REPRESENTATIVE FOR
CHILDREN AND YOUTH

Amanda, Savannah, Rowen and Serena:
From Loss to Learning

April 2008

Amended December 2009

April 16, 2008

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

Dear Mr. Speaker,

I have the honour of submitting *Amanda, Savannah, Rowen and Serena: From Loss to Learning* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services. In this instance, the report deals with the April 26, 2007 referral made by the Select Standing Committee on Children and Youth.

Sincerely,

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Ron Cantelon, MLA
Chair, Select Standing Committee on Children and Youth

Mr. E. George MacMinn, QC
Clerk of the Legislative Assembly

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CHILDREN AND YOUTH

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Executive Summary

In April 2007, the Select Standing Committee on Children and Youth asked the Representative to investigate the deaths of four Northern B.C. children who died between 1999 and 2005. Amanda Simpson, Savannah Hall, Rowen Von Niederhausern, and Serena Wiebe were all between the ages of seven months and four years at the time of their deaths. Each had a family history of involvement with the child welfare system.

Their names are used in full in this report because all were the subject of coroner inquests in 2007. However, their names also form the title of this report to focus us all on the heart of this investigation – four young B.C. lives whose voices are no longer heard.

The death of a child affects everyone, whether as a personal loss or a collective sadness. As individuals or as a concerned community, we not only ponder *how* and *why* a child died, we also ask if there is anything that could have been done to prevent it.

That essential question drives this child death investigation. By looking closely at the lives and deaths of a number of children, the Representative's report moves from a detailed look at individual cases towards overall analysis of system of supports, whether significant improvements have been made in the years following their deaths, and eventually to what remains to be improved. It serves a crucial public accountability function.

The Representative's role is not one of fault-finding. In this report there are occurrences where it is clear that errors or misjudgements by individual service providers or their supervisors are a crucial part of the unfolding story. There is no easy way around this, nor should there be. However, where this arises, the greater good can be served by also assessing broader issues of supervision, quality assurance and operation of the child protection system.

The work of the men and women on the stressful front lines of the child protection system must always be honoured. When a child dies who has been involved with the system, people at all levels of the system experience a deep emotional impact and sense of loss. We owe them all a genuine commitment to acknowledge the challenges and complexities confronting families and professionals, while at the same time ensuring death reviews are allowed to be a respectful opportunity for learning. The surviving siblings, parents and extended families require our compassion and support. Ensuring that the death of their loved ones not be invisible may be one of our most effective expressions of that compassion.

> ...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, so that future injuries or deaths can be prevented...
>
> A secondary purpose...is one of public accountability...the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right.
>
> – Honourable Ted Hughes, QC, *BC Children and Youth Review*

The Representative's investigation has determined that the system failed these Northern B.C. children on numerous levels. This knowledge must drive us to seek out the enduring lessons for today's practitioners. The silencing of these children's voices must stir us to move from loss to learning.

This report is the first external, independent and completely comprehensive investigation relating both to the services these children and their families received, and the circumstances relating to their deaths.

Although these deaths occurred before the creation of her new independent office, the Representative determined – and the Select Standing Committee agreed – that these particular deaths raised questions around systemic issues that warranted further investigation.

Given the time span of the involvement in the child–serving system of the children and their families (in excess of a decade), the Representative's office conducted extensive evaluation of the practice and policies during the entire period. Specific efforts were made to identify shifts in policy and practice, where the system has improved and strengthened, and where ongoing challenges remain.

The Representative's process examines broad issues, for example (but not limited to) child protection practice issues during the child's life, and communications between parties involved in the child's life and after the death. These can include police, the medical community, the Aboriginal community, teachers, child care workers, coroners, and the government.

The first stage of this investigation involved a review of all records for each of the four children and their families. Materials and transcripts from the coroner's inquests were analyzed, and Ministry staff interviewed. Experts on the Representative's Multidisciplinary

Team then analyzed data and provided valuable advice for the Representative with respect to recommendations. The investigation also involved looking at the patterns, trends and risk factors which may have contributed to the deaths. Themes identified by the review of material, interviews and investigation, as well as those highlighted by the Multidisciplinary Team, were explored.

In addition, the Representative met with family members who wanted to discuss the death of their relative. Siblings, parents and other relatives of these children maintain a profound and personal interest in seeing improvements to B.C.'s child serving system. The Representative is deeply honoured by the trust some family members have placed in her, by their honesty and willingness to share their pain.

Issues identified in the lives and deaths of these four children that present challenges in current child and youth practice include:

- assessments of the children's safety falling below accepted standards
- significant guardianship practice deficiencies
- lack of thorough medical assessments for vulnerable children
- weaknesses in clinical supervision and case consultation
- lack of cultural planning for Aboriginal children in care, and cultural context in assessing safety
- insufficient communication between the Ministry and professionals in the community
- human resource challenges impacting the ability to provide safe and effective child welfare services
- uneven quality assurance practices not sufficiently focused on outcomes/results for children.

Examining these four deaths does not provide information to make sweeping conclusions on the child welfare system. It does identify systemic failings and cracks these children and their families fell through at the time, which leads us to examine progress to the current situation.

The detailed analysis that follows in this report focuses on identifying those enduring lessons that can be used to inform improvements to the child serving system and child protection.

1. Introduction

On April 26, 2007, the Select Standing Committee on Children and Youth referred the deaths of four children to the Representative for Children and Youth. The children are:

- Amanda Simpson (1994–1999)
- Savannah Hall (1997–2001)
- Rowen Von Niederhausern (2001–2002)
- Serena Wiebe (2004–2005).

The deaths of these four children occurred between 1999 and 2005. The Ministry was involved with the oldest of the children starting in 1997, and with her mother as early as 1991. For each of the children there was a history of parental involvement with the child welfare system. All four of the children were from the northern part of the province.

The Office of the Representative for Children and Youth was created by statute in November 2006. The Representative was appointed in December 2006 and the statute was amended and proclaimed in force on March 31, 2007. The Representative's statutory responsibility to review and investigate deaths or critical injuries of children receiving reviewable or designated services came into effect on June 1, 2007, with the proclamation of Section 4 of the *Representative for Children and Youth Act*. (Relevant sections of the Act are included in Appendix A.) These deaths were referred to the Representative by the Select Standing Committee on Children and Youth despite the fact that they occurred before the Act was proclaimed, because they were ongoing child death matters being evaluated by the Coroners Service.

The cause of death for each of these children had not been determined when the cases were referred to the Representative's Office, and internal reviews by the Ministry had not been released to the public or to the families. In the interest of public accountability, it was important to review the circumstances of the children's deaths.

Review of child deaths always presents significant opportunities — both to consider what was learned at the time and what may be learned now. Learning opportunities in reviewing these four childrens' deaths were even more significant because they died in an era when independent oversight for child deaths had been discontinued. Some of the cases had lingered in the system for many years without public bodies being engaged to determine how the children died or whether their deaths could have been prevented.

In the *BC Children and Youth Review,* the Honourable Ted Hughes recommended that the Representative for Children and Youth conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development. Mr. Hughes articulated his reasons for recommending this independent oversight and review of child injuries and deaths as follows:

> This review has brought me to the belief that 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, so that future injuries or deaths can be prevented. I recognize that not every injury or death is preventable, but it is important to take advantage of every opportunity to learn about possible improvements to policy and practice. The systematic review of deaths and injuries is one such opportunity.
>
> A secondary purpose for reviewing children's injuries and deaths is one of public accountability. The death of a child who is in the care of the Ministry or receiving Ministry services is a rare but tragic event and the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right (Hughes, 2006, p. 89).

In conducting a review or an investigation, the Representative is obliged to await the outcome of other processes, such as coroner's inquests, criminal proceedings or internal Ministry reviews. While these processes, with the exception of criminal proceedings, must be given one year to be completed before the Representative steps in, the role of the Representative's Office is a broad one. This allows the other processes to take place, but also enables the Representative to evaluate them and to consider whether the system of supports for children is adequate or whether improvements are to be recommended in addition to any that may have been identified by others. The Representative also has the benefit of tracking those improvements. The cases of the four children whose deaths are the subject of this investigative report were sent to inquest by the Chief Coroner in 2007. The last of the inquests was completed in November 2007.

In implementing the Honourable Ted Hughes's recommendations in 2006, the legislature directed the Representative to "conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives." The legislation also provides that, in some cases, a fuller investigation of a child's critical injury or death may be warranted. This could entail hearing witnesses and compelling their testimony. This report describes the results of such an investigation.

The Representative's role is neither fault-finding nor forensic. In the Representative's reports there may be cases when it is clear that errors or misjudgments made by individual social workers and their supervisors, or by other service providers, played a crucial part in the unfolding story. There is no easy way around this, nor should there be. The Representative recognizes that hindsight is of value but that it is not reasonable to look backward and question every decision and assess whether it met the perfect standards of practice. The basis for the investigation was to determine whether conduct and actions were reasonable and diligent in the circumstances.

In this process, the Representative acknowledges that the important work of social workers and others on the front-lines of the system requires making many delicate decisions under very difficult conditions. Assessing safety and well-being of children is not a mechanical process and judgment, professionalism, teamwork, and other factors will play a role in this work. The operative question is not whether the actions of individuals were ideal from our position looking backward, but whether they were reasonable in the circumstances at the time. The motivation for this investigation is to find the enduring lessons for the future and ensure that these can be brought to the front lines of the system. It is clear from the many discussions the Representative has had with front-line workers throughout the Province, that they are unwavering in their commitment to improve the system for children and are seeking opportunities to learn and improve the system of supports for vulnerable children.

The Representative's reviews of child deaths are rooted in a systemic approach. As recognized by international leaders in this area:

> A systemic approach to reviewing a child's death provides a change of focus from the conduct of an individual social worker to the more complex factors and interrelationships that invariably surround a child at risk. Child death reviews, regardless of their focus, can be used to improve services or they can be misused to search for a scapegoat....
>
> Rethinking our responses to child homicide has the potential to increase understandings of the dynamics that place children at risk, and to foster a culture of service improvement. It could be that using a systems framework of review that places practice in a wider context is more likely to contribute positively to the strengthening of services for children overall (Connolly, M., Doolan, M., 2007, p. 10).

The system approach requires a close analysis of broader issues of supervision, quality assurance and operation of the child protection system. The important work of those on the front lines of the child protection system must always be recognized. They have one of the most challenging roles in public service and they can function well only when they are supported, clear supervision is available, and coherent policies, practices and sufficient

resources underpin their efforts to keep children safe from maltreatment, abuse and neglect. The Representative has benefited enormously from discussions with front-line social workers in the preparation of this report and applauds their individual dedication and commitment.

In keeping with this sentiment, the Representative has not sought to attach blame for individual actions or inactions that may have been pivotal in the deaths of the four children. In three of these deaths, the system failed the children on numerous levels.

With the loss of these four children, the enduring lessons for today's practitioners must be found and tomorrow's system improvements made to ensure that those lessons have been learned.

In this report, and in those to follow, the emphasis will be placed on identifying those enduring lessons that should inform improvements to practice and help to secure better outcomes for the children and youth served by British Columbia's system of supports and services, especially for the most vulnerable children and youth, such as those who are abused or neglected or in state care.

The Representative is guided by the United Nations *Convention on the Rights of the Child* (1989) which guarantees every child personal safety and healthy conditions for their development (Article 3), the support of the state when their parents cannot meet their responsibilities (Article 18), or in those rare instances when children are intentionally maltreated and harmed or neglected, the certainty that the state will protect them with an effective and responsive child welfare system (Article 19). These important rights to personal safety and healthy development at the international level are not limited by exceptions based on geography, ethnic identity, or other circumstances.

Of the four children whose deaths are the focus of this report, three were Aboriginal. Their unique circumstances and the vulnerability of Aboriginal children, particularly in northern British Columbia, will be a necessary focus in improving the system. The system of supports for vulnerable children must extend fully to Aboriginal children, as it does to non-Aboriginal children. Important lessons may be drawn from this aspect of the lives of three of the four children.

The report

The report begins with a brief description of the investigative process and methods accepted by the Representative's Office for the preparation of reports on the circumstances of child deaths and injuries. Chapters 3 to 6 present narrative accounts of the four cases. An analysis of the issues identified in the investigation is provided in Chapter 7, and the findings and recommendations resulting from the investigation are detailed in Chapter 8. Technical terms used in the report are defined in the glossary.

Ministry names

The events covered in this report take place over the course of a 15-year period in which child protection and other services for children and families were delivered by three different ministries:

- Ministry of Social Services, 1992–1996
- Ministry for Children and Families, 1996–June 2001
- Ministry of Children and Family Development, June 2001–present.

In the interest of consistency and readability, the report refers to the "Ministry" throughout.

2. Methodology and Context

The review and investigation of child deaths and injuries must be thorough, analytical and fair. As complete an understanding as possible of the system and the events and circumstances in each instance must be developed, so that improvement, where appropriate, can be suggested. To that end, investigations must be informed by appropriate principles and statutes.

The work of the Office of the Representative for Children and Youth is guided in a general and over-arching manner by the United Nations *Convention on the Rights of the Child.* Article 3 of the Convention provides that the best interests of the child will be primary in public and social welfare services, that the child's well-being must be protected, and that "the institutions, services and facilities responsible for the care of protection of children shall conform with the standards established by competent authorities."

In evaluating the system of supports and services for vulnerable children, the *Child, Family and Community Service Act* also provides a touchstone. This statute and its regulations provide the basis for both mandated and voluntary services offered by the Ministry. It is also the platform upon which Ministry policies are based. Those policies, as well as any practice standards in effect to implement them appropriately, also provide an evaluation framework. Similar instruments are applied in reviewing service delivery on the part of other agencies and organizations involved with vulnerable children. In some instances it may be that the policy or practice guidelines are inadequate or in need of development. Child-serving systems, like all significant systems of support, exist to support vulnerable people when their families cannot or will not do so through incapacity or other circumstances. Continual evaluation and improvement in these systems is a hallmark of good governance for civil societies around the world.

Principles of administrative fairness are also of critical importance in providing objective and fair analysis. Administrative fairness requires that the subject of the review have the opportunity to be heard and to review and identify inaccuracies, in an atmosphere of respect and general fairness. To that end, Ministry staff members have been consulted throughout the process, including the Regional Executive Director and the Provincial Director, and drafts of this report have been shared with the Ministry and other organizations for the identification of inaccuracies. Careful attention has been paid to confirming source data and ensuring that all available data has been considered. Where information included was in the form of opinion or general statements, some corroborating evidence of circumstances supporting the opinion or statement was sought, both in consultation with the Ministry and independently.

The Representative's investigation

This investigation by the Representative's Office was completed in three stages.

The first stage involved a review of all records for each of the children and their families. This included all Ministry file materials, including the Deputy Director's reviews for two of the children and Director's case reviews for the other two children. In addition, other relevant records, including medical, legal and police records, were reviewed. (A complete list of documents reviewed is provided in Appendix B.) A review of current research on child abuse and maltreatment, assessment of child safety and medical assessment of neglect and abuse was also conducted. Relevant practice standards and policies that were in effect at the time the children and their families were served were also reviewed and considered.

Following the coroner's inquests into the four deaths, which were completed in November 2007, materials and transcripts from the coroner's inquests were reviewed and analyzed. Ministry staff were interviewed, and consultations were conducted with the North region management team and focus group interviews with front-line and supervisory staff. Ministry practice audits and critical injury and fatality case review documents were analyzed. A final confirmation of available documents and data was also carried out to ensure that all relevant materials were provided, and where not provided, that such information was not available or retrievable.

At the conclusion of the first stage of the investigation, the material was summarized and presented to the Representative's Multidisciplinary Team. The Multidisciplinary Team is a group of experts in the field of children's services. The team provides guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children. (Multidisciplinary Team terms of reference and membership are provided in Appendix C.) The team's discussions produced valuable advice for the Representative with respect to recommendations to improve the child welfare system.

During the second stage of the investigation, the themes identified through the review of material and interviews, as well as those highlighted by the Multidisciplinary Team, were further explored. Given the length of time during which the children and their families were involved in the child-serving system (in excess of a decade), it was important to conduct further evaluation of the practice and policies from the entire period. The themes identified include:

- assessment of child safety
- medical assessment of vulnerable children, including children in care
- coordination and sharing of information by the Ministry and other service providers and community partners
- clinical supervision of child protection workers

- quality assurance standards and practices
- changes in practice over time.

Following the advice of the Multidisciplinary Team, further analysis was undertaken to investigate trends and practice standards in the region over the period and to evaluate the Ministry's quality assurance and improvement model. Specific efforts were made to identify shifts in policy and practice, human resources and quality assurance, and to consider whether the system has been improved and strengthened since the children's deaths or whether ongoing challenges remain.

The third and final stage of the investigation process was the preparation of findings and recommendations. Before these were finalized, information about other deaths and injuries in the North region during the same period was also reviewed, to determine whether they showed similar patterns of evidence or if they provided objective indications of change in the system. This ensured that the findings were based on the best available evidence.

At the conclusion of the third stage, efforts were made to meet with family members who might wish to discuss the deaths of their children. The privacy interests of families must be respected and these meetings will therefore not be reported on, except to indicate that the siblings, parents and other relations of these children take a strong interest in seeing improvements made to the child-serving system in British Columbia. The Representative has assured them that British Columbians also share this view, and that the independent oversight role was created to play a part in that process.

How this investigation differs from others

Prior to the Representative's investigation, each of the four children's deaths had been through three separate and distinctly different processes: police investigation, Ministry review and coroner's inquest. Each of these processes looked at the circumstances of the specific child's death. However, because of their nature and purpose, they do not apply the systemic approach the Representative is able to use in looking at the strength of the child-serving system as a whole. For example, in none of the four inquests was the full Director's case review or Deputy Director's review put into evidence for the jury. However, it was open to counsel in their examination of witnesses to refer to those reviews to test the credibility or reliability of direct evidence of those witnesses.

Police investigations were conducted into all four of the deaths and no criminal prosecutions were undertaken in the end.

Ministry internal review processes were also conducted in all four of these cases: Director's case reviews were completed in two of them, and Deputy Director's reviews were completed in the other two. These internal reviews were limited to analysis of case

practice against expected standards. The two Deputy Director's reviews were simply file reviews involving no extraneous interviews or inquiries.

The coroner's inquests involved more broadly based evidence, including testimony from family members, Ministry staff, medical professionals and experts, and police officers. However, jury members are not in a position to review all Ministry file materials, medical information or police investigation files. The inquest process aims to establish a classification of death, and by nature, does not focus on an exhaustive analysis of all available information. The nature of these processes is that the evidence must be provided through the direct testimony of witnesses and not through documents such as internal Ministry reviews.

The Representative's investigation had the benefit of a review of all known file materials, interviews with key staff witnesses and other Ministry staff from the period and the present day, and review of the coroner's inquest transcripts and materials sought to be filed but not received into the record at the inquests. Practice audits of child protection and guardianship work in the region, along with the reviews of all fatalities and critical injuries from 1999 to the present, were also evaluated.

Following the complete file review and staff interview process, the investigation plan was expanded to include more detailed questions about how the risk assessment model was implemented in 1997 and about utilization of the risk assessment model by child protection workers. The quality assurance models in place at the time were considered. The tools used in practice by child protection workers were a matter of considerable interest.

In order to explore in more detail the issue of assessing child safety, the investigation team developed a series of questions for child protection workers and supervisors with respect to the way they utilize the risk assessment model, barriers to its use, communication between child protection workers and supervisors, and how collateral issues like inexperience and staffing shortages affect their work. The questions were asked of a small group of six front-line child protection workers in each of Smithers, Terrace and Prince George. A group of six team leaders was interviewed in Prince George, and a smaller group of team leaders was interviewed in each of Smithers and Terrace.

The investigation also consulted with individuals who were involved in the training and implementation of the risk assessment model, the North region management team, and current Ministry executive officers regarding social work and child protection practice.

The North region

All four of the children who are the subjects of this report lived in what is currently the Ministry's North region. In order to fully understand the context within which these children and their families were provided with services, it is necessary to consider that the characteristics that distinguish the North region from the other regions of the province.

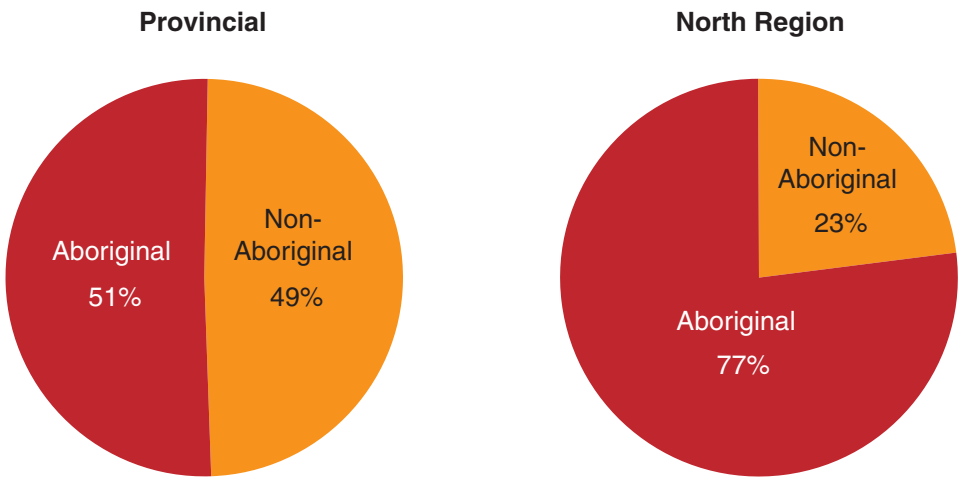
At just under 925,000 square kilometres, the North region encompasses 66.7% of British Columbia's land mass. With a population of 289,793 (2006 census), it accounts for 6.7% of the province's total population (4,320,255). In addition, the population of the North region is young: an estimated 8.2% of the province's 0–19 age group lives in the region.

The Ministry provides services from local offices in 18 communities: Prince George, Quesnel, Terrace, Fort St. John, Dawson Creek, Kitimat, Mackenzie, Prince Rupert, Fort Nelson, Chetwynd, Vanderhoof, Fort St. James, Burns Lake, Smithers, Dease Lake, McBride, Hazelton and Queen Charlotte City. There are six delegated agencies in the North region, representing 35 of the 51 First Nation bands in the region.

There are unique challenges in delivering services in a large number of small and often isolated towns, villages and First Nations communities across an area of this geographic size. These include staffing in isolated communities, doing child protection work in small communities, and the amount of time that can be taken up in travel. In the case of First Nations communities, there can also be jurisdictional issues between the federal and provincial governments.

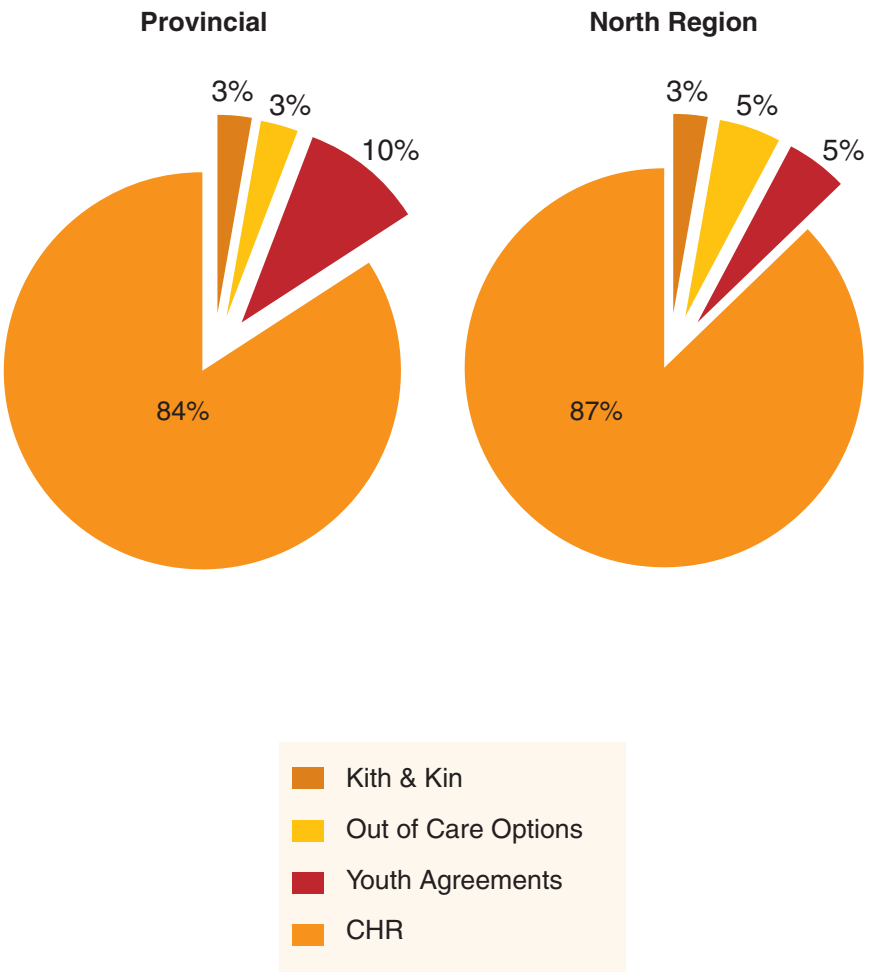
There are 51 First Nations bands in the North region, and 16.6% of the region's total population is Aboriginal, compared with 4.5% of the province's total population. Even more striking is the difference in the 0–19 age group population, of which 24.1% is Aboriginal, compared with 7.7% for the entire province (2006 census). At the end of February 2008, there were 1,023 children in care in the North region. The proportion of children in care in the North region who are Aboriginal is much higher than for the province as a whole (Figure 1).

Figure 1: Children and youth in care



In other ways, the North region more closely resembles the rest of the province. For example, a similar proportion of children and youth in the North are in living arrangements outside of their parental homes, not in the direct care of government but receiving provincial government services (Figure 2).

Figure 2: Children and youth out of parental home



Changes in the Child Welfare System

The period in which the events described in this report occurred was a time of constant change in the child welfare system in British Columbia. A major event in the history of child protection services in British Columbia was the release of the *Report of the Gove Inquiry into Child Protection* in November 1995. In 1996, in keeping with recommendations made in that report, children's services from across government departments were amalgamated in the new Ministry for Children and Families. The Children's Commission was established and given a mandate to provide oversight for services for children and youth, which included reviewing deaths and critical injuries.

In 1996, the Ministry began a process of regionalizing its services, starting with 20 regions and eventually collapsing them into five regions in 2002. There were many resulting changes in organizational structures and leaders. At the same time, there was considerable change in policies and practice standards. Notable developments included a new formal risk assessment process and more effort in the areas of practice audits and case reviews. In addition, Aboriginal agencies grew in number and assumed more responsibility for service delivery.

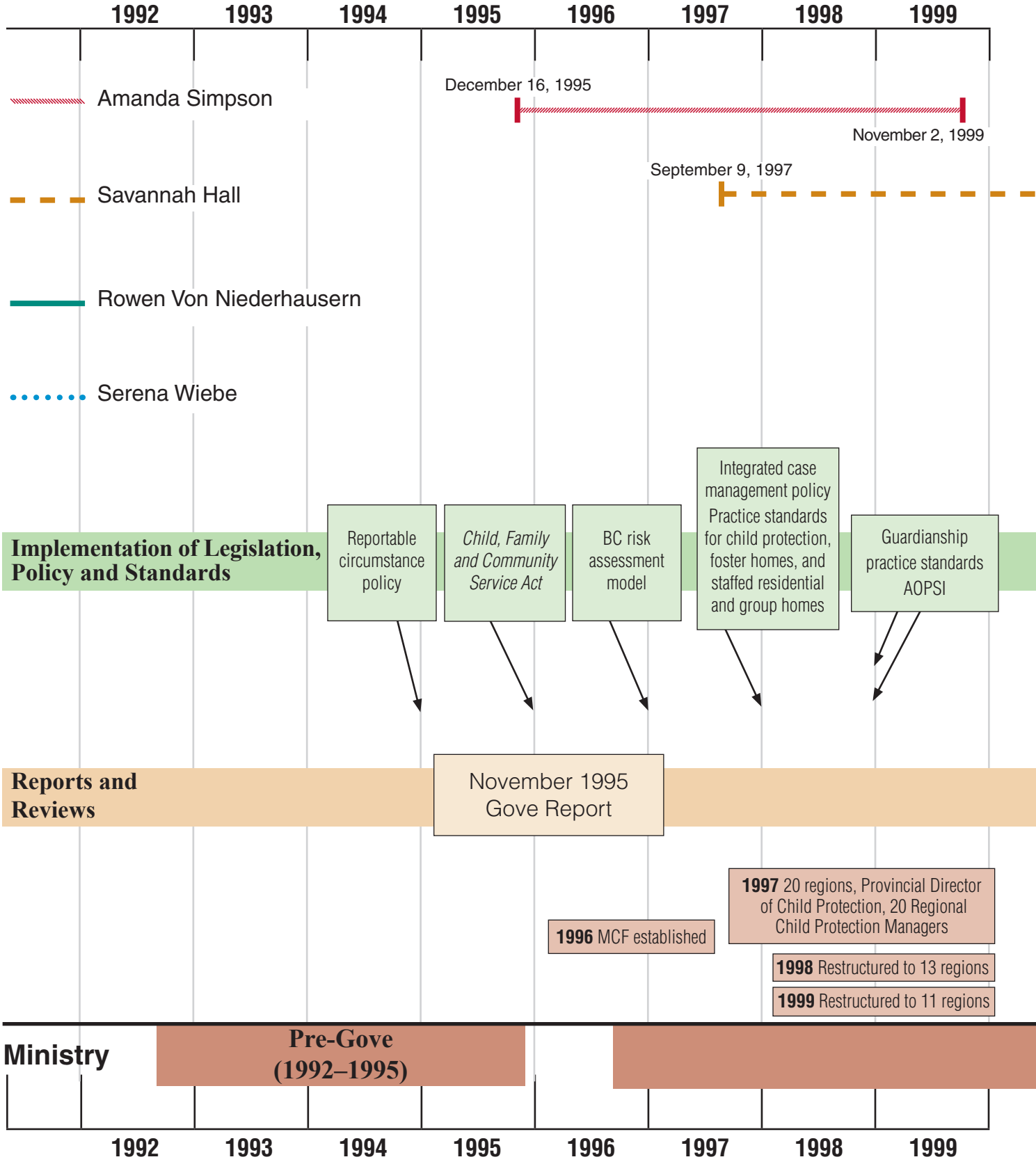
Further significant changes occurred in 2002, with a review of services and programs initiated by a new government, as well as targeted budget reductions and greater emphasis on alternatives to the removal of children from their families. During this period, oversight of the system was changed, and specific reviews of deaths and critical injuries of children involved with government services or the child welfare system were no longer conducted as a separate activity.

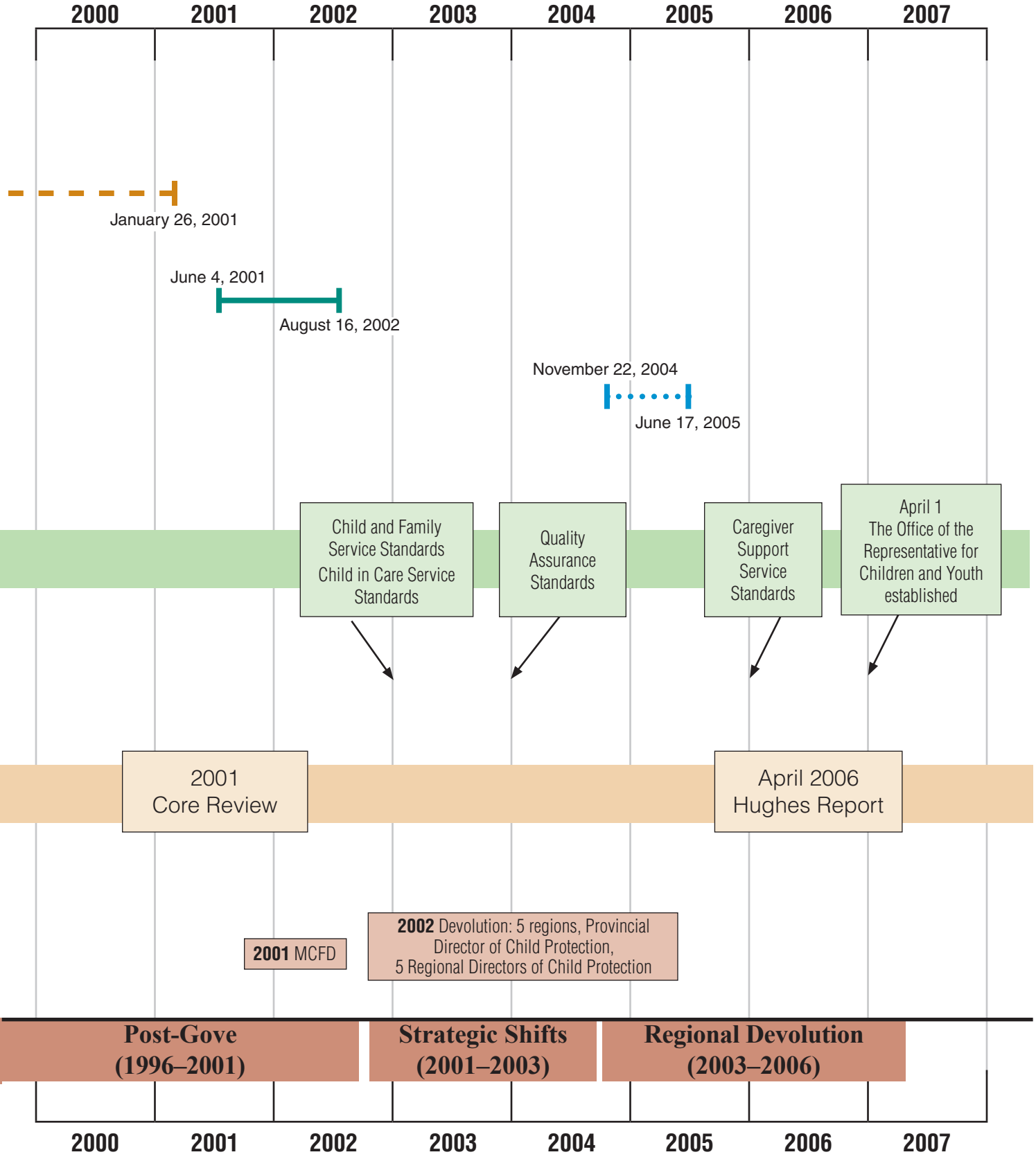
In the fall of 2005, when public concerns were raised following the death of Sherry Charlie, a young Aboriginal child, the Honourable Ted Hughes, QC was asked to conduct the *BC Child and Youth Review,* examining issues related to child protection, advocacy, and the monitoring and reviewing of services, including review of child deaths. Mr. Hughes spoke of his concern about the strategic shifts in the Ministry and whether they supported better outcomes for children or served a narrower set of administrative or political objectives. Mr. Hughes's trenchant observations regarding the need for stability and the strengthening of practice, with better evaluation of outcomes for children and stronger public accountability, are notable. Child safety has been a concern on the ground in the child protection system for many years and various strategies have been employed in the senior ranks of the Ministry to address better practice for children in British Columbia. In some instances, these have been laudable, but were dismantled before they became

functional, while in other instances, they were never committed to. In some cases, the work has started but is not evaluated regularly with public accountability. Mr. Hughes identified the keys to success: outcome measures for children, evaluations, and quality assurance and continual improvement through thoughtful, evidence-based change. There is much work to be done, and the Representative's Office wants to support the Ministry in succeeding in that work.

It is within the context of this changing system and its ongoing challenges in serving and supporting vulnerable children that the deaths of the four children are examined in this report. The timeline on pages 20-21 identifies the main strategic shifts and developments in the Ministry and social work practice during the lives of Amanda, Savannah, Rowen and Serena.

Timeline of Significant Events




2000
2001
2002
2003
2004
2005
2006
2007
January 26, 2001
June 4, 2001
August 16, 2002
November 22, 2004
June 17, 2005
Child and Family Service Standards
Child in Care Service Standards
Quality Assurance Standards
Caregiver Support Service Standards
April 1
The Office of the Representative for Children and Youth established
2001
Core Review
April 2006
Hughes Report
2001 MCFD
2002 Devolution: 5 regions, Provincial Director of Child Protection, 5 Regional Directors of Child Protection
Post-Gove (1996–2001)
Strategic Shifts (2001–2003)
Regional Devolution (2003–2006)
2000
2001
2002
2003
2004
2005
2006
2007

3. Amanda Simpson

Amanda Simpson was born on December 16, 1994. Amanda was Métis. The Ministry had received numerous complaints involving neglect and abuse, including complaints from the Simpson children themselves and from professionals involved with the family. Amanda died as a result of head and internal injuries on November 2, 1999. She was four years old. A coroner's inquest in June 2007 classified her death as a homicide. A criminal charge was laid and later stayed.

The Ministry had its first contact with Amanda's mother as a parent in January 1991. A family service file had been open to provide Amanda's mother's family of origin with services to address issues of neglect and alcohol abuse. The file was closed in January 1991. At the time, Amanda's mother was 17 years old and had just given birth to her first daughter. They lived in Prince George.

On February 12, 1991, the Ministry received a call reporting concern about an infant being neglected; specifically, it was suggested that she was being left unattended and was not being fed properly. The Ministry received another report on March 7, 1991, which alleged physical and emotional abuse of the infant. The child protection investigation that followed found that the infant was "at certain risk."

The Ministry assigned a teaching homemaker to the family to provide the young parents with assistance in caring for their infant and to instruct them on safe parenting. The couple accepted the services of the homemaker for six months, but declined counselling and other supportive services. A second child was born in 1993.

Homemaker services

The Ministry had regional contracts with various homemaking agencies to provide a variety of services. In some cases the primary role of a homemaker was to help with household tasks, while in others the emphasis was more on teaching homemaking and child care skills; most cases involved some combination of these roles. The teaching homemaker assigned to work with the Simpson family was tasked with assisting the parents in learning how to feed and care for an infant. The homemaker provided the Simpson family child protection worker with periodic verbal updates on the parents' progress in learning these skills.

Between February 1991 and June 1994, the Ministry received 15 calls related to the family. Of these 15 reports, 13 were assessed and designated as requiring an investigation. Identified concerns included allegations of neglect and abuse, including physical, sexual and emotional abuse. In addition, the Ministry and police received persistent reports of domestic violence. Two of the reports (September 1991 and June 1993) were incorrectly designated as Requests for Services. Of the 13 reports designated as requiring an investigation, three were investigated and for the most part were not completed to the standards of the day.

Amanda's parents separated in 1993. No child protection reports were made to the Ministry between June 1994 and September 1997. It is not known if circumstances changed for the family during these three years. Child protection staff suspected that the family had moved out of province, but the coroner's inquest in 2007 heard that the family remained in Prince George during this time.

Amanda was born on December 16, 1994, at Prince George Regional Hospital, the third of the couple's four children. Amanda's mother received no prenatal care. The hospital staff was unaware of the family's history with the Ministry or the history of domestic violence. The attending physician wrote that the mother was comfortable and confident in handling Amanda. Amanda was sent home with her mother and maternal grandparents. It appears that Amanda and her sisters lived with their maternal grandparents for a time. The fourth child was born in 1996.

The first new report about the family was received by the Ministry in September 1997, when Amanda was two years old. The oldest sister, then six years old, reported that she was frequently the only caregiver for her sisters, ages one, two and four years. She complained of a headache and was very tired. She also requested some help with caring for her sisters. The child was able to describe in detail a meal and bedtime routine she had created to keep her sisters quiet: she fed them "freezies and ice cream" and played with them. The child described a past incident in which one of her sisters had set off the fire alarm while playing with a lighter. She said that the girls were cold and wanted to start a fire to warm up. The fire department reportedly attended the home.

The child protection worker was concerned about the home environment and began an investigation. On September 11, 1997, this worker interviewed the child and passed the case on to a second child protection worker for completion. The intake was not registered on the new electronic case management system. When interviewed, the child confirmed that she was often in charge of her sisters and looked after them when her parents were out of the home, that they were often cold and hungry, and that "mom and dad were fighting, dad hurts mom" and they were scared.

The electronic management program was a new resource to support case management activities by social workers. When the office was later audited, in December 1998, there were many unfinished intakes requiring completion. The handwritten notes of the child protection worker indicated that some of the steps for an investigation had been completed; however, they were not entered in the new system.

The second child protection worker made a home visit and spoke with the mother. This interview was minimally documented and does not address the significant child protection issues disclosed by the child. Documentation on the file suggests that the second worker was unable to follow up and assess the information about the family because of workload issues. The child protection worker left the Ministry and the investigation was not completed. The file was still open when an additional report was made a year later.

On September 21, 1998, a caller reported to the Ministry that she had observed the mother smoking "a lot of pot" and yelling at her children. The caller reported that there were times when there was not enough food in the house, and alleged that the mother had assaulted a neighbour and that the RCMP were involved. This new report and the file was assigned to a third child protection worker.

Sometime in 1998, a new man became involved with the mother. He has subequently become her partner. Although it is not certain where he lived at this time, it was believed that he maintained a separate residence and was also resident in the Simpson home.

The investigation of the September 1998 report was reassigned to a fourth child protection worker on February 15, 1999. This child protection worker was part of the "float team" that was given a number of cases to complete. By this time she was responsible for following up on both intakes.

The fourth child protection worker began by finishing the September 1997 intake and sought consultation with the first child protection worker responsible at the time. The child protection worker then made a home visit, and learned that the parents had separated and that mother did not want services. No specific details were documented regarding the child protection issues.

Regarding the September 21, 1998 report, the child protection worker telephoned the Child Development Centre on February 15, 1999 and spoke to one of the supervisors who was involved with the three sisters. Three of the sisters attended the Child Development Centre. The supervisor reported that the girls were appropriately dressed and that the Centre had a good relationship with the mother.

Staffing issues in the Ministry's North region

During this period, the North region of the Ministry was experiencing significant human resource challenges. There was a high annual staff attrition rate. In the second half of 1998, 21 child protection, resource and guardianship workers had been hired. By October 1999, 10 of those staff had resigned. Only 161 of the 222 staff positions for child protection, resource and guardianship worker positions were filled. Approximately 30% of those workers had less than two years experience. In seven offices in the North region less than half the staff were permanent. Temporary workers filled some positions, while other positions were left vacant.

The Ministry Director's case review indicates that:

> ...between September 1998 and December 1998 the Prince George Child, Family and Community Service offices were audited. The audits identified a number of practice issues including the identification of some caseloads that had been minimally managed. As part of the regional response, all caseloads were reviewed and the outstanding work was prioritized for completion.

In December 1998, the four Prince George office teams were reorganized to comply with the provincial model of specialized child protection intake and investigation teams and separate family service teams. The Ministry headquarters sent a group of social workers to the North region to assist with child protection file investigation and closure. The group was called a "rapid response team," and was used in the North region and elsewhere in the province where staffing challenges prevented timely investigation of child protection reports.

The RCMP advised the child protection worker that Amanda's mother would be going to court on assault charges. It was the officer's opinion that this incident represented an ongoing dispute between Amanda's mother and the individual who had reported concerns about the children. The child protection worker assigned to the file called the family physician to ask about any injuries the mother might have sustained during the assault. There was little information on the medical file about the mother or the children.

The child protection worker also called the school and spoke to each of the teachers of the two eldest sisters. Neither teacher expressed concern about the girls' attendance or participation in school. One of the teachers had not met the mother. The other teacher told the social worker that the mother was "cooperative, positive and open." The child protection social worker also contacted the Child Development Centre, where three of the sisters participated in programs. The five-year-old attended kindergarten and daycare. The other two sisters attended daily and were reported to have been appropriately dressed.

Child Development Centres

Child development centres generally deliver a cluster of specialized services for children with special needs, including diagnostic, developmental and intervention services. Child development centres provide one or more of the following Ministry-funded services: Early Intervention Therapies, School-Aged Therapies, Autism Intervention, FASD Key Worker Services, Infant Development and Supported Child Development.

In rural areas, multiple services tend to be clustered in child development centres (as was the case in Prince George). While the total number of agencies providing these services is not easy to identify, there are 43 agencies in British Columbia delivering at least two of the following: Early Intervention Therapies, Infant Development and Supported Child Development. The British Columbia Association for Child Development and Intervention (BCACDI) represents approximately 25 agencies that provide services for children and youth with special needs.

Child development centres and other agencies delivering services for children with special needs and their families are primarily funded through contracts with the Ministry. Other sources of funding include foundations, individual and business donors, school districts and health authorities.

Following consultation with the supervisor on March 1, 1999, the child protection worker also went to the home and noted that "the home was impeccable, clean, tidy and well furnished." The mother reported that the children were in their rooms having a "quiet time" after school and two were napping. The children were not seen. The child protection worker also noted that there was food in the house and that the mother was co-operative. As a result, the child protection worker concluded that the family was not in need of services and that the children were not in need of protection.

The September 1997 and February 1998 intakes were also signed off on March 1, 1999. The supervisor noted his concern about the family's history of involvement with the Ministry in a notation on the file, but no plan was made to follow up and/or monitor the family.

On March 24, 1999, the Ministry received a report about abnormal bruising observed on the thighs and buttocks of one of the younger siblings. The caller noted significant behavioural changes in this child: she was soiling herself (when she had previously been toilet-trained), complaining of aches and pains, hoarding food and toys, and clinging to her mother.

The report was designated a child protection report and investigated. The children were interviewed on March 25, 1999. They reported being spanked and having their mouths washed out with soap by their "secret dad." Collateral interviews were also completed with both of the elder sisters' teachers. Amanda's teacher reported small behavioural changes. Amanda was interviewed and disclosed that she was spanked by her mother and stepfather and made reference to a spoon. The child protection worker noted that she was difficult to interview. When the worker spoke with the mother the next day, she denied that the children were spanked and stated that the man the girls were referring to – her new partner – did not live with them. He was not interviewed and no effort was made to determine whether he did live with the family.

On March 26, 1999, another report was made to the Ministry involving bruising on the two-year-old sister of Amanda. The child protection worker followed up with the medical clinic to find out whether the mother had sought medical attention for her daughter, and learned that the mother had been turned away. He also checked with the Prince George Regional Hospital and learned that the mother had sought medical attention for the two-year-old child, who had reportedly injured her finger in a car door as well. The child protection worker was concerned about hearing a report of another injury.

On April 6, 1999, the mother took the children to a clinic for medical examination. The child protection worker contacted the clinic and spoke with the physician who had seen the children. The physician who saw the children had not observed any bruising but agreed to follow up with a comprehensive medical evaluation of the children and indicated that she would alert the Ministry if she had concerns. It appears that this physician did not see the children again and eventually ceased working at the clinic. The police were not notified.

On April 7, 1999, the worker spoke with Amanda's mother again by phone. The mother said that her partner had left the home because he was upset about the allegations. The worker documented that he felt she was not being truthful, but might have been afraid she would lose her Income Assistance if it became known that she had a live-in partner. The intake file was closed. The children were found to be safe in their mother's care.

On May 11, 1999, the Ministry received a report involving concerns about Amanda's sibling. The reporter was concerned that Amanda's sibling was afraid to go home because her mother was going to beat her up after school as a punishment for stealing food. Amanda's sibling said that her mother had hit her with a hairbrush that morning before she left for school.

This report was accepted for investigation by the child protection worker, who then interviewed the sibling. The sibling told the child protection worker that her sisters were not hit by either their mother or stepfather.

The child protection worker contacted the mother by phone. The mother told the worker that everything was fine at home. She acknowledged the incident involving the theft of food and told the worker that her daughter was upset when she was caught. The mother denied hitting her daughter with a hairbrush and said she did not know how the child had misinterpreted the situation and was afraid to go home. The mother also stated that all of the children had been seen by a physician and were fine. The worker did not follow up with a home visit to interview the mother and the other sisters separately.

The worker did follow up with school staff, who reported that they understood that the girls lived downstairs and that it was the eldest sister's job to take care of her sisters and keep them quiet.

The investigation was concluded and the immediate safety assessment was completed, with a finding that the children were safe. There was no finding that the children were in need of protection. The intake was signed off by the Acting District Supervisor and later by a second supervisor (sign-offs by acting supervisors also required sign-off by a second supervisor).

On June 21, 1999, another report was received by the Ministry citing marks and bruises on one of the siblings. The reporter indicated that the child had been regressing in speech and toilet training. The reporter also expressed concern about previous child protection issues that had been reported and discussed with Ministry staff, but that persisted.

On June 22, 1999, the child protection worker interviewed a sibling who denied any spanking and spoke positively about the home. Another sibling was also interviewed and gave conflicting statements about being hit by the stepfather. Amanda was interviewed and indicated that their stepfather lived with them and walked her home from daycare. The child protection worker observed a bruise on Amanda's lower back.

A pediatrician examined a sibling on June 22, 1999. Ministry files indicate that background information was provided by the clinic coordinator and the child protection worker, but do not specify what this information consisted of. The medical examination found two tiny yellow-brown bruises on the child's lower back and upper stomach area. The other medical findings were reportedly within the normal range. Recommendations were made regarding the treatment of a cold and possible asthma. A medical-legal report was sent to the Ministry and received on July 2, 1999.

The pediatrician also examined Amanda and diagnosed her with "failure to thrive" because of her small size. She was reported to be below the fifth percentile for average growth in her age group. The medical records do not indicate whether this marked a change from her previous rating on the growth chart, but the pediatrician was concerned. There is no indication that the pediatrician consulted Amanda's previous medical records or contacted a physician who had examined her in the past. It appears that this might have been a difficult

task, because the family used walk-in clinics for medical care and did not have a consistent medical caregiver. Further testing was suggested but not completed. The pediatrician also indicated that the bruises on Amanda's back were not due to abuse and confirmed the "failure to thrive" diagnosis in a report received by the Ministry on July 23, 1999.

Amanda was examined by another pediatrician on June 23, 1999. Amanda said the bruises were the result of being pushed by her sibling onto a lawnmower. She denied being spanked. Amanda's mother had no explanation for the bruises.

The child protection worker met with the mother on June 28, 1999 to discuss the concerns. The mother's new partner was invited and did not attend. The mother indicated that her new partner did not live with them and that he almost never disciplined the children. The mother also denied physically disciplining the children and suggested that the children were confused by incidents from the past when she was in an abusive relationship with the children's father. The significant behavioural and physical changes in one of the siblings were not discussed.

On July 16, 1999, the child protection worker phoned the medical clinic and was advised that the older children had been seen and the physician was away. The pediatrician phoned the child protection worker on July 23, 1999, and indicated no concerns. The electronic intake report indicates that on this same date, a comprehensive risk assessment was completed by the child protection worker. The overall risk rating was "low." The intakes were signed off by the worker on July 23, 1999, with a finding that the children were not in need of protection, and signed off by the supervisor on July 27, 1999.

In October 1999, there were two additional reports of physical injury, one on October 8, and a second on October 29. Both reports involved injuries to one of Amanda's siblings including unexplained bruising. The first one was designated a child protection report. The child protection worker interviewed the child and found her to be "unfocused, inconsistent and somewhat dramatic." The child protection worker was unable to confirm that the child said anything about having a bruise. Other child protection workers had similarly assessed the child as not focused and inclined to exaggerate.

The eldest sister was also interviewed and stated that bruises on her sister's forehead were caused by her hitting her head on the headboard of the bed. She also indicated that her sister "told stories." The child protection worker followed up with staff at the Child Development Centre, who restated that the child was genuinely upset about the idea of going home that morning.

The child protection worker went to the children's home and spoke briefly with the mother. The worker confirmed with her that the two older girls had been interviewed and that there were no disclosures and no concerns. The mother did not recall the child complaining of a headache. She also stated that the children had had recent medicals and

that the subject child did tell stories. The mother indicated that Amanda had a follow-up appointment with a pediatrician after Christmas. The mother also indicated that she had called about some counselling, but no one had returned her call.

This intake was registered to be closed as there was "no evidence of physical harm or likelihood" and signed off by the worker on October 18, 1999. The supervisor had not yet signed it off. The worker noted on the intake record that "Reports coming from [this child]…need to be carefully assessed as to whether an investigation is necessary."

The Ministry Director's case review found that Amanda had been seen at the medical clinic on September 30, 1999. The pediatrician expressed concerns regarding possible sibling violence, as Amanda presented with bruises on her chest, back and knees. Amanda had indicated that she was pushed by her older sibling. The pediatrician reportedly spoke with the mother to express her concern about this. There was no previous information about a sibling being violent toward the other siblings. This information was not reported to the Ministry.

On October 29, 1999, Amanda's sibling reported being hurt by her mother's partner. The child reported that her finger was injured when she was hit. She was crying and upset, making statements including "please save me."

The reporter expressed concern this was the second time in three weeks that they had informed the Ministry of suspected abuse. The child protection worker informed the caller that she was not concerned. She suggested that the individual call the mother and discuss any concerns with her directly. The worker stated that she was not going to investigate, and suggested that the child needed counselling about "truth and fiction."

The individual who reported the child's injury was unsatisfied with this response and faxed a record of observations of the injuries to the Ministry office late in the afternoon of October 29, 1999. The file for these incidents was still open the next day, when Amanda was admitted to hospital.

On October 30, 1999, at 11:20 p.m., Amanda's mother and her partner brought Amanda to Prince George Regional Hospital by car. Amanda was in a coma, with massive head and abdominal injuries. She was very cold, had numerous bruises and was making little effort to breathe.

Amanda had been home with her mother's partner that evening, while her mother was working. Hospital admission records show that the explanation for Amanda's condition provided by the mother's partner at the hospital was the following:

- The family had supper around 6 p.m.
- Amanda was playing downstairs with her sisters and fell or was pushed off the top bunk bed, possibly striking her head during the fall. The time of the injury was not known.

- The partner heard a child crying and went downstairs to investigate.
- He found Amanda unconscious, with a nosebleed and a swollen head, and she was vomiting.
- He brought her upstairs, laid her in a bed and put a bag of frozen vegetables on her head to reduce the swelling.
- He called Amanda's mother at work and asked her to come home.
- When the mother arrived home, they drove Amanda to the hospital.
- The time between the injury and hospitalization was not known, but the mother's partner thought it was possible that Amanda was injured around 8 p.m. (more than three hours before Amanda was taken to the hospital).

The Ministry and the RCMP were notified, because the physicians who were treating Amanda found the explanation to be inconsistent with the severity of her injuries. The mother's partner was described by physicians as inebriated. He told police that he had consumed about five beers and a couple of shots of hard liquor before heading home at 6 p.m.

Examination at the hospital in Prince George revealed that Amanda had a severe skull fracture with associated bleeding in the brain. Some of the injuries were consistent with shaking. For example, there was bleeding in both retinas and the optic nerve sheath. Amanda also had a fractured collarbone and severe abdominal injuries consistent with blunt force trauma. There were numerous bruises on her body. One physician likened the injuries to those of a person who had been in a serious car accident while wearing no seatbelt. Because of the severity of her injuries, Amanda was later transferred to BC Children's Hospital Intensive Care Unit.

Amanda died on November 2, 1999 at BC Children's Hospital. The pathologist who did the autopsy concluded that Amanda's injuries were not accidental but consistent with inflicted trauma.

Reviews and investigations

Police investigation

In the days and weeks following Amanda's injury and death, the police interviewed a number of individuals, including the babysitter who cared for the Simpson children after Amanda was admitted to hospital, and relatives and co-workers of Amanda's mother and her partner.

Amanda's mother provided the police with limited information. When asked about her involvement with the Ministry, she described two interactions with the Ministry and stated that everything was fine. She said her children had been referred to a program for children who witness violence but that they did not go. The police did not have the Ministry file about the family and it does not appear that they requested this information.

Amanda's siblings, ages eight, six and three years, were interviewed by police several times. The information that the children provided was inconsistent. The police officers could not determine whether the story the children told about the events on the night Amanda was injured had happened on that date or at other times. The children were not able to differentiate between past instances of abuse and the events of the night that Amanda was critically injured.

Amanda's mother's partner reported that he didn't know how the initial injury had happened. He said that the older child dragged Amanda upstairs in an unconscious state, Amanda vomited and he carried her to the bathroom. He wanted to put her in a cold shower to keep her awake, because he had heard that that was what should be done for people with head injuries. He said he slid on the bathmat and dropped Amanda into the bathtub (or possibly onto the side of the tub) and fell on top of her. She didn't wake up. He showered her until his hands were cold, about three to five minutes. Amanda didn't wake up. He called Amanda's mother at work and asked her what to do.

He was charged with a criminal offence pertaining to Amanda's injury but not her death. The charges were stayed after Amanda died. No criminal charges were laid in connection with Amanda's death. The police investigation concluded in April 2004.

Ministry reviews

Six weeks after Amanda died, the Ministry completed a Director's case review, which involved staff interviews and a review of the complete file. The review resulted in 12 recommendations. The review is discussed in greater detail later in this report.

The Ministry completed a management review which resulted in two staff members being disciplined; one was reassigned and one was suspended.

Coroners Service investigations

The Coroners Service

The Coroners Service of British Columbia is responsible for the investigation of all unnatural, sudden and unexpected, unexplained or unattended deaths.

The coroner is responsible for ascertaining the facts surrounding a death and must determine:

- the identity of the deceased, and
- how, when, where and by what means the deceased died.

The death is then classified as:

- natural – a death resulting primarily from a disease of the body and not resulting secondarily from injuries or abnormal environmental factors
- accidental – death due to unintentional or unexpected injury; includes death resulting from complications reasonably attributed to the accident
- suicide – death resulting from a self-inflicted injury, with the intent to cause death
- homicide – death related to the deliberate actions of another person; does not imply blame or guilt
- undetermined – a death that, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

These classifications are consistent with the World Health Organization's system of death clarification.

When Amanda Simpson died in 1999, the Coroners Service's practice was to wait until all criminal processes had been completed before proceeding with its investigation. Amanda's death was also reported to the Children's Commission. An investigation was not completed by the time the Commission was disbanded in 2002.

The coroner provided the police with information about the cause of death and shared autopsy and toxicology reports. During the police investigation, there was significant consultation between the police and the coroner about the nature of Amanda's injuries.

The Coroners Service Special Investigations Unit reviewed Amanda's case in November 2001 and concluded in March 2002 that Amanda's injuries were consistent with "non-accidental inflicted traumatic injury," meaning that they were intentionally inflicted by another person. In January 2003, Amanda's file was transferred to another coroner while the police continued their investigation.

In April 2004, the coroner met with police and was advised that Crown counsel had not approved criminal charges in the case. The police requested that the coroner convene an inquest. According to information provided by the Chief Coroner, the coroner assigned to the case did not complete interviews with witnesses between 2004 and March 2006 because that coroner was uncomfortable doing those interviews.

Special Investigations Unit

In 1999, the Coroners Service had a Special Investigations Unit staffed by a full-time coroner (a Registered Nurse) and team of medical investigators (also Registered Nurses). The staff in this unit reviewed deaths involving more complex medical issues, advising the coroner as to the content of the public report and making suggestions for recommendations to resolve systemic medical issues. The unit was reorganized in 2004 to include a full-time coroner with specialized pediatric knowledge and field experience, and the services of a Chief Medical Consultant.

The Child Death Review Unit

The Child Death Review Unit of the Coroners Service reviews the deaths of all children age 18 and under in British Columbia once the coroner has closed the file, in order to:

- better understand how and why children die
- use those findings to prevent other deaths and improve the health, safety and well-being of all children in British Columbia, and
- gather data that can show trends in child deaths.

The Coroners Service also attributed the delays in Amanda's case to challenges in its case management system. Cases were not effectively tracked for compliance with case completion time frames. The Coroner's management team decided to delay the inquest until the Hughes review was complete. During the delay, the file was reviewed by the Coroners Service Child Death Review Unit. The file was transferred between two additional coroners before the inquest was completed in June 2007. The necessary interviews of witnesses in the case were completed before the inquest took place.

Coroner's inquests

When the coroner is finished investigating a death, the work is completed with either a written public report or an inquest. A written report includes the cause, classification and circumstances of the death and may include recommendations. The Chief Coroner has discretion to convene an inquest, or the Attorney General may direct the Chief Coroner to convene an inquest into an individual's death. Some inquests are required by legislation (the *Coroners Act),* as in cases where an individual dies in the custody of the police. Inquests may also be convened if the investigation of the death determines that it would be beneficial in:

- addressing community concern about a death
- assisting in finding information about the deceased or circumstances around a death, and/or
- drawing attention to a cause of death if such awareness can prevent future deaths.

Inquests are formal court proceedings, with a five-person jury, held to publicly review the circumstances of a death. The jury hears evidence from witnesses under subpoena in order to determine the facts of the death. The presiding coroner is responsible for ensuring that the jury maintains the goal of fact finding, not fault finding. The Verdict at Inquest includes the jury's classification of death and wherever possible its recommendations on how to prevent a similar death.

Although the inquest process is non–fault-finding, the public hearing of evidence provides some public accountability for agencies like the Ministry and the police.

Coroner's inquest

A coroner's inquest was held June 11–15, 2007. The jury classified Amanda's death as a homicide, which does not imply individual blame or guilt, as would a criminal or civil proceeding, but rather attributes her death to intentionally inflicted injuries. The jury made four recommendations, which are included in Appendix E.

4. Savannah Hall

Savannah Hall was born on September 9, 1997. A First Nations child, Savannah was in the Ministry's care from the age of eight months. For most of her life, she lived in the same foster home. Savannah died on January 26, 2001, as a result of extensive brain damage caused by lack of oxygen to her brain. She was three years old. A coroner's inquest in November 2007 classified her death as a homicide. No criminal proceedings were undertaken following her death.

Savannah's mother is a member of the Lake Babine Nation, in the Burns Lake area. The mother had a difficult childhood that involved abuse, neglect and removal from her parental home by the Ministry. She struggled with issues related to substance abuse, transience and domestic violence.

Savannah was born in Prince George on September 9, 1997, when her mother was 18 years old. As a condition of retaining custody of Savannah, her mother and Savannah stayed with a relative after Savannah's birth. The Ministry removed Savannah from her mother's care on October 16, 1997, when the mother advised the Ministry that she had moved from her relative's home and assumed responsibility for Savannah, contrary to the safety plan implemented at the time of Savannah's birth.

On November 5, 1997, the court returned Savannah to her mother's care under an interim supervision order. On February 6, 1998, Savannah's mother requested that Savannah be placed temporarily in care so that she could "straighten her life out." Savannah's mother admitted herself to detox, and Savannah was taken into care.

A **supervision order** is made by the court to ensure a child's safety when the child is returned home and to address ongoing maltreatment concerns (Section 41(1)(a) of the *Child, Family and Community Service Act,* 1996). A supervision order can have a number of conditions, such as regular scheduled and unscheduled visits with the family, mandatory parental attendance in a drug treatment program, family counselling, and anger management training.

On March 10, 1998, the court ordered Savannah returned to her mother's care under a six-month supervision order which had a number of terms including completion of a parenting program and counselling for alcohol and drug abuse and demonstrating stability in her personal life. The Ministry removed Savannah again on April 14, 1998, claiming that the mother was non-compliant with the terms of the supervision order. On May 7, 1998, the court found that the mother had not violated the terms of the supervision order and ordered Savannah returned to her mother's care.

A child protection investigation found Savannah in need of protection due to neglect; consequently, she was removed from her mother's care again on May 27, 1998. Savannah was placed with a foster family in the Prince George area.

On September 28, 1998, Savannah was moved to a second foster home, where three other children in care resided. Documentation in the file indicates that the move to the second foster home was originally intended to be a short-term placement for "respite" purposes. However, once Savannah was placed in the second foster home, no other placement plans were pursued.

The foster parents in Savannah's second foster home became foster parents in May 1989. Annual reviews of the foster home completed up to and including 1996 were consistently positive. The notes in the foster home file from 1997 to 1999 indicate that Ministry staff solicited and relied heavily on the foster mother's advice and opinions regarding medical care and appropriate placement of the children who had been in her home. As the Regional Child Protection Manager testified at Savannah's inquest, the foster parents were "trusted foster parents for a long time" with the Ministry.

In June 1997, prior to Savannah's placement, the Ministry received a report that children who had previously been in the foster home received cold showers and had their mouths washed out with soap as punishment. The foster mother denied the allegations. The resource worker who investigated the allegations by interviewing the children and the foster mother determined that they were unsubstantiated.

On January 14, 1998, the Ministry received a report from a residential assessment centre for children. The report was that a child alleged that the foster mother had disciplined her with cold showers and soap in her mouth. The guardianship worker interviewed the child and her brother, who also reported being put in cold showers and sent to his room for long periods of time when he was bad. The resource worker discussed concerns arising from the interviews with the foster mother, who again denied the allegations; the worker recommended continued use of the foster home.

The foster parents had been assessed and had received approval in 1992 for caring for children with more specialized needs, but not for children with severe mental or physical disabilities. The Ministry's review of Savannah's death later found that there was little evidence in the 1992 assessment to support the foster parents' ability to provide care for a high-needs child.

The files indicate that the foster parents wanted to care for children who were "reasonable" and "manageable." Soon after they were approved to care for children with special needs, the foster parents cared for a special needs child who screamed frequently. The placement was short-lived, as the family could not tolerate the child's behaviour. The file indicates that they stated they would not welcome the placement of a child with similar behaviour. They preferred to have children who were "workable."

In October 1998, shortly after Savannah's placement in the second foster home, a speech pathologist found that Savannah had delays in speech and personal/social development. Savannah was 13 months old. She was placed on an estimated two-year wait-list for speech therapy at the Health Unit.

Infant Development Program

The Infant Development Program serves children from birth to three years old who are at risk for or already have a developmental delay. Programs are available in communities throughout British Columbia, and are supported by the Ministry of Children and Family Development. Each program brings parents and professionals together to help children overcome developmental difficulties. Each local program works in partnership with a range of other professionals in the community. Services may include home visits, developmental assessments, playgroups, parent workshops and support groups, therapy consultation, and service coordination.

On December 10, 1998, the infant development worker (from the Infant Development Program) made her first visit to Savannah's second foster home. The infant development worker assessed Savannah and determined that she was experiencing global developmental delays ranging from two to eight months in different areas.

The infant development worker documented concerns about Savannah's foster home placement and communicated her concerns to Savannah's guardianship worker and Ministry team leader (supervisor). She recommended that Savannah receive more one-to-one care and attention and be assessed by a pediatrician. She was concerned that Savannah's development had regressed since her placement in the home two months before, and felt that Savannah was showing signs of neglect and possible abuse. The foster home, she believed, was too busy to meet Savannah's developmental needs.

The Ministry team leader reviewed the infant development worker's concerns with the Regional Child Protection Manager, who recommended that Savannah see a pediatrician as soon as possible. There is no indication in the file that this recommendation was acted upon. After the foster mother received the infant development worker's report and recommendations, she contacted her resource worker to report that she had reservations about working with the infant development worker. The foster mother believed that the assessment was flawed and rushed.

The issue was taken to the Regional Child Protection Manager, who expressed "every confidence" in the foster home. In an email to staff, he reminded them that "it is for the child's care we come together" and that staff should keep their personal feelings out of the situation. He did not support a change in Savannah's placement.

Soon after this discussion, another guardianship worker visited the home with a second infant development worker. The guardianship worker and the second infant development worker found that Savannah made good eye contact with the foster mother. They agreed with the foster mother and concluded that the original assessment was flawed. The infant development worker was changed, and the medical assessment suggested by the first infant development worker was not completed.

In January 1999, the new infant development worker attributed Savannah's delays in growth and development (four to five months behind her chronological age) to "change" and recommended that any future changes, such as an alternative placement, be undertaken gradually.

Social workers

All social workers who work in the child protection, family service and guardianship areas have different types of responsibility and authority under the *Child, Family and Community Service Act* and/or the *Adoption Act:*

- **Child protection social workers** collect information, respond to child protection reports, conduct child protection investigations, remove children, attend court and work with families to plan for the return of children or for continuing custody.
- **Guardianship social workers** manage the Director of Child Protection's role as guardian of children in **care.**
- **Resource social workers** are responsible for the recruitment and retention of foster homes, group homes and other residential and non-residential services.
- **Adoption social workers** manage adoption planning and placement of children for adoption with prospective adoptive parents.

On March 3, 1999, the guardianship worker for another child in the foster home contacted the resource worker to report concerns about child management methods used by the foster mother. The foster mother had reportedly brought the child to school in his pyjamas when he would not follow her directive to get dressed. The child was reportedly not allowed to sleep in his bedroom for a month and was having to sleep on a cot in the hot tub room because he had got up in the night to eat candy. The resource worker discussed these concerns with the foster mother and sent the foster home a letter in April 1999, reviewing the standards for foster children's bedrooms.

Also in April, Savannah was referred by the Infant Development Program for occupational therapy.

In May 1999, the number of children in the foster home rose to six, with four children in care, one infant placement pending adoption, and one natural child. On May 21, 1999, another infant was placed in the home for two weeks. The resource worker requested, and received, an exception to policy, as the foster parents were now caring for three children under the age of two. An exception to policy is required when there are more than two children under the age of two years in a foster home.

At this time, Savannah was 20 months old and began attending a day program at the Child Development Centre in Prince George. On admission to the Child Development Centre in May 1999, she was examined by a pediatrician, occupational therapist, psychologist and other members of the Centre's multidisciplinary staff. She was found to have delays in speech,

fine motor skills and social skills. She was assessed as needing speech and occupational therapy as well as physiotherapy to address her global developmental delays. Her name remained on the wait-list for speech therapy at the Health Unit.

On July 27, 1999, the foster mother asked the Ministry for a reassessment of her fostering contract. She stated that she felt Savannah was a special needs child and she therefore should be paid at a Level 2 rate. The foster mother reported that she was spending all her time looking after Savannah. She described Savannah as throwing toys and biting; she was "hard to take anywhere, a fussy eater, she had broken a crib and a playpen, ripped a mattress apart, and only seemed happy when fed." The furniture was reportedly destroyed during the night, when Savannah had "night terrors." Savannah's escalating behaviours, as described by the foster mother, were not examined by Ministry staff or a physician until more than one year later.

The Acting Community Services Manager denied the foster mother's request to be paid at a Level 2 rate for Savannah's care because, at this time, the foster home already had Level 2 contracts for three children in care and had recently adopted a newborn. The Acting Manager wrote, "I believe the reason behind only allowing so many children in a leveled home is because of the level of difficulty and the interactions become more complex as the number of children increase." An exception to Ministry policy would have been required to approve a fourth Level 2 contract. In response to the foster mother's request, the Ministry provided the foster home with the assistance of a homemaker for a few days a week.

On September 7, 1999, the resource worker requested a fourth Level 2 contract. This time, the Acting Community Services Manager provided temporary approval for three months based on the resource worker's recommendation. The Acting Community Services Manager subsequently renewed approval of a Level 2 contract until March 31, 2000.

By February 2000, the foster mother was having difficulties coping with the child whom the guardianship worker had been concerned about in March 1999 in relation to the foster mother's child management methods. This child had been in the foster home for nine years. The guardianship worker wrote, "She [the foster mother] is not coping well and [the child] is bearing the weight of this." The child was placed in a treatment facility in Prince George in mid-March 2000. He did not return to the foster home.

On August 10, 2000, a child protection worker visited the foster home to discuss the placement of another child. The worker noted that a piranha fish was kept in an uncovered tank. The worker observed that Savannah's bedroom was a dark, windowless room in the basement which was contrary to standards. The foster mother explained to the worker that Savannah was kept away from the family at night because her screaming would often wake family members. The worker also discovered that Savannah was being harnessed at night with a commercially made leather walking harness for children.

On August 16, 2000, the child protection worker's concerns were forwarded to Savannah's guardianship worker and the team leader. Both wanted to investigate the issue of the harness and referred the matter to the Regional Child Protection Manager, who did not support an investigation or a review of the quality of care in the foster home, but wanted to address the issues on an informal basis. An August 17th e-mail in the file documents the Regional Child Protection Manager's opinion that the foster parent would likely have received advice from a professional or done some "research" regarding the use of the harness.

The Regional Child Protection Manager recommended to staff that the foster parent discuss the matter with a pediatrician and asked staff to follow up.

On August 23, 2000, the guardianship worker and resource worker met with the foster mother to discuss the harness. The foster mother explained that she had been using the harness for some time because Savannah would shake cribs and playpens apart. She reported that she tried not to use the harness during the day when Savannah would have temper tantrums. The foster mother was told that she required the Director's permission to use the harness. The guardianship worker, who had six months' experience as a worker, gave permission to continue using the harness in the interim.

The medical and Child Development Centre records indicate that the foster mother received no direction from professionals regarding the use of the harness, and that the recommended medical consultation never happened. The issue of the use of the harness was not reviewed again until after Savannah died. The Ministry's review into Savannah's death revealed that the foster mother had been using the harness since the first time Savannah had damaged the crib, likely in the spring of 1999; Savannah was placed on her stomach to sleep, and the harness confined her to the centre of her playpen and prevented her from rolling over or turning around; the foster mother thought she had been given permission to continue using the harness; and the foster mother did not recall that medical follow-up was her responsibility.

A family physician examined Savannah on September 8, 2000. He documented a delay in Savannah's growth, as she had gained only two pounds in the previous 15 months. On September 13, 2000, a psychologist at the Child Development Centre saw Savannah. He concluded that it was not possible to assess Savannah because she was too young, and recommended re-referral in a year. He was of the view that Savannah was unlikely to understand the natural consequences of her behaviour and that she should be dealt with using a "kind, behavioural approach."

On October 11, 2000, the foster mother called the Ministry and reported her "worst day ever" with Savannah. She said Savannah had been violent, screamed for hours, bit herself, threw herself on the floor, was outright defiant, and only stopped screaming when she was given ice cream.

During the fall of 2000, the foster mother reported that Savannah had bruises on her legs, face and chin from throwing herself around. She also reported that Savannah had acquired a large bruise on her head at the Child Development Centre sometime in October 2000. According to Child Development Centre policy, such an injury required a written incident report, and none was filed. Savannah's birth mother verbally reported to a Ministry worker sometime in the fall of 2000 that she, too, had noticed bruises and abrasions on Savannah's face and arms. When this issue was examined at the inquest, it was determined that the reports were made but not thoroughly documented or followed up by the Ministry.

On October 11, 2000, a pediatrician examined Savannah to assess her developmental delays. Bruises were not noted in his report; however, the pediatrician found poor growth and weight and planned further tests to determine the cause. He was of the view that Savannah had a regulatory disorder and that her behavioural difficulties could be environmental in origin. He noted that the foster mother described Savannah as having a "mean streak." The medical report was not sent to Savannah's guardianship worker until after Savannah died, three months later.

On October 16, 2000, the infant development worker conducted an assessment and determined that Savannah's global developmental delays were becoming more pronounced.

On November 24, 2000, another complaint was made by a former foster child in the home about being punished, such as being hit over the head with a wooden spoon and not being allowed to eat supper for failure to do his chores. The complaint was similar to the 1997 and 1998 allegations made by other children who had lived in the foster home. The guardianship team recommended that the complaint be investigated as part of a review of the home. The Regional Manager of Child Protection ordered an investigation. Despite the standard that required the investigation to be completed within 30 days, it was not completed until after Savannah died.

Despite an ongoing investigation, the foster home was not taken off the list of emergency home placements and, on December 29, 2000, a sibling group of six children, ranging in ages from two to nine years, was placed in the foster home. On December 30, 2000, the Acting Community Services Manager granted an exception to policy to allow 10 children in care to reside at the foster home.

During the fall and winter of 2000, Savannah was periodically absent from the Child Development Centre. For example, she attended 12 of 19 classes in November 2000; 5 of 15 classes in December 2000; and 7 of 14 classes in January 2001. Some of these absences were attributed to minor illnesses, but many had no explanation. Savannah attended the Child Development Centre for the last time on January 15, 2001.

On the evening of January 24, 2001, a 911 call was placed from the foster home, indicating that a young child in the home had hit her head on a picnic table approximately an hour before, and that she was unconscious and not breathing. The foster parents were coached through mouth-to-mouth rescue breathing while emergency personnel were routed to the home.

Savannah arrived at the Prince George Regional Hospital at 10:30 p.m. She was in a deep coma, her heart rate was slow and her core body temperature was 31.7° C (normal body temperature is 36.8° C). Extensive medical support was required to keep Savannah alive.

Savannah's foster mother reported to the treating physician that Savannah had had a mild flu-like illness for about 10 days, for which the foster mother had not sought medical treatment. She further explained the following:

- During the daytime hours of January 24, Savannah had no appetite. She fell twice, once down two carpeted stairs and once either into a pile of toys or onto the corner of a small child's play picnic table. She was not injured on either occasion.
- At approximately 5 or 6 p.m., Savannah would not eat dinner. She was given a bottle containing a mixture of formula, raw eggs and puréed banana. Savannah was placed to sleep in a playpen in a room on the main floor of the home that was warm and contained the family's covered hot tub.
- The foster mother went to check on Savannah at around 7 p.m. and found her on her stomach. Her breathing was "funny." She was making short, gasping breaths.
- The foster mother sat beside Savannah's bed and listened to Savannah's breathing for about 20 minutes. When her breathing changed from gasping to gurgling, the foster mother got scared, took Savannah into the bathroom and called 911 at approximately 8 p.m.

The hospital staff found the explanation inconsistent with Savannah's condition and notified the RCMP.

Savannah was transported from the Prince George hospital to BC Children's Hospital in Vancouver in the early morning hours of January 25, 2001. Subsequent testing found that Savannah had suffered irreversible brain damage and was "brain dead." She was removed from medical supports and died on January 26, 2001.

The initial autopsy report, dated April 30, 2001, stated that Savannah died of lymphocytic myocarditis (an inflammation of the heart tissues) or "natural causes." The coroner and the pathologist did not suspect maltreatment. The coroner was aware that the Ministry was investigating Savannah's death but did not know that there were allegations of neglect and abuse in the foster home.

In March 2002, when the coroner provided the pathologist with information about allegations of abuse in the foster home, the pathologist changed his report to include the possibility that Savannah was intentionally smothered, and changed his finding with respect to the cause of her weight loss and lack of growth. The foster mother believed that Savannah suffered from fetal alcohol syndrome although Savannah was never diagnosed by a qualified professional.

Further, in light of the information about the alleged abuse and neglect in the foster home, the pathologist determined that Savannah's weight loss and lack of growth could not be attributed to the effects of fetal alcohol syndrome and additional information suggested the child suffered non-accidental injuries. The pathologist's conclusions were as follows:

> In conclusion, the documented findings in my autopsy report are unchanged but my interpretation of the findings have been modified by the new information that I received from [the coroner]. The additional information raises concerns that the child suffered non-accidental injuries and that inflicted factors, such as immersion hypothermia, may have caused or contributed to her hypoxic/ischemic brain damage. However, a potentially fatal natural condition, myocarditis, was identified at autopsy. In view of this, and absent a confession or witnessing of someone smothering the child or immersing her in cold water, I cannot unequivocally conclude that the child died from other than natural causes (Letter to Coroners Service, August 2002).

Reviews and investigations

Police investigation

The RCMP investigation immediately followed the death. Officers questioned individuals in the foster home but the home was never treated as a crime scene.

The RCMP investigation concluded in January 2002, when the pathologist found that Savannah had died of "natural causes," and before the March 2002 disclosure by Ministry staff of information about the alleged abuse and neglect in the foster home.

Although the police met with the coroner on a few occasions to discuss the autopsy report, no police investigative activities occurred between January 2002 and the fall of 2005. In the fall of 2005 and early 2006, the police conducted some additional interviews and requested new interviews with foster family members. The foster family members declined interviews. The additional police inquiries concluded in November 2007, shortly after the coroner's inquest.

Ministry reviews

After Savannah's death, the Ministry conducted an investigation of the allegations of abuse and neglect in the foster home, and also did a Director's case review.

The investigation of the allegations of abuse and neglect determined that the children were maltreated as alleged. The foster home was closed as a result of the investigation. No other foster children were placed in the home after January 2001.

The recommendations stemming from the Director's case review are discussed later in this report.

Coroners Service investigations

Savannah's death was reported to the Children's Commission in January 2001. An investigation was not completed by the Children's Commission before it was disbanded in 2002.

In May 2002, the Coroners Service Special Investigation Unit issued a report stating that Savannah's injuries were consistent with non-accidental inflicted trauma. The foster family declined to speak to the coroner and the Special Investigation Unit conducted a file review only.

In June 2003, the case was given to a second coroner for completion. The coroner interviewed the foster mother and found no new information. Other members of the foster family refused to be interviewed.

On December 10, 2004, the case was closed with an undetermined classification and with no recommendations. The coroner's report does not mention the allegations of abuse in the foster home and the closure of the foster home; however, the coroner who closed the case was aware of this information.

The Coroners Service reopened the case in the fall of 2005 in light of a request from Savannah's mother and her legal counsel. The resulting review of the case in 2005 and 2006 utilized recognized child abuse experts, and new information was uncovered through additional interviews.

In 2005, a forensic pediatrician and a pediatric cardiologist reviewed the medical records, the pathology report and a summary of the Ministry records. The pediatric cardiologist found that the mild inflammation of Savannah's heart tissue identified at the time of autopsy was not a reasonable cause of her death. Nor could this physician conclude that this condition contributed to her death. A second pediatric cardiologist, who examined the same information just prior to the November 2007 inquest, concurred. The forensic pediatrician found that Savannah was most likely intentionally smothered.

In December 2007, the Coroners Service attributed delays in completing the investigation into Savannah's death to the police investigation and a personal crisis in the foster family.

Coroner's inquest

A coroner's inquest was called in January 2007 and occurred between October 22 and November 3, 2007. The coroner's jury classified Savannah's death as a homicide. The jury submitted 17 recommendations with respect to Ministry practice, as well as recommendations for the Ministry of Health, the College of Physicians and Surgeons, the City of Prince George Fire Department and the B.C. Ambulance Service. These recommendations are included in Appendix E.

5. Rowen Von Niederhausern

Rowen Von Niederhausern was born on June 4, 2001. His mother had ongoing medical problems, and his parents had difficulty managing the family and the home. The Ministry was involved with the family before Rowen's birth, and starting again when Rowen was one year old. Rowen died as result of swelling in his brain on August 16, 2002, at the age of 14 months. A coroner's inquest classified his death as accidental. There were no criminal proceedings.

Rowen's mother had contact with the Ministry during her childhood. She had been severely abused as a child and, according to her physician, suffered long-term problems as a result of the abuse and neglect.

Rowen had two older siblings who were removed from their mother's care at a young age and adopted. They had been abused and suffered serious physical injuries. A close family member was convicted of the crime and served two years probation.

In September 1999, when Rowen's mother was with a new partner, she gave birth to her third child, Rowen's older sibling. A member of the hospital's nursing staff contacted the Ministry because she knew of the mother's family history. The Ministry instructed hospital staff not to discharge the infant from hospital without notifying the Ministry. Rowen's sibling went home with his parents prior to the Ministry receiving notification. When the Ministry was informed that the infant had been discharged, a child protection social worker attended the home and removed the child.

On December 16, 1999, after intensive psychological and medical evaluations and parental capacity assessments were completed, the child was returned to his parents' care under a supervision order that required frequent (daily at first) visits by the Ministry staff until the child was "fully mobile."

A **parental capacity assessment**: An assessment requested by the Ministry to determine a parent's ability to meet the needs of his or her child or children. It is performed by a psychologist or psychiatrist. There are no practice standards as to how this type of assessment is performed.

The family was provided with a teaching homemaker to assist them in developing parenting skills. A public health nurse visited the home weekly until February 2000.

The return of the child was conditional on his mother continuing to see a counsellor, his parents' participation in parenting courses, and no unsupervised access by the relative convicted of child abuse. According to the Ministry file, the parents abided by the conditions.

The parental capacity assessment noted that because of the parents' personality types, they might not recognize problems, or could deny or minimize the existence of problems in order to appear competent as parents. These tendencies were noted as having the potential to become serious should "outside stresses stretch their ability to cope." The parents were assessed as presenting "complex child protection and treatment issues" but capable of identifying the need for help with their children. The assessment indicated the mother had made gains in her ability to parent.

In February 2001, Ministry staff made an assessment as to whether services for the family could be discontinued. The supervisor directed the worker to complete a comprehensive risk assessment before closing the file, and to interview the parents and "collaterals" (other individuals, such as the family physician, the homemaker and other family members) to determine how the family was managing and whether they were able to safely care for a young child.

However, the file was closed in February 2001 without completion of these interviews. The worker reported that an assessment had been completed, but it appears that the supervisor did not ensure that the instructions about the interviews were followed. The worker concluded that the factors that had put the child at risk were no longer present. Rowen's mother was approximately six months pregnant with him at the time the file was closed. The Ministry was not aware of the pregnancy.

Rowen was born on June 4, 2001, the second child born to his parents, and the fourth child born to his mother. Rowen's mother was 27 years old at the time of his birth. The hospital did not notify the Ministry of Rowen's birth. The fact that the Ministry had previously asked that the older sibling not be discharged without notification had not been formally noted by the hospital at the time.

On June 11, 2002, when Rowen was one year old, the Ministry had its first contact with the family since the family service file had been closed. A community member reported hearing an infant screaming and believed no one was attending to the baby. The older child had been observed dangling out of a window of the family's mobile home and another time, playing near an unattended barbeque. The child protection worker consulted with her supervisor about the report. During this consultation, the worker learned of the history of the family's contact with the Ministry and the significant past concerns for the safety of the children.

The worker attended the home unannounced the day after the report was received. She found the parents sitting outside and the children sleeping together on the sofa in the living

room. Shortly after she arrived, smoke from an unattended pot on the stove filled the home. The worker was at the residence for about an hour, and most of that time was spent helping the family evacuate the children and clear the smoke from the home. She found that they needed to install smoke detectors. The home was "messy" and the family had many cats.

The worker learned that the mother had health problems and frequently spent the day in bed, and that the family was struggling financially. The father was the family's sole financial support and, as a result of the mother's health problems, was the children's primary caregiver.

The parents told the worker that they believed they were managing well and would ask a relative for help if they needed it. The worker left the home after directing the family to install some smoke detectors, to move the sofa so the older child could not get out of the window, and to ensure the safe use of the barbeque.

The worker followed up three weeks later. She noted that the home was in a messy state. She contacted the public health nurse and found out that Rowen was a little behind in his vaccinations. She also learned that the father had visited the health unit in February 2002 complaining of depression, exhaustion and "not being able to cope." He also had narcolepsy and took medication for this condition.

Rowen's mother had been having severe headaches and had possibly suffered a small stroke, resulting in some mobility problems. She spent entire days in bed and did not participate in much of the children's care. The family doctor was not contacted by the Ministry to provide a more detailed picture of the mother's health problems.

The family had the support of a relative who would occasionally help with the children, but the relative would not go into the family's home because she was allergic to cats. Another close relative was often at the home to help clean. This relative was the one who had been convicted of child abuse and was not supposed to have unsupervised access to the children.

On July 15, 2002, the worker returned to the home to review the home environment and found that her recommendations, including installation of smoke detectors, raising the barbecue off the ground and moving the furniture to ensure the children's safety, had been implemented. She spoke briefly with the parents and found them open to suggestions and co-operative. The father denied any use of drugs. The worker was of the view that, compared to the other families on her caseload, this family was coping well. She did not feel that they were in crisis. The worker closed the file on July 16, 2002, without consulting her supervisor. The children were found not to be in need of protection.

According to Rowen's father, in the early morning hours of August 16, 2002, he was trying to get Rowen to sleep. They were settled in a recliner in the living room. Rowen fell asleep on his father's chest. During the night, Rowen's father awoke and discovered that urine from Rowen's wet diaper had leaked onto his chest. Rowen's father changed and fed him

and they both went back to sleep. At approximately 9 a.m., the older child woke up and needed attention. Rowen was placed to sleep on his back on the sofa and his father went to prepare a bath for his older sibling. The father believed something was wrong and went back out to the living room to find that Rowen was not breathing and did not have a pulse. He called an ambulance, and was coached by the 911 operator in performing CPR.

Rowen was transported to the hospital. He was pronounced dead approximately an hour after he was admitted to hospital.

The autopsy was completed on August 17, 2002. The cause of death was diffuse cerebra edema (swelling of the brain). The pathologist concluded that Rowen did not die from a natural disease process and that he was not smothered, but that there was a possibility that he had been shaken. The findings were forwarded to the RCMP.

Reviews and investigations

Police investigation

The RCMP concluded its investigation in October 2005 and the file was closed. The case was presented to Crown counsel but charges were not approved.

Ministry review

The Ministry conducted a Deputy Director's review (a review of file material only) a year after Rowen died. The Ministry staff attributed the year-long delay in completing the review to the ongoing criminal investigation. The recommendations that resulted from the review are discussed later in this report.

Coroners Service investigations

Rowen's death was investigated by the coroner. In early 2006, the Coroners Service consulted with an expert on child abuse from the United States. The expert concluded that Rowen's death was a result of an episode of violent shaking. The expert found that the autopsy was incomplete and suggested changes to the autopsy protocols for suspicious child deaths, including a skeletal survey and, in cases where it is suspected that the child was shaken, more complete examination of the brain, spinal cord and eyes.

The changes were adopted by the Coroners Service. The expert's opinion on the cause of Rowen's death was forwarded to the RCMP. No new action was taken by the police.

Coroner's inquest

An inquest into Rowen's death was called in late 2006. The inquest was conducted approximately six months later and concluded on June 20, 2007. The coroner's jury found that the death was accidental. The jury's recommendations are included in Appendix E.

6. Serena Wiebe (John)

Serena Wiebe was born on November 22, 2004. Serena was a First Nations child. Serena's mother struggled with alcohol and drug addictions. Serena had three older siblings who had been removed from her mother's care before she was born. She died during the night, apparently in her sleep, on June 17, 2005. She was almost seven months old at the time of her death. A coroner's inquest in October 2007 classified her death as undetermined.

Serena Wiebe's mother is a member of the Yekooche Band, in the Fort St. James area, which is represented by Carrier Sekani Family Services. She struggled with alcohol and drug addictions for much of her adult life. Serena's mother had her first contact with the Ministry in March 1996, when she was 18 years of age and her first child was three weeks old. Ministry staff provided Serena's mother and her infant with services. A second child was born in 1998 and a third in 2000.

Between 1997 and 2000, the Ministry received three reports that the children were being neglected.

In May 2000, after the birth of the third child, the Ministry completed a comprehensive risk assessment. The children were found to be at risk for harm if left in their mother's care. A supervision order was put in place for six months. The children went to live with a relative as one of the conditions of the supervision order, and Serena's mother was asked to participate in drug and alcohol counselling.

Serena's mother was unable to meet the conditions for retaining custody of her children. In September 2000, a family member was granted permanent custody of the sibling group. Serena's mother maintained contact with her children. Serena's mother had no further contact with the Ministry until May 2, 2005.

Serena Wiebe was born on November 22, 2004, her mother's fourth child, but the first child born to her mother and a new partner. The person who made the report to the Ministry reported that Serena's mother and her new partner were drinking and smoking crack cocaine while caring for five-month-old Serena. The report was accepted for investigation in Prince George and the file was transferred to Fort St. James for "further assessment." The information was relayed not as part of an open child protection file but as part of a file transfer.

When the information was received in Fort St James from the Prince George office it was marked "for assessment only" so the worker decided to assess it as soon as possible. The worker found it difficult to locate the parents because they moved frequently and didn't have a phone. Serena's family was located living off-reserve near Fort St James.

The worker contacted a representative of the Yekooche Band's community-based response team who was also Serena's mother's paternal aunt. She was a member of a team that works closely with the ministry social workers concerning the welfare of children in its community. Volunteer members from the response team accompany ministry social workers whenever they are called out to community members' homes.

These two individuals visited Serena's family. They were also accompanied by a worker from Nezel Be Hunuyeh Child and Family Services. The visit was unannounced; the family had no prior knowledge of it.

Carrier Sekani Family Services

Carrier Sekani Family Services had Level 13 (currently known as Category 4, or otherwise Guardianship) delegation in 2005 and currently has the same level of delegation. The Aboriginal Operational and Practice Standards and Indicators (AOPSI) identifies Guardianship services as a unique level of delegation with respect to the ongoing management and care of children and youth in continuing care: this is in addition to Voluntary Services delegation that includes provision of voluntary agreements and the recruitment, support and retention of family care homes.

Nezul Be Hunuyeh Child and Family Services

Nezul Be Hunuyeh Child and Family Services Society signed an initial agreement with the Province in July 2002 to commence the delegation enabling process. The Agency was not operational for the delivery of delegated services in 2005.

When the workers met with the family, Serena appeared healthy and the parents were not under the influence of drugs or alcohol. The home was clean. The mother stated that she and the father were getting along well and that she was working hard to maintain a healthier lifestyle. She stated that she did not have any health problems and that she was not using drugs. The question of where the baby slept was raised. The record is unclear about the response provided by Serena's mother. One worker recalls that the mother said Serena slept "in our room down the hall," and that the bedroom was not explored for

appropriateness or safety. Another worker remembers that Serena's mother said she slept on the couch, and that she did not know if the mother meant that they had slept on the couch the previous night or that they slept there routinely. The workers learned that the couple took turns going out and if they were going to be drinking they had relatives who would care for the child.

The representative from the community-based response team told the ministry social worker that there was an informal safety plan among family members in place for Serena. She stated that family members visited Serena's mother as a way of monitoring the family. She stated that they would watch over the infant if they knew or suspected that her parents were drinking.

The ministry worker did not attempt to access any medical information about the mother because she did not have reason to do so. She observed that Serena looked healthy and well cared for, and she saw no evidence of drug use in the home. The worker confirmed that the infant was receiving routine medical care. The worker's supervisor stated that medical information was difficult to obtain from local doctors because they may feel bound by confidentiality provisions not to release information.

After a discussion with the supervisor, the ministry social worker submitted the file for closure with a finding that the child was not in need of protection. The worker believed that the Band's representative from the community-based response team would assist in monitoring the family, and no formal safety plan was laid out. She reported carrying a very high caseload as a result of chronic shortages of staff in Fort St James.

According to the coroner's report, in the days before she died, Serena had been ill with a mild flu-like illness. She had no history of any health problems. During the evening hours of June 16, 2005, Serena was placed to sleep with her mother on the sofa. Serena's mother had consumed some alcohol during the daytime hours and took a prescribed sedative before going to sleep. Serena died sometime during the night.

The autopsy was performed on June 20, 2005. No injuries were identified. The pathologist identified evidence of mild viral infection which may or may not have contributed to her death.

Reviews and investigations

Police investigation

The police concluded their investigation shortly after Serena died. There was no evidence to suggest that Serena's death was related to abuse or neglect. No charges were laid.

Ministry review

The Deputy Director's review of this case was completed 11 months after the death. The review generated four recommendations, which are discussed later in this report.

Coroners Service investigations

A coroner's inquest into the death of Serena was called in February 2007. The two-year delay was caused in part by the Coroners Service file management in the region. Coroners files were not effectively tracked for completion within the four-and-a-half-month time frame prescribed by Coroners Service policy. The Coroners Service attributes additional delays to the need to wait for Ministry staff to complete their review and implement any recommendations made as a result of the review. The regional coroner wanted to wait to make a decision about taking this case to inquest until the recommendations from the Ministry review were implemented.

There is no indication as to how the implementation of the recommendations affected the coroner's decision-making process regarding the conclusion of the case. The police investigation was not a factor in the delay, because there was no evidence to suggest that Serena's death was related to abuse or neglect and the police investigation was completed shortly after Serena's death.

Coroner's inquest

The inquest was completed on October 12, 2007. The coroner's jury classified Serena's death as undetermined, a classification consistent with sudden, unexpected infant deaths like Serena's.

The coroner's jury made nine recommendations to the Ministry, which are included in Appendix D.

7. Analysis

> Research throughout the world reveals how difficult it is to strengthen families and ensure all children are safe and well, so an open culture that encourages recognizing and learning from mistakes is needed. To err is human. In some respects, people are a source of fallibility but it is their flexibility, inventiveness, and intelligence that is required to recover from unanticipated system failures and to provide a good child protection system.
>
> – Dr. Eileen Munro (2008)
> London School of Economics

This chapter moves more deeply into the themes that emerged from the investigation into the deaths of Amanda, Savannah, Rowen and Serena. It also examines what the Ministry learned from these deaths and from other Ministry reviews and audits that were completed during the same period, and then looks at audits and reviews from the last two years.

Themes that emerged from the investigation

The themes that emerged from the investigation into the deaths of Amanda, Savannah, Rowen and Serena are:

- The need for more complete assessments of child safety
- More timely and thorough medical assessments of vulnerable children
- The importance of measures to preserve Aboriginal identity
- Better information sharing and coordination
- More effective supervision, and
- Adequate staffing levels.

Assessment of child safety

In 1996, in response to the recommendations of Judge Thomas Gove, and in particular those calling for strengthened child protection practice, the Ministry implemented a risk assessment model to assist workers with child protection investigations and the assessment of the likelihood of future abuse and neglect. In 1997, child protection consultants provided workers with training on how to utilize this new tool. In 1997 and 1998, new practice standards for child protection were developed and implemented.

These standards provided child protection social workers with clear expectations of the required standards of practice in the management of child protection cases.

The risk assessment model outlines key components of child protection investigations and assists workers in determining when to investigate a report, the time frame for an investigation, how to assess a child's immediate safety and at the conclusion of the investigation, how to determine a child's need for protection. The essential steps to making this determination include seeing and interviewing the child, the parents, other relevant family members, and members of the community such as teachers, daycare providers, physicians, nurses and anyone else who has pertinent information about the child and how the family is functioning.

Additional steps include observing the child – parent interaction, observing the child's living situation, reviewing the relevant past family records, and, when required, ensuring that the child has a medical examination. Once a child is found in need of protection, the model assists workers in assessing the risk of future abuse and neglect, and developing a risk reduction service plan. The model emphasizes that "deciding that a child needs protection requires a careful and objective examination and assessment of all of the facts, evidence, and professional opinion obtained during the investigation, which support or refute the child's need for protection" (BC Risk Assessment Model, p. 35).

The failure to assess children's safety adequately became apparent in the investigations of the deaths of Amanda, Savannah, Rowen and Serena.

Amanda Simpson's family came to the attention of the Ministry during periods, between 1991 and 1994 and again between 1997 and 1999. These contacts presented numerous opportunities to assess the safety of the children and family functioning, and to intervene. The family faced challenges that appear to have continued over a significant period of time, including domestic violence, poverty and possible drug and alcohol abuse. The family did not make use of the available supports to address the family issues. The frequent reports of suspected neglect and abuse suggest a mother, a father and later a new partner struggling to care for Amanda and her siblings.

The Simpson family's involvement with the Ministry began in February 1991. Between 1991 and 1994, 13 child protection reports were made to the Ministry relating to the Simpson children. Of these, the Ministry investigated three reports and none of these investigations were thoroughly conducted. Some of the inadequacies in the investigations include failing to gather and assess all of the family history, incomplete interviews with the children and the parents, and incomplete information from key members of the community. These inadequacies resulted in a failure to assess the children's safety and intervene in a timely manner.

The reports to the Ministry during 1997 and 1998 identified serious safety issues in the Simpson home, and demonstrate an escalation in reported abuse and neglect of the children. In September 1997, Amanda's six-year-old sibling described looking after her younger siblings for extended periods of time and starting a fire to get warm. The investigation into this report did not meet Ministry standards. The workers involved with the file did consider the family's long history with the Ministry and did gather information from sources other than Amanda's mother; however, the analysis of this information, which should have informed case decision-making, was absent in their finding the children not in need of protection. The investigation was not completed within the required 30 days and the file remained opened when the next report was received by the Ministry in September 1998.

The Ministry treated subsequent reports of neglect and abuse in 1998 and 1999 in the same manner. Investigations were incomplete and insufficient to fully understand what the children were experiencing. Only some of the investigative steps were completed. There were some collateral checks with teachers and staff at the Child Development Centre, interviews of the children and their mother and medical examinations of the children. However, interviews with the children were not child-focused, were done in a hurry, and did not address the alleged concerns. Absence of an investigative focus was also apparent in meetings with the mother. Neither the children's father nor the mother's new partner were interviewed. Medical examinations were not done in a timely manner and information provided by the social workers to the physicians was not comprehensive.

In at least three child protection reports, the children's concerns were not believed. In September 1997, Amanda's sibling reported having to care for her younger siblings. The account was detailed and the circumstances suggested it was credible. The investigation of the report consisted of comparing the child's story to her mother's account and preferring the mother's version. The interview with the mother did not address the reported concerns, nor was the mother confronted regarding the issues her daughters were reporting.

In 1999, there was no recognition of a pattern of abuse emerging from the reports of professionals involved with the children, as well as from the children's statements themselves. There was no recognition that children may often give conflicting statements because they are afraid, feel unsafe, and do not want to cause trouble for their parents.

In October 1999, the Ministry received a report about Amanda's younger sibling being hit by her mother's partner. The decision not to investigate was based on a notation in the Ministry file that the child was considered difficult to follow and capable of exaggeration. This was the second report of a similar nature in three weeks made by one of the Simpson children. The worker attended the school and talked to the children. Ministry staff made

the decision to direct school staff to discuss their concerns directly with the mother and to provide the child with counselling about "truth and fiction." The dismissal of the child's statements was not a reasonable conclusion and compromised the children's safety.

Savannah Hall was in the Ministry's care from May 27, 1998, until the time of her death on January 26, 2001. As her guardian, the Ministry had a legal obligation to act in her best interests, ensure her safety and promote her well-being. When a child comes into the care of the province, most of the rights, duties and responsibilities of a parent are transferred to the state and the state has the obligation to ensure that the child's individual needs are met. The *Child, Family and Community Service Act* enshrines in legislation a child's rights (Section 70) while in the care of the state.

During Savannah's placement in her second foster home, the Ministry missed a number of significant developments that signalled the need to reassess Savannah's placement. In December 1998, concerns about alleged neglect and abuse were raised, as well as issues regarding the ability of the foster parent to meet Savannah's developmental needs. The Regional Child Protection Manager's continuing confidence in the foster home compromised critical opportunities to reassess the foster mother's ability to keep Savannah safe and well.

The first warning sign appeared when the Infant Development Worker stated that Savannah might be suffering from abuse and neglect in the foster home. This was a missed opportunity to have Savannah examined by a pediatrician to assess her medical status and developmental needs.

In March 1999, the guardianship worker of another child in the foster home raised concerns about the foster mother's child management methods. The foster mother told her resource worker that she did not want the guardianship worker to meet with this child alone, despite Ministry standards that require frequent, regular and private contact with children in care, particularly for vulnerable children. The resource worker did not interview the child regarding the concerns, but met with the foster mother to review the standards relating to sleeping arrangements. In February 2000, the same guardianship worker documented that the child was bearing the weight of the foster mother's inability to cope. Again, neither of these complaints by the child's guardianship worker triggered an assessment of the capacity of the foster home.

In July 1999, the foster mother requested that payment for Savannah's care be increased to Level 2 from Level 1, as the foster mother indicated that she was spending all of her time looking after Savannah. This request was at first denied, because having four children on Level 2 contracts in one foster home was against Ministry standards. The Ministry later granted an exception to the policy on a temporary basis, for three months. A further exception was made in December 1999 until March 31, 2000. There was no formal

assessment of the foster mother's ability to meet the children's needs and no evaluation of the foster mother's request for additional resources.

Standards direct resource workers to conduct annual reviews of foster homes. Even though significant concerns had been raised in relation to the home between 1997 and 2000, the Ministry did not complete an annual review of the foster home during this period. These reviews provide an opportunity to identify concerns and limitations within the home. Annual reviews had been completed regularly until 1996.

In August 2000, when the child protection and guardianship worker learned that Savannah's foster mother was restraining her, neither asked for details about the use of the harness or examined Savannah to see if the harness had caused her harm. The standards for foster homes at the time included clear guidance on the use of restraint: it was expressly forbidden unless a child was in imminent danger.

Savannah's bedroom did not have windows, which was also contrary to standards. Despite the child protection worker's and the guardianship team leader's request for an investigation, the Regional Child Protection Manager did not support a review of the foster home or an investigation, even though the use of the restraint and the bedroom violated standards for foster homes, the restraint was possibly abuse, and the Protocols for Foster Homes directed a quality of care review at a minimum.

The issue of harnessing Savannah was not adequately addressed. Despite the Regional Child Protection Manager's request that a pediatrician be consulted about the use of the harness, no medical professional was ever consulted. The Community Services Manager testified at the inquest that as Savannah's guardian, it would have been more appropriate for the Ministry to consult with the pediatrician rather than to have left the issue in the hands of the foster mother to determine whether the harness was appropriate. Although permission to use the harness was granted on an interim basis and was conditional on the results of the medical consultation, there was no follow-up by the Ministry with a physician and the foster mother to determine whether the harness should continue to be used. This fell below accepted standards of practice and supervision.

The Ministry's trust relationship with the foster parents impacted Savannah's safety and well-being. Savannah's foster mother was seen as a "good" foster mother and a reliable resource for the Ministry over a long period of time. Personal opinions regarding Savannah's foster mother caused the Regional Child Protection Manager and the child protection and guardianship staff to minimize details that might otherwise have led them to a review of the foster home or change in Savannah's placement. If staff had not made a blanket evaluation that the foster mother was efficient and capable, they might have been more readily able to see the signs that the foster mother was not able to cope with Savannah's care. The foster mother's escalating concerns, her use of the harness and her

emerging negative response to Savannah's needs were all indications of the foster mother's inability to cope. While trust is appropriate in these relationships, transfer of responsibility to the foster parent for decision-making on restraint was not.

In November 2000, following another child's disclosure of being abused in the foster home, the Regional Child Protection Manager decided to conduct an investigation into the foster home. However, the foster home protocol was again not followed. The foster parent was not notified of the investigation or the allegations until after Savannah died. Although the investigation was ordered on November 28, 2000, it did not begin until after Savannah died, nearly three months later.

E-mails between the investigation staff and the guardianship staff indicate that due to a shortage of investigation staff at this time, the foster home investigation would be delayed. The delay in investigating the concerns was also based on the foster mother's reputation of being a "good" foster parent. It is likely that lack of objectivity was a factor in this decision. A review of the file suggests no evidence of an expected start date for the investigation or an assigned time frame to complete the investigation and report.

The worker assigned to investigate was not given information about the history of the complaints or information about the use of the harness. The guardianship team did not attend the home to determine whether Savannah and the other children were safe while they waited for the investigation to be completed. Despite an ongoing investigation, an exception to policy was granted and an additional six children were placed in the home on an emergency basis during the Christmas holidays.

At the inquest, the Regional Child Protection Manager testified that there were two missed opportunities for immediate investigation. First, had he known that there was no medical basis for the use of the harness, he would have proceeded immediately with an investigation. Second, if the November 2000 investigation had been started immediately as it should have, the Ministry would have come to an earlier conclusion that children were being abused and neglected in the foster home. These positions appear reasonable in the circumstances when the human resourcing challenges are factored into consideration.

From the time Savannah was admitted to Ministry care in May 1998 until her death in January 2001, she had five guardianship social workers. The last documented visit with her guardianship worker occurred on August 23, 2000. The visit prior to this occurred on May 23, 2000. According to guardianship standards, a child in care must be visited at least every three months. A child with Savannah's developmental difficulties required more frequent visits. Lack of regular and consistent contact with Savannah contributed to an incomplete picture of her functioning, what she was experiencing in the foster home, and how the foster mother was caring for her. In light of the conflicting information from the

foster mother and the Child Development Centre, it was imperative that Ministry staff determine whether or not Savannah's health and safety needs were being met. These deficiencies, caused by staffing changes, compromised Savannah's care.

When Rowen died in 2002, the risk assessment model was still in use however, problems relating to its use continued. Unlike Amanda's case, Ministry staff had a wealth of objective and reliable information on file that would have assisted the worker in making a decision about the safety of the children in the home and creating a viable harm reduction plan. The barriers to utilizing that information and understanding the dynamics of the family appear to have been more heavily associated with workload and the ongoing lack of clinical supervision.

The Ministry file indicates that the team leader was not consistently available and was not consulted on key issues, such as the information contained in the parental capacity assessment. The file documentation indicates that there was an attempt to adhere to policy, but without clinical supervisory oversight, the necessary consultation about the family did not occur. The team leader understood the family's history and knew of the success they had in the past with addressing safety concerns with the older sibling. The case practice with the elder sibling prior to Rowen's birth followed policy. The documentation on the file indicates that the family worked well with Ministry staff. The team leader had crucial information that would have been the basis of a plan to support the family and ensure the safety of the child.

When the Ministry was determining whether to discontinue services for Rowen's older brother in February 2001, the team leader had requested that a comprehensive risk assessment be completed before closing the family file. The worker reported that the assessment was complete despite not having conducted interviews with family and community members. The team leader signed off on the assessment and the file was closed. If the comprehensive risk assessment had been adequately completed, the worker might have discovered that Rowen's mother was six months pregnant with him at the time. The Ministry could have assessed whether the risk factors had been sufficiently addressed and the family's file closed or whether additional supports and monitoring were needed prior to file closure.

On June 11, 2002, the Ministry received a child protection report concerning Rowen and his brother. When the investigation was conducted, the Ministry failed to consider the family history, in particular the parental capacity assessment that indicated how complex these parents were to treat and provide services for. When the parents demonstrated that they had addressed the initial safety issues, the worker concluded the investigation early,

with the finding that the children were not in need of protection, and closed the file. In this case there was a failure to thoroughly investigate and assess the parents' ability to meet the needs of their two young children.

The worker in this case reported that Rowen's family was not as "troubled" as other families on her caseload. While this appears to be reasonable, expected standards of practice cautioned against weighing cases against each other in this manner. Clinical consultation with the team leader might have led the worker to review all of the information about the family in an objective and thorough manner. As well, completion of more collateral checks with other relevant professionals might have identified that the parents were having serious difficulty coping with their children.

Serena's death in 2004 once again reveals practice in completing child protection investigations that fell below the accepted standard. In this situation, the child protection worker did not thoroughly investigate the child protection concerns or adequately assess the impact of drug and alcohol abuse in the home. A representative of the Yekooche Band's community-based response team, a worker from Nezul Be Hunuyeh Child and Family Services and the child protection worker attended the home and met with the family. At the home, the child protection worker interviewed the family to determine the immediate safety needs of the child. The child protection worker assessed the home environment and found it suitable. The child protection worker did not further investigate the parents' addiction problems by interviewing other members of the family or the community, or consider whether the plan to leave the child with a family member when drinking was appropriate. Had the worker checked with the extended family and interviewed a range of knowledgeable individuals, she might have found that the mother's extended family was also concerned about Serena's safety. Given the family history, the recent report demanded a more thorough investigation.

The child protection worker's assessment of the home environment is questionable. Sharing a bed with an infant, particularly when the adult is excessively tired or under the influence of drugs or alcohol, is connected with an increased risk for sudden unexpected infant death. Sleeping on a sofa with an infant is a significant risk factor in sudden unexpected infant death (Canadian Paediatric Society, 1999, reaffirmed January 2002).

Case reviews

Between 1999 and 2005, the Ministry reviewed 22 children's deaths (in addition to those of Amanda, Savannah, Rowen and Serena) and one critical injury of a child in the North region. At the time of their deaths, 20 of these children and/or their families were receiving or had received Ministry child welfare services within the preceding 12 months. Two children who died were medically fragile and their families had received voluntary family support services.

These deaths were reviewed through Deputy Director's reviews. A Deputy Director's review is limited in the information it can provide, as no interviews are generally conducted with staff, service providers and/or foster parents. The opportunity to learn and to improve practice is circumscribed by a paper-only process. The methodology and application of this review tool has evolved over time. The Hughes Review found that time frames are rarely met and that the reasons for this are many. This investigation also found that the reviews were not completed in a timely manner. Out of the 22 case reviews, only two were completed within a reasonable time frame: one was completed in three months and the other in four months.

Figure 3 provides an overview of the 22 reviews completed in the North region between 1999 and 2005 (in addition to the four in this report).

Figure 3: Reviewed child deaths in the North region, 1999–2005

Type of Death indicated at time of Review	Number of Child Deaths Reviewed	Year of Death	Age Range at Time of Death	Number Aboriginal*	Number In Care at time of Death
Accidental	4	1997, 1999(2), 2001	4 – 17 years	4	1
Natural	7	1998(3), 1999(3), 2000	6 weeks – 14 years	5	3
Undetermined	6	1999, 2002, 2003(2), 2004, 2005	6 weeks – 14 years	2	none
Suicide	5	2002(3), 2003, 2004	12 – 18 years	5	1
Total	*22*	*1997 - 2005*	*6 weeks – 18 years*	*16*	*5*

*"Aboriginal" information has not been verified; however, some references in the reviews suggested that it was likely that the child was Aboriginal.

The one critical injury during this period was the only incident reviewed through a Director's case review, which includes a review of all files associated with the child's case and other related documents, as well as interviews with staff, foster parents, service

providers and any other relevant person. The child under review suffered extensive intentional injuries while in her mother's care. The family was under a supervision order at the time of the incident.

An aggregate examination of these reviews reveals similar deficiencies in practice found in the investigations of Amanda, Savannah, Rowen and Serena's deaths. However, there were some exceptions, where practice met the standards, investigations were thorough and comprehensive risk assessments were adequately completed. From examination of the 22 reviews, it is not possible to make a clear link between some of the inadequate practices and the child's death being reviewed. In part, the narrow review limits analysis and caution must be exercised in drawing conclusions about the strength of practice from these paper-only internal reviews.

Eleven of the reviews into children's deaths highlight inadequacies in assessing children's safety. The reviews identify problems with child protection investigations, such as the failure to obtain and assess all relevant family history, see and interview children, see and interview parents, and obtain information from professionals and other members of the community who may have relevant information about the child and family. In two reviews, inadequate supervision was identified as an issue. In seven reviews, there was inadequate documentation or lack of documentation.

Once findings of protection were made, the reviews reveal some difficulty with assessing the risk of future harm. In seven of the reviews, comprehensive risk assessments were inadequate or not completed. In five of the reviews, the risk reduction plans, which describe the planned interventions that will reduce risk, were inadequate or not completed.

The only critical injury reviewed by the Ministry during this period involved a 13-month-old child who was under a supervision order when she was the victim of an aggravated assault and nearly died in February 2001. The family had a history of alcohol abuse and domestic violence. The review found that Ministry staff did not adequately assess past family history or complete interviews with key family and community members. There was a lack of supervision and consultation with senior staff, the comprehensive risk assessment was incomplete and did not accurately assess risk factors, there was no risk reduction plan, and the terms of the supervision order were not adequate. There was a lack of understanding of the impact of alcohol abuse on the mother's ability to parent. The Director's case review also indicated that the office had serious staffing challenges between May 1999 and February 2001, and that office staffing levels often fell below 50% of its staff complement.

Medical assessments of vulnerable children

Physicians struggle with the assessment of child abuse and neglect, particularly when they do not have good information, or the time and focus to thoroughly examine a child.

As reported in the *BC Medical Association Journal:*

> Physicians practising in emergency departments, offices, and walk-in clinics often do not have the time to conduct more than a cursory examination, let alone a thorough review of the case history. If, on rare occasions, time is available for rigorous history-gathering from multiple sources, fee-for-service billing does not usually provide adequate remuneration. Some physicians say the degree of child maltreatment training they have received is limited and they do not feel comfortable providing an "expert" opinion, especially in complicated situations. Many consider child abuse to be an area of subspeciality. Lack of comfort with the subject matter and the possibility of having to provide court testimony can also be a barrier for some practitioners. Working without the support of a team, the physician can feel burdened with all interagency communication duties, crisis counselling, and service referrals (Jarchow, 2004, p. 68).

Similarly, there are challenges to providing quality medical assessments of children in care. Children who come into care may be placed in a foster home some distance from their biological families and their previous health care providers, or they may have had inconsistent medical care. There may be little reliable information about the child's medical history, thus complicating the assessment. Children coming into care may experience a higher incidence of chronic medical conditions, mental health problems, developmental and academic delays, and poor health related to the effects of poverty, prenatal exposure to drugs or alcohol, insufficient nutrition, under-immunization and dental neglect (Canadian Pediatric Association, 2008). Each of these factors should reinforce the need for thorough, timely and independent assessment of the health and well-being of children in care.

Given the challenges medical practitioners face in assessing vulnerable children, information sharing and collaboration by the Ministry and the health care system are essential for ensuring children's health and well-being. For Amanda and Savannah, the Ministry's failure to actively collaborate and communicate with medical practitioners contributed to inadequate medical assessments and unmet health needs.

While medical assessment for abuse and neglect was a significant issue for Amanda and her siblings, it is not possible to determine the full extent of the issue, as this investigation could not access the complete file. Neither the coroner nor the Ministry examined the medical records after Amanda died. The electronic record of Medical Services Plan billings was purged and all paper medical records have been destroyed in accordance with office procedures for archived records. The Ministry management review completed in December 1999 reported that Ministry staff found no instance of a physician finding an injury consistent with abuse.

Aside from two medical assessments by a pediatrician trained in recognizing child abuse and neglect, all medical care received by Amanda was provided by general practitioners

in a few clinics in Prince George. The family used walk-in clinics whenever they required medical care. Amanda and her siblings did not have a consistent family doctor.

In one instance noted in the Ministry files, the worker was concerned about a bruise and asked Amanda's mother to take Amanda to the local clinic to have a physician examine it. A physician examined Amanda 13 days later and found no bruising. Neither the worker nor Amanda's mother provided the clinic with sufficient information about the injury or the family history to enable the physician to conduct a complete assessment of the injury. The responsibility to take Amanda to the clinic was left to the mother. The physician was not made aware of the series of reports of abuse and neglect made in regard to the Simpson family.

The majority of the reports made about the Simpson family involved allegations of neglect, due to a lack of either food or supervision. Child neglect is the most prevalent type of child maltreatment. According to the Canadian Incidence Study of Reported Child Abuse and Neglect, a nationwide study to examine the incidence of reported child maltreatment, neglect is the primary category of child maltreatment, accounting for 30% of an estimated 103,298 substantiated child investigations in 2003. Despite its prevalence, the medial diagnosis of neglect remains difficult. One of the indicators of neglect is a non-organic "failure to thrive." This means the child is not developing according to the expected milestones and may be smaller, or developmentally delayed. Understanding the complete medical and social history of a family is an important element for evaluating possible neglect. Should a child present symptoms consistent with a failure to thrive, information regarding family functioning and possible neglect must be thoroughly shared with the health system.

In 1999, a pediatrician who specialized in recognizing child abuse and neglect examined Amanda. The physician did not find evidence of physical abuse but found that Amanda was not gaining weight and growing according to her developmental needs. Amanda was diagnosed with failure to thrive. The physician wanted to do more testing. The worker did not inform the physician that many of the reports made about the family involved lack of food. The worker was aware of the diagnosis of failure to thrive but did not follow up to ensure that Amanda had further testing, nor did the worker investigate to determine whether neglect was the cause of the lack of growth and development. Further evaluation was left to her parent, and was not carried out.

A physician examined the Simpson children on four occasions related to abuse allegations. A pediatrician who specialized in assessment of abuse and neglect conducted two of the physical examinations. In all cases, the children were never seen on the same days that the injuries were discovered because of delays in reporting and accessing medical care. The child protection worker did not attend the appointments and there is no record

of collaboration or information sharing between the worker and the pediatrician. The pediatrician who examined Amanda and her siblings was not provided with information about the family history with the Ministry or the reports of abuse and neglect that she needed to make a thorough assessment of the injuries she observed.

Like Amanda, Savannah was a child who should have been considered vulnerable given her development and experience of trauma. In many ways, all children who come into care, even temporarily, are subject to vulnerabilities above and beyond other children. Savannah's early life, with possible antenatal exposure to drugs and alcohol, coupled with her early experiences of neglect, were factors that placed her at risk for delayed development. When Savannah came into care at the age of one year, she already had a history of nutritional and physical neglect that affected her growth and development.

As was discussed previously, Savannah's plan of care, even as it related to Savannah's health needs, was not based on information provided by health care practitioners. For example, in her plan of care, considerable weight was placed on the need for Savannah to have a psychological assessment. If the guardianship worker had consulted the psychologist, the worker would have discovered that the psychologist had already seen Savannah and determined that he could not properly assess her for another year and was of the opinion that Savannah did not understand consequences and that she should be dealt with using a "kind, behavioural approach." Because the psychologist was not consulted, this valuable information was not incorporated into Savannah's plan of care and strategies were not implemented to best support her developmental needs.

The foster mother was trusted as a source of information, despite Savannah's significant health issues and statements that suggested that the foster parent might have misunderstood the child's behaviour and was ill-equipped to care for her. During the appointment with the pediatrician in October 2000, the foster mother described Savannah as having a "mean streak." This comment suggests that the foster mother misperceived Savannah's behaviour as malicious, as opposed to an expression of unmet developmental needs or a matter to be examined further with supports in place to assist her, if necessary. The guardianship social worker should have accompanied the foster mother to these types of appointments with Savannah.

Although Savannah was seen by a physician several times for treatment of minor illnesses, there was little information about her overall health, growth and development when she was placed in her first foster home. Given her vulnerability and history of neglect, her first foster family suggested that Savannah be referred to the Infant Development Program. By the time Savannah moved to her second foster home, early testing by the Infant Development Program indicated that Savannah's development was delayed.

By October 1998, it was apparent that Savannah had delays in speech and personal/social development. By December 1998, global delays in development were evident. By May 1999, the Child Development Centre assessed her as requiring speech and occupational therapy and physiotherapy to address her global developmental delays. By July 1999, the foster mother was reporting escalating behaviours, such as night terrors, temper tantrums, aggression, eating problems, and self-abusive behaviour. There was no assessment or diagnosis of her escalating behaviour. In September 1999, when the foster parents were temporarily approved as a Level 2 home for Savannah, there was no corresponding medical assessment of Savannah by a pediatrician or physician to determine the underlying cause of her behaviour and the appropriate interventions.

In August 2000, when Ministry staff learned that the foster mother was using a harness to manage Savannah's reported night terrors and associated destructive behaviour, the Ministry still did not ensure that Savannah was assessed by a pediatrician to determine the cause of her behaviour and safe and supportive management techniques. The foster mother or the Ministry never consulted with a medical practitioner to determine whether the harness was safe and appropriate in the circumstances.

When Savannah finally did see a pediatrician in October 2000, he found lack of growth and poor weight gain and required further examination to determine the cause. He was of the opinion that her behavioural difficulties could be related to her environment. Ministry staff failed to consult with the pediatrician after the assessment and therefore did not ensure that further appointments occurred so that additional testing could be completed. Savannah died before the Ministry received the report from the pediatrician; consequently, none of the pediatrician's initial insights about Savannah's health were factored into her plan of care and she did not benefit in any way from the assessment. Her health continued to deteriorate, with increasing absences from the Child Development Centre in the fall and winter of 2000, her behaviours remained misunderstood, and she continued to be mismanaged by her foster parents.

Savannah's development was not adequately assessed and her plan of care did not address her health needs. As summarized by the Ministry review:

> [Savannah] was identified as high needs at the time she was admitted to care. She was in care for almost three years. That period of time reflected most of her life. After thirty-one months, [Savannah's] workers were only marginally closer to fully understanding and responding to her high needs than they were when the child was first admitted.

The 1999 guardianship standards (as well as the current standards) state that children in care require an admission to care medical examination and "appropriate" medical care. In Savannah's case, appropriate medical care would have entailed timely diagnostic testing, a comprehensive plan of care to address her health problems, and collaboration

and information sharing between the Ministry and health care professionals. Reasonable standards of practice were not evident to diagnose her delay and support her healthy development.

Aboriginal identity

The United Nations *Convention on the Rights of the Child* (1989) states that an Aboriginal child has the right to preserve his or her identity, family relations, indigenous culture and religion and to use his or her own language. The recent United Nations *Declaration on the Rights of Indigenous People* (2007) further recognizes the importance of supporting Aboriginal children, particularly during family breakdown.

The *Child, Family and Community Service Act* mandates and guides staff to determine the Aboriginal heritage of the children and families served by the Ministry. The guiding principles specify that the safety and well-being of children are the paramount considerations and that the cultural identity of Aboriginal children should be preserved. The act also outlines the rights of children in care, which include the right to receive guidance and encouragement to maintain their cultural heritage.

Of the four children that were the subject of this investigation, Amanda, Savannah and Serena were Aboriginal. The investigation found that Amanda's Aboriginal identity was not determined until after she died. It was not assessed as a relevant matter in the Ministry reviews. Ministry intervention with Savannah and Serena was insufficiently informed by their Aboriginal heritage.

Savannah was the only child in care at the time of her death and for a significant part of her life. As an Aboriginal child in care, the legislation required preservation of her Aboriginal identity and involvement with her Aboriginal community. The Ministry did not support and promote Savannah's best interests, as it was obligated to do as her legal guardian, because it failed to preserve her Aboriginal identity and involve her Aboriginal community. For the siblings of Amanda who came into care after her death, this investigation has revealed the same problem.

Despite legislation requiring the Director to give priority to placing Aboriginal children with relatives and Aboriginal families (*Child, Family and Community Service Act*, s. 71(3)) there is nothing in the files to indicate that, in either of her foster home placements, the Ministry explored the option of placing Savannah with a relative or within the Aboriginal community. Even though Savannah had been in foster care for over two years and she was in continuing custody of the Ministry, there were no plans documented in the file for adoption or for long-term placement with relatives or her Aboriginal community. This investigation found that suitable relatives were available to care for Savannah, but no effort was made to consider them as caregivers.

As the Ministry review into Savannah's death noted, "Providing [Savannah] with an opportunity to develop a positive cultural and racial identity even at her developmental age required more than a scrapbook" (p. 26).

The foster parents appear to have been a significant barrier to fostering a positive connection with Savannah's family and culture. Savannah's mother testified at the inquest that the foster parents would not allow her to visit Savannah at their home and that the foster mother cancelled many visits. In the communication book used between the Child Development Centre and the foster home, the foster mother drew unhappy faces next to notes indicating when a visit between Savannah and her mother was scheduled. The Ministry review of Savannah's death found that the foster mother was not supportive of Savannah visiting with her mother.

Although the legislation requires Savannah's parent and her Aboriginal community to be involved in formulating her plan of care, their participation was not documented in the file. It appears that Savannah's plan of care was created without any input from her family or her Aboriginal community. This fell below the expected standard of practice.

Savannah was an Aboriginal child. This fact should have made a difference in how the Ministry, as her legal guardian, planned for her care and advanced her best interests. Instead, her Aboriginal identity and rights were overlooked or ignored, which limited the Ministry's ability to act in her best interests.

Case reviews

In the examination of the 22 child death reviews the investigation has found that consistent identification of whether or not children were Aboriginal and their community information was missing. When children were identified as Aboriginal, it was not clear what efforts were made to involve their Aboriginal family and community in planning for their safety.

Information sharing and coordination

> Child abuse can rarely be decisively established or dismissed on the basis of one item of information only. Even serious physical injuries, though arousing strong suspicion of abuse may be due to accident or illness, or there may be dispute about the perpetrator and, therefore, about what steps should be taken to protect the child. Identifying child abuse is more akin to making up a jigsaw puzzle than to any simple process of observation. And one lesson that has repeatedly come out of the inquiries into children's deaths is that one professional rarely sees many pieces of the jigsaw puzzle. Sharing information is crucial for children's safety.
>
> – Dr. Eileen Munro (2004)

The 1995 Gove report addressed the importance of information sharing and coordination among child protection workers, the police and the health care system. He found that social workers misunderstood what information they could disclose about a family during a police investigation or to a physician when concerns about abuse or neglect were being considered in a medical examination. Judge Gove recommended joint training of social workers and police officers to enhance understanding of respective roles and responsibilities.

In its 1998 annual report, the British Columbia Children's Commission made 46 recommendations about the need for better information sharing among service providers. The recommendations "resulted in inter-agency meetings, numerous reviews of information sharing requirements, and the development of clear protocols about information sharing between particular agencies" (Children's Commission, 1998, p. 60).

Lack of information sharing and coordination between the Ministry and other professionals in the community was an issue in Amanda, Savannah, Rowen and Serena's deaths and in the reviews conducted in the North region between 1999 and 2005.

In spite of the Simpson children's involvement with community supports, the school, the police and the health system, there was a lack of coordinated information sharing on their behalf. Professionals in each of these systems had valuable information about Amanda and her siblings that would have created a more accurate picture of the risk and poor level of functioning of the family. When viewed in conjunction with information provided by the children, consultation with professionals involved with the Simpson family would have provided a more thorough and objective assessment of the home situation, the children's well-being and their risk of harm. The child protection investigation policy directed workers to access information from all of these sources. There was a consistent failure to gather information from the full range of sources in these different yet integral systems of support.

Despite multiple reports of abuse and neglect between 1997 and 1999, the Ministry did not report any of these to the police. Community professionals reported that one of the children was being sexually abused and had other suspicious injuries; additional reports of suspected physical abuse were made to the Ministry on two occasions in October of 1999. According to Ministry policy then and now, all injuries of suspected abuse must be reported to the police. Workers recorded that they did not think that the injuries to the Simpson children were severe. They decided not to report them to the police. Despite a history of domestic violence and involvement in the justice system by the adults in the household, the Ministry did not consult with the police to ascertain what knowledge they may have had in relation to the Simpson family from 1997 to 1999.

Protocols guide information sharing practices, particularly with police, and the child protection system depends on the coordination of information between the Ministry and

the police to ensure child safety. The Ministry did not involve the police and hence did not benefit from what the police might have brought to the evaluation of the children's safety.

In Savannah's case, there was inadequate sharing of information between the Ministry and medical practitioners and the Ministry and staff at the Child Development Centre. There was no consultation between Savannah's guardianship worker and medical practitioners. Savannah's foster mother was the sole source of information and contact for Savannah and the health practitioners. As previously discussed, the Ministry failed to consult with a physician in regards to the harness.

The Child Development Centre and medical records at the time of Savannah's death indicate that she suffered from fetal alcohol syndrome and attention deficit hyperactivity disorder. However, Savannah was not diagnosed with either of these conditions by a physician. It appeared that she was given these labels by her foster mother. Better information sharing and coordination among Savannah's guardianship worker, the foster mother, physician and Child Development Centre staff might have resulted in a better understanding of Savannah's needs and a proper assessment and diagnosis of her condition.

There was further absence of meaningful information sharing and coordination between the Child Development Centre and Savannah's guardianship worker. Although Ministry staff attended weekly conferences at the centre to discuss all of the children in the Ministry's care attending the Centre, notes do not reflect detailed observations of Savannah. The Child Development Centre did not follow up with the Ministry in regards to Savannah's unexplained absences from the centre in the fall and winter of 2000. Her teacher noted that Savannah had some unexplained bruising, but she did not ask the foster mother for an explanation nor report it to the Ministry.

The Child Development Centre staff's observations of Savannah's behaviour differed from those of the foster mother. While the foster mother reported aggressiveness, temper tantrums, and self-harming behaviour and described Savannah as having a "mean streak," the staff at the Child Development Centre had different experiences of Savannah. At the inquest, Savannah's teacher at the Centre between September 1999 and September 2000 testified that she did not see these other behaviours reported by the foster mother, with the exception of the temper tantrums. She explained that initially Savannah had many temper tantrums but they decreased noticeably, from about twice a day to once a week, as Savannah responded well to clear and consistent guidelines, redirection and a lack of response to her tantrums. According to the teacher, Savannah was not aggressive, did not scream or yell frequently, did not cry a lot, would wake up frightened and need comforting, and was improving in her attention, self-care and fine motor skills. Communication with staff from the Child Development Centre would not only have provided valuable information about Savannah's development but might have caused

the Ministry to question the appropriateness and effectiveness of behaviour management techniques used by the foster home.

Savannah's guardianship workers were responsible for a developing and implementing a comprehensive plan of care that should have included an informed and detailed plan to address her health, educational, emotional, developmental, social, familial and cultural needs. Her last comprehensive plan of care was dated September 27, 2000 and was not complete in many areas. Most of the information included in the plan was obtained from Savannah's foster mother. Input from medical practitioners who had been involved with Savannah, such as a physiotherapist, occupational therapist, psychologist, physician, and pediatrician, was not obtained. The guardianship workers did not seek the views of the Child Development Centre staff, who had frequent interactions with and different observations of Savannah.

Despite the valuable information medical practitioners and the Child Development Centre staff had about Savannah, based on observations, assessments and professional interactions, Ministry staff failed to consult these professionals to develop a plan of care for Savannah that would support her development and promote her well-being. The lack of this information resulted in goals that were inappropriate for Savannah. For example, Savannah's poor growth rate and possible regulatory disorder were not addressed in the plan of care.

Similarly, Rowen's death raises the issue of lack of information sharing and coordination between Ministry workers and medical practitioners. Rowen's mother had significant medical issues, including severe headaches and mobility problems. Her direct care of her children was limited, especially after Rowen's birth. Rowen's father consulted with a public health nurse about depression and feelings of being unable to cope with his home situation. The worker did not consult with the family doctor to understand the parents' health conditions and the impact they had on the parents' ability to care safely for their children. Consulting medical practitioners about Rowen's parents health conditions would have been another opportunity for the worker to understand the information in the parental capacity assessment and the seriousness of Rowen's mother's illness.

Poor information sharing and coordination among Ministry staff and other professionals is also evident in Serena's case. No medical information was available about her mother's struggles with addictions because the Ministry worker did not attempt to access it.

There was a similar lack of information sharing and coordination between the representative of the Yekooche Band's community-based response team and the Ministry worker. The representative of the Yekooche Band was a relative and had concerns about Serena's mother's ability to care for Serena. The extended family had enacted an informal safety plan for Serena if they knew or suspected that her parents were drinking.

Case reviews

The children's deaths and critical injury reviewed during the 1999–2005 period also revealed problems with information sharing and coordination among Ministry workers and key professionals in the community. The critical injury review identified lack of information sharing and coordination between the Ministry and the hospital and the Ministry and the police.

Supervision

Clinical supervision and case consultation are essential to the delivery of child welfare services (Gove, 1995). Effective supervision minimizes the impact of personal bias and reduces the likelihood of incomplete and inadequate practice. It also provides mentoring and supports the development of strong intervention skills for front-line social workers. The BC Risk Assessment Model directs that "it is important for reasons of objectivity and thoroughness that this process of examination, assessment, and decision be undertaken jointly by the social worker and the supervisor" (The BC Risk Assessment Model, p. 35).

Clinical supervision and case practice consultation is seen in nearly all of these cases as lacking in focus and a clear understanding of the issues these cases presented. Each death presents a clear example of child maltreatment.

In Amanda's situation, issues of neglect and escalating abuse were apparent. The role of clinical supervision is to assist the social worker throughout management of a case to identify patterns that are emerging (i.e., signs of neglect and abuse). File documentation suggests one supervisor was confused about the role and responsibility of a supervisor. This supervisor signed off a file despite concerns about the history of the Simpson family. This supervisor recognized the pattern of reports of neglect and abuse but the extent of the action suggested was only to make a notation on the file. The supervisor did not have a discussion with the worker, direct that more information be collected or inquire into what services were provided to assist the family before the matter of intervention could be determined. The opportunity to intervene in this instance was lost. The opportunity to strengthen the practice of the front-line workers was not possible given the limited capacity of the supervisor.

In the case of Savannah, there was little supervision provided and there was an apparent lack of knowledge regarding child development and understanding of Savannah's special needs. Due to the frequent changes in Savannah's guardianship worker it was the supervisor's role to ensure continuity of service to Savannah.

Similarly, with Rowen and Serena, supervision and case practice consultation were not effective in directing the staff to complete more thorough investigations.

Case reviews

The children's deaths and critical injury that were reviewed from the period 1999–2005 also identified a lack of clinical supervision and case practice consultation at critical decision making points.

Staffing levels

The supervisory and general staffing levels are recurrent themes in the investigation of the four children's deaths. These challenges appear to have limited the capacity to deliver effective child protection services to Amanda, Savannah, Rowen and Serena.

Ministry documentation indicates that the North region was experiencing high staff turnover as well as staffing shortages when the Ministry was involved with Amanda's, Savannah's, Rowen's and Serena's families. In early November 1999, the then Regional Executive Director for the North region brought concerns regarding the critical staffing levels to the attention of senior executive. Concerns were expressed that social workers could not be recruited quickly enough and that practice standards could not currently be met in some offices.[1] On November 23, 1999, the then Regional Child Protection Manager of the North region provided the Regional Executive Director with a paper entitled "Provincial Staff: A Northern Perspective," outlining concerns with the current ideas to help increase the staffing level in the North region. It stated:

> At present time staffing in the northern region is below the "critical mass". Social workers are looking around and seeing rapid turnover of experienced colleagues and no folks replacing them. In a number of cases….there is only one, or no permanent social work staff remaining. From this perspective it is surprising more aren't leaving.[2]

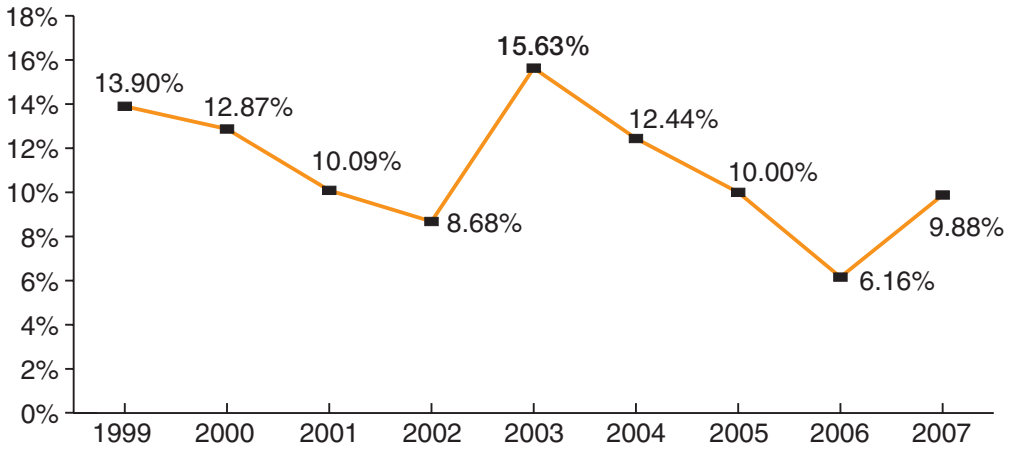
A Ministry briefing note dated January 21, 2000, regarding the North region's workload management and practice standard strategies identified that the region had "58.8% of its protection/guardianship social workers available to manage…workload levels." The briefing note went on to relate that there were no offices in the region that were fully staffed at the time and that with a 58.8% regional staffing level, "protection and guardianship standards are not currently being met."[3]

The North region experienced significant staffing shortages beginning in 1999, and had concerns about the ability of its offices to meet practice standards. Figure 4 shows the turnover rate for child welfare social workers (excluding supervisors) within the North region from 1999 to 2007. The turnover rate fluctuated between a high of 16% in 2003

[1]"The Northern Region's Staffing Crisis – A Historical Review". Attached to a letter to the Acting Associate Regional Executive Director for the Northern Region from the then Regional Child Protection Manager dated October 30, 2000.
[2]"Provincial Staffing – A Northern Perspective" Attached to a letter to the Regional Executive Director from the Regional Child Protection Manager dated Nov. 23, 1999.
[3]Ministry for Children and Families. Briefing Note. January 21, 2000.

and a low of 6% in 2006. Between 1999 and 2000, the turnover rate was identified as being at a constant rate of one fully delegated social worker per week on average.[4] A briefing note to the Minister stated that as of October 1999, only 161 of the 222 child protection, resource and guardianship positions were occupied in the North region. Thirty-five staff members had six months or less experience, 19 had six months to one year of experience, and 11 had one to two years experience. As a result, 30% of child protection, resource and guardianship social workers in the North region had less than two years experience.[5]

Figure 4: Percentage turnover of child welfare social workers in the North region (excluding supervisors)

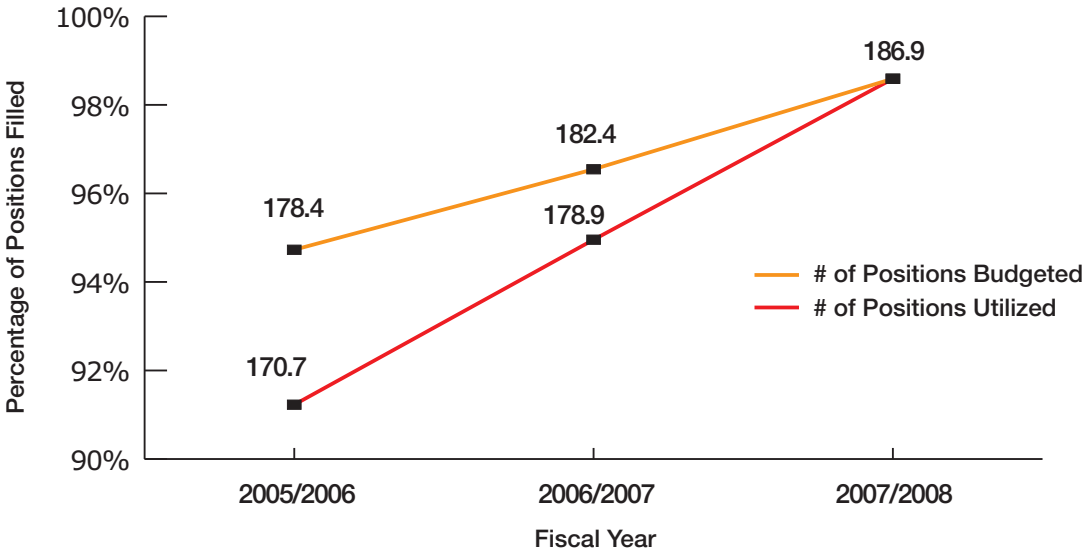


Unfortunately, consistent data is not available for the North region's allocated and filled staff positions for child protection social workers and team leaders prior to the 2005/06 fiscal year. However, as stated earlier, the Ministry did report that the North region only had 58.8% of its child protection and guardianship worker positions staffed in early 2000. According to a Ministry briefing note prepared for the Minister on December 3, 1999, the regional management team believed that with the implementation of the pre-employment training requirement, recruitment had effectively stopped in the North region. The North region management team identified strategies to address this situation. They borrowed staff from other regions and sought exemptions to pre-employment training. They also sought permission to hire graduates from out-of-province social work programs. These measures were successful in the short term. They did not appear to address the problem of retaining those staff, as evidenced by Figure 4, which shows high staff turnover rates in 2003 and 2004.

[4]Ministry of Children and Family Development. *Northern Region – Briefing Paper: A "Medium-Term" Strategy to Address Critical Staffing Shortages* attached to a letter to Acting Regional Executive Director Northern Region from the Regional Child Protection Manager, dated February 14, 2000.
[5]Ministry of Children and Family Development. Briefing note prepared for Minister, December 3, 1999.

Figure 5 identifies the gap between the number of child protection social worker and team leader positions allocated to the region and the number of positions utilized between the fiscal years 2005/06 and 2007/08. During this period the North region was experiencing comparatively less turnover in staff.[6]

Figure 5: Budgeted and utilized child protection social worker and team leader positions, North region



The analysis of the human resource situation in Figure 5 shows evidence that some of the strategies implemented by the Ministry to address low staffing levels in the North have met with success. In fact, between October 2001 and October 2004, the Ministry spent $1,058,993 on the "Northern Incentive Bonus" program to hire 109 employees. The program offered financial incentives to social workers who would move to the North region: a $4,000 initial bonus upon employment and an additional $8,000 upon completion of one year's employment in the North region. Seventy (64%) of the staff who were recruited with this incentive program continue to work in the North region.[7]

[6]Ministry of Children and Family Development. "Count of Child Protection Social Worker and their Team Leader Positions," attached to letter to Deputy Representative for Children and Youth from Assistant Deputy Minister, March 19, 2008.
[7]CHIPS (Corporate Human Resources Information and Payroll System) data provided by Ministry of Children and Family Development Assistant Deputy Minister to Deputy Representative for Reviews and Investigations, March 19, 2008.

According to the Regional Director of Child Welfare, the initial success of the program saw the numbers of staff increase. Currently the North region is staffed at 98%. Nine percent of the staff are of Aboriginal ancestry.[8,9]

The staff on Savannah's guardianship team struggled with vacancies in their team and a lack of experienced workers. According to the Ministry Director's case review of Savannah's death, staffing levels often fell to 61% in the Prince George office over the time that Savannah was in care. The review explains that where staffing did improve, it was most often due to the addition of newly hired and inexperienced workers. Savannah had two guardianship social workers between October 2000 and January 2001 who were still completing training. At the inquest, the team leader for Savannah's guardianship team from 1998 until approximately October 2000 testified that there was instability in staffing, with workers coming and going throughout this period.

According to inquest testimony, staff was not able to meet the standard for number of visits to the home to assess Savannah's well-being or complete the required annual foster home reviews at least in part because of these staff shortages.

In the Director's case review and in e-mails prior to Savannah's death, Ministry staff and the Regional Manager attributed the delay in investigating the foster home to low staffing levels. Reportedly, the assigned worker had no time to respond "to a foster home matter." According to the review, through the month of December 2000, staffing on the Investigation Team was down from six to two. Between November 2000 and January 2001, there were 123 intakes that required the Investigation Team's attention.

Summary of the issues raised by the four deaths

The investigation into the deaths of Amanda, Savannah, Rowen and Serena revealed several recurrent problems in practice. An analysis of the Ministry reviews of 22 children's deaths and one critical injury from the period 1999–2005 identified some similar issues.

First, in all four deaths, assessments of the children's safety fell below accepted standards of practice at the time. For the three children who were not in care, Amanda, Rowen and Serena, as well as for the case reviews completed in the North region from 1999 to 2005, more thorough and objective child protection investigations were needed. In particular, improvements in understanding family history, gathering information from family and community members, observing and interviewing children, minimizing the influence of personal opinion and completing investigations were warranted. For Rowen's family and for several of the case reviews completed in the North region, completion of the

[8]E-mail correspondence to Ministry of Children and Family Development Assistant Deputy Minister from Director of Integrated Practice, North region, March 17, 2008.
[9]Ministry document, Aboriginal Employees, MCFD, March 2008.

comprehensive risk assessment could have minimized the risk for future harm and identified needed support. As the legal guardian for Savannah, entrusted with the responsibility of ensuring her safety and well-being, the Ministry inadequately assessed her safety by failing to reassess the capacity of the foster home, to complete annual reviews, and to conduct investigations and quality of care reviews of the foster home when they were warranted.

Second, in all four deaths, human resource challenges lessened the ability to provide safe and effective child welfare services. However, not all of the shortcomings can be attributed to this factor alone. It is a contributing factor to practice falling below standard. In Amanda's case history, staffing shortages and lack of supervisory skills and experience contributed to inadequate oversight of the child protection practice, delays in investigations, incomplete investigations and lack of documentation. In Savannah's case history, staffing shortages contributed to a fluctuating staff, fewer home visits and delays in investigating her foster home. In Rowen's case history, lack of clinical supervision resulted in an incomplete investigation that did not adequately consider the family history or the perspectives of others in the community.

Third, insufficient communication between the Ministry and professionals in the community was evident in all four children's deaths. The failure to engage the police in Amanda's case resulted in the loss of a separate investigative lens to the children's circumstances, one that brought knowledge of the history of the adults in the household. Inadequate coordination between the Ministry and health care professionals was a barrier to ensuring a comprehensive medical assessment for abuse and neglect. Lack of communication among Savannah's guardianship worker, medical practitioners and the Child Development Centre contributed to a deficient comprehensive plan of care, labelling without diagnosis, a failure to adequately assess her functioning and development, the Ministry's unawareness of Savannah's unexplained absences from the Child Development Centre and unmet health needs. The absence of communication and collaboration between the Ministry and medical practitioners involved with Rowen's parents resulted in the worker failing to appreciate how the parents' respective health conditions limited their ability to care for their children. In Serena's case history, the failure to obtain medical information about Serena's mother's struggles with addiction, coupled with the lack of communication between the Ministry worker and the representative of the Yekooche Band's community-based response team, contributed to the worker's ill-founded conclusion that the mother's addiction did not jeopardize Serena's safety.

The case reviews of critical incidents from the period 1999–2005 similarly reveal problems with communication and information sharing among Ministry staff and other professionals in the community, in particular the police and medical practitioners.

Fourth, Amanda and Savannah's experiences illustrate a deficiency in ensuring thorough medical assessments for these vulnerable children. Amanda did not have a consistent doctor and neither the reports of abuse and neglect nor her family's history with the Ministry were shared with health care practitioners. Amanda and her siblings were not independently evaluated without the parent directing the check-up. In Savannah's case history, the absence of a detailed and informed medical plan of care and ceding all health care responsibilities to the foster parent resulted in the failure to have her medical needs assessed adequately.

Given the recurring problems evident in the four children's deaths, two key questions for this investigation were:

- How did the North region respond to or learn from each of the four deaths?
- Do the issues raised by the children's deaths suggest or reflect systemic problems in the child-serving system in the North region?

To answer these questions, this investigation examined the Ministry reviews and recommendations that followed the children's deaths, audits conducted in the North over the period 1999–2005, human resources data, and strategies implemented by the North region.

The North region's response to and learning from each of the four children's deaths

Identifying ways to improve policy and practice to prevent future injuries and deaths is a central purpose of reviewing children's deaths or injuries. The objective of a quality assurance system is to obtain information about how the child-serving system is functioning in order to improve service delivery and performance. The Ministry has two main tools for obtaining such information: Director's case reviews and Deputy Director's reviews of critical injuries and death; and audits of compliance with child protection and guardianship standards. This section of the report looks at whether the Ministry used the review process effectively to learn from the four children's deaths, and summarizes the recommendations arising from reviews of critical incidents in the North region in the period 1999–2005. The section also explores how audits conducted in 1999–2005 can inform our understanding of the effectiveness of the child-serving system in the North region.

The key difference between a Director's case review and a Deputy Director's review is scope. As noted earlier, a Deputy Director's review is a review of documents that includes files and any other related reports, whereas a Director's case review is more extensive and involves interviews of key people involved with the file. Once the findings process of a review is complete, the information is analyzed to identify practice issues.

Recommendations are then developed to address the issues identified in an effort to improve practice and enhance service delivery. A provincial computerized system tracks the implementation of recommendations, which is a separate process and is not reported on within the context of the report.

Staff from the Quality Assurance Branch at Ministry headquarters completed Director's case reviews of Amanda and Savannah's deaths. By the summer of 2002, the Ministry began preparing to devolve quality assurance functions, including case reviews and practice audits, to the regions. The North region completed Deputy Director Reviews of Rowen and Serena's deaths.

Amanda

The Director's case review following Amanda's death was completed in a timely manner and resulted in 12 recommendations intended to move the region towards safer and more effective child protection practice. The recommendations were implemented within the prescribed time frames. Additional child protection consultants and supervisors were hired to support workers. Outside the Prince George area, individual offices were provided with training in investigation and use of the risk assessment model if these issues were identified in practice audits or death reviews from the office's service delivery area.

Inconsistent regional leadership did hamper the efforts to fulfill the spirit and intent of these recommendations. The regional executive director left after the review of Amanda's death. An interim director was in place for several months while a replacement was found. The individual hired did not stay in the position for longer than six months and was replaced by another executive director. According to the interim regional director, the rest of the regional management team struggled after Amanda's death; morale was low and staff had difficulties moving forward in a positive direction. This must be understood as part of social work practice. Critical incidents can cause secondary trauma in workers, and the system may have had a tendency to find a worker to blame and lay the entire responsibility on one person's shoulders while not learning from the challenges posed across the organization and by the deficiencies in the quality assurance system. The front-line staff may never have had a chance to learn from the review given the turmoil in management.

Recommendations from the Ministry Director's case review following Amanda's death

1. The Regional Executive Director ensures that all child protection workers and the supervisors re-attend the child protection investigation training program and the risk assessment training program within 90 days.
2. The Ministry Training Branch is to co-ordinate the required investigative training and risk assessment training in Prince George within 90 days.
3. The Regional Executive Director immediately ensures that the Regional Child Abuse Consultant is not assigned to cover supervisory vacancies unless their position is adequately back-filled.
4. The Regional Executive Director ensures that the Regional Child Protection Manager advises all child protection workers and supervisors of the requirement for immediate case consultation, including when consultation should be sought, where case consultation is available and how it may be accessed. A copy of this direction to staff is to be provided to the Director's office within 14 days.
5. The Regional Executive Director ensures that the Ministry protocol with the school board be amended to include direction for who to contact in the Ministry when school personnel disagree with the Ministry response to a child protection report.
6. The Regional Child Protection Manager initiates and establishes regular practice forums and these practice forums are used to keep staff up to date on child protection practice and to continue to develop child protection knowledge and skills.
7. Regional Child Protection Manager immediately discuss with all child protection staff the practice standards respecting child protection reports and investigations, case consultation and reporting to the police.
8. The Regional Executive Director ensures that there is a written protocol developed between the Ministry and the RCMP and that staff are advised of the requirement to report cases of child abuse to the police. A copy of this protocol is to be provided to the Director's office within 30 days.
9. The Regional Executive Director ensures that all acting supervisors are advised of their sign-off requirements prior to assuming supervisory duties.
10. The Ministry commits funding in fiscal 2000/01 to support the establishment of a SCAN (Suspected Child Abuse and Neglect) team in Prince George for the purpose of providing expert medical assessment of abused/neglected children and children at risk of abuse/neglect.
11. The Assistant Deputy Minister of Regional Operations in consultation with the Regional Executive Director considers the establishment of an additional supervisory position and an additional child protection consultant position in the Northern Interior Region, Prince George office.
12. The Assistant Deputy Minister of Regional Operation ensures that the Northern Hiring Strategy is given priority implementation status.

Savannah

The Director's case review of Savannah's death was completed one year after her death. Some of the recommendations resulting from the review were not implemented. For example, the Regional Executive Director did not meet with staff to share the findings and discuss the review. The reason provided in the Ministry recommendation tracking system for the failure to debrief with staff was ongoing litigation relating to the closure of the foster home. Once the civil suit was resolved, however, the review was still not shared with the staff. It is not clear that organizational learning resulted from this review at the front-lines of the Ministry.

Moreover, the recommendation relating to guardianship training for all Ministry social work staff regardless of their role and function was rejected because it was extremely costly. The recommendation relating to restraints was rejected because the guardianship standards already addressed the issue. There was an existing standard which forbade the use of restraint unless a child was in imminent danger. No new communication was issued.

The recommendations failed to address some of the key issues that arose in Savannah's case such as her deficient plan of care, her inadequate medical assessments, the absence of fostering her Aboriginal identity and connecting her with her Aboriginal community, the failure to complete annual reviews of the foster home and follow foster home protocols, and lack of effective communication and collaboration between the Ministry and staff at the Child Development Centre. The failure to attach recommendations to some of the key issues that arose in Savannah's case minimized the learning that could result from her death. This investigation found no evidence that systematic learning from this review occurred with front-line workers.

Recommendations from the Ministry Director's case review of Savannah's death

The Director's case review of Savannah's death included the following recommendations:

1. The Assistant Deputy Minister for the Child and Family Development Division direct all Ministry staff to contact the local Nursing Support Service Co-ordinators for information and consultation for children with multiple or complex health needs.
2. The Assistant Deputy Minister for Regional Operation to consider that there be a priority hiring for child protection staff for the North.
3. The CEO/Regional Executive Director of the North ensure that all Ministry social work staff attends Guardianship training irrespective of their role and function in the Ministry.
4. The Manager of Guardianship in the Child and Family Development Division is to clarify the guardianship role of staff when there are staffing shortages in a region.
5. The Manager of Guardianship in the Child and Family Development Division is to review whether there is sufficient policy/practice standards with respect to the use of restraint for children in care of the Director. As well, this review should include whether it is necessary in light of the findings of this review to provide a Practice Directive to staff regarding the Director's expectation that a harness is not an appropriate restraint for a child.
6. The Manager of Guardianship in the Child and Family Development Division review the policy regarding "exceptions" to the number of children placed in foster homes with respect to the criteria, evaluation and process as to how these exceptions are determined.
7. The CEO/Regional Executive Director will ensure that the findings of this review are shared with the guardianship staff in the North in a practice forum. The précis of this review may be used for this purpose.
8. The CEO/Regional Executive Director and the designated manager re-evaluate what foster homes are used as emergency homes by after hours staff in the North with particular attention to the process of adding and removing foster homes for the list and the planning process for moving children from the emergency foster home to another placement in a timely manner.
9. The CEO/Regional Executive Director in conjunction with the appropriate designated manager for After Hours examine the delay in removing the Keene foster home from the After Hours/ Emergency foster home list following allegations of abuse in the home in November 2000.
10. The CEO/Regional Executive Director ensure that the policy and practice of Integrated Case Management is reviewed with the involved staff using the précis as a point of discussion.
11. The CEO/Regional Executive Director is to meet with the Executive Director of the Child Development Centre and staff to share the findings and discuss this review.
12. The CEO/Regional Executive Director ensure that the Manager for Resources and Contract Management review with Resources staff that bedrooms in foster homes are located appropriately for ready and easy access by the foster parent as well as to ensure the safety and well-being of the child in the foster home.

Rowen

The review of Rowen's death was delayed by one year due to the police investigation. Despite a police investigation and suspicious circumstances surrounding Rowen's death, the North region decided to do a Deputy Director's review only. This limited the opportunity to learn from the circumstances related to Rowen's death in a thorough and timely fashion. The seriousness of his injuries, the length of engagement with the Ministry and the gravity of the incident all warranted a more robust examination through the Director's case review process.

The recommendations were approved and implemented over one year after the completion of the review. Management communicated the review of Rowen's death to front-line staff by way of a verbal briefing in 2005. Front-line workers were not provided with the actual report. The worker involved in Rowen's case was provided information about the review two years after Rowen died. Interviewed for this investigation, the worker reported that little was learned from the review experience. She reported that the issue of assessing a child's safety while using the parental capacity assessment was not made clear to her as an area for stronger future practice. The staff involved in the case reported that the review of practice issues was brief and limited to the instruction to "look a bit more into the family history."

As was the case with Savannah, the recommendations missed some of the key issues identified in Rowen's death. There were no recommendations relating to supervision nor to communication and collaboration between the Ministry workers and medical practitioners.

Recommendations from the Ministry Deputy Director's review of Rowen's death

The review included three recommendations:

1. The Acting Regional Executive Director, North region, ensures that the Community Service Manager, Northwest share and debrief the report with the staff involved and reviews in particular, the practice issues identified by the report.
2. The Acting Regional Executive Director, North region, ensures that the Community Services Manager, Northwest facilitates the completion of the outstanding Comprehensive Risk Assessment and ensures it reflects the known history, including the Parental Capacity assessment.
3. The Acting Regional Executive Director, North region, will provide a written response to the recommendations to the Deputy Director, North region advising on the progress of the recommendations and copied to the Director, Quality and Devolution Management Branch, Child and Family Development Division, for tracking purposes, within 45 days of the date of the final report.

Serena

When Serena died in 2005, the review was completed in a timely fashion. As was the case with Rowen, the Ministry conducted a Deputy Director's review. As such, there was no interviewing of staff regarding the impact of staffing and supervision on their practice. The issue of supervision is raised in one recommendation but the wording is vague, recommending simply that the Community Service Manager reviews "the supervisory standard with the supervisor and ensures that operationally, there are no barriers to meeting the standards." The lack of input from staff in the office may have contributed to a broad recommendation with little opportunity for direct identification of practice issues pertaining to specific standards.

As was the case with Rowen, the review was shared with front-line workers in a verbal debrief. They did not receive a copy of the review. The worker involved in Serena's case reported that the information shared from the review did not lead to an improved understanding of how to consider a family's past history in assessing a child's safety. Since Serena's death, the worker reports that she has learned the importance of considering family history from other experiences and the value of good clinical supervision.

With respect to the recommendation regarding training for staff on the impact of adult addictions for the safety of children, the training provided did not specifically address this issue. The training addressed the general subject of addictions rather than the assessment of a child's safety in cases where parents struggle with addictions. The supervisor in the office has planned to reschedule this training.

The review of Serena's death failed to identify the role of the sleeping environment in the child's death. The staff has not received any training on safe sleeping environments for infants and children. The review and recommendations similarly did not address the issue of the need for Ministry workers and health care practitioners to clarify any misunderstandings related to information sharing.

Recommendations from the Ministry Deputy Director's review of Serena's death

1. That the Community Service Manager share the report with the staff and review the need to consider history when screening for section 13 circumstances and determining the most appropriate section 16 response.
2. That the Community Service Manager facilitate in-service training for staff in the area of addictions and the relationship to assessing risk to children.
3. That the Community Service Manager reviews the supervisory standard with the supervisor and ensures that operationally, there are no barriers to meeting the standards.
4. That recommendations #1 and #3, developed by the North region, is completed within 60 days and recommendation #2 developed by the North region, is completed within 90 days.

The four deaths

Of the four children's deaths, the learning opportunities were greatest following Amanda's death. The recommendations were implemented in a timely manner and addressed the practice issues identified. The turnover in management may have diminished the opportunity for front-line learning. The reviews of the other three children's deaths and the associated recommendations had limited effectiveness from the perspective of systemic learning and quality improvement.

Rowen and Serena's deaths were reviewed by way of a Deputy Director's review only. Of all the other reviews completed in the North between 1999 and 2005, other than Amanda and Savannah, only the critical injury was reviewed by way of a Director's case review. Between when the quality assurance function was devolved to the regions in 2002, and 2005 the North region only completed only one Director's case review. However the region has subsequently completed a second Director's case review.

Without the opportunity to interview staff, family and community members, a file review provides a less comprehensive analysis and may not capture how staff applied policy, what challenges they experienced in performing their work, the impact of lack of supervision, inexperienced staff, workload, staffing shortages, and the effectiveness of training. A less rigorous analysis results in less responsive and effective recommendations. It is evident from this investigation that there was and continues to be little organizational learning from reviews.

Important matters may have been overlooked as a result of the narrow terms of the file reviews. In Serena's case, the review failed to identify the issue of a child's sleeping environment and, thus, no recommendation followed regarding training on safe sleeping

environments for infants and children, a significant matter for vulnerable children and Aboriginal children (Coroners Service, 2005, p. 9–10).

The effectiveness of the reviews in promoting learning at the front-lines was limited by the manner in which they were shared with staff. In Savannah's case, the review was never shared with the staff. In Rowen's case, staff members were verbally briefed two years later and the practice issues identified in the review were not clearly communicated to the staff. In Serena's case, the worker reported that the verbal brief did not improve her understanding of the key practice issues that arose from the review. For reviews to serve their most basic educational purpose, they must be shared with workers, especially those at the front-lines of a complex system, in a timely and rigorous manner. Organizational learning requires consistent and planned information sharing, feedback and analysis. Front-line staff require greater support through detailed debriefing and training.

In some cases, the recommendations failed to address key practice issues which undermined the learning potential. For example, the need for a comprehensive medical assessment and a well informed plan of care were central issues arising in the investigation of Savannah's death. These issues were not raised in the recommendations stemming from the Ministry's review of her death. Similarly, in Rowen's case, the lack of communication between the Ministry and health care practitioner's, and concerns regarding inadequate supervision and staffing were practice issues that clearly emerged, but no recommendations were directed toward possible improvements in these areas.

Public accountability is one means of ensuring that the child-serving system responds effectively to tragic incidents. The Ministry does not share Deputy Director or Director Case Reviews with the general public or families whose children are injured or die. The absence of detailed public reporting of Reviews limits further potential learning and accountability. Many of these children's deaths and injury are invisible because they are vulnerable or in care. The public must be able to learn what happened to these children and what concrete steps were taken to improve the system, particularly if the system of support failed them.

The Ministry's learning from Savannah, Rowen and Serena's deaths was limited by the manner in which the reviews were shared with staff, the substance of the recommendations, and the type of review that was conducted.

Other child death and critical injury case reviews in the North region, 1999–2005

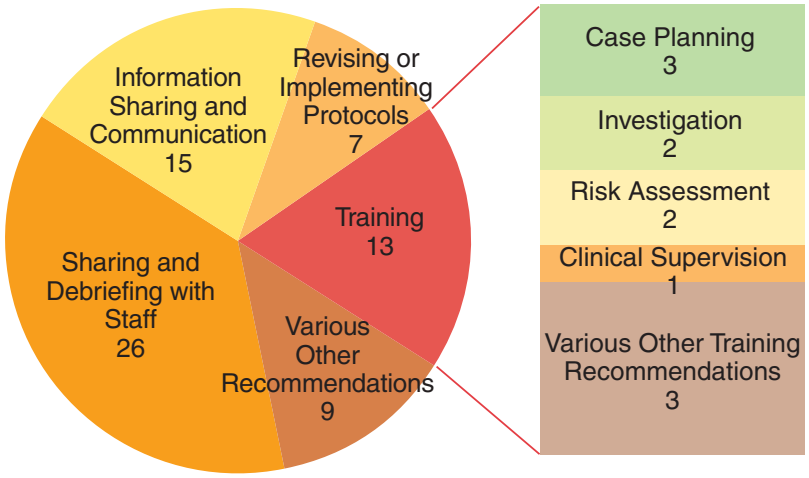
There were 70 recommendations in total from the 23 child death and critical injury case reviews completed between 1999 and 2005, in addition to those which came forward from the four deaths investigated here. According to Ministry's electronic tracking database, all recommendations have been recorded as complete. This investigation did not independently verify that this is accurate.

A number of similarities emerge in these recommendations:

- 26 were related to sharing and debriefing the report with staff
- 15 were focused on improved information sharing and communication within the Ministry and with community stakeholders
- seven were on revising or implementing protocols with community, and
- 13 involved additional training for staff.

Of the 13 recommendations for training, three were related to case planning, two to investigation training, two to risk assessment, one to clinical supervision training, and five covered various training areas. The remaining nine recommendations were on various areas such as new program development and timeframes to complete recommendations.

Figure 6: 70 recommendations from 22 Deputy Director's reviews and one Director's case review, 1999–2005



Practice audits, 1999–2005

The deaths of Amanda, Savannah, Rowen and Serena, as well as the deaths and critical injury of 23 other children, brought to the forefront a number of deficiencies in Ministry practice that recurred in the period 1999–2005. An examination of the Ministry's response to the four children's deaths revealed that organizational learning was limited. In order to determine what, if any, conclusions may be drawn regarding the strength of the child-serving system in the North region during this period, it was necessary to obtain and analyze additional evidence. The investigation examined Ministry practice audits conducted in the North region between 1999 and 2005 to try to ascertain whether the practice issues identified in the four deaths were indicative of systemic problems in the child-serving system.

In 1997 the Ministry developed and implemented a provincial child welfare practice audit program under the leadership of the Director of Child Protection to ensure that a high level of child protection and guardianship service was being provided to children and families in British Columbia. The audits were used to determine the current level of practice in an office, to assist in identifying training needs, and to provide information for use in updating and/or amending standards or practice. Every office in the province that provided child protection and/or guardianship services was scheduled to be audited on a four-year cycle by a provincially based practice auditor. The practice audits were compliance-based, and a set of quantitative audit tools were developed to measure compliance with the child protection and guardianship standards and policies that were effect. This program continued until 2002.

In July 2002 the Ministry suspended the compliance-based practice audit program and moved to a qualitative audit process. A qualitative audit tool was developed, and audits were managed regionally. This process consisted of in-depth reviews of individual cases and did not provide for a baseline measure of the current level of practice in an office. As this was seen as problematic, in March 2004 the Ministry executive decided to reinstate a new compliance-based practice audit program for the new service standards, which had been implemented in November 2003. This program is still in effect today. The audits are intended to determine the current level of practice in an office, assist in identifying training needs, and provide information for use in updating and/or amending practice standards or policy. These audits are managed under the leadership of the Regional Directors of Integrated Practice and are conducted by regionally based practice auditors. Offices are audited once every three to four years.

Since 2002, the Regional Director of Child Welfare (now called the Regional Director of Integrated Practice) has had responsibility for developing a regional audit schedule and administering the audit program in the region. Audits are conducted by regionally based auditors who report to the Regional Director. The Provincial Office maintains primary

responsibility for developing new audit tools and methodologies and preparing provincial summary reports of audit findings and recommendations. In June 2004 the quality assurance standards were implemented, outlining the requirements for practice audits.

As Ministry policy and practice has evolved, so too have the practice standards and their measures of compliance. From 1999 to 2002, audits measured compliance to all of the child protection standards and guardianship policies that were in effect at that time. Since 2004, audits have measured compliance to a subset of Child and Family Service and Child in Care Standards the Ministry considers to be critical.

In the period 1999–2005, the Ministry conducted practice audits in 36 North region offices that were providing child protection and/or guardianship services.

The audits from this period indicate that standards for conducting child protection investigations were for the most part complied with. The audits show compliance with the major steps of the investigation process. One area of particular concern identified in the audits is the development and implementation of a plan to keep a child safe and the reassessment of risk. Once a child protection investigation is complete, if a child is determined to be in need of protection an assessment of risk is conducted, a plan is developed to keep a child safe, and this plan is reassessed on a regular and ongoing basis. The audits results show that between 1999 and 2002 the compliance rates in the North region for completing risk assessments was 58% and for reassessing risk was 47%. The audit results from 2004 to 2005 indicate a compliance rate of 74% for developing and implementing a plan to keep a child safe and 47% for reassessing a plan to keep a child safe.

Another area of concern is with respect to guardianship practice. Guardianship practice refers to the guardianship duties that the Director under the *Child, Family and Community Service Act* has to children in care. When a child comes into care, some of the rights, duties and responsibilities of the parent are transferred to the state. In guardianship practice a key standard involves ensuring that every child who comes into care has a written plan of care. The plan of care should address the needs of the child in the areas of health, education, culture and identity, family and social relationships, social and recreational involvement, self-care and placement. The plan is developed in collaboration with the child, family, extended family, cultural community, child's caregiver and proposed caregivers within six months of a child coming into care and is reviewed regularly. If the child is Aboriginal the child must also have a cultural plan.

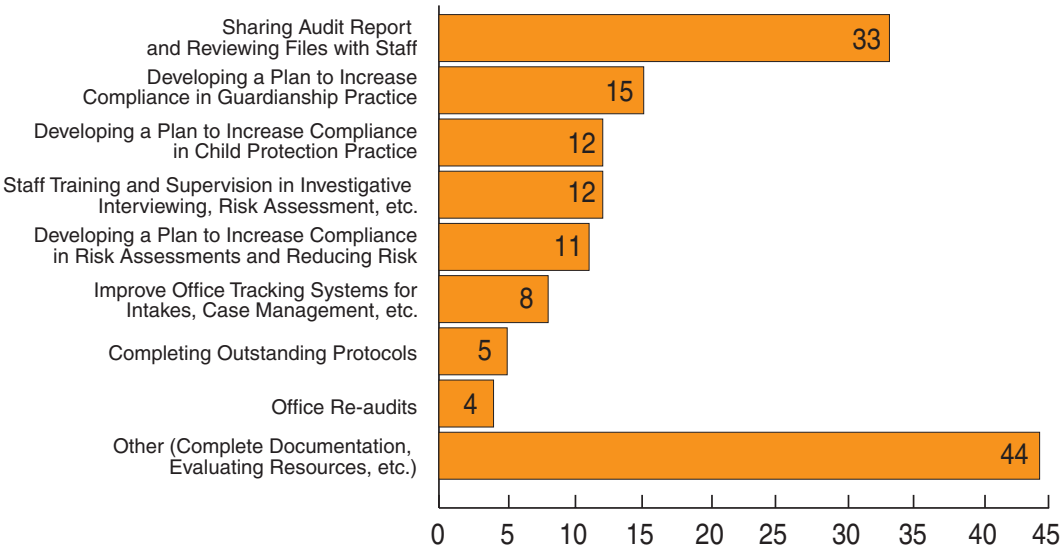
From 1999 to 2002, the audits measured compliance for comprehensive plans of care by looking at three distinct components: whether the plan of care was developed in a meeting with all of the key participants; whether the plan was completed in a timely manner; and whether the plan of care was thorough and adequate. In the audits done in the North region during this period, the compliance rate was 34% for developing a plan of care, 20% for completing the plan in a timely manner, and 29% for completing adequate

plans of care. Audits in 2004 and 2005 measured compliance for plans of care in one critical measure, which showed a 35% compliance rate for assessing and planning for a child in care.

The 36 audit reports contained 144 recommendations. A number of similarities in these recommendations are evident:

- 33 were related to sharing the audit report with staff and reviewing any files identified for further review or containing non-compliance ratings to complete any outstanding work;
- 12 focused on developing a plan to increase compliance in child protection practice in areas such as developing an initial plan of investigation, completing all steps required in a child protection investigation, seeing and interviewing children, and deciding whether a child needs protection;
- 15 focused on developing a plan to increase compliance in guardianship practice, with specific mention of improving practice in informing children of their rights and in completion of thorough and timely comprehensive plans of care;
- 11 were related to developing a plan to increase compliance with comprehensive risk assessments, risk reduction service plans and reassessing risk;
- 12 involved further training for staff and supervision in areas such as investigative interviewing, risk assessment, completing comprehensive plans of care, and specialized sexual abuse training;
- eight recommendations were related to developing or enhancing office tracking systems for intakes, case management decisions, guardianship practice or clinical supervision;
- five were related to completing outstanding protocols;
- four recommended re-audits of offices; and
- the remaining 44 recommendations covered a number of different areas, including ensuring that documentation is complete and evaluating contracted resources.

Figure 7: 144 recommendations from 36 case practice audits in the North region, 1999–2005



Practice audits and case reviews in the North region, 2006–present

Practice audits

In 2006 and 2007, results from nine office audits were examined. The audits in this sample indicate standards for conducting child protection investigations were, for the most part, complied with. The results from these audits suggest that practice remains inadequate in assessing risk and developing a plan to keep a child safe, once a child has been found to be in need of protection. Compliance in 2006 was 69%, and in 2007 it was even lower, at 52%. The 2006 compliance rate for reassessing risk is 59% and the 2007 compliance rate indicates an exceptionally low compliance rate of 16%. The audits suggest that over an eight-year period practice in the North has not significantly improved in these critical areas, even though the audits provide clear indications of practice deficiencies.

In the area of guardianship practice, the audits done in 2006 and 2007 show that the compliance rate for assessing and planning for a child in care increased slightly in 2006 to 52% from the 2004/05 rate of 35%. In 2007 the compliance rate dropped to 38%. This is not acceptable given the obligation the Director has to ensure every child has a comprehensive plan of care. The plan is essential in providing and maintaining continuity and stability to children. These deficiencies cannot be explained by human resources challenges alone, as these have been addressed in contrast to earlier years.

Interpreting the significance of these results with these measures is hampered by small sample sizes. For instance, in 2006 the compliance rate for assessments and planning for a child in care was 52%. However, this was based on a sample of just 21 cases throughout the whole region which limits the degree to which the results can be generalized.

The effectiveness of the audits as an indicator of performance may be not be reliable because these are not independent external assessments. Audits are performed and reported internally by the Ministry.

The objective of quality assurance is to ensure that the right services are accessible, timely and effective and support good outcomes for children. Quality assurance is a systemic function that allows quality to pervade an organization and for continuous performance improvement. A quality assurance system that identifies areas of excellence and those that require strengthening is key for public accountability and confidence. For example, a good system would identify whether workers are properly qualified and trained to perform their assigned duties. At present, this type of information is not available from the Ministry's audit system, and such information had to be derived from the employee payroll data system or delegation management system.

With respect to the critical measures used in the audits, it is not clear if the health and well-being of children and youth in care are receiving the attention needed. The elements of the plan of care need to become critical measures, too. Critical measures should be monitored for every child and youth and the quality assurance system should identify relevant and timely action when appropriate. Having these critical measures available electronically for social workers, supervisors, management and executive would enable key people to continuously assess performance and to take action when needed.

Case reviews

The investigation also looked at case reviews completed from 2006 to the present. The region provided five reviews completed during this period. Four Deputy Director's reviews were completed: two were on child deaths, one was on a critical injury and one was on a serious incident involving youth engaged in high-risk behaviour. One Director's case review was completed, on a serious incident involving a youth in care. In three of the reviews the children's Aboriginal status is not clearly stated.

The two Deputy Director's reviews completed on child deaths identify practice inadequacies similar to those found in this investigation and in the 22 child death reviews completed from 1999 to 2005. In one situation, the Ministry missed two opportunities to assess the family's current level of functioning, as the child protection report was not accepted for investigation when child protection concerns were evident. In the other review, past child welfare history was not incorporated into the investigation, so a thorough investigation did not occur. This review also identified a lack of supervisory consultation during the investigative process.

One Deputy Director's review was completed on the critical injury of a four-year-old Aboriginal child who was seriously abused and neglected in a placement with a relative under the Child in the Home of a Relative (CIHR) Program. This review identified a number of practice concerns, including inadequate assessment of the relative's ability to care for the child, incomplete child protection investigations, family history not informing the investigative process and case planning, and no reassessment of risk completed while the family was receiving ongoing protective services. It appears in this situation that supervisory oversight was lacking.

The final Deputy Director's review completed involved youths engaged in high-risk behaviours. While no death or apparent critical injury occurred from the incident, the Ministry states that the review was conducted to ensure that policy and practice requirements are met when serving youth who are difficult to engage. One youth was a child in care and the review found that a current comprehensive plan of care had not been completed. This youth was also frequently absent from her Ministry placements. The review found that these circumstances had not been reported as a reportable circumstances as required by standard.

A Director's case review was completed on a youth in care who may have experienced sexual abuse in a specialized residential resource. This review reveals practice deficiencies similar to those found in the other reviews, such as the investigation not being completed in a timely manner and inadequate planning for this youth with regard to the incident. It appears there was also a lack of supervisory consultation.

The region indicates that seven reviews are underway. Six of these reviews are in progress and one is on hold pending criminal proceedings. The six reviews in progress are Deputy Director's reviews; five involve child deaths and one involves a child who was critically injured. Most of these incidents occurred 12 to 18 months ago and the reviews remain outstanding. Current standards state that Deputy Director's reviews should be completed as soon as possible and within 90 days of the decision to begin a review. The decision to conduct a review is made as soon as possible and no later than 20 working days after the incident.

The review that is on hold is a Director's case review of an alleged intentional child death that occurred in 2006. The Ministry is unable to conduct a Director's case review when there are criminal proceedings in progress.

Conclusion

As the discussion in this chapter has shown, there are many different types of activity taking place in the Ministry. This includes activities such as qualifying front-line staff, case consultation and supervision, audits and reviews, and ongoing training to support practice and service delivery to children and families. However, the investigation has found that these many moving parts of the child protection system have been poorly coordinated and unfocused. Many teachable moments from audits and reviews of discrete events have shown that practice levels remain about the same as they were nine years ago.

Judge Gove, Judge Hughes, and now the Representative for Children and Youth have called for improved quality assurance in order to strengthen practice in the child protection system. There are many hard-working and dedicated people in this system. In order to improve results and practice, a more focused and concerted effort must be made. The next chapter presents the findings of this investigation and recommendations for moving forward.

8. Findings and Recommendations

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

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

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

Given this context, the key deficiencies relate to:

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

Overall finding

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

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

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

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

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

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

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

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

A note about the recommendations

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

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

Practice

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

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

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

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

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

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

Supervision and training

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

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

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

Recommendation 1(a):

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

Detail:

Practice issues are identified through:

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

Recommendation 1(b):

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

Recommendation 1(c):

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

Detail:

Annual reporting should include:

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

Recommendation 1(d):

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

Detail:

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

Recommendation 1(e):

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

Detail:

Annual reporting should include:

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

Recommendation 1(f):

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

Detail:

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

Recommendation 1(g):

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

Detail:

These should focus on:

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

Resources and staffing

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

Recommendation 2(a):

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

Detail:

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

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

Recommendation 2(b):

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

Detail:

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

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

Service standards

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

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

Recommendation 3:

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

Detail:

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

Quality assurance

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

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

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

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

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

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

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

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

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

Recommendation 4:

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

Detail:

This should include the following:

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

Case reviews

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

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

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

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

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

Recommendation 5(a):

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

Detail:

This responsibility would include:

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

Recommendation 5(b):

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

Detail:

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

Recommendation 5(c):

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

Recommendation 5(d):

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

Recommendation 5(e):

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

Recommendation 5(f):

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

Detail:

Posted individual summaries should include:

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

Audits

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

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

Recommendation 6:

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

Details:

This should be done by:

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

Reporting on children in care

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

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

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

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

> Recommendation 23: The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time.
>
> Reason: Measurements that are based on actual results will give the Ministry and the public a better understanding of the children and young people in its care, and what effects its programs are having on their lives (Hughes, 2006, p. 78).

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

Recommendation 7(a):

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

Detail:

These reports should include:

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

Recommendation 7(b):

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

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

Recommendation 7(c):

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

Detail:

This reporting should include:

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

Recommendation 7(d):

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

Detail:

The Council should:

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

Partners

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

Recommendation 8:

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

Health and medical care

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

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

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

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

Recommendation 9(a):

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

Detail:

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

Recommendation 9(b):

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

Detail:

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

Recommendation 9(c):

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

Detail:

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

Recommendation 9(d):

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

Detail:

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

Recommendation 9(e):

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

Detail:

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

The Canadian Paediatric Society recently observed:

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

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

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

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

(CPS, 2008, p. 130-131)

Recommendation 9(f):

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

Coroners Service

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

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

Recommendation 10(a):

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

Recommendation 10(b):

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

RCMP

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

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

Recommendation 11:

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

Conclusion

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

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

Glossary

adoption social worker: manages adoption planning and placement of children for adoption with prospective adoptive parents.

case management: a systematic approach to social work. Emphasis is placed on systems in which a client must function rather than on inner thought processes to help facilitate client change. Case management requires coordination of a multiplicity of services required by a child abuse and neglect client. Services are organized within a community setting, usually contracted by the Ministry. One of the participants is identified as the case manager, usually the social worker, to monitor services to ensure they are relevant to the client, delivered in a useful way, and appropriately used by the client.

child in care: any child under 19 years of age living under the care or guardianship of the Ministry of Children and Family Development.

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

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

Deputy Director's review: more limited in scope than the Director's case review and usually consists of a file review and focuses on the last five years of service involvement. A Deputy Director's review can assist the Director in determining whether a Director's case review is required.

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

failure to thrive: a medical condition that denotes poor weight gain and physical growth failure over an extended period of time in infancy. Weight is consistently below the third to fifth percentile for age. This may be associated with a decrease in height, motor development, and head size. It covers poor physical growth of any causes and may be organic due to cystic fibrosis, heart disease, and so on, or have a non-organic basis.

family development response: a specialized child protection response to a child protection report that promotes flexibility in determining the kind of support and service needed to keep children safe and families healthy in situations involving child maltreatment. The model assess eligibility for safety, service and risk, while allowing for greater engagement with families. A revised set of child protection standards and guidelines in B.C. aids social workers' decision-

making in conducting a thorough assessment of what each child and family requires. The use of this model does not preclude the necessity of deciding to assess a new report of child abuse and neglect and conduct an investigation should new concerns arise.

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

Fetal Alcohol Syndrome (FAS): the term used to describe the effects caused by drinking alcohol during pregnancy. These effects may include physical, mental, behavioural and/or learning disabilities with possible lifelong implications. Some children with FAS have physical disabilities, but many of the effects are not visible and may include problems with learning, memory, attention, problem solving, behaviour, vision and hearing. They may not understand social situations and their behaviour is often interpreted as problematic, rather than as a symptom of an underlying condition.

float team: a group of social workers who are available for temporary assignments across program areas within their region in order to provide support where required.

foster care: a form of substitute care for children who have been removed from their own homes. This is usually a temporary arrangement, lasting until a child can return home or a family plan for caring for the child can be made. In some situations the child is in foster home until the age of majority (19 in B.C.). Effective foster care ideally includes services for the child, natural parents and foster parents, and periodic review of the placement. Service expectations are guided by the Caregiver Support Service Standards. The foster home program is organized into different levels reflecting the skills and abilities of the foster parent, who is an independent contractor. Foster homes are managed through local Ministry offices by a resource team.

Gove Report (*Report of the Gove Inquiry into Child Protection*): report of the 1995 Commission of Inquiry into the adequacy of the services, policies and practices of the Ministry of Social Services as they related to the apparent neglect, abuse and death of Matthew John Vaudreuil.

global developmental delay: significant delay in two or more developmental domains: motor, speech/language, cognition, social/personal and activities of daily living.

guardianship social worker: manages the Director of Child Protection's role as guardian of children in care.

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

immediate safety assessment: an assessment that focuses on the child's present situation and does not attempt to predict the occurrence of future harm to the child.

infant development worker: a social worker who supports families that are raising young children at risk for or with developmental delay or disabilities.

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

integrated case management: a policy developed by the Ministry in 1998/99 to delineate the coordination of services and professionals that are multi-disciplinary in nature (e.g., child protection, health, education, mental health and youth justice) on behalf of a parent and or child to ameliorate and support improved functioning.

investigation: a process of inquiring into or tracing through inquiry, collection of information along with the interviews of parents, teachers, daycare providers, public health nurses, physicians, and extended family members to evaluate whether a child is in need of protection.

kith and kin placements/agreements: where a child who needs to be removed from his or her home is placed with a relative or close family friend, instead of being placed in the home of a stranger.

mandated agency: the agency designated by law responsible for receiving and investigating reports of suspected child abuse and neglect.

neglect: failure of a caregiver to provide a child with the physical, medical or emotional necessities for normal life, growth and development.

out-of-care options: a range of legislative options which support children living with members of their extended family, either temporarily or permanently. Kith-and-kin arrangements and/or a permanent transfer of custody to a family member or a significant person in the child's life are examples.

parental capacity assessment: an assessment requested by the Ministry to determine a parent's ability to meet the needs of his or her child or children. It is performed by a psychologist or psychiatrist. There are no practice standards as to how this type of assessment is performed.

preventable death: A child's death is considered to be preventable if the community (through legislation, education, etc.) or an individual (through reasonable precaution, supervision or action) could have done that which would have changed the circumstances that led to the death.

quality assurance: in the context of this report refers to a developmental strength-based approach in practice that supports decentralization of decision-making and sets in place a new quality assurance function to enable highly effective services across a continuum for the various programs delivered by the Ministry.

reportable circumstances: circumstances involving a death or critical injury of, or serious incident involving, a child in care, a child who is the subject of an agreement with a child's kin or other person, a child placed in the interim or temporary custody of another person under the director's supervision, a child receiving respite services, or of a child who has received services within the past 12 months. All of the above require the immediate notification of the designated director.

resource social worker: responsible for the recruitment and retention of foster homes, group homes and other residential and non-residential services.

respite care: provides the child with a brief, planned stay away from his or her family home.

risk assessment: an organized process that assists in the gathering of information to develop strategies for case decisions and outcomes.

risk reduction plan: a portion of a service plan that outlines how specific risks to the child will be addressed and reduced.

screening: the process of determining whether a report or referral of child abuse and neglect will be accepted and designated for an appropriate course of action under the legislation.

supervision order: a court order returning or placing a child in the custody of a parent or other person under specific conditions for a prescribed period of time.

voluntary (care) agreement: an agreement negotiated between the Ministry and a parent with respect to arranging care for a child for a limited period of time.

Appendix A: Representative for Children and Youth Act

Section 12 of the *Representative for Children and Youth Act* (2006) authorizes the Representative for Children and Youth to conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development. Section 15 authorizes the establishment of a Multidisciplinary Team to provide advice respecting reviews and investigations.

Investigations of critical injuries and deaths

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

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

(b) the critical injury or death

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

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

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

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

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

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

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

Multidisciplinary team

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

Appendix B: Documents Reviewed During the Representative's Investigation

Amanda Simpson

Ministry files

- Family service file, including child protection reports and investigative notes, 1991–1999
- Child Development Centre reports 1997-1999
- Medical consultation notes, Prince George Regional Hospital, October 1999
- Medical consultation notes, BC Children's Hospital, November 1999
- Court documents related to removal of the children, November 1999
- Briefing notes, December 1999
- Practice audits for Prince George offices, December 1999
- Management review, December 1999
- Deputy Director's file, including initial reportable circumstances documentation, draft notes for and completed Director's case review, December 1999
- Recommendations Tracking System (RTS) tracking of recommendation implementation
- Videotaped interviews with two Simpson children, December 1999
- Videotaped visits of the Simpson children with their mother, November and December 1999
- Press release, April 4, 2000
- Press clippings, 1999–2006

Medical records

- December 16, 1994, birth record, Prince George Regional Hospital
- October 30, 1999, admission, Prince George Regional Hospital
- October 31, 1999, admission, BC Children's Hospital

Coroner records

- Kimble report, November 3, 1999
- Post-mortem report, December 30, 1999
- Autopsy photos
- Transcript of inquest, June 11–15, 2007
- Verdict at inquest, June 15, 2007

Police records

- RCMP investigation file, Volumes 1–4
- Photos taken on October 30, 1999, Prince George Regional Hospital
- Photos taken on November 1, 1999, BC Children's Hospital

Savannah Hall

Ministry records

- Family service file, including all child protection reports and notes, September 1997–May 1998
- Court records from September 1997 supervision orders and August 2000 continuing custody order
- Guardianship file, including comprehensive plan of care (October 2000), related e-mails, notes to file and foster parent's diary notes
- Child Development Centre records, including initial consultation notes, updates and attendance record, May 1999-January 2001
- Records of supervised visits with birth mother
- Admission to care medical, May 1998
- Medical consultation notes, Pediatrician, October 2000
- Medical consultation notes, Prince George Regional Hospital, January 2001
- Medical consultation notes, BC Children's Hospital, January 2001

Ministry foster home file

- Initial application, references, review of home
- Annual reviews for 1997, 1998
- Case-related e-mails sent to and received by resource workers concerning foster home
- Record of names of 60 children who resided in the home
- Records of complaints and resolution of complaints of quality of care, neglect and abuse, 1997–2000
- Deputy Director's file, including initial report of the child's injury, protocol investigation notes, interview notes (three foster children) and draft Director's case review
- Recommendations Tracking System (RTS) tracking of recommendation implementation
- Court documents related to foster family civil suit, 2001–2005
- Press clippings, January 2001–February 2007

Medical records

- Admission to Prince George Regional Hospital, January 2001
- Admission to BC Children's Hospital, January 2001

Coroner records

- Kimble report, January 28, 2001
- Post-mortem report, April 30, 2001
- Autopsy photos
- Letter from pathologist concerning results of forensic consultation, April 30, 2001
- Letter from pathologist concerning changes to autopsy findings, August 27, 2002
- Judgment of inquiry, December 10, 2004
- Inquest transcript, October 22–November 3, 2007
- Verdict at inquest, November 3, 2007

Police records

- CD including post-mortem, statements, continuation reports

Rowen Von Niederhausern

Ministry records

- Family service file, including all child protection reports and investigation notes, September 1999–August 2002
- Parental capacity evaluation, December 1999
- Court documents concerning removal of sibling, September 2002
- Deputy Director's file, including initial report of the child's death and the Deputy Director's review, June 12, 2003
- Recommendations Tracking System (RTS) tracking of recommendation implementation

Coroner records

- Kimble report, August 16, 2002
- Post-mortem report, February 16, 2003
- Toxicology report, November 22, 2004
- Transcripts of inquest, June 18–20, 2007
- Verdict at inquest, June 20, 2007

Police records

- Complete RCMP investigation file, Volumes 1–2, including statements and continuation reports

Serena Wiebe

Ministry records

- Child protection report and case notes, May 2005
- Deputy Director's file, including initial report of the child's death and Deputy Director's review, August 8, 2005
- Recommendations Tracking System (RTS) tracking of recommendation implementation

Coroner records

- Kimble report, June 17, 2005
- Post-mortem and toxicology report, November 25, 2005
- Transcript of inquest, October 10–12, 2007
- Verdict at inquest, October 12, 2007

Police records

- Sudden death report, June 17, 2005

Other Ministry documents

Policy

- *Child, Family and Community Service Act* (1996)
- The Risk Assessment Model for Child Protection in British Columbia, 1996
- Practice Standards for Child Protection, 1998
- Standards for Foster Homes, 1998
- Practice Standards for Guardianship, 1999
- Protocols for Foster Homes, 1999
- Practice Standards and Guidelines for Adoption, 2001
- Practice Guidelines for Family Care Homes, August 2002
- Child and Family Development Service Standards, November 2003
- Family Development Response Reference Guide, December 2004
- Quality Assurance Standards, June 2004
- Director's Case Practice Audit Methodology and Procedures- draft, June 2004
- Critical Measures Audit Tool for Children in Care Service Standards (CMAT-CIC), May 2004
- Critical Measures Audit Tool for Child and Family Service Standards, (CMAT-CFS), May 2004
- The *B.C. Handbook for Action on Child Abuse and Neglect*, April 2007
- Responding to Child Welfare Concerns, April 2007
- Child, Family and Community Service Manual, Volume 2

Reports

- Ministry of Children and Family Development, *A New Era Update: Annual Report, 2001/02*
- Ministry of Children and Family Development, *Annual Service Plan Report*, 2003/04
- Ministry of Children and Family Development, *Annual Service Plan Report*, 2004/05
- Report on Regional Financial Control Framework, North Region, November 2004
- Director's case reviews and deputy Director's reviews, 1999–2007 (28 reviews in total)
- Audits, 1999–2007 (See Appendix E)
- North region, Foster Parent Recruitment and Retention, Strategic Plan, 2007

Documents provided by the North region

Training and recruitment:

- HR Strategy: Transition to Aboriginal Agencies, December 15, 2005
- Aboriginal Child Protection Recruitment Project: Proposal (Draft 2), August 2006
- North Region Strategic Human Resources: Staffing Action Plan, June 12, 2007
- Systemic Changes Since the time of Savannah Hall's Death, January 2001–present

Staffing:

- North region staffing levels from 1999 and 2005 forward
- Letter, Regional Child Protection Manager to Executive Director, North region, Current Provincial Staffing Strategy to "Assist" the North, November 23, 1999
- Briefing note, "Provincial Staffing: A Northern Perspective," November 23, 1999
- Briefing note, "The Northern Region's workload management and practice standard strategies," January 21, 2000
- Memorandum, ADM Regional Operations Division to Regional Executive Directors, Re: Northern Staffing Strategy, February 23, 2000
- Briefing paper, North region, "A 'Medium-Term' Strategy to Address Critical Staffing Shortages," February 14, 2000
- Letter, Regional Child Protection Manager, North region, to Acting Regional Executive Director, North region, Re: Northern Staffing Issues, February 14, 2000
- Letter, Director of Integrated Practice to Acting Associate Regional Executive Director, Current staffing situation in the Northern region, October 30, 2000
- Briefing note, "The Northern Region's Staffing Crisis: A Historical Review," October 30, 2000
- North region, SPO Incentive Program payments, October 2001–October 2004
- Issues note, "Practice Shifts," August 31, 2005
- E-mail, Director of Integrated Practice to ADM, Re: RCY request for information about regional training in Advanced Risk Assessment and Risk Assessment, March 17, 2008
- E-mail, Director of Integrated Practice to ADM, Re: Hiring of UNBC graduates, March 17, 2008

- E-mail, Director of Integrated Practice to ADM, Total regional allocation and burn 2003 forward, March 17, 2008
- Letter, A/Deputy Minister to Representative for Children and Youth, Re: Integrated case review framework, March 20, 2008
- North region, Aboriginal employees (no date)
- North region, FTE Complement – Child Welfare Social Workers (no date)
- North region, FTE Complement – Child Welfare Supervisors (no date)
- North region, SPO Hires by Year with Education Level (no date)

Protocols:
- Prince George Child Development Centre Protocol
- School District No. 57 Protocol
- SCAN Clinic Protocol (Effective December 1, 2001–March 31, 2002)

Quality assurance (Planning):
- Service Transformation Plan, North Region, 2004/05
- Service Transformation Plan, North Region, 2005/06
- Service Transformation Plan, North Region, 2006/07

Quality assurance (Monitoring):
- Investigations Open Beyond 30 Days
- Dispute Resolution Process Annual Report, 2004/05
- Audit and Review Trends, North Region, 2004–2006

Quality assurance (Evaluation):
- An Analysis of Case Practice in the North Region, 2005/06
- An Analysis of Case Practice in the North Region, 2006/07, Third Quarter End
- Overview of Themes Identified by Review: North Region

Quality assurance (Reports):
- North Region Children in Care Report, November 2007
- North Region Out of Care Options Tracking, 2007/08
- CFD Service Transformation Measures: Ready to Measure, North Region, Draft, September 2007
- North Region Selected Caseload Statistics Summary

Miscellaneous:
- North Region YTD Selected Stats Comparison, October 2006 and October 2007
- North Region YTD Selected Stats Comparison, November 2006 and November 2007
- Semi-Annual Service Activity Report, Northern Child and Family SCAN Clinic, April 1, 2007–September 20, 2007, Northern Health

Appendix C: Multidisciplinary Team

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

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

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

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

Members serve for a term of two years.

Specialists from other areas – such as the Public Guardian and Trustee, the Superintendent of Motor Vehicles, and experts from ICBC, child mental health and youth justice – are invited as required.

Multidisciplinary Team members

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

Dr. Geoff Appleton – Dr. Appleton is President of the BC Medical Association and an established family physician in Terrace. A significant part of his practice involves the medical care of children and youth, including those of Aboriginal descent. He also served as the Medical Director of the Terrace Child Development Centre for many years, and has expertise in working with children and youth with developmental disabilities and fetal alcohol spectrum disorder.

Gwen Budskin – Ms. Budskin is the Director of Child and Youth Services at the Prince George Native Friendship Centre, a position she has held for more than eight years. Ms. Budskin is also part of the Prince George Aboriginal Child and Family Commission and volunteers as a member of the Board of Directors of the Central Interior Native Health Society. Gwen is of Cree descent and was born and raised in northern B.C.

Les Dukowski – Mr. Dukowski is president of the B.C. Principals' and Vice-Principals' Association and is on secondment from School District 35 (Langley). He has taught for a total of 34 years, 22 of which have been as a school principal or vice-principal. Mr. Dukowski has coauthored a mathematics textbook series and contributed to the 1988 Sullivan Royal Commission on Education.

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

Karen Gallagher – Ms. Gallagher is the Manager of Quality Assurance in the office of the Provincial Director of Child Welfare at the Ministry of Children and Family Development. She holds a Masters of Social Work degree and has spent the last 28 years serving British Columbians both as a front-line social worker and as a senior manager for government and community agencies. Ms. Gallagher's has particular expertise in child maltreatment (physical, sexual, emotional), family service, and quality assurance.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 19 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service. After 25 years of policing experience and 17 years as a coroner, Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar

circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

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

Russ Nash – Mr. Nash is currently the Officer-in-Charge of a Major Crime Section with the RCMP. He has expertise in extensive criminal investigations and, in particular, in homicide investigations. He has been involved in a variety of RCMP programs focused on youth, including the D.A.R.E. program, and also volunteers as a coach and manager of youth sports teams.

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

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

Appendix D: Coroner's Jury Recommendations

Amanda Simpson inquest

To: Chief Coroner:

1. To hold a Coroner's inquest regarding a questionable death in a timely manner.

To: Minister, Ministry of Children and Family Development:

2. Form focus groups for all MCFD offices in BC, comprised of pertinent partners such as; the RCMP, school counselors, daycare workers, etc. to evaluate the performance of each MCFD office, with a mandatory action plan from the designated director to address any concerns listed, in a timely manner.
3. Continuous upgrading/training for all case workers team leaders, directors, etc. in the MCFD regarding child protection, interviewing, investigation, and risk assessment.
4. Review monies allocated to the MCFD to increase resources aimed at child protection.

Savannah Hall inquest

Recommendations for the Ministry of Children and Family Development:

1. MCFD should improve their procedures relating to the recording and sharing of all information relating to both substantiated and unsubstantiated allegations which may relate to the safety and welfare of children in care.
2. MCFD should develop and implement a single document, equivalent to the "Child Services Case Snapshot," which records all allegations against a foster home.
3. MCFD should require that foster parents be trained in First Aid and CPR (cardio-pulmonary resuscitation).
4. MCFD should revise and clarify the Standards for Foster Homes as it relates to the use of both mechanical and physical restraints. These standards should specifically require the approval of a physician prior to their non-emergent use.
5. MCFD should revise the Supervised Visit and Transportation Record so as to require the signature of the visiting natural parent, and that a copy of the record be provided to the natural parent.
6. MCFD should require immediate notification to the applicable police agency of all serious incidents involving physical injury to children in care.

7. MCFD should require that the ministry be notified of all physician visits made by children in care.
8. MCFD should ensure the availability of social workers to promptly respond to and investigate allegations involving potential harm to the child in care in those situations in which the child's assigned social worker is unavailable.
9. MCFD should ensure foster parents are provided with all available information regarding a child's history within 72 hours of placement
10. MCFD policies should require that all resources providing service to children in care immediately report to the ministry, and the ministry should investigate, unusual periods of absence from the resource.
11. MCFD policies should require that after-hours social workers have access to information relating to the proposed foster home, such information to include the number of children presently in care, the level of care provided by the foster home and the history of allegations made against that foster home.
12. MCFD information management systems should track all allegations against a foster home, including those relating to both quality of care and abuse or neglect.
13. MCFD policies should require a medical assessment before placing a special needs child in care.
14. MCFD policies should require that all social workers involved in the care of children in a foster home be provided with a copy of the annual review of the that foster home.
15. MCFD policies should require that all allegations about quality of care or abuse neglect be independently reviewed by workers that are not involved in the management of the foster home, or the care of children placed within that home.
16. MCFD policies should require that guardianship workers visit each child in care on their caseload not less than twice yearly; and
17. MCFD policies should require that the resource social worker review with each foster parent, at least once every five years, then applicable standards for foster homes.

Recommendations for the BC Ambulance Service (BCAS):

18. BCAS should modify the form of its Crew Report to allow for extra room for recording narrative.
19. BCAS should emphasize the requirement and importance of full charting of the Crew Report by all attendants.

Recommendation for the City of Prince George Fire Department:

20. The City of Prince George Fire Department should require a full recording on its Fire Rescue and Safety report of all significant scene circumstances when responding to calls involving personal circumstances.

Recommendations for the Child Development Centre of Prince George and District:

21. CDC should revise its procedures to improve reporting and communication with the MCFD regarding children in care.
22. CDC should require notification to the MCFD of any unexplained absences longer than 2 days of any child in care.
23. CDC should require reporting to the MCFD of any observations of suspicious bruises on children in care.

Recommendations for the College of Physicians and Surgeons:

24. The College should recommend to its members that they deliver to the MCFD copies of Consultation Reports relating to patients who are children in care.
25. The College should recommend to its members that the patient history regarding children in care be taken from other health professionals and MCFD workers, in addition to the history obtained from foster parents.

Recommendation for the Ministry of Health (MOH):

26. The MOH should investigate the development of a website which provides a central repository for medical information regarding children in care.

Rowen Von Niederhausern inquest

To: Chief Coroner:

1. Establish protocols for mandatory head to toe testing during autopsy following the unexplained death of any child. Update said protocols as new technology becomes available.

To: Minister, Ministry of Children and Family Development:

2. When enough flags have been raised regarding a family situation, the file should remain open and periodic checks continue for several years.

Serena Wiebe inquest

To: Minister, Ministry Children and Family Development:

1. That the Ministry of Children and Family Development implement standardized forms (templates) as a FIRST CONTACT form requiring determination of specific information from the reporter.
2. (a) That any and all information be included in the file; and (b) that, in the event of a file transfer, "loose" handwritten paper be forwarded by FAX to the appropriate location.

3. Contact efforts be logged by time, date, etc explaining social worker efforts to contact client.
4. That MCFD adhere to its proactive practice by providing resources for all needs in consultation with participating/target groups/agencies.
5. First Nation liaison/elders be given minimum formal training at least to a standard acceptable to MCFD.
6. Software be developed and utilized which provides:

   (a) a system or mechanism to reduce the possibility of wrong information or codes being entered into the computer system and (b) also ensures full and proper access to information.
7. Minister should make every effort to maintain Fort St James at full capacity with a team leader always on hand.
8. A face-to-face meeting between team leader and social worker before any case is closed: clear documentation of reasons to be kept on file.

To: Minister of Health (and)

To: Minister, Ministry of Children and Family Development

9. In the spirit of cooperation, Ministry of Health and MCFD work with concerned communities to establish an alcohol/drug treatment centre within the Fort St. James area.

Appendix E: Audits, 1999–2006

Office Code	Name of Audit	Year Completed
QMB	Terrace Child, Family & Community Service	1999
QXD	Skeena Resources – Terrace/Kitimat	1999
QLB	Terrace Intake and Investigation	1999
QME	Queen Charlotte City Child, Family & Community Service	1999
QCK	Smithers Child Protection and Family Services	1999
QCJ	Houston District Office	1999
QDB	PG – Family Services	1999
QDJ	PG – Westwood Family Services	1999
QGB	PG – Intake and Investigation - 1	1999
QGC	PG – Intake and Investigation - 2	1999
QMF	Dease Lake	1999
QCC	Vanderhoof	1999
QMD	Prince Rupert Family and Child Services	2000
QLC	Prince Rupert Child Protection Intake	2000
QDL	McKenzie Family and Child Services	2000
QCL	Hazelton Family and Services Team	2000
QMC	Kitimat Family and Child Services	2000
QCD	Fort St. James	2000
QCB	Burns Lake	2000
QCF	McBride/Valemount	2002
QME	Queen Charlotte	2004
QCD	Fort St. James	2004
QQC	Quesnel Child and Family Services	2004
QQD	Quesnel Child and Family Services	2004
QDN	PG Child and Family Services	2004
QCK	Smithers Child and Family Services	2004
QLC	Prince Rupert Child and Family Services	2005
QDB	Westwood Child and Family Services	2005
QJE	Fort Nelson Child and Family Services	2005
QCB	Burns Lake	2005
QME	Queen Charlotte Child and Family	2005
QGM	Youth Around PG – guardianship	2005
QLD	Prince Rupert Child and Family Services	2005

Office Code	Name of Audit	Year Completed
QMD	Prince Rupert Child and Family Services	2005
QJC	Fort St. John Child and Family Services	2005
QJH	Fort St. John Child and Family Services	2005
QGJ	McKenzie CFS	2006
QCC	Vanderhoof CFS	2006
QMC	Kitimat CFS	2006
QGB	PG CFS	2006
QGH	McBride CFS	2006
QJD	Chetwynd Child and Family Services	2007
QJG	Dawson Creek Guardianship Team	2007
QCD	Fort St. James Child and Family Services	2007
QCL	Hazelton Child and Family Services	2007

Appendix F: Suspected Child Abuse and Neglect (SCAN) Units

Unit	Location and Contact	Referral Area	Team Composition	Services	After-hours availability (acute needs)
Child Protection Service Unit (CPSU) Or The Child and Family Clinic (Outpatient) • Operating since 1972	BC Children's Hospital Vancouver, BC	Tertiary Care centre for all BC Primary referral area: Vancouver, North Vancouver, and Richmond	• 4 pediatricians • 0.9 FTE medical director • 3 FTE social workers • 0.9 FTE nurse • 1 FTE psychologist • 0.2 FTE psychiatrist • 2 FTE clerical	• Inpatient and outpatient services • Sexual abuse (acute and non-acute, 0-13) • Colposcopic evaluation • Physical abuse (acute & second opinion, 0-18) • Neglect • Consultation • Chart reviews • Child-focused psychological and psychiatric assessments (no ongoing therapy)	• 24 hrs/7 days a week • On-call CPSU pediatrician • Contact BC Children's Hospital
Children's Health Clinic • Operating since	Royal Inland Hospital Kamloops, BC		• 1 pediatrician • FTE Ob/Gyne • 0.6 FTE nurse • 2 FTE social workers • 0.5 FTE psychologist • FTE manager • 0.67 FTE clerical		
Health Evaluation, Assessment, and Liaison Team (HEAL) • Operating since 1995	Surrey Memorial Hospital Surrey, BC	Communities in the Fraser Health Authority (North, South, and East Fraser)	• 2 pediatricians • 1 GP • 1 FTE coordinator • 1 FTE social worker • 0.8 FTE nurse • 0.5 FTE child life specialist • 3 psychologists • 1 FTE clerical	• Outpatient service only • Sexual Abuse (non-acute, 0-18) • Colposcopic evaluation • Physical Abuse (non-acute/second opinion, 0-18) • Neglect (second opinion only) • Consultations • Chart reviews • Child-focused psychological assessments (no ongoing therapy) • Case conferences	• None • Hospital emergency departments (RCH, SMH, MSA)
Health Assessment and Resources for Children (HARC) • Operating since 1999	Queen Alexandra Centre for Children's Health Victoria, BC	Vancouver Island	• 2 pediatricians • 1 GP • 1 FTE social worker • 0.5 FTE nurse • 1 FTE psychologist • 1 FTE clerical	• Outpatient services only • Sexual abuse (non-acute) • Colposcopic evaluation • Physical abuse • Neglect • Consultations • Chart reviews • Child-focused psychological assessments (no ongoing therapy) • Case conferences	• None • Hospital emergency department (Victoria General)
Northern Child and Family SCAN Clinic • Operating since 1993	Community based (mall) 4186 15th Ave Prince George, BC	Communities in the Northern Health Authority	• 1 pediatrician • 1 GP • 1 FTE social worker • 1 FTE social worker/ coordinator • 0.8 FTE nurse • 1 FTE psychologist • 1 FTE clerical	• Outpatient services only • Sexual abuse (non-acute) • Colposcopic evaluation • Physical abuse • Neglect • Consultations • Facility used by police and Ministry of Children and Family Development for child interviews 24/7 • Mental health assessments of children (no ongoing therapy)	• None • Hospital emergency departments

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