IN THE MATTER OF: Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair

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AFFIDAVIT OF BRUCE RIVERS
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IN THE MATTER OF: Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair

AFFIDAVIT OF BRUCE RIVERS

I, BRUCE RIVERS, of the City of Toronto, in the Province of Ontario,

MAKE OATH AND SAY AS FOLLOWS:

1. I was employed as the Executive Director of the Children's Aid Society of Toronto (the "Toronto CAS" or "the Society") from 1988 to 2004. Prior to, during and subsequent to my time at the Toronto CAS, I have been involved in the child welfare system in Ontario and elsewhere in various capacities. Attached hereto and marked as **Exhibit "A"** is a copy of my Curriculum Vitae, which details this involvement.

2. As such, I have personal knowledge of the facts and matters set out herein, except where I indicate that such facts and matters are based on information and belief, in which case I believe them to be true.

3. In the mid to late 1990's the child welfare system in Ontario underwent tremendous public scrutiny. Approximately six to eight coroner's inquests were conducted during that period. The Toronto CAS was directly involved in three of these inquests.

4. The first coroner's inquest that the Toronto CAS had involvement in was the inquest into the death of Shanay Johnson. Shanay died at the age of 22 months at the hands of her mother. The family had an open protection file with the Toronto CAS at the time of the death, with an active family service worker involved. Shanay was in the care of Toronto CAS but was returned to her mother four months before she died.

5. The Shanay Johnson inquest took place in 1997 and resulted in 107 recommendations. I was present every day and testified at the inquest in my capacity

as the Executive Director of the Society. I was also working closely with legal counsel in preparing the testimony of the family services worker who had primary conduct of the case. Prior to the commencement of the inquest, due to the pressures of being publicly ostracized, the worker in question went AWOL and could not be tracked down by police. He did not appear at the inquest. He was tracked down after the inquest was over and has completely left the child welfare field since that time.

6. The second inquest that the Toronto CAS was involved in during my time as the Executive Director was the coroner's inquest into the death of Jennifer England. Jennifer was a child who was murdered by her mentally ill father at the age of six. She was in the care of Toronto CAS but was returned to her father. The inquest took place in 1998. Multiple staff members from the Toronto CAS were called to testify. I was present at every day of the inquest and also testified. The inquest resulted in 126 recommendations dealing primarily with issues of risk assessment as well as the impact of mental health issues on risk and assessment.

7. The third inquest that the Toronto CAS was involved in during my time as the Executive Director was the 2001 coroner's inquest into the death of William Edgar. William was 13 years old when he died in 1999 of asphyxiation as a result of the misuse of physical restraints during a behavioural issue in the group home he was living in. Although William resided in a group home outside of Toronto, the Toronto CAS was ultimately responsible for his care at the time of his death. I attended each day and testified at this inquest as well. The inquest resulted in 61 recommendations, primarily related to the use of physical restraints.

8. In addition to the three inquests aforementioned, there were about three to five other inquests into deaths of children in care that occurred in Ontario in the mid to late 1990's. In total, over 400 recommendations emanated from those inquests.

9. Furthermore, in April of 1996, the Office of the Coroner for the Province of Ontario and the Ontario Association of Children's Aid Societies, with support from the Ministry of Community and Social Services established the Ontario Child Mortality Task

Force, which I was chosen to sit on. The Task Force was created to undertake a review of the children who had died while receiving child welfare services during the two year period from January 1, 1994 to December 31, 1995.

10. In response to these inquests and the Child Mortality Task Force's report, major reform occurred in the Ontario child welfare system beginning in 1998. Amendments to the *Child and Family Services Act of 1985* were passed. A broad summary of the major changes to the *Act* is as follows:

a) the purpose of the legislation was changed to stipulate paramountcy of the interests and protection of the child. Previously, child safety was considered with the importance of the family and the preference for the least restrictive alternative in mind;

b) the *Act* became more child centered, rather than family focused, in terms of the predominance of safety rather than the interests of the parents. Greater priority was given to permanency planning for the child;

c) the definition of a child in need of protection underwent substantial change, with the lowering of the tolerance for risk. Neglect and emotional abuse were included, and the term "substantial risk" was replaced with simple "risk";

d) it was made clear that the onus on reporting was on everyone in the community, not just professionals who come into contact with the child. The requirement to report was also broadened to "suspicion of abuse".

11. A further significant aspect of the implemented changes was the development of a structured and standardized approach to case decision making through the introduction of the Ontario Risk Assessment Model.

12. While all of this work resulted in a number of positive changes to the child welfare system and addressed certain deficiencies, there were a number of unintended consequences that had a detrimental impact on the Toronto CAS and the child welfare system as a whole. The focus was almost entirely on the front end, investigative function of the system, with little consideration given to the impact that some of these changes would have in the long term.

13. My observations were that child welfare policy changes at that time were being driven by the deaths of a relatively small number of children in care. The policy changes were not research or evidence based but rather grounded in the recommendations that came out of the individual examinations of the circumstances surrounding these deaths. This resulted in an over reliance on risk and safety assessment methods that excluded information that would have helped to inform the overall assessment as to whether a child was in need of protection as well as the consequent steps that might be taken to ensure their safety. This public scrutiny and the resultant changes put the child welfare system out of balance and led to some negative consequences, which I have detailed below.

14. This increased public attention resulted in a significant increase in the number of direct reports of children in need of protection received by the Toronto CAS. It goes without saying this was in many ways a good thing. The increased awareness led to more children in need of protection receiving services.

15. However, I observed that it also resulted in a reactive response from the public, and as a consequence, a greater number of referrals came in that were based upon suspicion. This in turn created a great degree of pressure on the system to respond to this spike in referrals, with an increase in lengthy and detailed forensic investigations, some of which were based on unfounded information.

16. These changes along with child protection worker's growing aversion to taking risks and erring on the side of safety also resulted in a dramatic spike in the number of children admitted to care. Although I no longer have the data respecting children in

care at my disposal, I do recall that there was an increase from 10,000 children in care in the early 1990's to approximately 19,000 in 2004.

17. As a result of the increased number of children in care, as well as the stigma and perceived risk, a resulting shortfall in foster parents and caregivers was observed during that time as well.

18. The inquests and resulting policy changes also took their toll on the staff of the Toronto CAS. Beginning with the family services worker in the Shanay Johnson case that went AWOL, I began to see a pattern of staff who were involved in these inquests either leave the child welfare field altogether, move out of the province, or move into positions where they perceived there to be less risk.

19. It became more and more difficult to retain child welfare staff throughout the province. At the Toronto CAS, I observed that this was a particular problem at the intake/investigative team level. This department had the highest level of turnover after the inquests. The staff was under tremendous pressure in terms of their workload and the need to respond to all referrals and to respond quickly. The public scrutiny created huge pressure at the intake/investigative level and it became a constant struggle to retain qualified people to work in this department.

20. The inquests also took their toll on staff members who were not directly involved in the inquests, but observed what their colleagues went through. Staff members throughout the Society were clearly impacted by observing what their colleagues were going through. This sent a chill throughout the Society. I also observed that this caused social work staff to err on the side of caution and take no risks whatsoever when it came to the assessment of whether a child was in need of protection. This contributed to the aforementioned spike in the number of children coming into care.

21. The changes had the effect of placing extensive pressures on the family services workers to investigate, record, and report every aspect of the work they were doing. This had the unanticipated result of creating higher workloads, which now involved much more paperwork. As a consequence, direct services to families and children

suffered as workers struggled to keep up with the paperwork and their actual time spent with families and children decreased.

22. Along with the increase of children coming into care there was also a huge influx of child protection court cases and a corresponding backlog of same. This led to workers spending more and more of their time and energy in preparation of court cases rather than on working and spending time with the families they were servicing. More time was spent building a case against parents, rather than investigating and working on conciliatory solutions to problems. At the time, I recall that 70 to 80% of a child protection worker's time was spent documenting and with court related matters as opposed to providing face to face client service and support

23. I also observed that after the inquests it became more challenging for the Toronto CAS to engage and retain volunteers. Volunteers were a major part of child welfare in Ontario, and provided crucial assistance to the Society. Individual volunteers were engaged as tutors, special friends, big brothers, and big sisters and worked side by side with family services workers to assist in providing services to families. In and around the time the inquests were taking place there were approximately 1000 volunteers engaged with the Toronto CAS. As a result of the stigma and perceived risk that came with being involved in child welfare emanating from the public scrutiny, it became increasingly difficult to engage the requisite amount of volunteers.

24. During my time with the Toronto CAS we also did a considerable amount of private fundraising. We had a charitable foundation called the Children's Aid Foundation, which raised money for use in providing prevention services to families. I recall that as a result of the public backlash and criticism that took place during the inquests, we had a number of corporate donors who became apprehensive about having their names affiliated with the Toronto CAS. I recall having to do a huge amount of work with the Foundation and its donors to minimize the loss of donations.

25. Beginning in 2002, I was employed as an Adjunct Senior Lecturer at the Factor-Inwentash Faculty of Social Work at the University of Toronto. During this time, I

observed through my communication with Master's students within the Faculty that there was a hesitance on the part of these students to do their internship at a children's aid society and/or to consider child welfare as a viable option for their career. This was as a result of the increased public scrutiny of the child welfare system, which made them increasingly cautious about committing to being involved in child welfare.

26. Thus, as a result of the public attention and scrutiny accompanied by these inquests, and the consequential policy shifts, a number of unintended consequences were suffered by the Toronto CAS and the child welfare system as a whole. These consequences were detrimental, and although many positive changes were made, ultimately the child welfare system was put out of balance and many of the consequences were not in the best interests of the children of Ontario.

27. This imbalance was recognized by the government. Around 2003, the province embarked on a plan aimed at correcting the system imbalance. A system wide Child Welfare Program Evaluation was launched in order to address the issues. In 2004, the Child Welfare Secretariat was formed to oversee and evaluate key aspects the Child Welfare Program Evaluation. I was seconded to the Child Welfare Secretariat to become its Executive Director and worked in that capacity from 2004 until 2006.

28. These initiatives resulted in expanded intervention options within the system, which consisted of a more flexible intake and risk assessment model, a court process strategy to reduce delays and encourage alternatives to court, and a broader range of placement options to support more effective permanency planning. These initiatives all had the goal of correcting the imbalance in the system that was created as a result of the public outcry that followed these highly publicized inquests.

29. I also observed, albeit from a distance, a similar experience to what the Ontario child welfare system went through taking place in other provinces. Perhaps the most notable similar situation is what occurred in British Columbia following the Gove Inquiry. The Gove Inquiry followed the death of five year old Matthew Vaudreil. Justice Thomas Gove released his findings and recommendations in 1995. There was a marked shift in child welfare in the province following the release of the report, largely based on the

report's recommendations. Legislative amendments were put into place which diverted the focus of the legislation from a family support approach to a protection and investigative approach. Policies were implemented which required social workers to conduct child centered interventions based on rigorous investigative and monitoring procedures.

30. The Gove Inquiry led to a spike in the number of children apprehended in BC both during and after the Gove Inquiry. This was due to the fact that the Gove Inquiry resulted in a shift in the child protection practice in B.C towards removing children from their homes at least in part due to the fact that social workers were feeling attacked by the adverse publicity surrounding the Gove Inquiry. Attached hereto and marked as **Exhibit "B"** is an excerpt from the 2006 'Independent Review of B.C's Child Protection System' conducted by the Honourable Ted Hughes OC, QC, LL.D. (Hon.) which evidences as much. These results are very similar, if not identical, to what I observed and experienced in Ontario following similar inquests.

31. I had the opportunity to meet and speak with Justice Gove after his report was released at a Child Welfare League of Canada conference in Ottawa. I discussed with him some of the similarities between what happened in British Columbia following the release of his report and what occurred in Ontario following the inquests. Justice Gove informed me that he agreed with my impression that the impact of the pubic inquiries in Ontario and British Columbia were similar.

32. I also observed similar experiences take place in New Brunswick and Alberta. I was engaged in 2008 by the Ministry of Children and Youth Services for the Province of Alberta to chair two Special Case Reviews for child related deaths and provide recommendations. I observed a discernable pattern of such reactions in the wake of increased public attention to child welfare issues as a result of public inquests and inquiries.

33. I make this affidavit in good faith.

SWORN/AFFIRMED before me in the City of Toronto, in the Province of Ontario, on the 30th day of March, 2012

A Commissioner for taking Affidavits in and for the Province of Ontario

"P. Voula Kotoulas"

LSUC No. 54797T

BRUCE RIVERS