; and that it involves the parties in resolving the issue.	limited or no progress

Recommendation 30	
That the Ministry develop processes for resolving complaints by Aboriginal children, youth and families that incorporate and respect traditional cultural values and approaches to conflict resolution.	limited or no progress

Recommendations 29 and 30 are assessed at "limited or no progress." In 2002, MCFD regionalized its internal complaints resolution process. Each region and delegated Aboriginal agency operates a complaints process independently. Each is expected to adhere to the principles of administrative fairness and to use a facilitative and problem-solving approach to complaints about service or the breach of statutory obligations.

However, the Representative's advocacy staff report that the effectiveness of the processes varies depending on staffing levels/classifications, its perceived legitimacy within regional operations, the quality assurance framework that is in use regionally, and the technical

support that is available to support the process. Discussions with ministry staff indicate that central oversight of the complaint process has recently been instituted through the Integrated Policy and Legislation branch of MCFD, and that the branch is in the early stages of establishing its support role and mandate with respect to complaints processes.

Modern Approaches to Child Protection

(Recommendations 42–46)

The Hughes Review identified that long-term outcomes for vulnerable children are far better when they are kept safe within their families than when they are taken into care of the state. It therefore supported the newer approaches to child protection that have been introduced, such as Kith and Kin agreements and youth agreements, but also cautioned that the successful implementation of new approaches requires adequate resourcing, good planning underway and evaluative research. Modern approaches are ones that focus on problem-solving with family members to assess family risks and strengths, provide supports to families, and when necessary, involve extended families in providing safe, alternative care. Five recommendations of the Hughes Review are relevant to these issues:

Recommendation 42	
That government provide sufficient funding, staffing and training to support its newer approaches to child protection work.	limited or no progress

Recommendation 45	
That government provide training for current social workers and recruit individuals with necessary mediation and counselling skills to support the services transformation initiative.	limited or no progress

MCFD's draft plans describe only preliminary activities to support newer approaches to child protection. For example, MCFD indicates that it intends to undertake a recruitment and retention strategy to support the newer practice principles, with planning underway to be complete by March 2008. It also intends to redesign qualifications, competencies and training to support the newer approaches by December 2008, according to the draft plan.

In addition, while it is evident that related staffing and training initiatives have taken place, it is unknown whether they are more effective than what existed prior to the Hughes Review. For example, in 2006/07 more than 700 MCFD employees received training in family development response, family group conferencing and mediation but no comparative details

were provided. MCFD has reported that it increased the number of available child protection mediators by 10 in 2006/07, for a total of 48, which is a positive development, though this contributes only in a small way to these recommendations.

Recommendation 43	
That an external evaluation of all programs under the service transformation initiative, beginning with kith and kin agreements, be undertaken both during the implementation phase and then later, on an ongoing basis.	limited or no progress

Recommendation 44	
That program evaluation become a routine part of the Ministry's management role, to be carried out in consultation with the regions and with Aboriginal authorities, once established.	limited or no progress

Our understanding is that external evaluations are not being considered, so Recommendation 43 is assessed at "limited or no progress".

For Recommendation 44, MCFD's draft plans identify several program areas that are slated for internal review, including the Kith and Kin program by March 2008. Evaluations of fetal alcohol syndrome prevention work, rural youth development programs, and the Child and Youth Mental Health Plan are also indicated, with draft completion dates that vary from March to December 2008. However, these activities appear to be in the preliminary stages of development leading to a "limited or no progress" rating. It is also not known what methodology will be used to conduct these reviews.

Recommendation 46	
That the Ministry reinvigorate its campaign to recruit foster and adoptive parents and ensure that it is funded so that it can respond to public interest and participation.	implementation underway

In 2006/07 MCFD made some improvements to support foster and adoptive parents. For example, $31 million in new funding for foster parents is to be provided over three years, and $1.3 million is earmarked for the fostering and adoption campaigns that began this fall.

The recommendation is also addressed through the draft *Good Practice Action Plan*, which commits MCFD to improving its recruitment and retention of foster and adoptive parents.

This is expected to involve ongoing skill development and a rate increase for foster parents, increased post-adoption support, and attention to the backlog in screening adoptive parents and placing children.

Communication, Information Sharing and Privacy

(Recommendations 47, 57, 59–62)

The Hughes Review emphasized that better communication, consultation and coordination among individuals and agencies providing services would improve the safety and well-being of vulnerable children and youth, and that it would also enhance public accountability.

Recommendation 47	
That the Ministry establish a forum or council, including the new Representative for Children and Youth, the Coroners Service, the Ombudsman and the Public Guardian and Trustee, that will meet regularly to review developments and issues of common concern.	complete or fully operational

A Children's Forum was established and held its first meeting in December 2006. The initial meeting was to define the terms of reference and confirm its membership. In attendance was the Director of Child Welfare (MCFD), the Chief Coroner, the Public Guardian and Public Trustee, the Ombudsman and a representative from the Ministry of Health. (The Representative was not in attendance as she had not commenced her duties. There was agreement that the Children's Forum should be chaired by the Representative and meet quarterly in the first year or two.)

There have been three subsequent meetings chaired by the Representative, and the next meeting is planned for December 2007. The Provincial Health Officer has agreed to become a member. The Forum's current activities include the development of best practices for infant sleeping, a joint project between the Representative and the Ombudsman on MCFD's complaint process and the creation of a working committee on critical injuries and deaths.

Recommendation 57	
That the Ministry of Children and Family Development, in collecting linked data from other public bodies for the purpose of decision making about individuals, ensure that the absolute minimum information is collected and that each linking is necessary to enable the Director to deliver mandated services, and that the highest privacy standards are met.	limited or no progress

MCFD indicates that its current Confidentiality and Disclosure of Information Guide meets the standards referenced in Recommendation 57. The latest version of this document dated November 2007, which was recently provided, does not appear to address the recommendation.

Recommendation 59	
That the Ministry of Children and Family Development should not rely on research agreements to collect and link personal information from other ministries and public bodies: it has the authority under Child, Family and Community Services Act *s.96 to collect information and to use it to make decisions about individual children.*	complete or fully operational

MCFD has indicated that it does not rely on research agreements to obtain information necessary for case related planning underway and decision making, but does use the Director's authority under section 96 of the *Child, Family and Community Services Act.* The November 2007 Confidentiality and Disclosure of Information Guide references the Director's section 96 power to obtain information for the purposes of case-level decision-making. This recommendation is considered "complete or fully operational", although further supporting information would be useful.

Recommendation 60	
That the Ministry of Children and Family Development review the statutes that govern it to ensure that there are no statutory barriers to disclosure of information among program areas.	insufficient information provided

MCFD indicates it conducted a review in Spring 2006 and found no statutory barriers to the disclosure of information among program areas, but that cultural barriers may exist. However, no source documents were provided to permit an assessment of the recommendation or as evidence of efforts to address the cultural barriers since 2006.

Recommendation 61	
That the Ministry of Children and Family Development review its privacy policy documents to ensure that they are current, accurate and easily useable by employees.	limited or no progress

MCFD indicates that the revised Confidentiality and Disclosure of Information Guide referenced above meets this recommendation. However, the document does not meet

the spirit and intent of the recommendation, which speaks to the need for privacy policy documents that present information in an easily comprehensible format for field staff.

Recommendation 62	
That the Freedom of Information and Protection of Privacy Act *be amended to incorporate the "unreasonable invasion of privacy" test into s33.2, which authorizes public disclosure of personal information under certain conditions.*	limited or no progress

Amendments to the *Freedom of Information and Protection of Privacy Act* introduced in the last legislative session are said to address Recommendation 62, in part. The amendment does not appear to substantially address the recommendation.

Ministry Review of Child Injuries and Deaths

(Recommendations 31–41, and 48–53)

In assessing this series of recommendations relating to the review of child critical injuries and deaths, the final report of the Transition Steering Committee, the September 2007 draft of the Proposed Case Review Model and accompanying appendix (which provides an overview of Critical Injury and Death investigation Processes for MCFD), and public information on MCFD's website were reviewed. Discussions with MCFD confirmed that planning for the review function within the quality assurance framework is delayed.

Recommendation 31	
That the Ministry adopt a common review tool to guide the conduct of case reviews across all program areas that are relevant to the life of a child who has died or been seriously injured.	planning underway

The draft Proposed Case Review Model outlines a model for a case review process for the major program areas included in MCFD's mandate: child welfare (child protection, family development, guardianship, and adoption), child welfare to aboriginal children served by Delegated Aboriginal Agencies, Youth Justice, Child and Youth Mental Health, and Children with Special Needs, Child Care, youth served by the Maples Adolescent Treatment Centre, and services for the deaf and hard of hearing children and youth.

An examination of the information provided reveals there is not yet a "common review tool" to guide the conduct of case reviews across all program areas. Each program area has separate clinical guidance and policy which varies from program area to program area, as to

what is required to be reported and, subsequently, what to review or investigate further. As an example, those serving children under the *Child, Family and Community Service Act* (Child Welfare - Aboriginal, Family Development, Children in Care, and Children with Special Needs) and Child and Youth Mental Health are directed by either legislation or policy to review critical injuries and deaths when the child has received services in the preceding twelve months. Youth Justice only reviews or investigates deaths where youth justice supervision has occurred within the previous twelve months. There appears to be no policy associated with critical injuries of young people under youth justice supervision.

At least two of MCFD's regions have attempted an integrated approach to case reviews of critical injuries and fatalities, but these efforts have highlighted problems with information sharing between the programs. These efforts preceded the Hughes Review and continue today. We note that the information barriers remain.

Recommendation 32	
That the Ministry adjust its timelines for its internal reviews, ensuring timeliness, but taking account of current capacity. Once established, the timelines should be made public.	implementation underway

Each program area identified above has timelines stated in its respective policies. There are small variations in the timelines from program area to program area. In the child welfare area, reporting out on timelines regarding Director's Case Reviews is available on MCFD's website as a part of the Child Fatality Case Review Summary Report. Information was not provided regarding whether or not reviews are completed according to the required time frames within the other program areas, and this information has not been posted publicly.

Many Deputy Director Reviews (child welfare area only) are completed within the prescribed timeframe, while many Directors' Reviews appear to take longer than the eight-month timeframe. This is attributed by MCFD to a lack of qualified staff to complete the reviews and, occasionally, to the need to postpone a review until a criminal process has concluded.

Recommendation 33	
That the Ministry undertake reviews of critical injuries and deaths of children receiving services from any of its program areas.	planning underway

All of the designated services mandated under either legislation or policy require that critical injuries and fatalities be reported, with the exception of Youth Justice, which requires that only fatalities be reported. Each of these areas requires reporting of the incident, an initial

review and a disposition as to whether a further case review is to be conducted. Reporting is done electronically as part of a case management system for each of the program areas.

According to the latest posted audit results for the child welfare area, compliance is just under 50 per cent of incidents identified from case files of children and youth receiving services. Compliance with reporting in the other program areas is less clear, or not clear at all, in the absence of audits of compliance.

There are some continuing challenges in reporting incidents, as many of these children receive services from service providers contracted by MCFD. Not all service providers are electronically linked to MCFD. As an example, some children in receipt of mental health and addiction treatment services are not receiving those services from a designated social worker.

In addition, the MCFD electronic case management systems are not linked. The lack of electronic interconnectivity from program to program contributes to inconsistent reporting of these incidents. In order to know whether a child is injured or has died a report must be made. In rare cases deaths have occurred while a child is in receipt of mental health services from a contractor and MCFD was not informed. The child welfare and aboriginal program area in the Provincial Office is the only area that receives daily reports of deaths from the Chief Coroner's Office and a monthly report from Vital Statistics. It is not clear if there are protocols in place between other program areas and the Coroner's Office and Vital Statistics. There appears to be no plan in place to address this issue.

Recommendation 34	
That the Ministry rename its internal injury and death reviews and clarify the scope of each.	planning underway

Recommendation 35	
That the death or critical injury of a child who is in care always be subjected to a review, regardless of the circumstances.	implementation underway

Recommendation 36	
That the Ministry develop clear criteria to guide the decision as to whether to review the death or critical injury of children who are receiving or have received Ministry services.	implementation underway

Recommendation 37	
That the Ministry review injuries and deaths not only of children who were receiving Ministry services at the time of the incident, but also of children who had received Ministry services during the 12 months preceding, and in exceptional circumstances, going back even further.	limited or no progress

The draft Proposed Case Review Model has identified two types of reviews to be used across MCFD's program areas. The methodology and scope of the review is defined for each type.

Currently, regulation or policy in all program areas requires the reporting of critical injuries and fatalities of children in care and or in receipt of services in the preceding twelve months (with the exception of Youth Justice which does not require the reporting of critical injuries). Each of these reports is the subject of an initial review and then a case disposition to conduct a further review. It appears that only legislation and policy for children served under the *Child, Family and Community Service Act* provides criteria to determine the need to conduct a further review. There do not appear to be clear criteria for the other program areas such as youth justice or child and youth mental health. There is no information regarding new policy for the review of children who died or were injured beyond the preceding twelve months.

Recommendation 38	
That the Regional Executive Director be responsible to decide whether a review should occur; record the reasons for that decision; establish the terms of reference for the review; decide who will do the review; and finally, sign off on the recommendations that result.	implementation underway

This is the current practice within MCFD. The Regional Executive Director is the most senior manager within the region responsible for operations and service delivery. New policy in the child welfare area reflects the role of senior decision makers within the regions and at provincial office in the review process. In special circumstances, which include children being served by more than one program area or who have received service from more than one region, the Provincial Child Welfare Director must be involved in the decision to conduct a review. However, there is as yet no cross-ministry policy that guides and defines these roles across all program areas.

Recommendation 39	
That the Provincial Director of child welfare retains the authority to conduct a review.	complete or fully operational

The process outlined in Recommendation 39 is standard ministry practice.

Recommendation 40	
That the Ministry provide required orientation, training, and mentoring for practice analysts who will conduct reviews; and maintain a list of qualified reviewers.	planning underway

A review of the September 2007 draft of the Proposed Case Review Model proposes that a training and mentoring plan will be in place. However, there is no evidence of a work plan for the training and mentoring of the staff who will conduct reviews (practice analysts and or consultants). MCFD has developed a screening process and set of common qualifications that all reviewers must possess prior to working on case reviews in the child welfare program area. It is less clear whether this is established in the other program areas.

Recommendation 41	
That the Ministry make use of multidisciplinary teams in its child injury and death review process.	limited or no progress

There appears to be no progress regarding this recommendation other than the discussion of the use of a multidisciplinary team in the Proposed Case Review Model. MCFD's proposed case review model does address this issue to a limited degree, in that MCFD plans to evaluate several options with respect to multidisciplinary reviews, and to make a decision as to their use before the end of the current fiscal year.

Recommendation 48	
That the Child, Family and Community Services Act, *which sets out powers and duties of the provincial Director be amended to include the power to produce reports of internal child death reviews and to state that although the main purposes of the report is learning, public accountability is a purpose of these reports.*	planning underway

Only one example of an individual child fatality review appears to be available publicly. The draft Proposed Case Review Model indicates that MCFD is reviewing options to facilitate the public release of fatality and critical injury reviews, and will make a decision shortly as to which method balances the needs to maintain the child's privacy with the need to be publicly accountable. As a result, Recommendation 48 is assessed at "planning underway".

Recommendation 49	
That the Child, Family and Community Services Act *be amended to allow the provincial Director to make information sharing agreements with other agencies for the purpose of multidisciplinary child death reviews.*	limited or no progress

MCFD has not yet established a multidisciplinary team to support the case review model. Limited information is provided with respect to this recommendation in the Proposed Case Review Model draft. It is unclear how this function will be supported in law.

Recommendation 50	
That the Child, Family and Community Services Act *be amended to require the provincial Director to give, on a confidential basis, a complete copy of the final child death review report to all agencies that participated in the multi-disciplinary child death review team.*	limited or no progress

It has not been possible to determine whether this is under active consideration as MCFD has not incorporated a multidisciplinary approach to case reviews.

Recommendation 51	
That in its annual reports, the Ministry of Children and Family Development provide a statistical report on its reviews of deaths and critical incidents, as well as the recommendations that resulted from those reviews, and a progress report on their implementation.	planning underway

MCFD has not placed in its annual reports a statistical report on its reviews of deaths and critical injuries, or the recommendations, or the status of the recommendations arising from them. In the draft Proposed Case Review Model the issue of public reporting is addressed in a limited manner. MCFD is studying various methods of reporting publicly on child critical injuries and deaths, and the recommendations made in reviews, while maintaining the privacy of the child and ministry staff. There are statistics regarding the numbers of critical injury and fatality reviews on the MCFD website.

Recommendation 52	
That twice a year the Ministry of Children and Family Development publicly release a summary of each child death review it has completed during the previous six months. The summaries would contain no names, dates or places.	implementation underway

MCFD has recently posted on its website a summary of observations from fatality case reviews in the child welfare area (2001–2006). There is one individual fatality case review posted from 2005. Individual case reviews are not routinely posted. The draft Proposed Case Review Model does not indicate a plan to address more fully this recommendation. MCFD is reviewing several methods of facilitating public release of critical injury and fatality reviews in order to decide which method balances the needs of maintaining the child's privacy and the need to be publicly accountable. The recommendation is therefore assessed as "planning underway".

Recommendation 53	
That if the death of a child who was in care or known to the Ministry has already been disclosed by police, a court or the Coroner, the Ministry be permitted by the Child, Family and Community Service Act *to disclose the child's name and relationship to the Ministry and the contents of the Ministry's case review, to the extent necessary for accountability but without unreasonable invasion of privacy.*	limited or no progress

There is no reference in the draft Proposed Case Review Model to the public release of the results of a case review where the child's name has already been disclosed by police, a court or the Coroner. There is as yet no proposed amendment to the *Child, Family and Community Service Act* to address this recommendation.

The Coroners Service Role

(Recommendations 9–11)

The Hughes Review identified the role of the Coroners Service with respect to child deaths as both necessary and complementary to the roles of MCFD and the Representative. In recent years, the Coroners Service has developed specialized expertise in investigating the deaths of children through its child death protocol.

Recommendation 9	
That the Coroner's child death investigation function, with funding as reflected in Budget 2006 be continued.	complete or fully operational

Recommendation 10	
That the Child Death Review Unit within the Coroners Service continue.	complete or fully operational

Recommendation 11	
The Coroners Act *should be updated, in line with the Coroner's role today; and expectations of the office should be clarified.*	complete or fully operational

Each of these recommendations is complete or fully operational. A new *Coroners Act* that updates and clarifies the role of the Coroner's office has been passed and brought into force. Through sections 47 and 48 of the new Act, the Child Death Review Unit (CDRU) in the Office of the Chief Coroner was established. The CDRU published its first specialized report on the subject of drowning. The child death review function also continues to operate and is funded at 2006 levels.

A New Plan for External Oversight

(Recommendations 1–8, 16, 54–56, 58)

Together, the following 13 recommendations establish a framework for legislative oversight of the system that serves vulnerable children and youth. These recommendations are assessed as complete or substantially implemented.

However, it is important to highlight two changes requested by the Representative, related to recommendations 3, 4, 5 and 54. The first is to include the Ministry of Employment and Income Assistance's (MEIA) Child in the Home of a Relative (CIHR) program as a designated and reviewable service under the Representative's mandate. That can be simply accomplished by an order-in-council regulation, and would permit the Representative to independently monitor and assess whether the program is effective or responsive to the needs of children and adolescents. The second request involves a minor legislative amendment which would allow the Representative to disclose personal information when it is determined to be necessary in the public interest and not an improper breach of privacy.

Recommendation 1	
That a Representative for Children and Youth be appointed as an Officer of the Legislature, for a five year term, renewable to a maximum of 10 years.	complete or fully operational

The Legislative Assembly of British Columbia appointed the first Representative for Children and Youth on November 27, 2006, following a formal selection process undertaken by the Special Committee to Appoint a Representative for Children and Youth. The *Representative for Children and Youth Act* was fully proclaimed in stages and the Representative officially took up duties on April 1, 2007 once the legislation was proclaimed. The Representative is an independent Officer of the Legislature, appointed for a term of five years.

Recommendation 3	
That the Representative for Children and Youth be mandated to support and advise children, youth and families who need help in dealing with the child welfare system, and to advocate for change to the system itself.	complete or fully operational

Recommendation 4	
That the Representative for Children and Youth be mandated to monitor, review, audit and investigate the performance and accountability of the child welfare system, but that this mandate be reviewed in five years and revised as appropriate at that time.	complete or fully operational

Recommendation 5	
That the Representative be mandated to review certain child deaths and critical injuries. Reviews are to be limited to those children who were in care at the time, or who had been receiving Ministry services during the preceding year. The deaths and injuries to be reviewed are those due to abuse or neglect; or to an accident occurring in unusual or suspicious circumstances; or to self inflicted injury or injury inflicted by another; and only if the child welfare system might have contributed in some way to the death or injury. Critical injuries are those that are life-threatening, or cause serious or long term impairment.	complete or fully operational

Recommendation 6	
That legislation permit the Lieutenant Governor in Council or the Standing Committee to refer a death to the Representative, leaving it to the discretion of the Representative to determine whether to undertake a review or not, and to report to Cabinet.	complete or fully operational

Section 6 of the *Representative for Children and Youth Act* gives the Representative responsibility for the three key functions described in Recommendations 3, 4 and 5.

Through the definition of "designated services", the advocacy and monitoring functions encompass the broader child welfare system, including services or programs provided under the *Adoption Act*, the *Child Care BC Act*, the *Child Care Subsidy Act*, the *Child, Family and Community Service Act*, the *Community Living Authority Act* and the *Youth Justice Act*; early

childhood development and child care services; mental health services for children; addiction services for children; and services for youth and young adults during their transition to adulthood. Part 4 of the Act also establishes that the Representative may undertake reviews and investigations of critical injuries and deaths as outlined in Recommendation 5.

The recommendation that the monitoring function of the Representative be reviewed in five years is outlined and potentially expanded through section 30, which requires the Select Standing Committee on Children and Youth to review the Act, either in its entirety or in part, in five years.

Recommendation 6 is given effect through section 12 (2), which permits the Select Standing Committee on Children and Youth to refer to the Representative for investigation the critical injury or death of a child, even if the surrounding circumstances do not meet the criteria required for the Representative to initiate an investigation. Sections 12 and 16 require that the Representative report back to the Standing Committee, a Legislative body, rather than to Cabinet, which in the view of the Representative provides greater independence.

Recommendation 7	
That the Representative have powers of a Commissioner of Inquiry under the Inquiry Act.	complete or fully operational

Recommendation 7 is implemented by section 14 of the *Representative for Children and Youth Act* which provides the Representative with the required powers.

Recommendation 16	
That at least one of the three senior positions at the new Representative for Children and Youth be held at all times by an Aboriginal person; and that the Representative actively recruit some Aboriginal staff at all levels of the organization.	substantial implementation

The Representative for Children and Youth is a First Nations person from the Muskeg Lake Cree Nation. The Deputy Representative for Advocacy, Aboriginal and Community Relations is a member of the Nisga'a Nation. At present, 30 per cent of the staff at the Office of the Representative for Children and Youth are of Aboriginal heritage, and recruitment of Aboriginal people at all levels of the organization continues to be a focus for the Office.

Recommendation 54	
That the Representative for Children and Youth Act *contain an authority to collect information that is at least equivalent to s.11 of the* Office of Children and Youth Act; *provisions to ensure that the records it requests are delivered promptly and without charge to the Representative; and to permit public disclosure of personal information if it is in the public interest, necessary to support the findings and recommendations, and not an unreasonable invasion of privacy.*	substantial implementation

Recommendation 55	
That the Representative for Children and Youth Act *clearly provide for the creation, use and disclosure of linked data sets for purposes specified in the Act.*	complete or fully operational

Recommendation 56	
That the Representative, in collecting linked data from Ministry of Children and Family Development and other public bodies for the purpose of fulfilling its monitoring role, develop policies and practices to ensure that all identifying information is removed from public reports and that the highest privacy standards are met.	implementation underway

Recommendation 58	
That the Representative for Children and Youth Act *contain a provision similar to s.9 of the* Ombudsman Act, *requiring that information collected by the Representative be kept in confidence, with a limited right of disclosure.*	substantial implementation

Recommendation 55 is considered "complete or fully operational" as the legislation is quite clear with respect to the Representative's ability to use data to inform her work.

Recommendations 54 and 58 are assessed as substantially implemented. While the *Representative for Children and Youth Act* does generally address each of those recommendations, some potential issues that may arise during the practical application of the Act have been identified. For example, the Representative has requested a minor amendment to allow

disclosure of personal information relating to a review or investigation when it is in the public interest to do so. At the current time, the Representative is unable to confirm or deny whether or not she is actively carrying out a key part of her mandate with respect to an individual case.

Recommendation 56 is assessed at "implementation underway". The Office of the Representative for Children and Youth is in the process of developing policies, procedures and mechanisms, including privacy policies for the internal handling of information, reporting publicly and ensuring that privacy of individuals is appropriately respected.

Recommendation 2	
That the Legislature strike a new Standing Committee on Children and Youth, and that the Representative and Deputy Representatives report to this committee at least annually.	complete or fully operational

Recommendation 8	
That the Representative be mandated to report to the Minister, the Legislature and the public through annual reports and special reports. This reporting will include reporting on compliance with recommendations, by the Ministry and other public bodies.	complete or fully operational

The Select Standing Committee on Children and Youth was established in April 2006. The Representative is required to report through sections 16 (investigations or reviews), 17 (service plans), 19 (annual reports) and 20 (special reports) of the *Representative for Children and Youth Act* and through the Committee's Terms of Reference.

Appendix: Document Listing

Legislation

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British Columbia. *Community Services Interim Authorities Act.* S.B.C. 2002, Ch. 58.

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