REPRESENTATIVE FOR
CHILDREN AND YOUTH

# Special Report

## Reporting of Critical Injuries and Deaths to the Representative for Children and Youth

December 2010

# 1 Purpose of this Special Report

This Special Report[1] was sparked by a recent incident in which the Representative was advised through the media and by family members that a vulnerable special needs girl who was known to the Ministry of Children and Family Development (MCFD) was left for several days with the body of her deceased mother. The Representative heard of this circumstance almost two months after it happened.

The seriousness of this case and the way that she became aware of it, in combination with other specific examples of non-reporting by MCFD, convinced the Representative that a Special Report was urgently needed, as ongoing efforts with MCFD at resolving the issue of notification of critical injuries and deaths have not been fruitful. The Representative is concerned that public confidence in the system of independent review of critical injuries and deaths will be impacted if immediate policy changes are not made to bring ministry practice into compliance with the duty to report.

In particular the Representative was asked the question "Why wasn't this case reported to your Office?" This Report strives to answer that question, and address the underlying policy gap in reporting matters to the Representative to enable her performance of the oversight function of reviewing critical injuries and deaths of children. In relation to the case of the child with the deceased mother, following a review of the file and of relevant information from within and outside the ministry, the Representative has determined that a critical injury has in fact occurred. The Representative has completed a review under the *Representative for Children and Youth Act (RCYA)*, and has commenced a full investigation of this matter. However, the Representative has to date still not received an official ministry report of the critical injury in this case. Discussions with senior ministry officials suggest a notification will not be forthcoming.

The Representative will release a full public report on this case within the next several months, when her investigation is complete. The investigation will closely examine the interaction between the ministry and this family, and whether the harm suffered by the child could have been prevented.

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[1] Section 20 of the *Representative for Children and Youth Act* (*RCYA*) states that: "the Representative for Children and Youth may make a special report to the Legislative Assembly if the Representative considers it necessary to do so."

MCFD's duty to report critical injuries of children receiving reviewable services is required under s. 11(1) of the *Representative for Children and Youth Act (RCYA)*:

> 11 (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for a review under subsection (3).

Failure to comply with the legal reporting obligations set out in s. 11(1) may result in an injury or death not being reviewed or investigated by the Representative. Notification of an occurrence of an injury or death permits the Representative to undertake her independent function of reviewing and investigating ministry practice in cases where children with whom the ministry is involved are critically injured. The trigger for the independent review function is the notification process required in section 11. Failure to report or notify is a serious issue which must be resolved in a timely fashion.

The Hon. Ted Hughes' landmark report, the *BC Children and Youth Review* (the 'Hughes Review') was issued in April 2006, almost five years ago. The Hughes Review prompted government's unequivocal commitment to creating an *independent* oversight office that would, among its core functions, review and investigate the deaths and critical injuries to children with whom the ministry has been involved:

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

The Hughes Review emphasized that the Representative's review and investigation function is not intended to adjudicate criminal or civil liability. Its purpose is to help the child-serving system to learn lessons and improve future practice through careful assessment and recommendations made by an independent office that the public can trust. The important focus of the review and investigative function is to consider how services support children or may be strengthened to effectively support children.

The Representative acknowledges that external accountability mechanisms are sometimes difficult to implement in practice. There may be a natural temptation on the part of some public officials to resist oversight, or to respond to it in a fashion that is narrow and defensive. This is of course where the responsibility of MCFD leaders comes into play. It is the fundamental responsibility of the Minister of Children and Family Development and its senior officials to ensure that the ministry fully complies with the letter and the spirit of the reforms created by the *RCYA*. This is particularly so as failing to notify the Representative can undermine her practical ability to perform her statutory functions.

In this context, it is the Representative's view that it is not appropriate for ministry leadership to encourage or tacitly endorse a narrow view of the *RCYA* that limits the duty to notify the Representative of a critical injury to a child. Members of the Legislative Assembly and the public would expect MCFD to take a broader view. That view should be informed by the reality that welcoming the involvement of the Representative can only assist the ministry and the children it serves by fully and effectively exercising the independent review and investigation function.

In fact, in response to a question in the House during debate on the *Act* during the committee stage, the Attorney General of the day offered the following view of the purpose of s. 11(1) powers:

> This subsection, I would suggest with respect, really is pretty expansive, and it's mandatory. It states that they "must provide information." It can't be any more compelling or mandatory than that. I would have some concerns if the words were "may" and "permissive," but this is "mandatory" here.[2]

In order for the investigative powers to be effective, a system of notification must be in place to ensure the oversight agency actually knows about individual cases. This issue was described by the Supreme Court of Canada several years ago in relation to the government's reaction to the creation of a provincial Ombudsman: *British Columbia Development Corporation v. Friedmann (Ombudsman*), [1984] 2 S.C.R. 447. In that case, as here, the government had justified its attempts to limit the Ombudsman's role by employing narrow and "strained" interpretations. In rejecting the government's approach, the Court made this statement, which the Representative believes applies fully to the context here:

> ... his powers of investigation can bring to light cases of bureaucratic maladministration that would otherwise pass unnoticed. The Ombudsman

[2] Report of Proceedings (Hansard), Debates of the Legislative Assembly, Thursday, May 18, 2006, p. 5063

> "can bring the lamp of scrutiny to otherwise dark places, even over the resistance of those who would draw the blinds": *Re Ombudsman Act* (1970), 72 W.W.R. 176 (Alta. S.C.), *per* Milvain C.J., at pp. 192-93. On the other hand, he may find the complaint groundless, not a rare occurrence, in which event his impartial and independent report, absolving the public authority, may well serve to enhance the morale and restore the self-confidence of the public employees impugned.

To date, the Representative has not been successful in encouraging the ministry leadership to ensure that its policies and practices regarding its legal duty under s. 11(1) are those that she fully expects, or that would be contemplated by the Hughes Review, or by the members of the Legislative Assembly who unanimously voted to impose this obligation on the ministry.

# 2 What the Hughes Review Recommended: The Review of Critical Injuries

The Hughes Review began in the wake of serious public criticism of MCFD after its release of an internal review of the death in Port Alberni of a Nuu-chah-nulth child who had been under the supervision of an agency delegated by the ministry. A similar tragic incident involving a child who died had, several years earlier, been the genesis of the Gove Inquiry.

Several changes resulted from the Gove Inquiry, including the creation in 1996 of an oversight body, known as the Children's Commission, to review deaths and critical injuries of children in the province. The Children's Commission was subsequently abolished by the government following the core services review in 2001-02.

The Hughes Review examined the strengths and weaknesses of that office, and the problems that ensued when it was abolished in favour of a system of purely internal ministry review of its own practice – of the ministry investigating itself. Hughes was candid in stating that "the question that has most challenged me in this review" is whether there should be an external body to review injuries and deaths to children within the child welfare system. After careful consideration, Hughes recommended as follows (p. 36):

> I am proposing that the Representative for Children and Youth assume responsibility for reviewing injuries and deaths of children who are in care or receiving Ministry services. It will be a more limited role than that performed by the Children's Commission. The primary method of reviewing child injury and deaths will be to examine aggregated information, and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives.

Hughes recognized that the degree of review or investigation required in a particular case would depend on the circumstances (p. 37):

> The Representative should have discretion to determine the kind of review that is appropriate in the circumstances. It may be a matter of collecting and reviewing information on a number of deaths with similar

> characteristics (for example, youth suicides by hanging), to identify trends or patterns that will inform and educate the child welfare system and the public. It may mean a paper review of an individual injury or death. Or, it may entail a full scale investigation of an individual case, involving interviews of witnesses and compelling evidence.

Hughes defined the types of cases where the Representative's role would come into play (p. 37):

> The Representative should have the authority to review child injuries and deaths if the Ministry's services, policies or practices may have contributed in some way to the injury or death and:
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> a. the injury or death is, or may be, due to neglect or abuse; or
> b. the injury or death occurs in unusual or suspicious circumstances; or
> c. the injury or death is, or may be, self inflicted, or inflicted by another person.

Importantly for the purposes of this Report, Hughes recognized that, from a public policy and learning perspective, critical injuries may be an even more important source of learning than child deaths (p.36):

> International studies suggest that it may be a mistake to torque the entire system based on the results of one or two tragic cases that occur in circumstances that might not be repeated. Critical injuries, which occur more often, may be a better indicator of needed change.

Hughes did not find it necessary to undertake an extensive discussion of the definition of a 'critical injury.' In a footnote, Hughes described critical injuries as those that "are life-threatening or cause serious long term impairment to the child's health."

It is unlikely that Hughes would have intended that the ministry interpret this definition as narrowly as possible when discretion is required by the oversight body to determine which incidents reported require further review and or investigation in order to promote public accountability.

# 3 The Legislature's Response to Hughes' Recommendations

The Legislature acted unanimously and promptly to enact the *Hughes Report* Recommendations, issued on April 7, 2006. By November 2006, the *RCYA* had been enacted. The provisions enabling the Representative to review and investigate critical injuries and deaths came into effect on June 1, 2007.

The Legislature made several important decisions in the process of translating the *Hughes* recommendations into legislative language. For the purposes of this Special Report, the four key decisions that were made when the *RCYA* was enacted are highlighted:

1. The Legislature agreed with Hughes that the Representative's review and investigation role is to focus on opportunities for learning by *public bodies* involved with children. Thus, where a child or family has been receiving a "reviewable service" at the time of, or in the year previous to, a critical injury or death, MCFD has a duty to report the incident to the Representative: *RCYA*, s. 11(1). "Reviewable service" was defined as follows:

   "reviewable services" means any of the following designated services:

   (a) services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*;
   (b) mental health services for children;
   (b.1) addiction services for children;
   (c) additional designated services that are prescribed under section 29(2)(b).[3]

   This first key decision was intended to ensure that if, for example, the ministry had conducted a child protection investigation, and a death or critical injury occurred within a year, the Representative would be able to review and if necessary investigate the child protection response, and report publicly on whether or not the investigation was conducted in accordance with the standards the public can expect for the conduct of those investigations.

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[3] The additional designated services are those service and programs under the federal *Youth Criminal Justice Act* and the Child in the Home of a Relative Program: *Representative for Children and Youth Regulation*, s. 3.

2. The second key decision made by the Legislature was that a full investigation by the Representative should be the exception rather than the rule. While the Representative is to receive reports of all deaths and critical injuries involving reviewable services, the Representative must carefully screen those reports. Some reports raise no systemic issues at all. Others do raise such issues, but those issues can be addressed in the form of aggregate reviews, based on documents, where data is aggregated and identities kept confidential in the public report.

   As made clear in the *RCYA*, the Representative only conducts a full investigation where, after a review, the Representative determines that:

   > (a) a reviewable service, or the policies or practices of a public body or director, may have contributed to the critical injury or death, and
   > (b) the critical injury or death
   >  (i) was, or may have been, due to one or more of the circumstances set out in section 13 (1) of the *Child, Family and Community Service Act*,
   >  (ii) occurred, in the opinion of the representative, in unusual or suspicious circumstances, or
   >  (iii) was, or may have been, self-inflicted or inflicted by another person.

   In fact, the Representative's work reflects the legislative intent that investigations are the exception rather than the rule.

3. In order to properly screen, review and, if necessary, investigate a file, the Representative must be aware that it occurred in the first place. Thus, the third key decision made by the Legislature was to create a formal legal duty on the ministry and other public bodies to bring the cases in question to the Representative's attention.

   The *RCYA* imposes this legal duty on all public bodies, but of course in practice this means MCFD as the principal public body with institutional knowledge of these files:

   > 11 (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for a review under subsection (3).

Section 11(1) does not prevent the Representative from undertaking a review or investigation if a death or critical injury comes to her attention by some other means. The failure of a public body to do its duty cannot fetter the Representative in the performance of her statutory duties. However, the Legislature obviously knew that the Representative's accountability mandate would be undermined if she had to depend on families or the media bringing cases to her attention for review and potential investigation.

The ministry has the information, and it is the ministry that must inform the Representative of the information. This is not optional. The ministry's full, fair and effective exercise of its duty under s. 11(1) is therefore critical to the capacity of the Representative's Office to properly perform its function.

4. The fourth and final key decision made by the Legislature in this area was, in *expansion* of the *Hughes Review*, to broadly define "critical injury":

"critical injury" means an injury to a child that may

(a) result in the child's death, or

(b) cause serious or long-term impairment of the child's health.

The breadth of this definition reflects its function as part of a notification section. The definition does not allow the ministry to delay notifying the Representative's Office so that it can assess whether an injury has in fact resulted in serious or long term impairment of a child's health. The key question is whether it may have either serious or long-term impairment of the child's health, or whether it may result in the child's death.

The statutory language here is significant. It is well-established that "health" includes mental and emotional health, and that the impacts of many traumatic events (as for example happens in physical and sexual abuse or when a child witnesses of other traumatic events) often do not fully materialize until well after the trauma has occurred.[4]

This statutory language recognizes that it would be absurd to draft a notification section requiring the MCFD to wait and see if a particular injury had a particular impact on a particular child months or years later.

[4] For the purposes of this Special Report, the point is noted that the law regards health as including psychological and emotional health, and that injury includes psychological injuries.

A stricter standard might well be appropriate for the ministry in deciding whether to remove a child from his or her parents as part of a child protection investigative framework.[5] However, that strict standard is not applicable in deciding whether the Representative should be notified of a case for the purposes of reviewing ministry practice for purposes of learning lessons and enhancing public confidence.

The *RCYA* does not ask the ministry to wait and see whether a child who has experienced a traumatic event is an exceptionally resilient child or youth whose case does not have to be reported. It does not ask the ministry to hire a battery of experts to decide whether a particular injury "may" in the long run affect a child's health. It does not ask the ministry to wait months or years to decide whether harm has in fact materialized. In this regard, the Representative decided that the recent case that prompted this Report met the test of the *RCYA*. The Representative has received no information that the ministry sought an expert medical opinion regarding harm to the youth despite the obvious concern about emotional trauma which could reasonably be expected in such a tragic circumstance.

[5] This is for example the case in s. 13 of the *Child, Family and Community Service Act*, which defines "emotional harm" as requiring the child to actually demonstrate severe anxiety, depression, withdrawal or self-destructive and aggressive behavior." While this test is sensible where the question is the standard for the State removing the child from a family, it is unhelpful and inappropriate when applied to whether the ministry should notify the Representative for purposes of undertaking a review or investigation of its practice. That is why the *RCYA* adopted broader language.

# 4 The Ministry's Policy

The ministry's policy and practice regarding how and when it notifies the Representative of critical injuries under s. 11(1) of the *RCYA* is unacceptably deficient. In fact, the ministry created no policy specifically tailored to its legal duty under s. 11(1) to report to the Representative and has worked in the context of a previous system not suited to this purpose.

Since 2007 the ministry has, as a matter of administrative practice, simply tacked the Representative's Office onto certain notifications that it issues as part of an internal ministry policy that was created in June 2004 for a different purpose, prior to the *Hughes Review* and the *RCYA*. It does not appear that this policy has been reviewed or revised since the *RCYA* was enacted.

That ministry policy is called "*Child and Family Service Standard 25 (CFS Standard 25)*", a copy of which is appended to this Special Report. The documentation of this *Standard 25* identifies the responsible program area as "Child and Family Development Service – Transformation Division." It is not clear if this program area still exists as part of MCFD organizational structure. However, it is the Representative's understanding that final responsibility for policy lies with the Deputy Minister's Office, and that the policy is expected to be consistently applied in the various MCFD regions and delegated entities.

The ministry's purpose in creating *CFS Standard 25* in June 2004 was to direct its line staff concerning when a "designated director" had to be notified of a "death, critical injury or serious incident." The stated purpose of those notifications is as follows:

> It provides opportunities to objectively review, receive feedback and learn from these incidents. It also provides opportunities for the designated director to support individuals, including staff, who are affected by these events.

*CFS Standard 25* is a ministry creation, using ministry-created definitions designed for the ministry's own internal purposes in assessing when its senior officials wish to be notified of events that happen on the ground. For that purpose, *CFS Standard 25* draws

a distinction – not found in the *RCYA* – between what it defines as a "critical injury" and a "serious incident":

> "critical injury": An injury that may result in a child's death or may cause serious or permanent impairment of the child's health, as determined by a medical practitioner.
>
> "serious incidents": circumstances involving a child who:
>
> (a) Is in life-threatening circumstances, including illness or serious accident.
> (b) Is lost, missing or continually running away to a situation that places him or her at high risk of death or injury.
> (c) Is missing for more than 10 days.
> (d) Is a victim of abuse or neglect by an approved caregiver, caregiver's staff or caregiver's child.
> (e) Is the victim of abuse or neglect by a care provider or care provider's family in an out of care placement.
> (f) Has been exposed to a high-risk situation or disaster which may cause emotional trauma.
> (g) Has been involved in crimes of violence or major property damage.
> (h) Has been abducted.

*CFS Standard 25* requires that all critical injuries be reported to a designated director if a child has received services within the past 12 months. On the other hand, a serious incident does not have to be reported unless one of the following conditions apply:

- The child is in care,
- The child is subject to an agreement with a child's kin or other person,
- The child is in the interim or temporary care of another person under the director's supervision, or
- The child is receiving respite services.

The common denominator of the first three of these conditions is that the serious incident has happened while the child is actually in the care of the ministry or in the care of a person under ministry supervision. If a "serious incident" happens outside actual ministry care or ministry supervised care, the policy does not apply and a serious incident does not have to be reported to ministry senior management. For example under this policy, an incident involving a child sexually abused by a parent or relative does not have to be reported to ministry management, even if the ministry had recently undertaken a child investigation of the home, and even if the family has been receiving ongoing ministry services such as respite services.

The respite care provision is problematic because it does not define if the child is in or out of care, or what the service status is. A common-sense reading would indicate that an injury of a child who is the subject of a respite care agreement should be reported. The Representative notes that the injury not reported to the RCY relating to the child with the deceased mother involved respite services.

Standard 25 works operationally through a series of templates the ministry has created for staff to use for reportable circumstances in several categories:

- Critical Injury;
- Fatality;
- Alleged Abuse or Neglect in an Out-of-Care Living Arrangement;
- Alleged Abuse or neglect of a Child-in-Care by an Approved Caregiver;
- Alleged to Have Committed a Crime of Violence or Major Property Damage;
- Life Threatening Medical Condition or Illness;
- Missing Child or Child in High Risk Situation.

Completed templates are transmitted by email.[6] The Representative is added to the distribution list in the case of a "critical injury" as the ministry defines it. The Representative is not added to the list in any other case. The serious gap this creates is obvious in practice as a range of matters falling within the purview of the Representative are not reported.

[6] The distribution list consists of a standardized list of Provincial Office Officials and a few officials in the region. The former includes: Assistant Deputy Minister of Quality Assurance; Senior Director, Practice, Advocacy and Integrated Quality Assurance; Manager, Quality Assurance Team; Practice Analyst, Integrated Quality Management; Manager, Practice Support and Issues Management; Analyst, Divisional Operations Branch; and Practice Analyst, Practice Support and Issues Management. Regional staff are also on the distribution list. For example, a recent report on a fatality from Fraser region was also sent to the following regional staff: Team Leader, Children and Youth with Special Needs; Community Services Manager, Community Services; and Community Services Manager, Community Manager's Office.

# 5 Non-compliance

The Representative notes that a reporting system dependent on a practice standard that pre-dated the Hughes Review and the *RCYA* is a system designed for a different purpose. Even within that system, the level of consistency of practice through uniform reporting practices in all regions of the ministry is not satisfactory. According to ministry audit reports, from January 1, 2007 to November 2010, only 38.1 per cent of all audited files were fully compliant with the standard – meaning that they met the standard required. Overall, 57.1 per cent of the audited files were non-compliant, while another 4.8 per cent were "partially" compliant.

If compliance with the Standard is this low, based on the ministry's own internal audit process, it cannot possibly function as an effective or failsafe vehicle for ensuring that the ministry complies with its legal duty to report all relevant critical injuries to the Representative. The use of *CFS Standard 25* as the reporting mechanism for critical injury and death incidents is seriously deficient and results in ongoing system failures to comply with s. 11(1) of the *RCYA*.

Even for those reports that are consistent with the expectations of *CFS Standard 25*, there are three fundamental problems when this mechanism is utilized as the primary tool for the ministry's duty to report to the Representative's Office under s. 11(1) of the *RCYA*:

**1. Serious Incidents**

*CFS Standard 25* describes several categories of "serious incidents" that the *RCYA* would clearly regard as being critical injuries in view of the analysis already set out above:

- A child facing life-threatening circumstances, including illness or serious accident.
- A child who has been abused or neglected while in the care of an approved caregiver or a family under ministry supervision.
- A child exposed to a high-risk situation or disaster that may cause emotional trauma.

As the ministry does not regard these as being critical injuries under the *RCYA*, there is grave concern that on an ongoing basis, the Representative has not been notified of entire categories of critical injury cases that ministry management knows about, but is not referring. Two concrete examples of the problems the serious incident definition has caused follow.

The Representative learned of criminal proceedings arising from a child suffering serious sexual assaults and incest at the hands of her abusive father. The Representative understands that if these incidents happened today, the ministry would not report them. The ministry's view appears to be that sexual assault, and even incest, is not a critical injury because it is only a "serious incident" in their internal classification system. Yet this particular long series of sexual assaults, physical assaults and incest resulted in serious physical and emotional harm to the child.

In a second troubling case, also brought to the attention of the Representative through the criminal justice process, a 17- year-old youth was taken to hospital in a severely disturbed state, having made suicidal gestures and written a suicide note. He was certified under the *Mental Health Act,* and kept in hospital. This youth was in care, and was in a foster home. He was left with a caregiver on several occasions who shared drugs with him, and engaged him in sexual activity and grooming for sexual activity.

This incident was not reported to the Representative because it was reported within the ministry as "Alleged Abuse or Neglect of a Child-in-Care by an Approved Caregiver." Initially, the ministry refused to even provide the name of this youth to the Representative. Recently, the reportable circumstance report has been provided, after much argument and persuasion that the matter should have been reported to the Representative. Because this incident occurred within the context of an approved caregiver, it is by default not a "critical injury" in the ministry's system, and therefore would not have been reported to the Representative in absence of the Representative's demands.

These cases are not isolated incidents and there may well be others of equal note and concern. They reflect an institutional policy that excludes the Representative's Office from being notified of entire classes of cases.

It is well known that sexual assault and incest may carry significant and permanent psychological impacts. While the Representative appreciates that there are times when some incidents require a measure of judgment as to their objective seriousness, she would expect those to be discussed with her Office and a protocol developed around their definitions. The Representative cannot accept that the ministry can simply decline to report any physical or sexual abuse incidents under the *RCYA* based on an internal policy it developed for a different purpose before the *RCYA* was ever enacted.

## 2. Incidents Outside Ministry Care

*CFS Standard 25* does not require "serious incidents" to be reported to MCFD management unless the incident happens while the child is in the ministry's placement or that of an approved family. Obviously, if a policy is structured so that ministry management is not even told about an incident, chances are slim to none that the Representative will ever be notified by the ministry under s. 11(1) of the *RCYA*.

As noted above, the *RCYA* imposes a much broader duty to report than does *CFS Standard 25*. Section 11(1) of the *RCYA* requires the ministry to report to the Representative any critical injury where the child was receiving any reviewable service within the preceding year. Unlike *CFS Standard 25*, the child does not have to be under ministry care or supervision when the incident happens.

The rationale for the broader *RCYA* provision is obvious. Review and investigation are sometimes necessary precisely because the ministry has not intervened with the family. One of the very purposes of the Representative's function is to assess whether child protection investigations have gone wrong. It is little comfort to the public to be told that a child was not harmed while in ministry care if the very problem was the child was not taken into ministry care in the first place, or was not offered appropriate supports or supervision.

As previously noted, the problems this has caused recently came to the fore when the Representative was advised through the media and via family members that a vulnerable child was left for several days with her deceased mother. There had been child protection intakes in the 12 months previous to the incident, one of which resulted in a child protection investigation. The family had been receiving and was currently eligible for ministry respite services at the time of the mother's death.

The ministry took the view that *CFS Standard 25* did not technically require ministry management to be notified in this case.[7] The stated rationale was that child protection investigations are not relevant for the purposes of the policy, even though the quality of such investigations may be highly relevant for quality assurance purposes and for learning about ways to improve practice and prevent similar circumstances. Even when a family is entitled to respite services, as was the case with the child with the deceased mother, the ministry considers that a child is not "receiving respite services" under its policy unless the child is actually in the respite service placement when the incident

[7] Ministry management learned of this case only because of a standing direction given to staff by the designated director, which went beyond the policy. However, that did not change the ministry's view that the Policy did not apply, and that the Representative's office was not required to be notified.

happens. This interpretation is too narrow and cannot be adopted as a policy approach grounding reporting of injuries or deaths to the Representative's Office.

The ministry's explanation regarding why *CFS Standard 25* does not apply in the case of the child left with the deceased mother is based on a very narrow view, and fails to meet the test of notification in s. 11(1) of the *RCYA*. The explanation provided is not satisfactory.

**3. Critical Injury Policy too Narrow**

Even where the ministry accepts, under its own narrow interpretation, that there is a "critical injury" under *CFS Standard 25*, the policy is too narrow. *CFS Standard 25* only requires MCFD management to be notified where the child has been receiving ministry services over the past year. By contrast, s. 11(1) of the *RCYA* requires that the Representative be notified when the child or the child's family was receiving a reviewable service within that period. The *RCYA* definition reflects the Legislature's intention to ensure that there is the broadest capture possible of the ministry's involvement with a family, in order to enable the Representative to properly undertake her review and investigation function.

Finally, the ministry definition states that a critical injury can only be present "*as determined by a medical practitioner.*" This qualification was not included in the *RCYA* for the reasons outlined above.

# 6 Recommendation

It is well established that all public bodies, and especially government ministries, have a serious and solemn obligation to comply with their legal duties in good faith. The failure to comply with those obligations is a very serious matter. Where, as here, those legal duties pertain to children, the matter is even more serious as children cannot independently seek redress and may experience poor outcomes without scrutiny of services provided. Where there is failure to fully and adequately notify an independent officer of an injury, that independent officer's ability to undertake her mandate may be placed in jeopardy.

The following recommendation is made to address the concerns outlined in this Special Report and to bring the notification process into alignment with the legislation and function of the Representative's Office.

## Recommendation

That MCFD develop and implement a Critical Injury and Death Notification Policy that complies with s. 11(1) of the *RCYA* as discussed in this Report.

## Detail:

- The policy should be developed in consultation with the Representative.
- "Critical injury" should be defined so as to include at least those life-threatening circumstances, abuse or neglect and high risk situations or disasters presently described as serious incidents in *CFS Standard 25*.
- The policy must make it clear that a critical injury does not require a medical assessment before notification is given to the Representative.
- The policy must indicate that the reporting obligation applies if the child or family was receiving a reviewable service within the past 12 months – that it does not matter whether the child was or was not in a ministry or ministry-supervised placement when the incident took place.

- The policy should state expressly that where there is an ambiguity regarding whether notification should be given to the Representative, that notification be made and the independent oversight body can apply the test required in the *RCYA* to make a final determination, and permit the Representative to hear from the ministry should they take a contrary view after the matter has been duly reported.
- The policy draft should be forwarded to the Representative for comment by January 7, 2011.
- The policy should be finalized, be clearly communicated to staff in all MCFD offices, delegated Aboriginal Agencies, and service provider partners or public bodies, and be fully implemented by March 1, 2011.

# 7 Conclusion

Public confidence in the child-serving system depends on accountability and transparency. The public also needs to see that ongoing learning, such as that achieved through reviews of cases, is carried out in order to ensure that improvements are made in services to children and their families after tragedies occur. The recent incident of the special needs child with the deceased mother is a critical injury that should have been reported to the Representative's Office.

The Representative will release a public report on this case once the investigation underway is completed. However, improving the system for reporting injuries and deaths to the Representative's Office requires immediate policy change.

The recommendation to make an immediate and simple improvement is designed to address public confidence in the accountability and transparency of the system of oversight, and the Representative calls upon government to immediately undertake the recommended change.

REPRESENTATIVE FOR
CHILDREN AND YOUTH

| CFS STANDARD 25: NOTIFICATION OF DEATH, CRITICAL INJURIES AND SERIOUS INCIDENTS | |
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| **STANDARD STATEMENT** | Immediately inform the designated director when:<br>• there is a death or critical injury of, or serious incident involving, any of the following:<br>– a child in care<br>– a child who is the subject of an agreement with a child's kin or other person,<br>– a child placed in the interim or temporary custody of another person under the director's supervision, or<br>– a child receiving respite services<br>• there is a death or critical injury of a child who has received services within the past 12 months.<br><br>Inform the child's family members and take action to support the family and extended family as appropriate to the circumstances and as soon as possible.<br><br>If the child is Aboriginal, immediately inform the child's Aboriginal community or identified delegated agency.<br><br>The designated director undertakes an initial review to determine what actions to take, including:<br>• undertaking a more extensive review, coordinated with other agencies that are required to investigate or review<br>• involving the Aboriginal community in the review if the child is Aboriginal, and<br>• ensuring that those involved receive feedback and the opportunity to discuss the findings. |
| **INTENT** | This standard requires that the designated director be fully informed of the death of or critical injury involving a child who receives services under the CFCSA, or of a serious incident involving a child in care, a child placed in the interim or temporary custody of another person under the director's supervision or a child receiving respite services. It provides opportunities to objectively review, receive feedback and learn from these incidents. It also provides opportunities for the designated director to support individuals, including staff, who are affected by these events. |
| **REFERENCES** | |
| **POLICY** | **Informing and supporting the family and extended family**<br>When there has been a death or critical injury of, or serious incident involving, a child in care, a child who is the subject of an agreement with a child's kin and others, a child placed in the interim or temporary custody of another person under the director's supervision, or a child receiving respite services, as soon as possible:<br>• inform the child's family, extended family, community, and delegated agencies, and |

- take action to support the family and extended family as appropriate to the circumstances as soon as possible.

Support options may include:

- referral to available community supports (see Child and Family Service Standard 7: Support Services to Strengthen Capacity)
- working with the child's family and community to assist in planning and coordinating a response that will help them cope with the situation and prevent further incidents from occurring
- financial or in-kind assistance for travel costs associated with medical treatment within available resources, and
- in the case of the death of a child in care, and within available resources, financial assistance for the family to attend the funeral.

**Notifying the designated director of the death, critical injury or serious incident**

Immediately notify the designated director of:

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

**Submitting an initial report of death, critical injury or serious incident**

Submit an initial report to the designated director within 24 hours of learning of a death, critical injury or serious incident.

**Designated director's initial response**

Within two working days, the designated director reviews the report and indicates whether:

- an additional written report is required, and
- specific information should be included.

**Submitting an additional report about a death, critical injury or serious incident**

Within 10 working days of being informed that an additional written report is required, prepare the report and submit it to the designated director.

Prepare the additional report in coordination with others who have or may have a role in providing information about the circumstances, including:

- the child's family, extended family and community
- agencies or individuals that are or were directly involved in providing the child with services

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| | • agencies that have a responsibility for investigating the incident, and<br>• if the child is Aboriginal, the child's Aboriginal community.<br><br>Prepare the additional report in coordination with any other agencies, including the police, coroner or school, that are involved in investigating the incident.<br><br>Ensure that the child's family, extended family, and agencies or individuals that were directly involved in the incident or in providing services have the opportunity to discuss the content of the additional report.<br><br>**Designated director's response to a required additional report**<br>Within five working days of receiving a required additional written report, or at any time after receiving the initial report, the designated director will indicate whether a further review is required, the nature of the review, and whether a referral will be made to an external review body.<br><br>**Involving the Public Guardian and Trustee**<br>Where there has been a death or critical injury of a child in care or a serious incident that may affect the immediate safety or health of a child in care, consult with the Public Guardian and Trustee about the role they may play in protecting the child's financial or legal interests. (See Children in Care Service Standard 7: Involving the Public Guardian and Trustee). |
| **ADMINISTRATIVE PROCEDURES** | **Initial written report of death, critical injury or serious incident**<br>Complete the initial written report of the death, critical injury or serious incident using the "Initial reportable circumstance" template in Word. (To access the template, select "Ministry template," then select "CFCS other templates," and "Initial Reportable Circumstance."<br><br>**Additional written report of death, critical injury or serious incident**<br>There is no required prescribed template for required additional written reports. |
| **ADDITIONAL INFORMATION** | |
| **KEY DEFINITIONS** | **care provider:** a person who cares for a child under one of the out-of-care living arrangements available under the CFCSA, including sections 8, 35(2)(d) and 41(1)(b)<br><br>**caregiver:** a person with whom a child is placed by a director and who, by agreement with the director, has assumed responsibility for the child's day-to-day care.<br><br>**critical injury:** An injury that may result in the child's death or may cause serious or permanent impairment of the child's health, as determined by a medical practitioner.<br><br>**serious incidents:** circumstances involving a child who:<br>• is in life-threatening circumstances, including illness or serious accident<br>• is lost, missing or continually running away to a situation that places him or her at high risk of death or injury |

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| | • is missing for more than 10 days<br>• is a victim of abuse or neglect by an approved caregiver, caregiver's staff or caregiver's child<br>• is the victim of abuse or neglect by a care provider or care provider's family in an out of care placement<br>• has been exposed to a high-risk situation or disaster which may cause emotional trauma<br>• has been involved in crimes of violence or major property damage, or<br>• has been abducted |

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