

Summary of the Director's Case Review into the Death of CW

CW was a two-year-old First Nations girl who died on or about September 21, 2002. The child's body was found in a shallow grave during the weekend of September 21, 2002 on the Lakahahmen Reserve, in British Columbia. Prior to her death, the child was in the care of her father. On July 8, 2002 the child came to the attention of the Ministry of Children and Family Development (MCFD) and Xyolhemeylh, a delegated Aboriginal agency, through a child protection report. The child and her father were subjects of ongoing protective family service from Xyolhemeylh at the time of the child's death. Following a criminal investigation into the child's death, the child's father was charged with manslaughter, indignity to human remains and assault causing bodily harm .

Xyolhemeylh Program, Sto:lo Child and Family Services is the fully delegated First Nations Child and Family Service agency which provides on reserve child protection services to the 19 Bands of the Sto:lo Nation and 4 affiliated bands located in the Fraser Valley. This Agency also provides child protection services to all Aboriginal people living off reserve from Langley to Yale, BC. CW's death is the first child fatality in the agency since it started providing delegated child and family services in 1993.

The purpose of this review was to examine of Ministry of Children and Family Development and Xyolhemeylh involvement with CW and her father to ensure that policy, standards, and practice requirements regarding the provision of child protective family services were met. Aboriginal Delegated Agencies operate under the guidance of the *Aboriginal Operational and Practice Standards and Indicators (AOPSI)* manual.

The Terms of Reference for the Director's Case Review

1. Did the Ministry and Agency's responses to the information reported in July 2002 meet the required standards?
2. Did the case transfer from the Ministry to the Agency follow established protocols?
3. Was appropriate case consultation sought and or provided for the management of the case?
4. Did the agency complete an assessment of risk in accordance with Aboriginal Practice Standard #22 (Level 15)?
5. Was the risk reduction service plan adequate to ensure the safety and wellbeing of the child?

Summary of Director's Case Review Findings

- The Agency did not meet all requirements of the standards in relation to the information reported in July 2002. There were notable gaps in the investigation process and a lack of depth of analysis of the information gathered during the investigation.
- The transfer from the Ministry to the Agency followed established *Intake and Investigation Protocol between Xyolhemeylh and MCFD* with the exception of establishing that the family was Aboriginal prior to attending at the hospital. This omission did not affect the outcome of the investigation.
- There was limited case consultation sought or provided for the management of the case. Further, investigating staff did not recognize the risk factors and therefore could not communicate these to the Supervisor.
- Failure to recognize risk factors and to receive supervision led to an early finding of the child being in need of protection due to neglect and set the stage for confusion about the nature of risk and subsequent planning for this child and father.

- No risk assessment was completed as required by Aboriginal Practice Standard #22 (Level 15).
- No risk reduction service plan was developed to adequately ensure the safety and well being of the child.
- Xyolhemeylth file transfer policy and practices were not followed so that clear communication of the investigation findings, the need to complete a comprehensive risk assessment and risk reduction plan did not occur.
- Community residents and collaterals may have had information key to the circumstances and the safety of the child, however, they were not forthcoming nor were they sought out by Xyolhemeylth staff.

Recommendations Arising from the Director's Case Review

The following recommendations were developed in consultation with Xyolhemeylth and MCFD regional staff. The recommendations involve training, policy, protocols, procedures, community development, and standards.

Training:

1. Xyolhemeylth conduct in-service training with all staff to review practice standards related to child protection investigations and protective family services. As well, this in-service training should include a review of the necessary approvals and security clearance for adults staying or visiting in foster homes.
2. Xyolhemeylth conduct a refresher seminar with all staff on the risk factors and indicators of physical, sexual and emotional abuse and that Xyolhemeylth consider asking a senior member of the Child Abuse Team from BC Children's Hospital to be a key presenter in the refresher. This refresher should include clarification of the role of professional consultation and the responsibilities of child protection investigators in decision making in child protection investigations. As well, the book *Beyond Blame: Child Abuse Tragedies Revisited* by Peter Redar, Sylvia Duncan, and Moira Gray should be reviewed with all staff as part of the training.
3. That a senior member of the Child Abuse Team at BC Children's Hospital be asked to deliver training on risk factors and indicators of child abuse and neglect at the Level 15 training for Aboriginal Child Protection workers.
4. Xyolhemeylth and MCFD ask the BC College of Physicians and Surgeons to review the medical documents and drawings of the child's injuries and provide feedback to the staff and physicians involved in this case. Services for Aboriginal Children and Families Division of the Ministry of Children and Family Development will prepare and distribute an advisory on the SCAN teams for distribution to each of the delegated Aboriginal Agencies.

Policy:

5. Xyolhemeylth develop a policy regarding consultation with supervisors and child protection consultants in all child protection cases where there is physical injury, including where injuries occur when children are in care.
6. Xyolhemeylth develop a format and clear expectations about documentation of investigations and ensure that all staff comply with the requirements.
7. Xyolhemeylth review the internal case and file-transfer policy with all staff and ensure compliance and develop and implement a system to track file movement and transfers.

8. Xyolhemeylth review internal policy regarding supervisors' documentation of case supervision, consultation and transfer conferences with all supervisors and ensure compliance.

Protocols:

9. Xyolhemeylth familiarize all staff with the *Provincial/Territorial Protocol on Children and Families Moving Between Provinces and Territories* so that staff are aware of the need to use this protocol when child protection investigations involve children and families who have lived in other jurisdictions in Canada.
10. Xyolhemeylth and the Ministry of Children and Family Development jointly review their protocols with the Fraser Valley Health Region and the RCMP to ensure that these organizations are current with the changes in scope and responsibilities of Xyolhemeylth and MCFD with respect to Family and Children's Services.

Procedures:

11. Xyolhemeylth ensure that all child protection staff take cameras when interviewing children in child protection investigations where physical abuse is suspected so that any physical injury may be documented and to have two workers attend the investigation of an abuse allegation.

Community Development:

12. Xyolhemeylth continue to work with all the Community Care Committees to address child safety and impact of a community code of silence during investigations.

Standards:

13. An additional standard similar to the Practice Standard #31 (p. 50) in Practice Standards for Child Protection (MCFD) should be included in AOPSI practice standard #28. Practice Standard #28 refers specifically to files that have no protection issues and is silent on those that have protection issues. In addition, AOPSI Level 15, is ambiguous regarding when, and if, to complete risk assessments when transferring protective family service cases and voluntary family service cases. This should be clarified.
14. AOPSI should be revised to include a specific time frame within which a worker must physically meet with a child after a child protection file or protective family service file has been transferred from one worker to another.