Report on the
Core Services Review
of the Children's Commission
and
Overlapping Services Provided by the Child, Youth and Family Advocate, the Ombudsman, the Coroner and Ministry of Children and Family Development

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EXECUTIVE SUMMARY

I was asked to identify the core services of the Children's Commission and to consider how they could be provided most effectively and efficiently. This involved reviewing the responsibilities of the Children's Commission, the Child, Youth and Family Advocate (the "Advocate"), the Coroner's Office, the Ombudsman, and the Ministry of Children and Family Development ("MCFD") (collectively the "Agencies") to identify overlap and duplication. On the basis of my review, I was also asked to make recommendations about how to address any issues of overlap and duplication. My recommendations are submitted jointly to the Attorney General and the Minister of Children and Family Development, with respect to the Children's Commission, the Coroner and MCFD, and solely to the Attorney General with respect to the Advocate and the Ombudsman.

I consulted with the Agencies involved and with many others who shared their perspectives on the work of the agencies and the issues that arose in the course of my review, and who directed me to many useful documents.

There are four key functions undertaken by the Children's Commission: handling individual complaints about MCFD, monitoring MCFD, reviewing child fatalities and advocating for systemic change. All these functions are undertaken, in some measure, by one or more of the other Agencies. Conceptually, I start from a clean slate and consider what structural model would allow government most effectively and efficiently to fulfil these functions.

I conclude that having two specialized children's officers is neither efficient nor effective, but that one children's officer would assist government in effectively carrying out its responsibility to children whose families do not have the capacity, in whole or in part, to look after them without government support or intervention. In general terms, the task of this children's officer will be to provide an informed and independent focus on government's child welfare policy.

With respect to the complaints function, I conclude that the current model of an internal informal complaints process, an internal formal complaints process, an external review process by the Children's Commission (including, potentially a formal hearing before a Panel), and the overriding review authority of the Ombudsman, is not an effective nor an efficient way to handle complaints about MCFD.

The goals of a complaints process should be to achieve the best outcome in the circumstances of the particular complaint; and to improve the services provided by MCFD in the future. An effective complaints process should allow the perspectives of those who are affected by a decision of MCFD to be fully taken into account in the decision-making and leave those who have brought forward the complaint feeling respected and heard by government. The process of dealing with the complaint should improve, rather than undermine, the ongoing relationship between the front line worker and the children and families involved.

A process is more likely to be effective in achieving these goals if, among other things it is accessible, timely, simple, problem-solving rather than confrontational, marked by respectful and open communications, responsive and acknowledging to the complainant, and if it involves the parties to the conflict in resolving the conflict.

In my opinion, these criteria are best met by eliminating the current Children's Commission's complaint process, and having the Ombudsman as the sole external review authority. Internally, the complaints process I envision would be reframed as an opportunity for improvement in service quality. Children, families and interested community members who have conflicting perspectives on an issue concerning a child or family receiving services from MCFD will be encouraged to take the issue to the front-line social worker and/or the social worker's supervisor. If, after having the opportunity of being heard at this level, the individual who raised the issue remains dissatisfied, he or she will have two options: the first option will be to seek a review of the decision by the manager directly responsible; the second option, (which will also be available in the event that the line manager does not resolve the conflict) will be to involve a regional quality improvement manager who will not have been part of the initial decision-making. The quality improvement manager will review the complaint and attempt to resolve it informally, and if that fails, will make a formal recommendation to the Regional Executive Director. An outside mediator may be brought in to help resolve particularly intractable disputes. The precise organizational set-up of the internal complaints process may vary if and when the delivery of child welfare services is reorganized. It will remain crucial and integral to the recommendations of this report that there be an internal complaints process consistent with the principles highlighted in the report.

With respect to complaints, the children's officer will, for the most part, not provide direct individual advocacy services to children and families, but will have an important role in removing barriers to children advocating for themselves and family and interested community members advocating on behalf of children. The children's officer's goal will be to ensure that in the child welfare system, the child's perspective is always considered and the child's interests are the focus of the decision-making process.

With respect to the monitoring function, I envision that the question of how well MCFD is doing its job will become increasingly transparent through publicly reported performance measurements. MCFD and the Children's Commission are currently both conducting audits of plans of care of children-in-care. I envision that MCFD alone will be legislatively mandated to carry out systematic audits of plans of care. MCFD and the Children's Commission are both conducting reviews of critical injuries of children-in-care. In addition, when informed of a critical injury, the Public Guardian and Trustee's office is the third agency to investigate. The Public Guardian and Trustee does this as the guardian of the child's estate, to determine whether legal action is warranted. I envision that critical injuries will continue to be conducted by MCFD and that the only external agency investigating these incidents will be the Public Guardian and Trustee's office.

The children's officer will have a monitoring function in relation to MCFD that will be fulfilled in various ways. The children's officer will receive, for review, copies of reports generated in the course of MCFD's complaints process, audits of plans of care, reviews of critical injuries and deaths, and whatever other reports are generated as part of MCFD's internal monitoring. In addition, the children's officer will receive from MCFD, copies of the Ombudsman's final reports relating to investigations of complaints against MCFD, the Public Guardian and Trustee's critical injury reports and the Coroner's child fatality reports. To the extent necessary, the blanket of confidentiality will extend to the children's officer. The children's officer will have the authority to make further inquiry to answer any unanswered questions arising from the reports received. The children's officer will seek independent feedback from children, youth, families, agencies working with MCFD and other interested community members, about how the child welfare system is performing.

With respect to child fatality reviews, currently the Children's Commission reviews the circumstances of all children's deaths and reviews in-depth the lives and deaths of more than half of children who die, with a view to determining the adequacy of services to the child during the child's life, examining public health and policy matters, and making recommendations. Both the Children's Commission and the Coroner's office review the deaths of all children who die unexpectedly. Both the Children's Commission and MCFD review the deaths of all children who die in the care of MCFD or who have received services from MCFD within 12 months of their death. I envision that the Children's Commission's child fatality review function will be discontinued and elements of it will be incorporated into the Coroner's service. In particular, the Multidisciplinary Team currently under the auspices of the Children's Commission will be under the auspices of the Chief Coroner and will be expanded to include a representative of MCFD, and possibly a representative of the College of Physicians & Surgeons. The children's officer will be on the Team. The Multidisciplinary Team will have access to confidential records and reports concerning the child's death, including reports of internal hospital investigations. MCFD will continue its child fatality reviews, which will be legislatively mandated and will include reviewing fully the services provided by MCFD during the child's life.

In the proposed model, the children's officer will be a full-time Order-in-Council appointment for a term certain, with a level equivalent to a Deputy Minister, administratively accountable to the Attorney General. The children's officer will report publicly annually, or more often if the children's officer deems it important. The children's officer will seek to inform the public and the government about child welfare issues**,** and will be available to do special investigations at the request of the Minister of Children and Family Development or the Attorney General.

1. INTRODUCTION

In this report, I will refer collectively to the Children's Commission the Child, Youth and Family Advocate (the "Advocate"), the Coroner's Office, the Ombudsman, and the Ministry of Children and Family Development ("MCFD") as the "Agencies".

Mandate

My mandate includes the following:

1. to review the responsibilities of the Agencies to identify areas of potential overlap or duplication;
2. to identify the core services of the Children's Commissioner and to consider how they could be provided most effectively and efficiently;
3. to make joint recommendations to the Attorney General and the Minister of Children and Family Development to reduce or eliminate overlap and duplication in the delivery of services by the Children's Commissioner, the Coroner's Office and MCFD; and
4. to make recommendations to the Attorney General to address issues of overlap and duplication in the delivery of services to children and their families by government, the Ombudsman and the Advocate.

In fulfilling my mandate, I consulted with many individuals who were very forthcoming in sharing with me their insights. A list of those I consulted is attached as an appendix to this report. In some cases, particularly with the Agencies that are the subject of my review, my consultations were over several meetings and for many hours. With some exceptions, I did not consult with stakeholders' groups, as that was not part of my Terms of Reference. I was also supplied with, or directed to, many useful documents for review. A draft of this report was provided to the Children's Commissioner, the Advocate, the Chief Coroner, the Ombudsman, the Deputy Attorney General and the Deputy Minister of MCFD, for their feedback, which has been incorporated into this final draft.

This report contains my recommendations and the basis for them.

Children's Officer

It soon became apparent in the course of my review that the current model of having two government offices, external to MCFD, dedicated to the interests of children, was not the best one. The issue I struggled with was whether having one children-focused officer, outside MCFD, was an effective and efficient way to deliver the core functions of government in this area, and if so, what functions that children's officer should have. I did not find it useful to consider whether, if there is to be one children's officer, that officer should be the existing Children's Commissioner or the Advocate. I preferred to start conceptually from a clean slate. Therefore, in this report when I am discussing a future model, I refer to a "children's officer". This officer, if there is one, could be called

the Children's Commissioner, or the Children's Advocate or some other appropriate name.

Function Categories

In dealing with the issues arising from my review, I have found it useful to organize my thinking into four categories relating to the four key functions fulfilled by the Children's Commission. These categories are:

1. Handling individual complaints about MCFD,
2. Monitoring MCFD,
3. Reviewing child fatalities, and
4. Advocating for systemic change.

The functions in each category are interrelated. For example, the Children's Commission's function of reviewing child fatalities is, in part, a mechanism for monitoring MCFD. Also, systemic advocacy on the part of the Children's Commission arises from the information gathered through the complaints process, reviews of child fatalities and other monitoring of MCFD, and is effected, in part, by recommendations made in the course of fulfilling these monitoring functions.

Limitations

I see my task to be to assess whether the current structural model is fulfilling the core functions of government in this area, both efficiently and effectively, without unnecessary overlap and duplication. If the answer is "no", I am to recommend what structural model would work best in the future. My task is not to assess how successfully each Agency has fulfilled its mandated functions in the past. On the other hand, understanding how effectively and efficiently the functions have been fulfilled in the past is necessarily an important factor in assessing what model would work best in the future.

I am conscious of my limitations in making assessments of how the current model has worked. I have not had the means of doing any objective measurements of performance, whatever those measurements might be. Nor I have consulted widely with clients of the Agencies, although I have had access to studies that have reported on client feedback. I have, however, listened to the experiences and views of many who have worked in and with the current model, and while the views expressed are necessarily subjective, they are nevertheless, in my opinion, very valuable in making an assessment of what model might work best.

A challenge to making good structural recommendations is how to take into account, appropriately, the very real impact that incumbent officeholders, institutional culture, historical events and amount of resources have on how any given structure functions in practice.

Underlying assumptions

Because of the rather subjective nature of this review, I think it is important for me to be as transparent as possible about the underlying assumptions that affect my assessment. Some of these assumptions I have taken from the Core Review presentation of MCFD, and others from the Core Services Review Guidelines. They include the following:

1. Part of the current Government's vision is to provide better services for children.[2]

2. Government's role in relation to children is: to enhance the capacity of families and communities to care for their children; to protect children from abuse, harm or neglect when the capacity of families and communities breaks down; and to care for children whose families and communities are unable to do so.[3]

3. MCFD is the government ministry that has the primary responsibility for fulfilling government's role in relation to children. This is done largely at the field level, in the interactions between social workers and children, their families and other resource people in the community, and also, when the state assumes the responsibility to care for an individual child, in the interactions between that child and the child's foster parents or direct custodians.

4. Risk-taking cannot be avoided in the government's fulfilling its role in relation to children. In many circumstances, there are risks involved both in leaving children with, and removing children from, their families. All children are at risk as they grow to adulthood; children whose families require services from the state or are in its care, tend to be at higher risk than others. Three interrelating propositions flow from these assumptions that are relevant to this review.

    a. An important goal of any structuring of who performs the functions under review should be to enhance the capacity of those who make decisions, or interact with children, on behalf of the state, to manage the inevitable risks well, and to engage fully the resources available to the child, including those of the child, the child's family and the community to minimize negative risks for the child.

    b. Secondly, it is the nature of risk that negative consequences will sometimes result to children, and, therefore, the assumption that someone must be at fault for any negative consequence is wrong.

    c. Thirdly, negative results for children can be an important learning experience about how to minimize risk to children in the future; review

[2] Guideline for the Core Services Review, August 2, 2001, p.2
[3] MCFD Core Review presentation, page 3.

of negative results can be counterproductive if it instead has the effect of encouraging those in the front lines to make their priority avoiding the risk of criticism.

1. Implementing the goals of government in relation to children and their families is the responsibility of MCFD, and confusion about responsibility and accountability for this function should be avoided.

2. Despite government's stated intention to act in the best interests of children, it is unrealistic to assume that the interests of the child and those charged by government with the task of fulfilling this goal will always be identical. The diverse responsibilities, limitations, interests and accountabilities of government will inevitably result in the child's interests not always being the primary focus.

3. For the most part, better decisions will be made by government about its involvement with children if the perspectives of the children, their families and their communities are understood and taken into account when government makes decisions about children.

4. Children have unique obstacles to having their perspectives heard by government, and special effort and skill is needed to lessen these obstacles.

5. Public confidence is not high in the capacity of a government ministry to appropriately fulfil, without external oversight, government's responsibility to forward and protect the interests of children. To some extent, this may be for historical reasons and could change, but the emotionally charged nature of this government function makes it likely that the public demand for external oversight will continue, or, at least, reemerge from time to time.

In this report, I will summarize the current functions of the Agencies. I will analyze separately the complaint, monitoring, fatality review and systemic advocacy functions, considering whether each is a core government functions, and if so, which office or offices can most effectively and efficiently perform the function. I will outline my proposed model, flowing from my analysis, and consider some additional issues relating to the proposed model. I will summarize the proposed future of the current functions of the Children's Commission and the Advocate. Finally, I will highlight what needs to be done to put the proposed model into effect.

II. CURRENT FUNCTIONS OF THE AGENCIES

In considering the current functions of each of the Agencies, I have grouped them into the four categories, complaints, monitoring, fatality review and systemic advocacy. The legislation establishing each Agency does not necessarily frame the Agency's functions in terms of the categorizations I have used.

Functions of the Children's Commission

Complaints

- Referring complaints to appropriate other processes
- Investigating and analyzing complaints about breaches of rights of children-in-care, and about provision of services for a child by MCFD
- Informally resolving complaints, including referral to mediation
- Conducting formal hearings of complaints by an independent tribunal panel with the authority to order that a breach of rights by MCFD cease, or a MCFD decision be reconsidered, and to make recommendations about how the issue might be resolved by MCFD
- Setting standards for internal review of complaints by MCFD

Monitoring MCFD

- Reviewing and hearing complaints about MCFD
- Investigating deaths of children-in-care or known to the Ministry
- Investigating critical injuries of children-in-care
- Reviewing plans of care for children in continuing custody of MCFD
- Tracking compliance with recommendations from the Children's Commission
- Monitoring adherence to standards set by the Commission for internal complaints

Child fatality reviews

- Collecting information and reviewing the circumstances of the deaths of all children in B.C.
- Investigating certain deaths, chosen at the discretion of the Commission, to determine the adequacy of services or to examine public health or policy issues
- Convening a Multidisciplinary Team to review children's deaths investigated by the Children's Commission
- Making recommendations to government and outside government agencies arising from the fatality reviews
- Tracking compliance with those recommendations

Systemic advocacy

- Recommending policy on the basis of hearing complaints, investigating deaths and critical injuries, reviewing plans of care
- Engaging in research projects
- Informing the people of BC about the state of the province's child and family-serving system, including through annual and special reports

Functions of the Advocate

Complaints

- Providing to children, youth and adults, information and guidance about how to put forward complaints about breaches of rights of children and youths, and about services provided by MCFD to children, youth and families
- Intervening in high conflict complaints to ensure that the perspective of the child is taken into account and that the focus on the child's interests is not lost
- Promoting and coordinating advocacy services for children, youths and families in communities
- Appearing on behalf of children in front of Children's Commission complaint Panels
- Overseeing the MCFD complaints process

Child fatality reviews

- Being a member of the Children's Commission's Multidisciplinary Team to review child fatalities

Systemic advocacy

- Listening to the views of children, youth, families and communities about government services to children, youth and their families
- Providing information and advice to government about services to children, youth and their families
- Providing information and advice to communities about services to children, youth and their families
- Developing, with First Nations communities, protocols for a relationship with the Advocate's office, as a requirement for delegation of child welfare authority
- Reporting annually to the Legislative Assembly on issues concerning legislation, policies and practices about services for the rights of children, youth and their families

Functions of the Coroner

Child fatality Reviews

- Investigating all unexpected, unforeseen and unexplained deaths
- Authorizing a post mortem examination and other examinations or analysis deemed warranted
- Inquiring, without a jury, into the circumstances and means of a death, and report the results of the inquiry to the Chief Coroner
- Conducting an inquest with a jury, to determine the circumstance and means of death and make recommendations arising from the death
- Through the Chief Coroner, bringing the findings and recommendations of coroners and coroner's juries to the attention of appropriate persons, agencies, and ministries of government

Systemic advocacy

- Making recommendations for systemic changes arising out of the circumstances of individual deaths

Functions of the Ombudsman

Complaints

- Responding to complaints of individuals about practices and services of public bodies, including the MCFD, and in some cases, resolving the complaints informally through negotiations
- Investigating, and making findings and wide-ranging recommendations in relation to, a broadly defined scope of complaints of individuals against public bodies, such as MCFD, including investigating actions or practices that are:
    - contrary to law, unreasonable, unjust, oppressive, or improperly discriminatory,
    - made, done or omitted for an improper purpose, without adequate or appropriate explanation of the reasons, negligently, or with unreasonable delay,
    - made, done or omitted under a statute, rule of law or practice that is unjust, oppressive, or improperly discriminatory,
    - based on a mistake of law or fact or on irrelevant grounds or consideration,
    - related to the application of arbitrary, unreasonable or unfair procedures, or
    - otherwise wrong
- Reviewing the internal complaints procedures of MCFD

Systemic advocacy

- Initiating an investigation of potential systemic unfairness by a public body, such as MCFD, and making recommendations for change to practice, policy and legislation
- Advocating for fair, reasonable, appropriate and equitable administrative practices and services by public bodies, including MCFD
- Reporting annually, or by special report, to the Legislative Assembly about issues, within his mandate, deemed by the Ombudsman to be of public interest
- In the case of children, using Canada and BC’s adherence to the UN Convention on Children’s Rights, as a standard against which to measure administrative practices and services

Functions of MCFD

Complaints

- Resolving complaints about breaches of rights of children-in-care, and about provision of services by MCFD for children informally at the social worker/ supervisor/ manager level, including reconsidering decisions
- Providing an internal formal complaint mechanism through a regional designated complaint reviewer, with the operational managers' having the final authority to change any clinical decisions
- Reviewing some complaints at provincial headquarters
- Determining policies/standards for internal review of complaints

Monitoring

- Reviewing reportable incidents, including deaths of and serious incidents involving children-in-care or children who have received services in the previous 12 months
- Reviewing serious practice issues in response to complaints from clients or advocates, and referrals from external review bodies or regional management staff
- Auditing compliance with provincial practice standards, including conducting practice audits of all MCF offices over a three year cycle
- Reviewing, by headquarters on a quarterly basis, computerized tracking data as to the implementation of internal and external recommendations
- Auditing plans of care of children in continuing custody, and identifying by computer when plans of care do not exist
- Auditing residential care settings to measure compliance with foster care and residential standards, and reviewing each care setting by field staff annually
- Conducting exit interview with children leaving care

Child fatality reviews

- Conducting Deputy Director's reviews of the circumstances of the deaths of all children who die in care, or who have received services in the previous 12 months, and file reviews in approximately one-half of the deaths
- Conducting Director's in depth reviews of the deaths of children-in-care where serious practice concerns have been identified in a Deputy Director's review

Systemic advocacy (This term can only loosely be used in relation to the MCFD in that MCFD is, in a sense, the "system".)

- Defining the objectives of government policy in relation to children and their families
- Implementing those objectives through internal policies
- Setting practice standards
- Engaging in research

III. THE COMPLAINT FUNCTION

I do not think that many would question that responding to complaints from those receiving government services is a core function of government. True, the courts are an institution outside government designed to handle complaints, including complaints from individuals about government. Courts, however, have their limits in dealing with complaints about administrative action, and also their limitations in terms of effectiveness and efficiency. The Ombudsman is an institution with independence from government to deal with complaints about administrative action. Also, the Ministry complained about will need to have some internal process to deal with individuals or groups who are unhappy with the Ministry's decisions, actions, policies or practices. Whether it is a core function of government to deal with complaints about how a government ministry fulfils its functions, beyond funding the Ombudsman's office and having an internal ministry complaints process, is an open question. Currently, dealing with complaints about MCFD is an area of overlapping functions among the Children's Commission, the Advocate, the Ombudsman and MCFD. Overlap inevitably causes inefficiencies. The issue here is: is this overlap necessary in order for government to effectively fulfil the function of responding to complaints about MCFD?

Goals of complaints process

The substantive goals of a complaints process are twofold: to achieve the best outcome in the circumstances of the particular complaint; and to improve how services are provided in the future. The process goals are also twofold: to allow the perspectives of those who are affected by a decision, action, policy or practice to be heard so that they can be taken into account in government decision-making; and to leave those who have brought forward the complaint feeling respected and heard by government. Many of the conflicts that lead to complaints in the child welfare system are between individuals who have an ongoing relationship, the most important one being between the child who is in the care of the state and the front line worker who is directly responsible for that care. Another important goal of a complaints process in relation to MCFD decisions is to improve, rather than undermine, that relationship.

A process is more likely to be effective in achieving these goals if, among other things it is accessible, timely, simple, problem-solving rather than confrontational, marked by respectful and open communication, responsive and acknowledging to the complainant, and if it involves the parties to the conflict in its resolution.

In my opinion, the current model of an internal informal complaints process, an internal formal complaints process, an external review process by the Children's Commission (including, potentially a formal hearing before a Panel), and the overriding review authority of the Ombudsman, is not the most effective or efficient way to achieve the goals set out above.

The current Children's Commission complaints process

Currently, a child, a child's parent or other person representing the child, and the Advocate may make a complaint to the Children's Commission about the breach of the rights of a child-in-care, or about a decision concerning the provision of services for a child by MCFD. The Children's Commission fields telephone calls from complainants, and refer the complainants back to the MCFD internal complaints process. Staff are often involved in assisting complainants to access the MCFD process, to understand that process, and to help work out problems with it. If the MCFD internal complaints process has been exhausted and the subject matter of the complaint is not being dealt with in another process, staff of the Children's Commission will gather and assess relevant information, and will often attempt to resolve the dispute informally. If the dispute is not resolved informally, the Children's Commissioner reviews the complaint file and determines, in accordance with Section 18 of the Children's Commission Regulation, whether to dismiss the complaint or refer it to a tribunal for decision. Reasons for dismissing a complaint include lack of jurisdiction, withdrawal or abandonment of the complaint, request by the child that the complaint be withdrawn, the existence of an alternative satisfactory remedy in another process, the fact that the matter is before the court, or a judgment that referring the matter to a panel would result in no apparent benefit to the child.

If the matter is referred to a Panel, the Panel of one, two or three, which may or may not include the Children's Commissioner, conducts a review. The Panel members are chosen from a roster appointed by the Attorney General, which includes child welfare professionals and community representatives. The Children's Commissioner, or someone designated by the Children's Commissioner, chairs the Panel. The Panel can choose to have representations in writing or by conference call, but in practice the Panel reviews have, for the most part, involved formal hearings with witnesses. The Children's Commission has found the use of formal hearings as the preferred process to have created a timeliness problem of concern to the Commission. At most hearings, lawyers have been present representing MCFD, and the Children's Commission reports that this has driven other parties to hire lawyers, or if they cannot afford lawyers, to feel disadvantaged in the process. A representative of the Advocate has participated in some cases, occasionally at the request of the Panel, to represent the interests of the child.

The Panel hears the evidence and determines whether the complaint is justified. The Panel may make an order that the breach not continue or that the person in charge of administering the service reconsider the decision, and may make recommendations about how to resolve the issue. The Panel may also request that the Director (the official within MCFD with guardianship authority) to notify the Children's Commissioner about what steps have been taken, and to give reasons why the Panel's recommendations were not followed. The Children's Commission receives the report of the Panel and the response from the Director, and considers whether to advise the Minister and whether to make the report public.

The Children's Commission in 2000 opened 339 complaint files. Many of these were referred back to the MCFD to deal with by their internal complaints process. During 2000, 23 of the complaint calls resulted in formal acceptance of a complaint for review by the Commission. 30 accepted complaint files were carried over from the previous year. During 2000, 25 complaint files were closed as resolved, 8 were dismissed by the Children's Commissioner pursuant to Section 18 of the Regulation, and 6 were referred to the Tribunal Division. More than half of complaints referred to the Panel, are resolved after the Panel is struck but before the Panel process is completed. An average of 8 to 10 complaints per year, go through the entire panel process.

The Panel hearings are held months, sometimes years, after the initial filing of the complaint. The timing of the Panel hearing is dependent on a number of variables, including how quickly MCFD provides the information the Children's Commission requires, the efforts that are made to settle the complaint prior to referral to the Panel, and the timeliness of MCFD's internal process.

In the 339 complaint files opened in 2000, 1079 complaint issues were raised. Of those issues, 387 were about alleged a breach of rights, and 692 were about ministry decisions. The most common breach of rights issue was about the level or quality of care received by children-in-care, with complaints about the inadequacy of services to children with special needs being on the rise. The most common MCFD decisions complained about were related to plans of care, in particular, guardianship placement decisions.

Assessment of the Panel process

No one I spoke to thought that the Panel process was efficient. Some thought it was effective as a "stick", the threat of which got the attention of MCFD and made MCFD more susceptible to informal resolution of complaints.

The Panel process does not appear to be responsive to complainants. It involves many months delay (at least six months, sometimes more than a year) before the complaint is resolved. It is not user-friendly, being overly formal and legalistic, often involving lawyers representing the parties. It was suggested to me (by others other than MCFD) that the process itself might be deterring legitimate complaints because people do not want to go through the process. It certainly is not responsive to the needs of children to have their issues dealt with quickly. Six months is a long time in the life of a child.

The Panel process is exceedingly expensive. The Children's Commission estimated that their average cost for each tribunal hearing is about $7,000 – $8,000, including the cost of a lawyer to advise the Panel. When the Ministry, Advocate and individual costs are included, they estimate an average of $15,000 per complaint. This may be a conservative estimate. MCFD assessed its own costs for one hearing to be over $100,000 when it took into account time taken by social workers and others away from their other tasks. There are better ways that these resources could be allocated.

The Panel process is not designed to enhance the possibility of MCFD learning from a complaint. It certainly involves a resolution far removed from the source of the conflict

that gave rise to the complaint. I have heard from MCFD and others that Panels have been aggressively adversarial towards MCFD. Feedback from the Children's Commission suggests that the adversarial nature of the Panel process has more to do with MCFD's defensive approach to the Panel hearings, and the fact that a case only goes to the Panel when all other processes have failed. Recommendations from Panels have often not well-received or well thought of by MCFD. It is, of course, an issue whether the explanation for this lies with poor recommendations or lack of appropriate openness on the part of MCFD to constructive criticism. Whatever the cause, the effectiveness of the Panel process in terms of improving MCFD services has to be questioned.

The question was asked of me: if others have access to independent tribunals to hear complaints about government services, why not children? One obvious answer is because a tribunal process does not work well for children. But also, one has to ask, regardless of what other tribunal processes may be available in other situations: why is a formal tribunal process necessary to deal with the issues that children-in-care or children receiving MCFD services have with MCFD?

When competing rights are at stake, the protections provided by the formalities of a tribunal process may be worth the inefficiencies of the process. The issues considered by the Children's Commission Panels, however, do not involve competing rights. However they are framed, they are essentially about whether the MCFD is fulfilling its function properly to implement government's goals in relation to the children for whom it bears responsibility. True, some times, the issue before the Panel is whether a child's rights have been breached by MCFD. These rights are established for children-in-care in Section 70 of the *Child, Family and Community Service* Act, which is the code for the child welfare system in British Columbia. It is MCFD's statutory responsibility to do its job of implementing the child welfare system in a way that is consistent with these rights. The underlying issue, therefore, even in rights cases, remains whether MCFD is doing its job in accordance with the law and its stated goals and policies.

Dealing with the issue of how MCFD is doing its job is not enhanced by the formal presentation of evidence with the opportunity to examine and cross-examine witnesses. This is an adversarial approach to resolving a conflict. Adversarial processes undoubtedly have their value in getting at the truth. They are not conducive to openness to criticism and self-correction, which is what is needed in the case of administrative actions of the sort that are the subject of complaints to the Children's Commission. Also, adversarial processes, whatever their other values, have never had a positive effect on the ongoing relationship of the parties to the process. If there has indeed been a breach of an individual child's rights in that child's ongoing relationship with MCFD, avoiding future breaches is more likely if the relationship between the child and the individual worker complained about is improved, rather than further undermined, by the process itself.

As to the argument that the Panel process is an effective "stick" to be used against MCFD, whether the use of sticks effectively improves performance is debatable. Even if it is acknowledged that a stick may occasionally be useful in addressing the power imbalance between MCFD and those it serves, there are, in my opinion, more efficient

sticks than a formal panel process, among them the power of a respected children's officer to go public if all else fails.

The Option of Review by the Children's Commissioner

One suggested alternative is to eliminate the Panel process but maintain the Children's Commission as an independent reviewer of complaints, with the Children's Commissioner functioning in a similar manner to the Ombudsman.

That alternative raises the question: why have both the Children's Commission and the Ombudsman available to review complaints about MCFD? Doesn't this create unnecessary duplication?

It was pointed out to me that there might not be duplication in that the existence of the Children's Commission likely reduces the number of complaints received by the Ombudsman about MCFD. I was unable to conduct a statistical analysis of whether the number of MCFD complaints handled by the Ombudsman was reduced once the Children's Commission was in place. I was told by the Ombudsman's office that, with some exceptions, before the Ombudsman will deal with a complaint, the Ombudsman expects a complainant to go through the MCFD internal complaint process and the Children's Commission process if the complaint is within the Children's Commission's mandate. Once through the Children's Commission process, it is open to a complainant to complain to the Ombudsman either about MCFD or about the Children's Commission process itself.

Whether or not there is duplication, there is definitely overlap. Like the Children's Commission, the Ombudsman's office, functioning through its child and youth team, reviews decisions and actions of the MCFD in response to individual complaints. The Ombudsman focuses most often on procedural issues. The Children's Commission also looks at many of the same procedural issues.

It was, however, pointed out to me that there was a significant difference between the role of the Ombudsman and the Children's Commission in handling complaints about MCFD. The Children's Commission, as well as looking at procedural issues, often makes a judgment as to, whether the decision, action, practice or policy of MCFD is substantively right or wrong.

Looking at the statutory mandate of the Ombudsman, this procedural/substantive distinction becomes less clear. The Ombudsman is given, under the *Ombudsman Act*, the mandate to investigate whether a decision of MCFD is arbitrary or based on reasons; whether it is consistent with the relevant government policy and the law; whether, indeed, the policy or law itself is unjust, oppressive or improperly discriminatory, and whether the perspective of the child (or any individual affected by the decision) has been appropriately heard. There is, also, the catchall in Section 23 of the *Ombudsman Act*, that provides that the Ombudsman may investigate whether the action and practice is "otherwise wrong". Significantly, I was told by the Ombudsman's office that among the laws with which the Ombudsman routinely looks for consistency are the enumeration of the rights of children-in-care in the *Child, Family and Community*

Services Act, and the rights enumerated in the UN Convention on the Rights of Children, to which Canada is a signatory. The Children's Commission also adjudicates whether there has been a breach of the rights in Section 70 of the *Child, Family and Community Services Act*,

The practical difference between the mandate of the Children's Commission and the Ombudsman is that the Children's Commission is more likely to second-guess the judgment of MCFD in relation to children-in-care and children receiving services from MCFD. When the Ombudsman looks at a complaint about how MCFD has exercised judgment in a given set of circumstances, and concludes that MCFD's decision is based on reasons and is not arbitrary, that it is consistent with government policy and the law, and that the child (or anyone else affected by the decision) has been appropriately heard, then the Ombudsman is more likely to stop there. The Ombudsman defers to MCFD's expertise in making such judgments, although he will question how that expertise was applied in making the decision. In practice, the Children's Commission is not as inclined to be deferential to MCFD"s expertise and is more likely to make a finding that MCFD's judgment in the circumstances was wrong, and make a recommendation that the decision be changed.

To the extent that the Children's Commission and the Ombudsman's mandates overlap, it is difficult to justify two agencies. If the Children's Commission was somehow more accessible, timely, and effective than the Ombudsman's office perhaps the duplication of function could be rationalized. There is no evidence to that effect. In fact, if anything the contrary may be the reality. Certainly, MCFD's perspective is that the Ombudsman's response to complaints, prior to the creation of the Children's Commission, and now, is more effective than the Children's Commission's response. This may be viewed as a suspect judgment given that it comes from the agency under review, but the view from within MCFD was consistent with other more objective opinions I received. This somewhat critical view of the Children's Commission's handling of complaints might be related to the fact that the Children's Commission process often involved the Panel process. Historical issues that created a somewhat adversarial relationship between MCFD when the Children's Commission was first established may also be a factor. Certainly, I was given illustrations of how the Children's Commission currently attempts, like the Ombudsman's office, to resolve complaints informally, and I was told by the Children's Commission that they view the informal resolution of complaints as a core function. The fact that 11 out of 25 complaints files opened in 2000 were resolved informally bears this out. Whether the Children's Commission could be just as effective as the Ombudsman or not, the question remains: why two external agencies performing the same function?

One argument in favour of the Children's Commission performing this complaints review function is expertise; the Children's Commission, because of it focuses exclusively on children, can become expert in children's issues and issues relating to MCFD. I am not convinced that this argument should prevail and that the potential for more specialization should be a determining factor. The Ombudsman's office does have a child and youth review team, which has over the years developed significant expertise in handling complaints of this nature. Furthermore, balanced against the advantages of specialization is the fact that the Ombudsman's office offers a greater

breadth and depth of understanding of ministries and agencies, other than MCFD, which impact on children and youth.

What remains then is the question of whether the Children's Commission's complaint function is justified because the Children's Commission is more likely than the Ombudsman to review substantive as well as procedural issues. Does the Children's Commission's oversight of the judgment calls of the personnel in MCFD effectively and efficiently further the goal of government to provide better services for children? Mistakes in judgments on the part of MCFD will be made. Complaints are a way of bringing these mistakes to the attention of those who might be able to effect a change in the judgment call. At the end of the day, however, those who are accountable for the judgment calls ought to be the ones reviewing them. A complaints process is, in my opinion, flawed that involves a government agency, which is not directly accountable for the outcome of the judgment call, second-guessing the judgment of those who are.

Even if the Children's Commission process does, at times, involve second-guessing MCFD's judgment calls, it does not necessarily result in the substitution of MCFD's judgment because the Children's Commission can only make recommendations. If the decision-making continues to rest with MCFD, then a complaints process that involves reviewing a judgment call, in order to be effective, needs to be focused on enhancing good decision-making. I have already raised the fact that questioning from outside can be counter-productive to good decision-making because it tends to result in defensive rather than an open, learning response. Also, there is the usual complaint about an outsider second-guessing judgment calls: that is, that the outsider cannot possibly have the same grasp of all the factors that need to be balanced in making the judgment call, and, therefore, is unlikely to exercise as good judgment in the circumstances.

The criticism of a totally internal process is that it does not recognize the existence of a potential conflict of interest between the decision-makers and the child or persons affected by the decision. It also does not take into account the power imbalance that exists in these circumstances, or put another way, the obstacles that exist for children and the families who receive MCFD services, without the assistance of some outside authority, to having their perspectives heard and taken into account by MCFD in the course of MCFD decision-making.

The Ombudsman's office is external to MCFD and is independent and as such, provides a counterbalancing authority to MCFD for the individual adversely affected by MCFD's decision-making. The Ombudsman is, by his mandate, committed to eliminate obstacles for individuals being heard by government agencies. The Ombudsman's office has demonstrated sensitivity to the particular difficulties faced by children in being heard.

In conclusion, it is my opinion that only one complaint review process to handle complaints against MCFD is justifiable, and the Ombudsman's office can more effectively and efficiently fulfil this function than can a specialized children's officer.

Individual advocacy in the complaints process

There is another potential role for a government funded children's officer in the complaints process and that is as an advocate for the individual child who is complaining. The role of an advocate is to pursue the best interests of the child, to ensure that the child's perspective on those interests is understood by whoever is making decisions affecting the child, and to insist that the child's perspective be taken into account by the decision-maker. Is this a core function of government? I think that the answer, at least with respect to children-in-care, is a qualified "yes". The state is standing in the place of the parent for a child-in-care. A core function for a parent is to be an advocate for their child.

Whether it is a core function of government to advocate for children not "in care" but who are receiving services from MCFD is another issue. Many of the parents of these children, for various reasons, are not able to provide the natural advocacy that other parents can.[4] If the government is seeking to work more in partnership with families and communities in relation to children whose well-being requires state intervention, then the distinction between children-in-care and children who are receiving services from government may not be so clear-cut. The provision of government "parental" type services to children might be seen more as a continuum, one end of which are children in the continuing custody of the state. In all cases, the child's perspective should be taken into account in decision-making, and the child may need an advocate, other than the child's parent, to ensure that happens.

The current Advocate's mandate extends beyond children to youths who by definition include young people who are over the age of 19 but who may be entitled to receive designated services. In most cases, these are young people with "special needs" and/or who were in care when they were children. Whether advocating for young people in these circumstance, who are by law adults, is a core government function is a different issue than advocacy for children under 19. On the other hand, the notion that children suddenly become ready to advocate for themselves when they turn 19 is artificial. Many children who have never been in the care of the state have parents who are looking after their interests beyond the age of 19, even though there may not be a legal obligation to do so.

If the state has any individual advocacy responsibility for children-in-care, or for children or youths who receive services from MCFD, then how can this responsibility effectively and efficiently be met?

First, MCFD should and does advocate on behalf of the children in its care and for whom it provides services. This includes making certain that the children's perspectives are heard and taken into account when decisions are made that affect

[4] Like all generalizations, there are some glaring exceptions. The most notable are the parents of children with "special needs" who are receiving services from MCFD. My understanding is that, while many of these parents are physically and emotionally exhausted, and have great difficulty in balancing their care giving responsibilities with advocating on behalf of their child, the parents of "special needs" children are often very adept at individual advocacy. They have had to be.

them. MCFD, however, is a bureaucracy with inevitable limitations of time and resources for advocating for individual children for whom it is responsible. Also, MCFD is the decision-maker, and it is inevitable that the bureaucratic decision-maker will have some resistance to taking the time necessary to ensure that the child's perspective is fully heard, and may have interests with respect to the decision that potentially conflict with those of the child. In certain situations, effective advocacy will likely require an advocate other than the social worker.

Whether it is a high priority for government to fund individual advocacy services for every child who has a complaint against MCFD is questionable. My understanding is that the former Advocate from the beginning of the creation of the office and her appointment, and the current acting Advocate, have taken a limited view of the Advocate's in terms of individual advocacy. An effort was made not to create a bureaucracy to provide individual advocacy services throughout the province, in the realization that there are more efficient and effective ways of fulfilling that function. Instead of providing individual advocacy services through regional offices, the Advocate has seen her role as enabling, and building the capacity of, children to advocate for themselves, and of families, social workers, foster parents, and communities to advocate on behalf of the children for whom they are responsible.

The Advocate's office receives approximately 3000 advocacy requests per year. The Advocate's office estimates that this is about 10% of individuals or children with concerns about MCFD decisions or actions that affect them. Approximately half of the calls are from family members. Less than 20% are from the children and youth themselves. Four of the Advocate's staff provide individual advocacy services.

One intake worker talks to all adult callers and coaches them about how to take forward their concern effectively. If the concern is a child protection concern, the caller is referred to MCFD to report the concern. The Advocate's office also reports child protection concerns to MCFD but does not follow up on them. Many of those seeking assistance from the Advocate's office require no more than information and affirmation. The intake worker may make a telephone call or two to open some doors within MCFD for the caller.

Two full-time advocacy officers deal with individual complaints when more than one or two calls is required to resolve the issue, or when the individual is having some difficulty accessing the MCFD internal complaints process. These more complicated complaints are often about placement of a child-in-care and usually involve a number of adults with diverse viewpoints about the child's best interests. In these more complicated cases, the advocate staff tries to interview the child involved to ascertain the child's perspective on the issue. The staff member also talks by telephone to interested adults. Often, the staff member will meet with the whole group of interested adults. The thrust of the Advocate staff member's effort is to try to open up the process and to de-escalate the existing conflict. The staff member seeks to make certain that the voice of the child is heard, and asks questions that bring back the focus of the discussion to the best interests of the child.

The three individual advocacy staff are supervised by the Manager of Client Services, who works with MCFD's regional manager responsible for handling complaints internally, or takes up issues with the Regional Executive Director that cannot be resolved locally. The Manager of Client Services participates in public speaking and education with numerous stakeholders, including newly hired MCFD social workers, aboriginal agencies and college classes

When complaints go to a Children's Commission panel, the Advocate's office sometimes represents the child in the process. If the Panel process is eliminated, then that individual advocacy service will obviously not be required.

In my opinion, the Advocate's focus on capacity building rather than direct individual advocacy makes sense. Providing individual advocacy services from a provincially based office has limits in terms of accessibility to children. To provide extensive local advocacy services would be very expensive. On the other hand, enabling and building the capacity of others to advocate individually is a useful role that a children's officer could play. This enabling and capacity building could include picking up the telephone and informally trying to assist in the resolution of a complaint. It could mean being a source of information about the appropriate internal process for bringing the perspective of the child forward. It could involve assistance in filing a complaint with the Ombudsman's office. It could also include providing training or other resources or seed funding for community or youth groups that themselves provide individual advocacy services.

There will be instances, however, when individual children need assistance in putting forward their perspectives that is beyond the capacity of themselves, their families or their community to provide. The obstacles may be more complex than usual, and removing them may involve an ability to navigate the system beyond the capacity of the child and his or her natural advocates. In these cases, the Ombudsman's office has a role to play if a complaint is lodge with that office. Making certain that the child's perspective is heard and taken into account by a decision-maker is an issue of administrative fairness. Also, MLA's are available to advocate on behalf of their constituents, to ask questions and open doors.

Nevertheless, if there is a children's officer, then in my opinion, it is appropriate for that children's officer to play, from time-to-time at the discretion of the children's officer, a direct individual advocacy role. This will be important when the issue at stake is viewed by the children's officer to be an important one, and when there is an apparent need to redress any power imbalance that may exist between a child and MCFD, in the circumstances.

Retaining an advocate on an *ad hoc* basis, as required, is an alternative to full-time government personnel providing individual advocacy. I think that the choice of how individual advocacy services are best delivered, should by the children's officer.

In summary, I do not think that individual advocacy is a sufficient reason to have a children's officer external to MCFD. If there are other good reasons to have a children's officer, however, then I think that officer would have a useful role to play in enabling and

building the capacity of children and their natural advocates to advocate on behalf of children who are in care or who are receiving services from MCFD. I think that having an office, external to MCFD, which is perceived to be unequivocally on the side of children, fielding of calls from children or adults unhappy with MCFD, and making follow up telephone calls to open doors for those individual within MCFD, is an effective way for government to respond to complaints about MCFD. In certain circumstances, I can see the children's officer playing a direct role by allocating a staff member, or contracting someone else, to be an advocate on behalf of an individual child in high conflict disputes with MCFD.

A Children's Ombudsman

A model suggested to me was to divide the Ombudsman's functions between children and non-children issues and to create the office of Children's Ombudsman to deal with the children's issues. The advantage of such a division is that it would avoid duplication and overlap, while at the same time recognizing the importance of children, their special vulnerability in relation to government, and the obstacles they face in having their interests and perspectives heard. It avoids children's issues getting lost in the larger mandate of the Ombudsman that covers all government ministries, crown corporations, educational institutions, health related government services, and professional and occupational associations. It ensures the development of expertise in dealing with children's issues. Although currently there is a children and youth team within the Ombudsman's office, that is an administrative decision of the Ombudsman, and there is no guarantee that children will always have special resources allocated to them by the Ombudsman of the day. Also, if the Children's Commission no longer handles complaints, it is fair to assume that complaints to the Ombudsman involving MCFD may increase. Without additional resources, the Ombudsman may be hampered in handling these additional complaints in a timely, efficient and effective manner.

A potential disadvantage to dividing up the Ombudsman's function is the difficulty in categorizing government functions in terms of whether they relate to children or not. This is probably a surmountable problem, but one needs also to ask whether it makes sense to divide up the Ombudsman's oversight of government agencies on a functional basis. While the focus of government action in relation to children is in MCFD, other ministries are often involved. The knowledge and understanding gathered by the Ombudsman's office in handling "non-children's" issues across the breadth of government agencies under the mandate of the Ombudsman can be brought to bear to the handling of "children's" issues. Furthermore, if the MCFD appears to be functioning relatively well in terms of administrative fairness, then it is good public policy that the Ombudsman has the discretion to focus the resources of the office to other areas of concern.

The Saskatchewan model divides up the review of complaints function between the Ombudsman and the Children's Advocate. They work out of the same office and have managed informally to divide the complaints between them. The larger numbers of complaints that the Ombudsman's office in BC has to deal with would make this approach likely unworkable. There would need to be a defined functional division with the possible limitations outlined above.

In my opinion, splitting the Ombudsman into two functional units, one of which is focused on children, cannot be justified solely for the purpose of dealing with complaints about MCFD. In fact, with respect to the external complaints function such a division might well be counter-productive. I will revisit the model of a Children's Ombudsman when I consider the systemic advocacy function.

Special investigation initiated by the Minister or by the Attorney General

Before ending discussion of the external complaints function, I want to raise another mechanism for handling complaints: that is, a special investigation by someone external to MCFD, initiated by the Minister of Children and Family Development or through the Attorney General. I expect that this option would be used only in rare circumstances. It does, however, provide an alternative when a complaint becomes politically high profile resulting in public controversy. In those cases, an internal review may not be sufficient to secure public confidence in MCFD's exercise of judgment. A review of both the process and the substantive issues relating to the complaint, by a recognized and knowledgeable person external to the Ministry, may be the most effective and efficient way to resolve the controversy. In my opinion, the role of special investigator could appropriately be played by a children's officer who would have the stature and specialized knowledge necessary to make an independent assessment in which the public could have confidence. A special investigator could also be retained on an *ad hoc* basis.

The current legislation governing the Children's Commission provides that any minister may request a special investigation. I assume that this provision is, in part, a reflection of the broad mandate of the Children's Commission to consider issues not directly related to MCFD. In my opinion, sufficient latitude would be provided by extending to the Attorney General the authority to initiate a special investigation.

MCFD's internal complaints process

I have some reluctance to make any recommendations to modify the existing complaints process within MCFD. For one thing, making policy recommendations as an outsider is rather inconsistent with one of my underlying assumptions: that is, that MCFD is in the best position to know what policies will work to further its goals. For another, the current complaints process is the end product of considerable work within the MCFD, on its own initiative and in response to the recommendations of the Children's Commission and the Advocate. The process has also received approval from the Ombudsman's office[5]. Why tinker with it?

On the other hand, the better functioning the internal MCFD complaints process is, the less important it is to have an external complaints process designed specially for MCFD. To report fully, it is necessary for me to explore what MCFD's complaint process should look like, at least in general terms.

The Children's Commission has the statutory mandate to "set standards to be applied by prescribed ministries or agencies of the government to help ensure that their internal review processes are responsive to complaints about decisions concerning the provision of designated services to children."[6] The Advocate's statutory function includes ensuring "that children, youths and their families have access to fair,

[5] The Ombudsman approved MCFD's current complaints process as it is set out in policy, but has not done an assessment of the actual implementation of this process.
[6] Section 4(1)(d), *The Children's Commission Act*.

responsive and appropriate complaint and review processes at all stages in the provision of" designated services.[7] The Ombudsman's office also has a mandate to review MCFD's internal complaints process in terms of its consistency with the principles of administrative fairness, and to make recommendations for change if necessary.

In October 1997, MCF (as it then was) in consultation with the Children's Commission, implemented a province wide Complaint's Resolution Process. In early 1998, the Ombudsman did a review of the MCF Complaint Resolution Process, and found that, for the most part, it was an adequate remedy for those with complaints about MCFD services. As a result of that positive assessment, the Ombudsman's Intake Team began referring complaints back to that internal process.[8] Subsequent statistics showed that fewer than 10% of individuals who were referred back to the regional complaint resolution process returned to their office.

On the other hand, it was reported to me that the Children's Commission staff have found that many of the complainants that are referred back to the MCFD internal complaint process by them return to the Children's Commission expressing considerable concern and frustration with the internal review process. They express confusion regarding the difference between the "informal" and the "formal" process, the applicable timeframes, confusion about responsible review authorities, and the ability of other MCFD staff to change decisions.

The Children's Commission retained consultants to evaluate the MCF complaints process, the Children's Commission complaint review process and the services to callers provided by the Advocate's office. They reported their findings in January 1999 and then again in March 2001. In response to external recommendations and its own internal consideration, MCFD developed a modified Complaints Process Policy that became effective October 31, 2001.

Despite what has already been done, in my opinion, a fresh look should be taken of the MCFD complaints process. In the course of my investigations, I spoke with two individuals, including the Director of Regional Operations for the Ministry of Human Resources, who were key in developing an entirely different approach to complaints in the Ministry of Human Resources, and with the Community Living Services Advocate who deals with complaints related to the community living services part of MCFD's mandate. I also had some very helpful input from the Advocate's office about how to make the complaints process responsive to complainants. The representatives of the Youth In Care Network whom I spoke to also gave me an interesting perspective. I was left with the impression that the current internal complaints process is working better in some regions than others. I also expect that further reform of the process could have a role to play in MCFD's commitment, referred to in their Core Review presentation, to a strategic shift to open, accountable and transparent relationships, and its commitment

[7] Section 2(b), *The Child, Youth and Family Advocacy Act*.
[8] An exception was made for complaints from children or youth in institutions, or who were at risk or denied service, or for whatever reason were considered a priority by the Ombudsman.

"to advance and support a community based system of family services that promotes, innovation, equity and accountability".

However the internal complaints process is structured it should, in my opinion, seek to do the following:

a. Make clear that the goal of the process is to make the best decision in the matter that is being complained about and to improve the quality of Ministry services in the future, and that input from the child involved, and from interested family and community members, will aid in achieving that goal;
b. Encourage a problem-solving approach to resolving the issue rather than an adversarial one;
c. Expect from the decision-maker an open, learning stance rather than a reactive, defensive one;
d. Be simple, timely and accessible;
e. Increase the interaction, in the process, between front-line staff and the child that is the subject of the identified concern, and the family or community members raising the concern;
f. Contain the complaints process within the region, making the Regional Executive Director the ultimate decision-maker;
g. Discourage intervention by headquarters in Victoria;
h. Encourage the expression by the child, the family and interested community members of their perspectives on the issues raised; and
i. Further the goal to promote and develop the capacity of families and communities to take increasing responsibility to care and protect vulnerable children and youth and to advocate on their behalf.

Thought should be given to not calling it a "complaints" process at all. Language can be important. One of the youths I spoke to commented on the fact that using the word "complaint" creates a barrier to access. Many children, family and community members who might have important input into decisions by front-line workers do not like to see themselves as "complainers". Also, calling something a "complaints process" increases the formality involved, which in turn, detracts from the goals of being simple, timely and accessible. MHR called their process a "Service Review Process". Concerns raised by clients should not be seen as complaints to be reacted against but opportunities to improve service delivery.

Crucial to shifting from a defensive culture to an open, learning culture will be to keep the handling of the issue, as much as possible, at the field level. There will, of course, be exceptions, but I heard that the current tendency of headquarters to become involved in complaints is viewed as being counter-productive in the same way that the Children's Commission's complaints process is.

While I recommend that the expectation should be that the social worker and team leader will be the front-line for handling client concerns, I do not think that it can realistically be assumed that social workers and team leaders will be equally adept at dealing with "complaints" in an open, inclusive way that furthers the stated objectives of

MCFD. Training in dispute resolution and administrative fairness will be helpful in developing these skills. Commitment in the leadership levels to the new approach will also be an important catalyst to changing the practice of front-line social workers.

In the event that the concern is not adequately addressed in the first instance by the social worker and team leader, I recommend that two internal alternatives by offered to complainants:

1. Request for review by the manager in the direct line of responsibility; and/or
2. Request for the intervention/review of an internal manager-level MCFD employee in each region who I will call the Regional Quality Improvement Manager.

Bringing in the Regional Quality Improvement Manager should be an option available at any stage to accommodate those who feel reluctant to bring up their concerns directly with the social worker or the social worker's supervisor. This may be because of a breakdown in the relationship with the social worker, or a concern about bias for those responsible for the original decision, or a fear of reprisal from the social worker with whom the client must have an ongoing relationship.

The option of an appeal to a Regional Quality Improvement Manager is designed to provide an option to go to someone else internally who knows the system but who was not involved in making the decision under review and therefore, does not have, and is perceived not to have, a vested interest in the decision with which the client takes issue. I considered a model in which this individual was external to MCFD. I was convinced that by making the individual external, many advantages would be lost. In particular, involving someone who has an insider's knowledge about how the system works and has the trust of those whose decisions are being reviewed has been found to be effective. The potential for turning a complaint into a learning experience is enhanced.

While requesting the intervention of the Regional Quality Improvement Manager would be part of the formal complaints process, these individuals would be expected to act, to a large extent, informally in that they would be expected to go back to the front-line to bring the original decision-maker into the process of resolving the complaint. They would need to be particularly skilled in a problem-solving, open communications approach. The Regional Quality Improvement Manager would fulfil an internal educative function. While Regional Quality Improvement Manager would not usurp the line Manager's decision-making authority, I envision that the Regional Quality Improvement Manager would review the facts and make an independent assessment. If the issue could not be resolved informally, I see the Regional Quality Improvement Manager's having the authority to make a formal recommendation to the Regional Executive Director.

A criticism I heard of how the internal complaints process has been working in practice is that, in some areas, the internal Manager designated to deal with complaints have too many competing demands on their time, and are doing the complaints work "off the side of their desk". I have also heard that some are so overwhelmed with dealing with complaints that the quality assurance part of the job has taken a lower priority. I also understand that the classification level of Quality Assurance Managers is lower than the

classification level of the managers to whom the social workers and team leaders report. This undermines their authority if they take a different view of the issue than does the line manager.

What I envision is someone at the same level as the other regional and community managers, who like them reports to the Regional Executive Director. Given that there will continue to be a quality monitoring and improvement function at headquarters, I recommend that the Regional Quality Improvement Manager have a dotted line reporting relationship with whomever is responsible at headquarters for this function. I understand that this is likely to be an Assistant Deputy Minister. If community/regional governance becomes a reality, consideration might be given to having this individual have some independent reporting functions to the governance body.

I recommend that the responsibilities the Regional Quality Improvement Manager would include some responsibility for building the capacity of line workers, be they social workers, supervisors, or managers, to respond in an open way to input from children, families and other interested community members.

I recommend that a third option should be readily available for particularly intractable disputes: that is, bringing in an external mediator on an *ad hoc* basis. Section 22 of the *Children, Family and Community Service Act* provides for mediation or other alternative dispute resolution mechanisms to help resolve issues relating to a child or a plan of care. A roster of qualified mediators already exists. My understanding is that the use of mediation varies from region to region. I think that consideration be given as to why some regions are not using mediators with a view to removing obstacles to its use.

In questioning the need for a formal panel process, I suggested that the underlying issue when a breach of a right set out in Section 70 of the *Child, Family and Community Service Act* is alleged, is whether MCFD is doing its job properly. Having said that and having advocated reconsideration of the use of the word “complaints”, I think that it will continue to be important to expressly allow children-in-care a formal process to put forward an allegation of a breach of a right set out in Section 70 of the *Child, Family and Community Service Act*. A right requires a remedy if it is to be more than a hollow statement of good intentions. Without an express mechanism to deal with allegations that a child’s right had been breached, the only alternative would be to seek a remedy in court. While the formalities of the current panel system are, in my opinion, not an effective alternative, I think that the proposed internal “complaints” process should be expressly available to children-in-care as a means to deal with alleged breach of rights. A child-in-care who alleges a breach of a Section 70 right could request the Regional Quality Improvement Manager to review the allegation. If the Regional Quality Improvement Manager cannot informally resolve the issues raised by the allegation, then Regional Quality Improvement Manager will make a determination of whether a breach of rights has occurred and recommendation to the Regional Executive Director as to how the breach could be rectified. It will also be open to a child-in-care to make a complaint to the Ombudsman about a breach of Section 70 rights.

I noted at the outset of this discussion of MCFD’s internal complaints process that the Ombudsman has approved the current process. I have considered whether the

implementation of the recommendations I have made would undermine that approval. The Ombudsman's recently released *Public Report No. 40: Developing an Internal Complaint Mechanism* assisted me in this consideration. I am assuming that MCFD will continue to have written material available setting out a clear definition of what type of complaints it can appropriately respond to, and explaining its process for handling complaints. I also assume that suitable time frames for responding to complaints will continue to be in place. While I have emphasized the interactive, joint problem solving, educative aspects of the process, this does not preclude compliance with the more formal requirements outlined by the Ombudsman in his report. For example, when a supervisor or a line manager considers all relevant information and the perspectives of those affected by or interested in the decision, and decides whether to change the initial decision, the reasons for the decision should be provided in an intelligible way to the complainant.

Finally, I want to be clear that I understand that significant decentralization and fundamental reorganization is currently being contemplated within MCFD, including possible devolution of authority to communities or regions. My proposal, that increased effort be made to resolve disputes as close to where the dispute arises as possible, is consistent with this strategic shift. It may be that the precise organizational set-up I propose will need to be modified because of the new structural context. I do not see this to be a problem, but I want to emphasize the importance to my overall recommendations that there be an internal complaints resolution process in place, which is consistent with the principles of the one I have proposed and acceptable to the Ombudsman, regardless of how MCFD organizes its service delivery.

IV. MONITORING MCFD

Monitoring whether MCFD is doing its job of effectively implementing its goals is undoubtedly a core function of government. Having goals and strategies to implement those goals only goes so far. Monitoring is needed to measure whether the goals are being met and to determine if the strategies designed to meet the goals are being implemented, and if so, if they are effective strategies. If strategies are not being implemented or are proving ineffective, then change in policy or practice should result. So monitoring is integral to policy development and implementation. The question is whether this monitoring function is most effectively and efficiently conducted internally, externally or a combination of both.

Fundamental to understanding how government effectively fulfils the function of monitoring is the concept of Ministerial responsibility. The Minister is responsible for ensuring that the Ministry implements government objectives. Monitoring is integral to successfully fulfilling this responsibility in that it provides the necessary knowledge to the Minister about whether government objectives are being met. Also, because what is observed in the monitoring process is the basis for policy and practice change. It follows that those responsible for change need to be involved in monitoring, and that the Minister who is ultimately responsible for the Ministry's output must also be responsible for monitoring and must implement that responsibility internally in the Ministry. The Minister cannot rely on an external agency, which is not responsible to him, to fulfil exclusively the monitoring function.

Aside from the integral interrelationship between monitoring and responsibility for outcomes, effective monitoring requires in depth understanding of how the system works. This kind of in depth understanding is more likely to reside inside rather than outside of an organization.

Just because monitoring must by done internally, does not necessarily preclude an external watchdog who also performs a monitoring function. The integral relationship between monitoring and responsibility for outcome does, however, suggest caution in confusing the distinction between monitoring by an external watchdog with no policy-making responsibility, and monitoring by the Ministry as an integral part of Ministerial responsibility for policy-making within the Ministry. In my opinion, that distinction has not always been clear in the functioning of the Children's Commission. While the Children's Commission only has the power to recommend and to monitor recommendations, the exercise of that power has on occasions led to the Children's Commission essentially mandating how MCFD fulfils its responsibilities, thereby paradoxically, while on the face of it, holding MCFD accountable for its policies, effectively undermining MCFD's policy-making responsibility.

Currently, there is duplication in the performance of the monitoring function. The Children's Commission monitors MCFD by reviewing and hearing complaints, by investigating deaths and critical injuries of children-in-care and children who have received services from MCFD, and by reviewing plans of care for children in continuing custody. MCFD also conducts a review of fatalities and critical injuries of children-in-care and those who have received services from MCFD in the 12 months prior to the

incident. In addition, MCFD reviews serious incidents involving a child in care, including exposure to high risk or life-threatening circumstances. Currently, a report of the incident is reviewed by the Deputy Director, who decides whether the circumstances warrant a file review. In approximately half of fatalities and in critical injuries when practice issues are raised, the Deputy Director conducts file reviews. No file review is conducted if the death was expected and explained. In certain instances, when serious practice concerns are identified through a Deputy Director's file review, the Director undertakes a more comprehensive review involving extensive interviewing. MCFD reviews plans of care for children in continuing custody as part of the audit and tracks plans of care found non-compliant in the Children's Commission's audit. In addition, the MCFD computer system identifies children for whom there is no current plan of care.

Duplication of monitoring functions raises questions of efficiency. There are inherently some inefficiencies in having both an internal and an external monitoring function. The issue, then, is whether these inefficiencies are justified because external monitoring effectively enhances the likelihood that MCFD will meet its objectives.

I will consider separately the effectiveness of the Children's Commission's review of children's deaths because there are special arguments for retaining an external role in that monitoring process.

Critical Injury reviews

With respect to reviews of critical injuries, there is another overlapping of responsibility that needs to be considered. The Public Guardian and Trustee (PGT) is the guardian of the estate of children in the continuing care of the Director. This means, however, that if a child in continuing care is seriously injured, the PGT has a responsibility to investigate the circumstances to see if a lawsuit on behalf of the child is in order. Especially given the rather broad view that the Supreme Court of Canada has recently taken with respect to vicarious liability, this could well include investigating whether a child-in-care could successfully sue the Ministry itself for damages resulting from the critical injury. Needless to say, the Ministry has a potential conflict of interest in these situations. I understand that while MCFD has acknowledged the importance of bringing the PGT in to investigate incidents causing serious injury to children-in-care, there is not an effective protocol currently in place for the PGT to be informed of critical injuries involving children-in-care. This should be rectified.

While the focus of the PGT in looking at a critical injury incident is more limited than that of the Children's Commission, occasions will arise when both are looking at the same incident. Given the obligation of MCFD to conduct its own assessment of what happened and to consider if there are policy and practice implications of the incident, there will in some instances be three investigations of the same incident. This is not efficient. To the extent that the goal of the review is improving the quality of service, the internal review is likely to be more effective than the external review. This is, in part, because those involved in the review, as insiders, will have a better grasp of the nuances of what is to be learned from the incident. They are also accountable, and therefore, have the responsibility to learn and to make change. In my opinion, the main

value of the Children's Commission review is to be an external check on whether MCFD has failed to recognize and acknowledge its responsibility for an incident. This is one of the issues that the PGT has to concern himself with as well. In addition, the Children's Commission has a concern about general safety and prevention issues. MCFD is in the best position to deal effectively with these issues. The question is to what extent an external monitor, other than the PGT, makes that happen.

In my opinion, the systematic external review of critical injuries of children-in-care should be left to the PGT. While I do see some value in monitoring MCFD in this area, beyond the PGT's limited-purpose investigations, in my opinion, doing reviews of every critical incident is more than is necessary. MCFD does not conduct Deputy Director or Director reviews of each incident because in many cases, use of resources in this way is not warranted. A children's officer with an external monitoring function, in my opinion, should get copies of all internal reports and reviews of reportable incidents and copies of the PGT's reviews of critical injuries. The children's officer would then have the authority to ask follow up questions. Because the reports may not have enough information to trigger concerns, the children's officer could do random file reviews as a way to monitor whether incidents are being reported properly.

Auditing plans of care

With respect to auditing plans of care, it was reported to me that the prevailing view among the social workers whose plans of care have been subject to Children's Commission's review is that the reviews are not effective. They are considered by line workers to create a paperwork headache that takes them away from more important work, than to help in terms of improving the quality of plans of care. This is not a challenge to the notion that plans of care should be in place for children in continuing care, but rather a questioning of the usefulness of the way the Children's Commission's plans of care monitoring function is carried out. Others who I spoke to outside MCFD questioned the continued usefulness of this particular form of external audit. The problem may be that the external reviews are paper, rather than practice, focused. The internal review of plans of care, on the other hand, are focused on whether a plan of care is actually in place, and if so, whether it is a good plan of care. I have concluded that externally monitoring plans of care may have been helpful initially to motivate the comprehensive implementation and monitoring of plans of care, but now they are simply a duplication that are not effective in improving the quality of MCFD practice. Again, if there is to be a children's officer with a monitoring function, the children's officer should be copied the internal audits and computer printouts with respect to plans of care.

With the exception of child fatality reviews and the PGT's investigation of critical injuries, I am left with the conviction that the investigative part of the monitoring function should primarily be done exclusively within MCFD. Like the complaint review function, fatality and reportable incident reviews should be viewed as a learning experience. They should be conducted regionally, but not by the managers with the direct line responsibility. Effective monitoring of how MCFD is doing within the region should be the responsibility of the Regional Executive Director. I envision the Regional Quality Improvement Manager as a resource for the Regional Executive Director in fulfilling this

responsibility. The Regional Quality Improvement Manager could conduct investigations when policy and practice concerns are raised and when it is not appropriate for the line managers to conduct the investigation. The Regional Quality Improvement Manager could also have the responsibility of ensuring that the planned monitoring mechanisms are being implemented and are working effectively.

Headquarters will have some residual monitoring function of the regions so I would see the Regional Quality Improvement Manager having a dotted line reporting relationship on these issues to the appropriate Assistant Deputy Minister.

To the extent possible the monitoring mechanisms of MCFD should be transparent so that they can be accessed and understood by the public, thereby rendering additional external mechanisms unnecessary.

External Monitoring

While monitoring of MCFD, for the most part, needs to be internal, in my opinion, there is merit in maintaining some external oversight function, particularly in light of the major strategic shifts and cutbacks currently contemplated by MCFD. In my opinion, this function should be performed by a children's officer, who has a particular mandate to focus on the interests of children, not a more generic government auditor. In light of the thrust of government towards performance measurement and reporting, the time may come when an external monitor of MCFD, at least one funded by the government, is not required, but, in my opinion, that time has not yet arrived.

I am sympathetic to the questioning of the need for an unelected official to monitor a government Ministry, when there is an elected Minister of the Crown who has that responsibility. I think that wisdom, however, rests in not taking too big a leap in that direction all at once. The public and the media have from time-to-time expressed considerable skepticism about the capacity of government to effectively protect and look after children. Given the complex and emotional nature of child welfare issues, it seems unlikely that that skepticism will disappear. Public skepticism can more easily be responded to by government, if there is a respected official, with independence from MCFD, who is actively involved in a monitoring function and is knowledgeable about child welfare issues and well acquainted with MCFD policies and practices,

In my opinion, a children's officer could fulfil this external monitoring role effectively without conducting, on a routine basis, independent investigations of critical injuries or audits of plans of care. The children's officer should be provided with all the data generated by the internal monitoring mechanisms. If on reading the internal reports the children's officer has further questions, the children's officer should have the authority to pursue those questions, and, in special circumstances, initiate his or her own investigations. To deal with the possible limitations of internally generated reports, the children's officer should also have the authority to do spot checks, and to ask questions about the internal monitoring mechanisms.

With increased public performance measurements and reporting, confidentiality may be less of an issue in the future. In any event, confidentiality concerns should not be an

obstacle to the children's officer's obtaining whatever information the children's officer deems relevant.

If there is to be an external monitoring function resting with a children's officer, a distinction needs to be made and understood between monitoring whether MCFD is effectively implementing its goals through its policies and practices and second-guessing what those policies and practices should be. The function of the children's officer should be to assess, and to report publicly, on whether MCFD is fulfilling its express objectives, not to tell MCFD how to do its job. Without clarity on this point, confusion can result as to who is responsible. That is to say, MCFD ought not to be making changes because it feels compelled to follow the direction of an external children's officer, but rather because of its own assessment that these changes are necessary to effectively implementing its goals.

V. CHILD FATALITY REVIEWS

Current mandate and practice of the Children's Commission

The recommendation in the *Gove Inquiry into Child Protection* was that Children's Commission's mandate to review children's deaths extend only to children and youth who are in the care of the province or who are receiving child welfare services.[9] When the Children's Commission was set up, the proposed mandate was expanded to collecting information about the deaths of all children, and investigating a child's death when the Commission considered it "necessary to determining the adequacy of services to the child or to examine public health and policy matters".[10]

The Children's Commission has implemented this mandate by gathering information on all deaths of B.C. children and youth who die before their 19th birthday and all deaths of children and youth from other jurisdictions who die in B.C., and conducting reviews of all unexpected deaths and the deaths of all children in the care of the government or who were receiving services from MCFD, regardless of whether or not the deaths were unexpected. In 2000, 363 deaths were reported to the Commission of which the Children's Commission reviewed 215 in depth. Since the Children's Commission started reviewing child fatalities in September 1996, when the Children's Commission took a retrospective look at children's deaths back to 1988, 586 Fatality Review Reports have been publicly released and a further 125 reviews have been completed and are awaiting release.

The Children's Commission's child fatality reviews are based, in part, on investigations conducted by other agencies, such as the Coroner and the Police. In addition, the staff of the Children's Commission interview family members and the personnel of relevant government services. The goal of the review is to determine what were the preventable aspects of the death, and to try to construct a pattern of support from public services during the lifetime of the child, asking whether the quality of service was up to the applicable standards. The services looked at include child welfare, schools, health care, justice and special needs. The public health and policy issues considered include suicide, alcohol and drug abuse, child abuse and neglect, safety issues, and early infant deaths.

Draft fatality reports are reviewed by a Multidisciplinary Team, which includes a representative from the Coroner's office, the Deputy Advocate, the Deputy Provincial Public Health Officer, a paediatric specialist from Children's Hospital, and other individuals with specialized experience and knowledge of the issues. The Multidisciplinary Team's input is incorporated into the reports. A draft is sent to the agencies and Ministries mentioned in the report and their responses to the recommendations are included in the final report before it is made public. The recent reports that I looked at ranged from 15 to 51 pages in length. The coroner's reports relating to the same death ranged from 2 to 8 pages in length. The final Children's

[9] *Gove Inquiry into Child Protection*, Volume 2, p.144.
[10] Section 4(1)(a) *Children's Commission Act*.

Commission fatality reports are usually made public one and a half to two years or more after the death of the child.

The Children's Commission tracks recommendations made in the reports and the agencies' responses to the recommendations are updated. To date, approximately 700 recommendations have been made to various agencies. About 500 of these recommendations were made in the early years of the Children's Commission. Fewer recommendations have been made recently, in part, because the recommendations became repetitive as the issues raised by the deaths were often the same as in previous reviews. Of the 700 recommendations made, approximately 300 have been fully implemented, another 300 have been partially implemented, and approximately 100 have not been implemented at all.

The Children's Commission has an extensive database that is believed by the Children's Commission to be unique in the world. The base data for all children's deaths is obtained from the Vital Statistics Agency. Data obtained in the course of the Children's Commission's fatality investigations is added. A new data collection system recently implemented is expected to improve the efficiency and effectiveness of the data collection function. On the basis of the information in the fatalities database, two special reports have been completed, one on youth suicides and the other on the role of alcohol in the lives and deaths of children in British Columbia. The database is also being used for academic research purposes and the Children's Commission is a partner in a national research project on suicide of children-in-care. The Children's Commission has received positive feedback from outside British Columbia for its innovative work in this area.

Comparison with the Coroner's services

The Children's Commission's mandate to review child fatalities overlaps and goes beyond that of the Coroner. The Coroner investigates and inquires into all unexpected, unforeseen or unexplained children's deaths. The Children's Commission reviews all the child deaths that the Coroner does. In addition, the Children's Commission reviews the deaths of children-in-care or children who have received services from MCFD even if their deaths are outside the Coroner's mandate because the deaths were expected, foreseen and explained.

The nature of the Coroner's review is different from that of the Children's Commission. The Coroner investigates the death immediately after the death and, usually, attends at the site of the death. The Coroner's goal is to have 85% of investigations completed within 4 months of the death, the exceptions being when a criminal investigation takes precedence and results in delay. The Children's Commission reviews are not commenced until months after the death, and are not usually completed until about a year and a half to two years or more from the date of death. The Coroner's inquiry focuses on the specific circumstances surrounding the death and the immediate causes of the death. The Coroner conducts a primary level investigation, talking directly with the parents, caregivers and other parties involved in the circumstances leading to the child's death. The Children's Commission's focus is more on the life of the child and the adequacy of government services provided to the child, including the services of the

Coroner's office. The Children's Commission largely relies upon investigations performed by other agencies, such as the Coroner and the Police, about the immediate circumstances surrounding the death. There are exceptions. I was given some examples of the Multidisciplinary Team's questioning the findings of earlier Coroner or Police investigations, resulting, in a couple of cases, in the Police reopening their investigation.

Comparison with MCFD's death reviews

MCFD does its own internal reviews of the deaths of all children-in-care and children who have received services from MCFD. The Children's Commission reviews all of these deaths as well. Within MCFD, the initial review is a review by the Deputy Director of the circumstances of the death as reported from the field. In approximately one half of the deaths reported, the Deputy Director does a file review. If serious practice issues are identified by the Deputy Director, the Director conducts a comprehensive review, including interviewing relevant ministry staff, community "partners" and family members and reviewing relevant reports and case records. The Director's reviews are similar to the Children's Commission's reviews, except that the Director's reviews are focused on whether there are MCFD practice issues involved in the death. The Children's Commission's reviews consider MCFD services throughout the child's life. Also, the Children's Commission looks at services from other agencies, not just MCFD. The Children's Commission's reviews are made public; MCFD's reviews are not. The Director's death reviews are usually conducted within a few months of the death, although they may be delayed because of police investigations. The Children's Commission's reviews may be delayed from the same reasons. The Children's Commission's public reports are usually not released until more than a year after the Director's reviews.

The issues

It is indisputable that the investigation of unexpected, unforeseen or unexplained deaths of children is a core government function. It is also a given that the Coroner should investigate unexpected, unforeseen or unexplained deaths of children, and that that function should not be given to a specialized children's officer, to the exclusion of the Coroner. The expertise in how to investigate the immediate cause of death rests in the Coroner's office which has an experienced team supported by medical investigators, pathologists and toxicologists. Children's deaths should be treated at least as seriously as adults and all the expertise of the Coroner's office should be brought to bear in assessing the circumstances surrounding the death of a child and determining its immediate cause.

In my opinion, it is also an important part of MCFD's self-monitoring that it review the circumstances of all children who die in the care of MCFD or who have received service from MCFD, and that it conduct an in depth investigation of all such deaths that raise any policy or practice issues for MCFD. The concern has been raised that the rule that limits MCFD reviews to the deaths of children who have received services during the 12 months prior to their death is problematic It can lead to very important issues going unrecognized. For example, a file may have been closed prematurely, or a youth has

become completely alienated from the service system. A file review, currently being conducted by the Children's Commission, could reveal these practice issues. In my opinion, MCFD's inquiry of children's deaths should be triggered if the child has ever had services from MCFD, and should include a review of all services provided to the child during that child's life. This fatality review function should be the responsibility of the Regional Executive Director, who under the proposed reorganization of MCFD will be the designated Director under the *Child, Family and Community Services Act*, and who is responsible for the regional operations. I see no problem, however, with delegating the initial review to a Deputy Regional Director to screen out any deaths that raise no policy or practice issues. Deaths that would not require an in depth review would include those from natural causes when the level of service provided by MCFD is not an issue, or accidental deaths that raise no concerns about the care or services provided by MCFD during the child's life. Whenever policy or practice concerns are raised, the Regional Director should conduct the review. The review should seek to answer the question: what is there to learn from this child's life and death that can improve the quality of MCFD's services and that might prevent future harm to children.

The issues around the child fatality review function for me to consider in this report are the following:

3. Should the external inquiry of an unexpected death of a child include inquiring into the adequacy of government and medical services during the life of the child, beyond the immediate circumstances of the child's death?
4. What is the most effective and efficient way to structure the delivery of reviews of unexpected, unforeseen or unexplained deaths of children?
5. Is there a need for an external review of children who die in the care of MCFD or who have received service from MCFD, if the deaths of those children are expected, foreseen and explained?
6. Should the data collection and research function, with respect to children's deaths, currently undertaken by the Children's Commission be continued, and if so, who should have that responsibility?

The Value of the Children's Commission's fatality reviews

Before attempting to answer these questions, it is important to consider the value of the current Children's Commission's fatality reviews. I heard varying opinions on this subject in the course of my review.

I heard that reopening issues about the child more than a year after the death resulted in unwarranted distress for grieving families, and prevented earlier closure for those families. Countering this, I heard that families often expressed gratitude that a public official was looking in such detail into their child's life and death, and that the Children's Commission's reviews led to closure for families.

I heard skepticism as to the value of a fatality review published so long after the event. Countering this, the delay was justified as necessary to allow other agencies to do their investigations, and as occasionally valuable in that it allowed the perspective of time to be brought to bear on the circumstances of the child's life and death.

I heard that the Children's Commission investigators, at least in the early years, were unnecessarily adversarial and assumed that blame must rest somewhere for any child's death to the point that fault was found when it did not exist. Countering this, I heard that these complaints are the inevitable reaction to the introduction of a new external review agency, and with time, both the reviewers and the agencies being reviewed adapt to each other. Certainly, I did get feedback, even from the detractors of the Children's Commission's role in fatality reviews, that the adversarial approach of the Children's Commission had lessened over time.

I heard that the duplication of the Children's Commission's reviews with what is done internally, many months earlier, results in a waste of MCFD's human resources that could better be applied elsewhere. Countering this, I heard that the resource burden on MCFD as a result of the Children's Commission's fatality reviews was not particularly large. There are approximately twelve deaths of children-in-care per year, and approximately sixty deaths of children who have received services per year. From the Children's Commission's perspective, the role of MCFD is just to provide file information and to review draft reports to ensure fairness. Also, one or more staff are interviewed. Furthermore, whatever the resources required, an important external monitoring mechanism would be lost if there was no external reviewer who asked the hard questions about whether the services provided the child during the child's life were adequate and met MCFD's standards.

I heard that the recommendations coming from the Children's Commission's reviews were often off-base because of lack of expertise on the part of the investigators about the issues they were commenting on, and/or their lack of understanding of the systems they were recommending should be changed. Countering this, I heard that the Multidisciplinary Team had considerable expertise and that many of the recommendations were vetted by the Team and virtually all were modified as a result of discussion at the Multidisciplinary Team level.

I heard that even if the recommendations made sense in terms of the system in place at the time of death, in the delay from the time of the death to the completion of the Children's Commission's investigation, the system had changed and the recommendations were no longer relevant.

It is difficult to measure whether recommendations from the Children's Commission have been effective in bringing about positive change. The number of recommendations made and reported to have been put into effect is some measure of success, but even with respect to recommendations that are reported as implemented, the question remains whether the changes would have been implemented in any event, or whether the implemented changes, in fact, furthered the welfare of children.

I had access to a draft study prepared by Margo Tubman and Kathryn Thompson for the Ministry of Attorney General on the effectiveness of the fatality recommendations by

the Children's Commission to that Ministry.[11] The study found that the fatality recommendations often lacked accuracy. A significant number were misdirected to the Ministry of Attorney General, and a significant proportion of those reflected a lack of knowledge of the Ministry of Attorney General's business or judicial processes. The impact of the recommendations was found to be minimal. No new programs or initiatives resulted. Changes were in the nature of fine-tuning, and little was added to the current knowledge of the Ministry.

Fatality reviews directed to the Ministry of Attorney General are only a small part of the Children's Commission's work, and therefore, one needs to be cautious about extrapolating from this study to a general conclusion about the effectiveness of the Children's Commission's fatality reviews. A more comprehensive study would need to be conducted in order to draw broader conclusions. The study's limited conclusions, however, were consistent with anecdotal information I received from other sources, related to other agencies than the Ministry of Attorney General. The study certainly leaves me with unanswered questions about the added value of the Children's Commission's recommendations arising from the fatality reviews, especially for agencies and Ministries other than MCFD.

Among those who were more supportive of the Children's Commission's fatality review function were those who expressed the opinion that its value has diminished over time. It was suggested that recommendations got repetitive because, for the most part, there are only so many reasons why children die. What there was to learn from the deaths of children about government or medical services has already been learned. Recognizing the repetitiveness of recommendations, the Children's Commission ceased to repeat recommendations that had previously made in earlier reports. The result has been a significant reduction in the number of recommendations made as a result of child fatality reviews, again suggesting the possibility of diminishing returns.

It was noted in the Tubman/Thompson study that recent recommendations of the Children's Commission increasingly related less to the safety and protection of children specifically, but rather to the safety and protection of the public at large and as a result of that to the safety and protection of children only as a subset of the public at large. For example, a sizeable proportion of children's deaths are as a result of motor vehicle accidents. There are some children's issues that arise from these deaths, such as, when the driver is an under-age, impaired driver. Many motor vehicle accidents, however, are a result of unsafe driving practices. I am told that these deaths are often a result of children killing children. There are, however, many deaths caused by adults killing children and adults indiscriminately. The value of having a specialized children's officer, rather than the Coroner's office, look at these deaths in depth and make recommendations is questionable.

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[11] This study was contracted by the Ministry of Attorney General, as part of the core review, to examine ways of assessing effectiveness for the agencies for which the Attorney General is accountable. The Children's Commission has not reviewed this study or had the opportunity to verify the data. The usefulness of the study in terms of assessing the effectiveness of recommendations arising from the fatality reviews is questioned by the Children's Commission because the recommendations to the Ministry of Attorney General represent such a small proportion of recommendations made.

A member of the Multidisciplinary Team suggested that the effectiveness of the Children's Commission fatality reviews has been undermined by the fact that the institutions that could effect remediation were not at the Multidisciplinary Team table. For example, the College of Physicians & Surgeons has the responsibility to deal with the standards of practice of physicians, and MCFD has the responsibility to deal with the standards of practice of the social workers in its employ, yet, neither the College of Physicians & Surgeons nor MCFD participate in the MTD's review of recommendations arising from the Children's Commission's investigation.

Another obstacle to the effectiveness of the Multidisciplinary Team raised by a member of the team is the lack of access to the reports of internal hospital reviews of the circumstances surrounding an unexpected death. These reports are confidential and are not released to the Children's Commission. The view was that, without this information, the Children's Commission's capacity to comment intelligently on the medical services provided to the child leading up to the death was severely restricted.

In summary, there were those I spoke to who felt strongly that the Children's Commission's fatality reviews provide a useful, multidisciplinary child-focused perspective on the adequacy of medical and government services provided to children who die, and that they raise issues and generate important information and recommendations for change that would be lost if that function were discontinued. I am told by those in the Children's Commission that the model for fatality reviews that they have developed is considered by those that work in the field in Canada as being an advance from a model that gives the function exclusively to the Coroner's office. On the other hand, significant questions have been raised for me as to whether the Children's Commission's fatality reviews have in the past, or would in the future, add significantly to the welfare of children.

Should the external inquiry of an unexpected death of a child include inquiring into the adequacy of government and medical services during the life of the child, beyond the immediate circumstances of the child's death?

The Coroner in looking at the cause of death has a mandate to consider whether the lack or poor quality of government services or medical services contributed to the death of a child. The Coroner also has the responsibility to ask how the child's death could have been prevented, and the authority to make recommendations for systemic change arising from the circumstances of the child's death. The Children's Commission, however, goes beyond the immediate circumstances of the child's death, and looks more broadly at the entire life of the child, asking whether the services provided during that life were adequate and up to acceptable standards, and making recommendations based on its determination of this question. A question for this review, therefore, is whether this broader inquiry is important in fulfilling government's core function to monitor the services provided to children?

One value of the broader inquiry presumably is that it provides a more thorough basis for determining whether inadequacy of services contributed to the child's death. If, however, it is clear that inadequacy of government services was not the cause of the

child's death, then the value of reviewing those services in depth is less obvious. With the possible exception of child welfare services, a review, triggered by the death of a child, of government and medical services that, on the face of it, were not a factor in the child's death is a rather oblique monitoring tool. In my opinion, fatality reviews should be just that: reviews of how a child died and how that death might have been prevented.

I suggested that child welfare services might be an exception, and that is, in part, because when a child dies, other than for natural causes, then by definition, the child has not been protected. If the child welfare system has been involved with that child, and has recognized a need for services, then it may be appropriate that the adequacy of the services provided should be looked at, and the question asked: is there anything to learn from this child's death and life that might improve the child welfare system?

I need to introduce a cautionary note here. The tragedy of a child dying at the hands of a parent is such that, as a society, we want to learn from that death and improve our child welfare system so that, in some way, the child's life and death can be seen to have had purpose. Though this is a natural public reaction, it needs to be responded to with caution. The deaths and lives of children who die prematurely at the hands of their parents are not always a good basis for recommending systemic change.

When a child's death is at the hands of a parent, the assumption is that there has been a continuum of violence leading up to the death. From this flows the conclusion that the child welfare system needs to be redesigned to allow for earlier detection and prevention of child homicides. This conclusion is, in part, based on a further assumption that other more usual forms of maltreatment, which the child welfare system is designed to deal with, also fit into the continuum of violence model. From this assumption, it is concluded that fixing the problems that lead to child homicides at the hands of parents will lead to an improved child welfare system. A measurement of the success of the system is expected to be seen in the reduction of child homicides.

Nico Trocmé and Duncan Lindsey in their article, "What can child homicide rates tell us about the effectiveness of child welfare services?" [12] conclude that the discontinuities between child homicide data and child maltreatment data suggest that use of homicide data to measure the effectiveness of child welfare services is not warranted.[13] They suggest that one reason for this is that child homicides do not generally represent the endpoint of a continuum of violence ranging from inadequate parenting to maltreatment to death. [14] Furthermore, there are differences between child homicides and the kind of child maltreatment that is the more usual problem facing child welfare workers. For example, studies have indicated that homicidal parents are more likely to suffer from psychiatric disorders than are maltreating parents. Also, there are some indications that homicidal parents are generally younger than non-homicidal maltreating parents,

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[12] Trocmé, N. and Lindsey, D., What can child homicide rates tell us about the effectiveness of child welfare services*? Child Abuse & Neglect*, (1996), Vol. 20, No. 3, pp 171-184.
[13] Ibid, at p. 176.
[14] Borget, D. and Bradford, J (1990) Homicidal Parents, *Canadian Journal of Psychiatry*, Vol. 35, p.p. 233-238, found that in 60% of the child homicides at the hands of parents they reviewed there was no evidence of a pattern of escalating violence typical of the battered child syndrome.

and are more likely non-biologically related. Socioeconomic factors correlate to rates of maltreatment but not to fatal maltreatment. If the profile of homicidal parents is different than the profile of non-homicidal, maltreating parents, this has implications for child welfare policy. The authors conclude that "over reliance on homicide statistics could contribute to further narrowing the scope of child welfare by stressing procedures geared primarily to preventing child homicides."[15]

The authors' issue is with the usefulness of statistics for measuring the success of the child welfare system, not with the appropriateness of learning lessons from examining the lives of individual children who have died unexpectedly. However, what they say about statistics raises the question of how appropriate it is to make recommendations about how to run a child welfare system, based on the tragic lives of children who die unexpectedly at the hands of their parents.

In my opinion, if there are lessons to be learned about the services provided during the life of a child who has died for causes not related to those services, those lessons are best learned internally where the full context of running a child welfare system is understood. If it is not already being done, the internal reviews of the deaths of children-in-care or who have received services from MCFD could usefully include a thorough review of all services provided during that child's life. To the extent that there is external monitoring of those services, other than in the furtherance of the Coroner's mandate to determine the cause of death and make recommendations on prevention, in my opinion, it is appropriately limited to the children's officer being provided a copy of the internal report. To duplicate this function by having the children's officer do a separate investigation appears to me to be neither an efficient, nor an effective, monitoring mechanism.

[15] Trocmé, N. and Lindsey, D., *supra*, p. 182.

What is the most effective and efficient way to structure the delivery of reviews of unexpected, unforeseen or unexplained deaths of children?

On the face of it, it would seem that the duplication of having both the Children's Commission and the Coroner investigate a child's death is inefficient.[16] If the Coroner inquires thoroughly into the issue of whether inadequacy of government or medical services contributed to the child's death, then why have another external officer do a review of the same issue?

In my investigations, I heard some hesitancy about having the Coroner be the exclusive investigator of children's deaths. One of the concerns was that Coroner services vary in quality because they are exercised locally, often by Coroner's appointed on an *ad hoc* basis. The specialized knowledge of the Children's Commission's Multidisciplinary Team would not be available if the current Coroner's service model remains in place. It would be unrealistic to try to duplicate that expertise in the small communities where many Coroners function, especially in the north and the interior where many of the more difficult government services issues arise.

It may be that the extent to which local Coroners have to rely solely on local resources is exaggerated by those who raise this concern. It is true that the investigative and inquiry powers rest with the local Coroner. On the other hand, the Coroner's services are organized regionally and Regional Coroners have supervisory responsibility over local Coroners. I was told that it is common practice for the regional office to be consulted by the local Coroner if complications arise in the investigations. Furthermore, the Chief Coroner has overall responsibility to "supervise, direct and control all coroner's in British Columbia in the performance of their duties".[17] There is, therefore, a centralized responsibility for quality control. The Chief Coroner's office makes specialized resources available for the local coroners. For example, in the case of a child's death, I was told that a paediatric pathologist is brought in on all homicides or suspicious deaths. Likewise, in the case of suicides, a behavioral psychologist is consulted.

It was also suggested that the decentralized functioning of the Coroner's services does not provide the opportunity to see trends, or pick up issues that the overview conducted by the Children's Commission's Multidisciplinary Team allows. While the Chief Coroner acknowledged that an overview approach might have been missing in the past, the value of considering prevention issues by looking at aggregate data is recognized in the Coroner's new strategic plan. This plan includes further computerization and the development of a more robust and capable relational database than currently exists.

The Children's Commission, however, provides an overview service beyond the keeping of aggregate data. The Multidisciplinary Team goes over each child's death that has

[16] My use of the word "duplication" has been objected to because of the different objectives, processes and outcomes of the Coroner's office and the Children's Commission.
[17] Section 392)(a) *Coroners Act*.

been investigated by the Children's Commission. The expertise and the multi-disciplinary constituents of the Children's Commission's Multidisciplinary Team make it a valuable tool for answering the question: what can we learn about how to improve government services from the circumstances of this child's life and death to prevent future deaths for similar causes?

The somewhat different concept of interagency child death review teams is being increasingly used in the United States. Michale J. Durfee, MD, George A. Gellert, MD, MPH, MPA, and Deanne Tilton Durfee look at this development in an article entitled "Origins and Clinical Relevance of Child Death Review Teama."[18] The authors conclude that multi-agency child death review team is an idea whose time has come. These teams, as described in the article, are different than the Children's Commission's Multidisciplinary Team. The core team includes representatives from the coroner's office, law enforcement agencies, prosecuting attorneys, child protective services, paediatricians with child abuse expertise and health professionals, including public health nurses. Their involvement is immediately after the death. Law enforcement, child protective services, coroner's investigators and public health nursing team members all conduct home visits and investigations. Their investigations sometimes lead to criminal proceedings. The focus of the teams is on the detection, management and prevention of fatal child abuse. Mostly, they look only at deaths with suspicious causation that are selected through an established protocol. Confidentiality of medical records is maintained within the team process. The team functions with little or no specific funding, the resources from the team coming from member agencies.

The advantages of the multiagency team approach are outlined at page 32 of the article. They include:

> "All teams save costs through increased effectiveness of interventions and reduced duplication of efforts
>
> … The multiagency team process is more vigorous than a single agency process, more capable of clearly identifying a case that is suspicious, and more able to deal with special challenges, such as the difficulty of identifying the perpetrator out of multiple caretakers, separating out physical findings that confuse the determination of cause of death, or distinguishing sudden infant death syndrome from suffocation. The results are more focused, more complete, and the process is more accountable.
>
> … Child death review also creates an opportunity for a systematic review of agency actions (and inactions). This has been particularly important with respect to improving and integrating interagency communications, and allowing agencies the opportunity to address deficits in their own systems.
>
> … Health professionals with previous contact with the child or family can improve their clinical judgment and case management skills by learning retrospectively from the follow-up information obtained through child death review.

[18] Children Today, Vol. 21, No. 2, pp. 29-33.

> … Team education allows … professionals to become a resource for detecting and referring medical and social problems that predispose a family to violence."

The multiagency approach described in the article is very exciting and, in my opinion, is a direction that should be considered seriously in British Columbia. It is a concept that needs to be thought out thoroughly but it has the potential to be a highly effective and efficient mechanism that could substitute for a multiple of child death investigations currently being done by various agencies. I am told that multi-agency versus the multidisciplinary approach was assessed at the time that the Children's Commission's fatality review process was developed, and the multidisciplinary approach favoured as an external review activity. The multi-agency approach is not a monitoring tool, but rather an alternative way to do suspicious child death investigations.

If the multiagency child death review model described above is viewed as too ambitious or something to consider in the future, in my opinion, the Multidisciplinary Team review function currently in the Children's Commission should be transferred, with some changes, to the Chief Coroner's office in the interim. The changes I recommend would include giving the Chief Coroner's Multidisciplinary Team confidential access to internal hospital reports and internal MCFD reports. Also, in my opinion, MCFD should be at the table, as should the children's officer. Consideration should also be given to involving a representative from the College of Physicians & Surgeons as this is the body with the responsibility for maintaining the standards of medical practice in the province. The Chief Coroner's Multidisciplinary Team should have the authority to make recommendations above and beyond any recommendations made by the local Coroner, assuming that the Chief Coroner's Multidisciplinary Team does not take over the local Coroner's responsibilities to investigate and inquire into child deaths.

I recognize that by discontinuing a review of children's deaths by a children's officer, separate from the Coroner's review, the function of an external monitor of the Coroner's function will be lost, to some extent. By mandating that a multidisciplinary team be part of the Coroner's services and that the children's officer be part of that team, in my opinion, sufficient external overview is maintained.

Is there a need for an external review of children who die in the care of MCFD or who have received service from MCFD, if the deaths of those children are expected, foreseen or explained?

In my opinion, there is minimal value added by an external investigation and review of the deaths of children who die of natural causes in the care of MCFD or who have received service from MCFD. It is questionable that looking in depth at the life of a child who has died of natural causes is more valuable than doing a spot audit of a living child who is in the care of MCFD. In fact, there is potentially more value in looking at the services being offered a living child because they can be altered to good effect.

This opinion is not held by the Children's Commission who argued that significant issues are raised by the deaths in this population, which consists primarily of severely disabled, medically fragile, highly vulnerable children. These issues include quality of life, quality and responsiveness of services and funding issues. I agree that these are important issue but I am not convinced that they are most efficiently dealt with in the context of fatality reviews.

If there are practice or policy issues arising from the life or death of a child who is in the care of, or who has received services from, MCFD, these issues should be looked at internally through a Regional Director's review. As with critical injuries, the internal review has an advantage over the Children's Commission's review as a learning exercise that could result in change. This is, in part, because the internal review is usually completed considerably closer to the time of death; in part, because those conducting the review understand the system better; and finally, because MCFD has the authority and responsibility to implement any policy or practice changes flowing from the review.

As with critical injuries, I recommend that copies of all internal MCFD reports of children's death be provided to the children's officer. The children's officer could then raise further questions, or ask to review the file, if in the children's officer's opinion policy or practice issues may have been overlooked.

Should the data collection and research function, with respect to children's deaths, currently undertaken by the Children's Commission be continued, and if so, who should have that responsibility?

Concern was expressed that an important research tool would be lost if the Children's Commission's fatality review function was discontinued. At the same time, I heard some external skepticism about the level of sophistication of the Children's Commission in organizing and understanding the data available to it. I am not in the position to judge the Children's Commission's data organization and new computer system, but I did read the two reports that the Children's Commission has published based on the data it has collected so far, and they appeared to be valuable studies.

It makes sense that data from all children's deaths could be useful for epidemiological studies. I had assumed that these types of studies were a function of the Provincial Health Officer. I was told that that office does not have the resources to do the work

that the Children's Commission currently does. Even if those resources were increased (an unlikely proposition), the Provincial Health Officer is concerned with all public health issues and could not justify focusing its limited resources on children's issues, except from time to time, when those issues became a public priority.

I understand that British Columbia's Vital Statistics Agency is unique in the breadth of information it currently collects, and that its database is exceedingly sophisticated. If the Children's Commission is currently collecting useful research data about all children's deaths, beyond that already collected by the Vital Statistics Agency, I see no reason why that data could not in the future be collected by the Vital Statistics Agency and stored in its database.

To the extent that the Children's Commission adds to its database, information obtained through its investigations, I see no reason why the Chief Coroner could not collect this information and organize its database in a similar way to the Children's Commission. It may be that the Children's Commission's experience could be of assistance to the Chief Coroner as he implements his strategic plan to do more prevention analysis on the basis of aggregate data.

With respect to making use of the Children's Commission's database for research purposes, it would seem more effective to have that research done in the universities or other research institutions. If the goal of the research is good government policy, then the Ministry responsible for that policy may want to be involved in terms of directing the research. For the most part, however, it would seem more effective to have that Ministry contract a researcher to do the work, than to try to do it in-house. If the issue is death prevention, then the office of the Chief Coroner would contract the researcher. I can envision a role for a children's officer to be a catalyst to encourage research on children's issues, particularly interagency issues, but I think to expect significant research expertise in the office of the children's officer is unrealistic.[19]

Summary

In summary, I recommend that a part of the Children's Commission child fatality review function be transferred to the Coroner's office. This should involve the expansion of the Coroner's focus to include a broader look at whether medical and child welfare practice or policy issues contributed, in any way, to the child's death. Considering these issues is arguably within the Coroner's services current mandate but is not necessarily Coroners' current practice. In my opinion, the inquiry of the Coroner need not include considering and commenting on services provided during the life of the child that were not causally connected to the child's death. Nor do I see the need to expand the Coroner's mandate to include investigation of deaths of children in the care of the

[19] I am aware that the Children's Commission will have developed research capacity and that some member of the Children's Commission staff have experience as researchers. I am referring here to the level of expertise that can only be expected to be found in research institutions whose members all have doctoral degrees, and are learned in the most up-to-date research techniques.

Ministry or who have received services from MCFD that would otherwise not be within the Coroner's mandate because they were expected, foreseen and explained.

In my opinion, the value added to the Children's Commission's death reviews by the Multidisciplinary Team is worth preserving. I recommend that the concept of a multi-agency approach to suspicious deaths, such as been introduced in a number of states in the United States, be looked at in depth.

In the meantime, I recommend that a Multidisciplinary Team be constituted under the auspices of the Chief Coroner to review all unexpected, unforeseen and unexplained deaths, including suspicious and accidental deaths and deaths resulting from medical misadventure, and to make appropriate systemic recommendations. I recommend that MCFD and, possibly the College of Physicians & Surgeons, have a presence on the Chief Coroner's Multidisciplinary Team so that those with the responsibility for child welfare and medical standards and who have the expertise about how the system works will be involved in the development of appropriate recommendations for change.

By adding a Multidisciplinary Team to the Coroner's operations and expecting more comprehensive inquiries into whether the inadequacy of child services was a factor in the child's death, I believe that the criteria, recently developed by the Federal/Provincial/Territorial Working Group on Child Death Review will, for the most part, be met. That is, that the reviewer be:

7. external to, and independent from, the organizations and agencies subject to the review;
8. have statutory powers to ensure access to information;
9. have the authority to make recommendations and be able to monitor compliance with recommendations;
10. have the ability to make public reports, and
11. utilize a multi-disciplinary approach.

The one criterion that is arguably not met by the proposed model is the monitoring of compliance with recommendations. I envision that being done, in the case of recommendations about the child welfare system, not by the Coroner, but rather by MCFD and the children's officer, both of which will be a part of the review team.

I recommend that MCFD be required to review the circumstances of the deaths of all children-in-care or children who have received services from MCFD, regardless of the cause of their death. That review should include looking at the services provided by MCFD during that child's life. If there are any practice concerns raised by the review, an in depth internal investigation should be conducted with a view to improving the quality of MCFD's services in the future.

External monitoring, other than the Coroner's review, should be limited to the children's officer's receiving copies of all internal MCFD reports with the authority to follow up with further inquiries.

VI. SYSTEMIC ADVOCACY

Is systemic advocacy a core function of government? If systemic advocacy means proposing change in legislation and policy relating to the child welfare system in British Columbia, then the answer is "yes". Government should always be in the business of improving its systems.

How can this systemic advocacy role be most effectively and efficiently done? First, it must be done by MCFD. MCFD has a responsibility to effect intelligent change over time, including bringing forward proposals for legislative change when appropriate for the purpose of furthering the best interests of children. In my opinion, a children's officer could also play a useful role in this government function. Coming up with ideas for appropriate change in a system is, to some extent, a creative exercise. A children's officer can provide another, above the battle, perspective that could enrich the forward vision of MCFD.

Having said that a children's officer's role in monitoring should not extend to telling MCFD how to do its job, I still think that encouraging systemic change naturally flows from the children's officer's monitoring role. One of the outcomes of monitoring is becoming aware of the need for change. A watchdog for children's interests should not only report on the success or failure of the system to do what it says it will do, but also act as a catalyst for intelligent change in the system by presenting children's interests in a forceful way. The effectiveness of the presentation will be enhanced if the children's officer's representations are rooted in knowledge of children's perspectives on the issues.

Because MCFD has the responsibility to propose and implement change, MCFD should have the primary research function within government so that the change proposed will be based on up-to-date knowledge and thinking about child welfare issues. There is no reason why MCFD and the children's officer could not work effectively in partnership in this area, not duplicating each other but interacting in a positive way. For example, what is produced internally by MCFD in terms of research could and should be provided to the children's officer. The children's officer, on the other hand, could pull together outside experts to focus on an overriding issue that MCFD does not have the time to consider fully, or which involves government Ministries other than MCFD. An example of this is the work the Children's Commissioner did on convening a symposium on Fetal Alcohol Syndrome and publishing a special report on the subject. Conducting a project like this may not be a core government function but it does have the potential of enhancing government's effectiveness in fulfilling its core functions.

A children's officer can also play a role representing British Columbia nationally and internationally, and can bring back from other jurisdictions ideas that enhance provincial thinking.

Advocacy on systemic issues involves public education. I envision a children's officer having that role, which would be effected, in part, by the children's officer's annual public report, but also by the children's officer going out to all parts of the province to

speak to children, families and interested community members. The Children's Commissioner, the Advocate and the Ombudsman and Deputy Ombudsman have all done this.

Education is a two-way street. Part of what the children's officer is doing in talking to children, families and communities, is to get their feedback on how the system is working. MCFD should also be doing this, but inevitably, those affected by MCFD will feel more open in giving critical feedback to a children's officer who is independent of MCFD than to MCFD directly. In my opinion, a children's officer can be of assistance to MCFD in getting effective feedback about how it is doing its job.

I have made a distinction between individual advocacy and systemic advocacy. To some extent it is a false dichotomy. Contact with individual children provides the children's officer with grounding for its public advocacy. An advocate cannot act in a vacuum. As a voice for children's interests, a children's officer needs to hear what children are saying. Also, by having a children's officer, the government is providing to individual children someone who is unequivocally on their side. I heard from the Youth In Care Network representatives that this was very important to children-in-care, and that while some social workers performed more as advocates for children than others, they wanted someone outside the system in that role.

VII. REVISITING THE CHILDREN'S OMBUDSMAN MODEL

In my discussion of the complaints function, I considered the model of a children's ombudsman. I concluded that splitting the Ombudsman's office functionally to carve off a mandate for a Children's Ombudsman could not be justified, and in fact, was arguably contraindicated, in terms of the effective handling of complaints. In my opinion, the main justification for a designated Children's officer is that officer's independent role in monitoring the child welfare system and advocating, primarily on a systemic level, but sometimes on an individual level, on behalf of children receiving services from that system. Could a Children's Ombudsman effectively fulfil all those functions?

With respect to the review function, my understanding is that the Ombudsman functions primarily in response to individual complaints. This appears to me to be an appropriate self-imposed restriction for an office that is designed to protect the individual from arbitrary action on the part of the state. To expect an ombudsman to fulfil a systematic monitoring function is to expand, and perhaps, confuse the Ombudsman's traditional role.

There is a more significant risk of confusion of roles if the Ombudsman takes on an advocacy function.

In the course of my review, the issue was raised whether an advocacy role is consistent with the need for impartiality on the part of the Ombudsman in dealing with complaints. In the case of MCFD, the Ombudsman must deliberate between the opposing views of a complainant and of MCFD as to whether MCFD has violated the principles of administrative fairness and due process. In those deliberations, the Ombudsman must remain impartial on the issue before him. Given this, can the Ombudsman then also advocate on behalf of individual children, or advocate systemic change, in relation to MCFD?

This same issue was discussed in the Ombudsman's Public Report No. 22, "Public Services to Children, Youth and Their Families in British Columbia", November 1990. The then Ombudsman, Stephen Owen reconciled this potential conflict by pointing out that there is a link between child advocacy and the child's right to be heard. The right to be heard is an essential element of administrative fairness. The Ombudsman is not neutral when it comes to administrative fairness, and therefore, can properly advocate if that means ensuring that the rights of children and youth to have their views fairly and independently represented when important administrative decisions are being made. In a subsequent discussion paper published in October 1993, entitled "Advocacy for Children and Youth in British Columbia", the Ombudsman's office recommended the establishment of a separate Child and Youth Ombuds office.

Despite the obvious interrelationship between advocacy for children and the goal of administrative fairness, I remain of the view that it would not be good public policy to give a child ombudsman an express advocacy function. In my opinion, to the extent that a specialized children's officer, external to MCFD, is involved in individual complaints against MCFD, the children's officer should be understood, by the child or

other person complaining, to be clearly on the side of the child, and not deliberating on conflicting perspectives.

The same concerns apply on a systemic level. The Ombudsman appropriately does investigations that are about systemic, not just individual issues. If investigation of an individual complaint, or series of complaints, suggests the need for systemic change, then the Ombudsman may initiate a systemic investigation, and as a result of such an investigation, make recommendations for systemic change. The investigation, however, is just that. The Ombudsman ought not have a particular outcome in mind at the beginning of the investigation. The process involves listening to different perspectives, and not advocating for one. An advocate, on the other hand, does have an outcome in mind, and seeks to persuade others of that outcome. A children's officer, with a systemic advocacy function, has a child focused perspective on what a child welfare system should look like. The focus of the Ombudsman, on the other hand, is not partial to one group or another. To the extent that the Ombudsman is an advocate, it is for administrative fairness applicable to all members of society, not for policies that further the interests of one group, in this case children.

VIII. THE PROPOSED MODEL

Core to my recommendations is that there should be one rather than two children's officers. Part of my mandate was to look at other jurisdictions. Within Canada, Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Nova Scotia, have specialized children's officers; New Brunswick, Prince Edward Island and Newfoundland do not. Innocenti Research Centre UNICEF publication, No. 8, June 2001, "Independent Institutions: Protecting Children's Rights" contains what I am told is an incomplete list of existing "independent, statutory bodies to monitor, promote and protect the rights of children". This list suggests a growing number of children's officers throughout the world. Just because others are doing it is, of course, not sufficient cause for British Columbia to have a children's officer, but it is reason to give pause before eliminating both existing children's officers.

In the course, of my review, I considered a model with no children's officer. If our system of ministerial responsibility is functioning, I asked myself, why do we need a children's officer outside the ministry responsible for the child welfare system? The answer that came to me in the course of my review was that a children's officer, responsible to government but outside MCFD, would assist the Minister of Children and Family Development, the Executive Council and the Legislature, to effectively carry out their responsibilities to children whose families do not have sufficient resources to care for them without government intervention. The essence of the added value that a children's officer brings is an informed focus on government's child welfare policy and practice, purely from the point of view of the interests of the children served by the system. Without a specialized children's officer, these interests might well be lost because of the combined incapacity of the parents of these children and the other-than-children's interests inherent in a large government bureaucracy.

There may come a time when what goes on within MCFD is so transparent that there is no need for a government funded official to be an outside watchdog of MCFD. In my opinion, that time has not yet come. At this time of major restructuring of MCFD in order to devolve authority to regions and communities, and in the face of significant spending cuts within MCFD, the public's need for reassurance about how the child welfare system is functioning is likely to be particularly high. Because the child welfare system may look very different within a few years, a statutory review provision as to the continuing need for a children's officer should be considered.

In the course of analyzing each of the four functions currently being performed by the Children's Commission (complaints, monitoring, fatality reviews and systemic advocacy), I have critiqued the current structural model and made recommendations as to how those functions could most effectively and efficiently be performed by government. I now propose to pull together all these recommendations and to draw a picture of the replacement model I envision.

The children's officer

I envision that there will be one children's officer, external to and independent of MCFD, with staff sufficient to carry out the proposed functions. The children's officer will be a voice for children who are clients of the child welfare system, and will seek to bring their perspectives to bear in the line decision-making within MCFD, and in the determination of government policy respecting the child welfare system. The children's officer's mandate would not extend beyond the child welfare system to encompass children outside the child welfare system, for example, youths involved in the justice system.[20]

I envision that the children's officer will be available to the Minister of Children and Family Development, and to the Attorney General, to do a special investigation into any complaint about how MCFD is fulfilling its mandate and to report back to the Minister, with recommendations. With this exception, the children's officer will not adjudicate on complaints or make formal recommendations to MCFD about how a complaint should be resolved. The children's officer will provide limited individual advocacy services, such as those currently being provided by the Advocate, including fielding calls from children, youth, and family and community members, who have a dispute with MCFD. The children's officer will provide information and encouragement to increase the capacity of the callers to advocate on their own behalf, and to navigate the internal MCFD complaints process. The children's officer, if necessary, will make telephone calls to reduce obstacles for children, youth and families in being heard by the decision-makers within MCFD. If the children's officer concludes that the conflict amongst those with different perspectives on the issue in dispute with MCFD is threatening to get out of hand to the point that the children's interests are no longer the focus of the dispute, the children's officer may become more actively involved. In those situations, the role of the children's officer will be to voice the child's perspective, and to seek to refocus the dispute on the interests of the child. This is likely to involve interviewing the individual child and intervening in the conflict by asking relevant questions of the disputing adults.

The children's officer will work to eliminate barriers to the children's perspectives being heard by the MCFD decision-makers, and will seek to build the capacity of children to advocate for themselves, and the capacity of families, social workers, foster parents and communities to advocate on behalf of the children for whom they have some responsibility. Capacity building by the children's officer could take the form of providing information or guidance to children, youth, or other interested individuals, about how to navigate the system, or conducting training sessions for community advocates, or working with front line social workers to enhance their capacity to incorporate the child's perspective into their decision-making. The children's officer will work with First Nations who have, or are seeking, delegated child welfare authority, to ensure that the perspectives of children are considered by the First Nation in the exercise of this authority.

[20] I have been told that youth involved in the justice system may well require increased advocacy efforts, but coming up with a model of how this could most effectively and efficiently done, in my opinion, requires further study.

The children's officer will monitor how the child welfare system is functioning in British Columbia. When I use the word "monitor", I do not mean that MCFD will in any way "report" to the children's officer, but rather that the children's officer will keep a watching brief on how MCFD is doing in fulfilling its stated goals. The children's officer will fulfil this monitoring function in the following ways. The children's officer will be a member of a multidisciplinary team, under the auspices of the Chief Coroner, which reviews child fatalities. The children's officer will be provided with copies of reports generated in the course of MCFD's internal monitoring function, including reports on internal complaints, reportable incident and death reviews, audits of MCF offices, audits of plans of care, audits of residential care settings, and reports on exit interviews with children leaving care. The children's officer will be provided, by MCFD, with the final reports received from the Ombudsman following his investigation of complaints against MCFD, and with reports of the PGT's reviews of critical injuries. The blanket of confidentiality relating to this information will cover the children's officer so that confidentiality will not be a barrier to the children's officer receiving relevant information. The children's officer will have the authority to initiate further investigations in order to answer any outstanding questions arising from the monitoring information received by the children's officer. Beyond these follow up inquiries, the Children's Officer will have the authority to initiate a broader special investigation if the Children's Officer deems it necessary in order to fulfil the Children's Officer's monitoring role. The children's officer will seek independent feedback from children, youth, families, community agencies working with MCFD, and from other interested members of communities, on how the child welfare system is performing in their community.

The children's officer will report annually, or more often if the children's officer deems it important to do so, to the government and to the public about the state of the child welfare system in British Columbia. The children's officer will educate the public and the government about child welfare issues, and provide the children's officer's analysis, from the perspective of the interests of children-in-care and children and youth who receive child welfare services from the government, of the policy issues facing government. The children's officer will not tell government how to do its job but will advocate for children's interests by illuminating the consequences to children of the current policies and practices of MCFD. In so doing, the children's officer will be a resource for MCFD in its fulfilling its continuing goal to improve the quality of its services to children, and a resource to the Minister of Children and Family Development, other members of the Executive Council, and the Members of the Legislature in their pursuit of effective child welfare policy.

Should the children's officer be an officer of the Legislature?

I stated that I envisioned the children's officer as independent of MCFD. An issue arises as to whether this independence requires that the children's officer be an officer of the Legislature. The Children's Commissioner is not an officer of the Legislature; the Advocate is. Making the children's officer an officer of the Legislature would be a statement of the children's officer's independence from government. This is important if the children's officer must be protected, and be seen by the public to be protected, from government influence in the fulfilling of the children's officer's function.

In my opinion, the children's officer, as I envision the office, does not need to be independent of government to the degree of say, the Ombudsman. On the contrary, I see the children's officer as being part of government and assisting government in doing its job to protect and look after the interests of children who require protection and other child welfare services from the government.

With respect to public perception of independence, the Advocate's office reports that their experience is that children, youth and those who care for them take considerable comfort in the independence of that office, and in knowing that they are talking to someone who is outside of MCFD and of government. They see their ability to assure individuals and communities of the Advocate's independence has been essential to building trust. I agree that a perception of independence is an important element of trust. It is difficult to assess, however, how central being an Officer of the Legislature is to this trust. There are examples of Order-in-Council appointees who are viewed, in the context of the communities in which they work, as being independent. The Chair of the Labour Relations Board comes to mind. I have not done any objective testing of the issue, but I would expect that the public is not likely to be concerned about the nuances of the difference between being an Officer of the Legislature or an Order-in-Council appointment for a term certain. If this is true of the public at large, it will be even truer of children and youth. The children's officer, whether an officer of the Legislature or not, is likely to be perceived to be a "government" official. The key point to convey is that this government official is on the side of children-in-care and children and youth who receive services from MCFD, and is advocating within government for their interests.

To be effective, the children's officer needs to have the respect of the decision-makers within government so that he or she will be listened to. If the government has lost confidence in the children's officer to the point of wanting to dismiss the children's officer before the end of his or her term, then the likelihood is that the children's officer has ceased to be effective.

The appointment and recall procedures for officers of the legislature are cumbersome and require agreement by both government and opposition members in the Legislature. A risk is that, from the point of view of the government, the wrong person could be chosen, perhaps as a result of political compromise, and, unless the Opposition is on side, virtually nothing can be done to rectify the mistake during the lengthy term of the legislative officer.

At the same time, the children's officer needs to feel free to make critical comment about MCFD, publicly if necessary. There are ways of giving a children's officer that freedom other than making them an officer of the legislature. True, an Order-in-Council appointment, even for a term certain, can be rescinded at any time by another Order-in-Council. There will, however, be constraints on the government to do this if the reason behind the termination is solely that the children's officer is making public statements about MCFD, which are embarrassing to the government but justified. First, the children's officer has a public platform. It is unlikely that the termination of such an appointment would go unnoticed in the media. The government's embarrassment is only likely to be accentuated by firing a children's officer in these circumstances.

Furthermore, depending on where the children's officer is within the term of office, the termination could be a significant financial cost to the government.

In my opinion, in the case of the proposed children's officer, a sufficient measure of independence can be ensured without making the children's officer an officer of the legislature. As with the Children's Commissioner, the children's officer should be a full-time Order-in-Council appointment for a term certain. I think that the term should be long enough for the children's officer to become established in the position but not too long so that if the government loses confidence in the children's officer, it is not financially too onerous to replace the incumbent. The term of the children's officer should be renewable so that if an individual is performing the role effectively that individual can continue in the office. The children's officer should be at a level equivalent to a Deputy Minister as a mark of the importance that the government places on the position, and also, because Deputy Ministers have special benefits that recognize a vulnerability to continued employment.

The children's officer should be administratively accountable to the Attorney General. I suggest this for two reasons. First, the children's officer position can be seen, conceptually, as one manifestation of the Crown's exercise of its *parens patriae* responsibility to look after the interests of children within its jurisdiction. Within government, the *parens patriae* responsibility falls to the Attorney General. Secondly, the Attorney General has the responsibility for ensuring that British Columbia fulfils its responsibilities under the UN Convention on Children's Rights to which Canada is a signatory. The children's officer is one way in which the British Columbia government furthers children's rights.

On the issue of independence, it is relevant that, if the children's officer is an Order-in-Council appointment, the position will be within the jurisdiction of the Ombudsman. This means that if there is a complaint that the children's officer, who is an Order-in-Council appointment, is somehow not acting independently, as contemplated in the legislation, the Ombudsman could investigate and make a determination and recommendations for change.

Handling of complaints about MCFD

I envision that complaints from children-in-care, children and youth who receive services from MCFD, and from family members, and interested community members, will be handled internally within each region of MCFD, with the only external review process being to the Ombudsman's office.

I assume that the Ombudsman will apply the same criteria to dealing with complaints about MCFD as the Ombudsman applies to complaints about any other agency. I am also assuming that the Ombudsman will continue to have a child and youth team, in recognition of the special obstacles that exist for children in being heard by government and non-government agencies within the mandate of the Ombudsman. I would, however, not recommend legislating that the Ombudsman is required to have a Deputy Ombudsman responsible for children, or a special Child and Youth Team. That should appropriately be left to the discretion of the Ombudsman, to be determined in the context of the other priorities of that office.

As for the internal complaints process, I envision that, regardless of any internal reorganization or devolution of authority to community or regional boards, it will continue to meet the criteria of the Ombudsman for an acceptable Internal Complaints Mechanism, and that it will be framed as a problem-solving process that welcomes the conflicting perspectives of children, youth, family members and other interested individuals in the community and as an opportunity for quality improvement. Those who take issue with a decision of a line social worker will have two options: one, to seek a review of the decision by the social worker, by the social worker's supervisor, or by the relevant Manager who would be the final stage in the formal internal appeal process; the second, to apply for review by and assistance from a Regional Quality Improvement Manager who will not have been involved in the making of the original decision.

MCFD will establish a clearly communicated expectation of line decision-makers to be open to perspectives, from children and others, that may conflict with the line decision-maker's own perspective. To put this into effect, training and effective supervision in this area will be required.

The Regional Quality Improvement Manager on receiving an application for involvement in any dispute between a line decision-maker and a child, youth, family member or interested community member, will attempt to resolve the dispute informally by engaging the line decision-makers, in an educative way, in the process of resolving the dispute. In the event that the dispute cannot be resolved informally with the assistance of the Quality Improvement Manager, the Regional Quality Improvement Manager will have the authority to report directly to the Regional Executive Director with recommendations as to how the dispute should be resolved.

The Regional Quality Improvement Managers will be the same level employee as the other managers and will report directly to the Regional Executive Director with a dotted reporting line to the Assistant Deputy Minister responsible for quality improvement. A responsibility of the Regional Quality Improvement Managers will be to build the capacity of line decision-makers within MCFD to respond in an open way to input from the children for whom they are responsible, and from families and other interested members of the community.

At all times, assistance from an outside mediator will be an accessible option to attempt informal resolution of particularly intractable disputes.

Monitoring within MCFD

I envision that MCFD will develop increasingly sophisticated performance measurements that are made public. In addition, MCFD will continue to use and improve computerized information services to flag non-compliance with its policies and practice standards. MCFD will continue its cyclical audit of local offices. MCFD will be legislatively mandated to put in place its own systematic audits of plans of care for children in continuing custody, the focus of which will be less on the documentation of the plan, and more on whether an appropriate plan is in place and being implemented. MCFD will continue to review reportable incidents, including critical injuries, and will be legislatively mandated to review the deaths of all children who die in care or who have received services from MCFD. The death reviews will include a full review of MCFD

services provided to the child during the child's life. When policy or practice issues are raised by the reportable incident or the death, the Regional Director will conduct a more in depth review, designed to prevent future similar incidents or deaths.

I envision that the Regional Quality Improvement Officer will be involved in the internal monitoring function, and will have the following responsibilities, in addition to the complaints related responsibilities outlined above:

a. Making certain that the perspectives of the community agencies dealing with MCFD as to how MCFD is doing its job are received by MCFD;
b. Being available as a resource for the Regional Executive Director to investigate concerns regarding quality of service;
c. Ensuring that the planned monitoring mechanisms are being implemented and are working effectively; and
d. Reporting to the Regional Executive Director and to the Assistant Deputy Minister responsible for quality improvement about the state of the quality improvement initiatives of MCFD.

External child fatality reviews and external reviews of critical injuries of children-in-care

I envision that the Chief Coroner will incorporate into the Coroner's service some of the elements of the Children's Commission's approach to child fatality review. In particular, the Coroner will thoroughly investigate the government and medical services provided to the child during the child's life and ask whether inadequacy in these services in any way contributed to the child's death, and will include this aspect of the Coroner's inquiry in the Inquiry Report. The Chief Coroner will convene a Multidisciplinary Team to review all unexpected, unforeseen and unexplained deaths of children, within a reasonable time of the deaths. The Chief Coroner's Multidisciplinary Team will include a representative from MCFD, and possibly a representative from the College of Physicians & Surgeons, and will have access to confidential records and reports concerning the child's death, including reports of internal hospital investigations.[21]

I further envision an in depth feasibility assessment of a multi-agency team approach to investigating suspicious children's deaths, including on the team representatives from the Police, MCFD, and the Coroner's services, as well as paediatric pathologists, and medical experts in child abuse.

I envision that the work done by the Children's Commission in terms of developing a valuable database regarding child fatalities will not be lost but will be continued through a joint effort of the Vital Statistics Agency and the Chief Coroner's office.

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[21] I understand that the confidentiality of these hospital records is highly contentious, especially with physicians and their insurers, and others in the health sector. With respect to release of this information to the Children's Commission, I expect that the concern has been that once they are given to the Children's Commission, they become public documents. I am envisioning that they would continue to be under the cloak of confidentiality. I recognize that this is a very complex issue that will need to be considered further.

Finally, I envision that an effective protocol will be functioning within MCFD to ensure that the PGT is notified of serious injuries suffered by children in continuing care.

IX. THE PROPOSED FUTURE OF THE CURRENT FUNCTIONS OF THE CHILDREN'S COMMISSION AND THE ADVOCATE

Under the proposed model, the following Children's Commission's functions will no longer be done by a children's officer: (If the function is currently being done by another agency that agency is noted in parenthesis.)

- Investigating complaints about breaches of rights of children-in-care, and about provision of services for a child by MCFD (MCFD and Ombudsman)
- Informally resolving complaints against MCFD (MCFD and Ombudsman) (The children's officer, as an advocate for the child, will from time to time facilitate the informal resolution of disputes with MCFD, but that function is different than the current Children's Commission's function of informally resolving disputes.)
- Conducting formal panel hearing of complaints about breaches of rights of children-in-care, and about provision of services for a child by MCFD
- Investigating critical injuries of children-in-care (MCFD and PGT, in part)
- Tracking compliance with recommendations from the Children's Commission
- Monitoring adherence to standards set by the Commission for internal complaints (Ombudsman)
- Recommending policy changes within a formal complaints process and on the basis of Children's Commission's investigations of deaths and critical injuries, and audits of plans of care
- Reviewing the circumstances of the deaths of all children in B.C.
- Investigating the unexpected deaths of children (Coroner)
- Inquiring into the adequacy of government and medical services provided to children who died, when there is no causal connection between those services and the death (MCFD will be making this inquiry with respect to its own services.)
- Investigating the deaths of children-in-care or who had received services from the MCFD when the deaths are not within the Coroner's mandate (MCFD)
- Engaging in research projects (MCFD)

The following Children's Commission's functions will be done by the children's officer:

- Conducting special investigations for the Minister of Child and Family Development or for the Attorney General
- Monitoring MCFD including by reviewing data arising from complaints, critical injuries and child fatalities reviews done by other agencies, including MCFD.
- Monitoring compliance with the recommendations arising from child fatality reviews
- Conducting further investigations, at the children's officer's initiative, as a result of concerns raised from data obtained through monitoring, including having access to source data and original files (The children's officer will have the additional authority to do random audits.)

- Informing the people of BC about the state of the province's child and family-serving system, including through annual and special reports
- Facilitating child-focused research
- Reporting publicly, annually or as deemed necessary

The following Children's Commission's function will be transferred to another Agency: (The Agency to whom this function will be transferred is noted in parenthesis.)

- Systematically monitoring plans of care for children in continuing custody (MCFD currently fulfils this function as part of its general audit, but will be legislatively mandated to do regular plans of care auditing.)
- Collecting information for a comprehensive data base regarding children's deaths in British Columbia (to the Vital Statistics Agency and/or the Chief Coroner)
- Convening a Multidisciplinary Team to review all children's deaths (to the Chief Coroner)
- Making recommendations to government and outside government agencies arising from the fatality reviews (to the Chief Coroner's Multidisciplinary Team)

Under the proposed model, the following Advocate's functions will no longer be done by a children's officer:

- Appearing on behalf of children in front of Children's Commission complaint panels
- Overseeing the MCFD complaints process (The Ombudsman) (The children's officer will not have a specific overseeing role in relations to the MCFD complaints process but will be interested in its functioning in that it is a part of the child welfare system which the children's officer will be generally monitoring. For example, the children's officer will be concerned, and may want to express that concern, if the MCFD complaints process is creating obstacles to children being heard.)

Under the proposed model, the following Advocate's functions will be done by the children's officer:

- Providing to children, youth and adults, information and guidance about how to put forward complaints about breaches of rights of children and youths, and about services provided by MCFD to children, youth and families
- Facilitating, as an advocate for the child, the informal resolution of individual disputes with MCFD
- Intervening in high conflict complaints, as an advocate for the child, to ensure that the perspective of the child is taken into account and that the focus on the child's interests is not lost
- Promoting and coordinating advocacy services for children, youths and families in communities
- Being a member of the Children's Commission's Multidisciplinary Team to review child fatalities

- Listening to the views of children, youth, families and communities about government services to children, youth and their families
- Providing information and advice to government about services to children, youth and their families
- Providing information and advice to communities about services to children, youth and their families
- Developing, with First Nations communities, protocols for a relationship with the Advocate's office, as a requirement for delegation of child welfare authority
- Reporting annually to the Legislative Assembly on issues concerning legislation, policies and practices about services for the rights of children, youth and their families

X. WHAT NEEDS TO BE DONE

To put the proposed model into effect, the following needs to be done:

1. The *Children's Commission Act* and the *Child, Youth and Family Advocacy Act* need to be repealed and replaced with a new statute creating the office of the children's officer, setting out the mandate and powers of the children's officer, and containing other necessary statutory provisions.

2. The name of the children's officer needs to be decided.

3. Whether to have a statutory review of the need for a children's officer in five years time needs to be decided.

4. The extent to which collateral amendments are required to the *Child, Family and Community Service Act*, the *Coroners Act*, the *Public Guardian and Trustee Act*, the *Freedom of Information and Protection of Privacy Act*, the *Evidence Act*, or any other relevant statute to allow for the transfer of confidential information to the children's officer needs to be considered.

5. Consultations will be needed with other interested groups and agencies, such as the medical community and hospital authorities and the Information and Privacy Commissioner, before proceeding with changes that would allow for freer exchange of confidential information.

6. The *Child, Family and Community Service Act* needs to be amended to mandate internal reviews of the deaths of, and services provided to, children-in-care and children who received services from MCFD, and the regular auditing of plans of care by MCFD, and possibly to legislatively mandate other monitoring mechanisms within MCFD. Given the expected move to delegate more authority to the Regional Executive Directors, a more comprehensive amendment to the *Child, Family and Community Service Act* will likely be necessary.

7. The logistics of going from two children's officers to one need to be worked out.

8. MCFD needs to review its complaints process and implement the changes recommended in this report, with the modifications required by any new organizational structure.

9. A decision has to be made by MCFD to create a Regional Quality Improvement Manager, or equivalent, at the level of other regional managers, with a job description that includes the responsibilities recommended in this report.

10. An implementation plan needs to be developed to deal with issues such as how to deal with complaints during the interim before final implementation, and how to communicate changes.

11. The *Coroners Act* needs to be amended to include a provision for a Multidisciplinary Team to review children's deaths and make recommendations, and to clarify the Coroner's obligation, in the case of children's deaths, to look at whether inadequate medical and child welfare services contributed to the child's death.

12. Consideration needs to be given as to how to effectively maintain the Children's Commission's child fatality database through some combination of using the services of the Vital Statistics Agency, transferring information and systems from the Children's Commission to the Chief Coroner's office, and expanding the Chief Coroner's capacity to maintain relevant child fatality data.

13. A decision needs to be made about whether to consider a multi-agency child death investigation team

Appendix: List of those consulted in preparation of report

Lynell Anderson, Manager of Finance and Support Services, Child, Youth and Family Advocate

Janice Aull, Executive Director, Strategic Management and Intergovernmental Relations, MCFD

Allan Anderson, Director, Investigations, Inspections, Standards Office, SG

Jeremy Berland, Executive Director, Services to Aboriginal Children and Families, MCFD

Larry Campbell, former Chief Coroner

Linda Clarkson, Child and Youth Investigation Team Leader, Ombudsman's office

Jay Chalke, Public Guardian and Trustee

Jennifer Charlesworth, trainer and educator contracted by MHR and MCFD

Susan Christie, Director, Agencies, Boards & Commissions, MAG

Julie Dawson, Deputy Director, MCFD

Kathryn Eggert, Manager, Child & Youth Services, Public Guardian &Trustee

Colin Elliot, Director, Child & Youth Services, Public Guardain & Trustee

John Greschner, Deputy Children's Commissioner and Chair, Tribunal Division

Judith Hayes, assistant to ADM, Regional Operations, MCFD

Chris Haynes, Deputy Minister, MCFD

Kim Henderson, Manager Regional Operations, MCFD

Kinsburh Healey, Complaints Analyst, MCFD

Jane Holland, Service Quality Review Advocate for Adults with Development Difficulties, MCFD

Dr. Perry Kendall, Provincial Health Officer

Howard Kushner, Ombudsman

John Lane, former Victoria Deputy Police Chief, member of Children's Commission's MDT

Gregory Levine, General Counsel, Ombudsman's office

Ian Mass, Deputy Child, Youth and Family Advocate

Laverne MacFadden, A/Child, Youth and Family Advocate

Wendi J. Mackay, Project Director, Administrative Justice Project

Jerry McHale, Assistant Deputy Minister, Justice Services Branch, MAG

Wayne Matheson, Director, Child Protection Division, MCFD

Cynthia Morton, former Children's Commissioner
Elaine Murray, A/Assistant Deputy Minister, Regional Operations, MCFD
Paul Pallan, Children's Commissioner
Brent Parfitt, Deputy Ombudsman
Deborah Parker-Loewen, Children's Advocate, Saskatchewan
Dr. Shaun Peck, Deputy PHO, member Children's Commission's MDT
Joyce Preston, former Child, Youth and Family Advocate
Honourable Linda A. Reid, Minister of State for Early Childhood Development
Lex Reynolds, Board Member, Child Protection Policy and Standards, MCFD
Mark Sieben, Manager, Child Protection Policy and Standards, MCFD
Terry P. Smith, Chief Coroner
Richard Stanwick, CRD Public Health Officer, member, Children's Commission's MDT
Kathryn Thompson, researcher contracted by MAG
Margo Tubman, researcher contracted by MAG
Dr. Morris VanAndel, Registrar, College of Physicians & Surgeons
Vital Statistics Agency representative
Barbara Walman, Director of Regional Operations, MHR
Youth in Care representatives