This is Exhibit " B " referred to in the affidavit of Cheryl Regehr sworn before me this 30th day of March 2012

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Inquiries into Deaths of Children in Care: The Impact on Child Welfare Workers and their Organization

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In recent years public inquiries into the murders of children have served to dramatically shift child welfare services throughout North America and Great Britain. The present study is a qualitative analysis of the impact of these death reviews and the subsequent changes to child welfare services on child welfare workers. The themes that emerged occurred at three primary levels, distress experienced by individual workers, radiated distress throughout the agency and weakened public and community support. Factors contributing to distress by individual workers included re-exposure to traumatic material, the all-consuming nature of inquiries and the critical nature of inquiries. Radiated distress occurred as a result of empathy for colleagues undergoing an inquiry and changes emanating from the inquiry which constricted practice and increased the policing function of child welfare. Finally negative media and public attention contributed to concerns that all members of child welfare organizations were under scrutiny and had become tainted. While accountability and continuous improvement of services are worthy goals, we must continue to search for accountability processes that do not have such a devastating impact on child welfare workers and their organizations.

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In April 1996, the Child Mortality Task Force was established in Ontario Canada to undertake a review of the children who died while receiving child welfare services during 1994 and 1995. This task force was formed in response to five coroner's inquests which were conducted to examine the deaths of children who were known to children's aid societies (Buck, 1998). The more than 400 recommendations emanating from the inquests and sixteen resulting from the Child Mortality Task Force, resulted in the Child Welfare Reform Agenda, which was initiated by the provincial government. This agenda included among other things, a review of child welfare legislation, introduction of a standardized Risk Assessment System and a review of the government's accountability system for CAS's (OACAS, 1998). In the end, we have witnessed an overhaul of child welfare in Ontario that has had profound implications for the child welfare system, the delivery of services and for workers themselves. The impact on children and families is as yet undetermined.

This process has by no means been unique to Ontario. In Canada, similar processes have occurred in other provinces. Stung by suggestions that child protection officials failed to save a little girl from neglectful parents, the New Brunswick government, in 1997, created an independent committee to review deaths in the child protection system (Morris, 1997). Specific expressed concerns were that social workers had become too family oriented and tried at all costs to keep the family together rather than put the needs of children first. The committee therefore, reviewed the manner and cause of death, the appropriate use of policies and procedures and the social workers' use of community linkages. These inquiries in Ontario and New Brunswick followed the earlier example of British Columbia, which subsequent to a process of death inquiries produced the Gove Report on child welfare reform (Brunet, 1998). Reports of similar inquiries and processes of child welfare reform emanate from England (Hill, 1990; Munroe, 1996; Sanders, Colton & Roberts, 1999) and the United States (Gellert, Maxwell & Durfee, 1995; Hutchison, 1993).

Among other issues, these inquiries have served to highlight inherent conflicts in the roles of child protection workers. That is, the conflicting pressures of attending to both the best interest of the child and concerns for the parents in the face of shifting public policies (Guterman & Jayaratne, 1994). Child welfare workers are charged with balancing society's wish to protect children from abuse while maintaining the family as the bastion of liberty (Munroe, 1996). Increasingly, child welfare workers are being held

accountable for failing to manage these competing demands. While mandatory reporting laws increased at a dramatic rate (Hutchinson, 1993; Lindsey & Regehr, 1993), criminal and civil courts have found child welfare workers liable for breaching family members' rights to remain together and conversely for failing to protect children at risk (Alexander, 1995; Alexander & Alexander, 1995; Reamer, 1995). In either case, social workers are blamed. Following the criminal indictment of a child protection worker in Illinois, a state attorney proclaimed that this would "send a message to all social workers that the state attorney's office will be reviewing their work to protect all the children of this country." (Alexander & Alexander, 1995, p.813, original in Chicago Tribune) Conversely, lawyers in British Columbia have charged that social workers post-inquiry, use an apprehend first and ask questions later strategy. "Social workers' intrusiveness constitutes an unlawful invasion of privacy." (Brunet, 1998, p16) These critiques are not new however. Brunet (1998) quotes a 1967 report of BC Human Resources Minister, Grace McCarthy as saying "[Social workers] are not articulate when it comes to clear-cut solutions to an individual problem. …[They] surround themselves in a great deal of mysticism either to confuse their superiors (and the tax payer) or to justify their existence." (p.17)

Inquiries have become prominent and powerful institutions. They are a socio-political phenomenon which has wide ranging effects on public policy and service delivery (Hill, 1990). In part, inquiries help society deal with moral panic. The public attention becomes focused on a phenomenon of child deaths, which is not necessarily driven by an increase in incidence, but instead a surge in attention. Inquiries are a means for government to demonstrate concern for an issue and to appease the public (Hill, 1990). Inquiries themselves have taken on a tone of moral righteousness. The motto of the Chief Coroner's Office for Ontario for instance reads "We speak for the dead." Broad statements recommending sweeping changes on the basis of dramatic cases can therefore not be questioned in this climate of might and right.

Prompted by scathing reviews, the past two decades have seen a shift in child protection work from treating families to surveillance, investigation and collection of assessment evidence. As a result of recommendations for reform, child protection services have become more tightly structured and regulated (Davies, McKinnon, Rains & Mastronardi, 1991). This places child protection workers in a further conflict between protecting children and helping them to maintain or restore their mental health, vs.

collecting data required for permanent placement of the child or criminal prosecution of the parent (Mason, 1991). Further, critics charge that despite the flood of inquiries, the understanding why children are killed has scarcely moved forward and the occurrence of child death has not been reduced (Sanders, Colton & Roberts, 1999). The causes of child death are likely to lie in factors unrelated to variations in practice or standards of practice (Sanders, Colton & Roberts, 1999). The focus on such courses of action diverts attention from societal causation and societal solutions (Hill, 1990).

While improved services to children and families is undeniably a worthy goal, the tone of these inquiries and their outcomes have not come without cost to the workers. Authors have cited a two-year turnover rate of 46 percent to 90 percent in child welfare practice (Drake & Yadama, 1996). Brunet (1998) reported that 250 of the 300 workers hired in British Columbia after the Gove report had quit because of case overload. "In fact faced with burnout caused by heavy workloads and lofty expectations, the ministry simply cannot get enough social workers to keep the front lines sufficiently manned." (Brunet, 1998, p.14). The alarming loss of staff in this demanding and highly specialized area of practice threatens the safety of children.

In addition to the stresses caused by increased and shifting demands, the process of inquiry itself is stressful. Gambbir (1999) reports a study of 73 physicians facing complaints before their professional licensing body immediately after resolution of the case. She found that even after the complaint was resolved, only 25 percent of respondents felt that their stress was eliminated, 45 % felt it was reduced, 19% felt it was unchanged and 8% reported an increase in stress. Anecdotal literature on child protection workers suggests that death inquiries have a devastating impact on morale. Staff become depressed and anxious, work becomes defensive and routinized, resignations are common and recruitment of new staff is difficult (Hill, 1990; Brunet, 1998).

Yet, despite the fact that death inquiries and child welfare reform have far reaching implications, no studies have focused on the impact of child death reviews on child welfare workers. The study reported in this paper is part of a larger, multimethod study aimed at understanding stress and trauma in child welfare workers. The purpose of this qualitative component of the study is to investigate the impact of the death of a child in the care of the CAS and the impact of subsequent inquests, internal investigations and public inquiries on workers in a child welfare agency.

Methodology

This research was conducted at the Children's Aid Society of Toronto, which is one of the largest board operated child welfare organizations in North America. The broader goal of the research was to understand stress and trauma in child welfare workers, one component of which was exposure to post-mortem reviews in the form of internal reviews, coroner's inquests and civil litigation. This particular agency had been subject to two coroner's inquests into the deaths of children. Data collection involved both qualitative and quantitative methods. The quantitative survey was distributed to all staff following meetings describing the nature of the study. A total of 175 questionnaires were returned from front line, clerical and management staff. While actual numbers of staff employed by the agency over the 3 months of data collection vary, this number represents an approximate 33% response rate.

Table 1
Overview of total sample of participants

(N=175)	Number	Percentage
Involvement in internal inquiry into child death	38	22%
Involved in cases examined by inquest	30	17%
Testified in inquest	9	5%
Involved in case leading to civil litigation	5	3%
Subject of civil litigation	2	1%
Actions were questioned in death review	32	18.5%
Actions were criticized in death review	15	8.5%
Co-workers actions questioned	43	25%
Co-workers actions criticized	27	15.5%
Media stories related to review they were involved in	50	29%
Extensive media stories related to the review	23	13%
Media stories related to self	11	6%
Extensive media stories related to self	2	1%

Of the total sample, 38 individuals or 22% indicated that they had been involved in a formal review of a child death. All of these respondents had been involved in internal reviews of a death. In addition, 30 individuals (17%) were involved with cases that were reviewed by a coroner's inquest

and 9 (5%) had been directly involved in the inquest. Five individuals (3%) reported involvement in cases that resulted in civil litigation and two individuals (1%) reported being the defendant in a civil litigation case. Sixty percent of the respondents indicated that they had colleagues who had been involved in formal reviews of child deaths. Thirty-two people (18.5%) indicated that their actions had been questioned during the review and 15 of these (8.5%) had their actions criticized. Forty-three people (25%) stated that the actions of their co-workers had been questioned and 27 of these (15.5%) were criticized. Finally 50 people (29%) indicated that there had been media coverage of an event in which they had been involved and 23 (13%) characterized this coverage as "extensive". Twenty people (11.5%) indicated that there had been coverage of the postmortem review and 12 (7%) felt this exposure was extensive. Eleven people (6%) had media stories relating directly to them, two of whom (1%) felt the coverage was extensive. This gives an indication of the direct exposure that workers within the agency had to death inquiries. It does not however address those secondarily affected through team discussions and media exposure.

All participants in the quantitative component of the study were asked if they would be willing to participate in an interview in order to more fully explore their experiences. Of those participants giving consent to be interviewed, 20 workers were selected. Due to concerns regarding confidentiality of data, names were immediately removed from the quantitative research instruments and thus the interview subsample was randomly selected from those agreeing to participate. Ten of those interviewed indicated that they had appeared in or been directly exposed to coroner's inquests. The remaining participants described the impact of the review on themselves and other workers in the agency. The sample size of 10 individuals directly exposed to coroner's inquests and 10 indirectly affected is consistent with recommendations for the long-interview method of data collection (McCracken, 1988). Interviews followed a semi-structured interview guide which included questions about critical events encountered on the job, exposure to death inquires, effects of critical events and inquires, and personal and organizational supports. Interviews were conducted by one of the researchers at a location selected by the participants, generally in their office and lasted 1-3 hours. The sessions were audio taped to ensure accuracy of data. Finally, consultation group meetings were held with members of three constituencies, management, front line

workers and union executive during which the initial data was presented and reactions were obtained.

Interview data was transcribed and analyzed for themes with the aid of a computer program (Nvivo). In the initial stage, open coding allowed for the development of broad categories, afterwhich selective coding allowed the researchers to attempt to develop a meaningful narrative of the experience of the workers. Other sources of data included the notes recording the interviewer's impressions and the notes from the consultation group meetings.

Lincoln (1995) and Erlandson and colleagues (1993) identify four primary criteria for judging the reliability of qualitative research, credibility, transferability, dependability and confirmability. In this study, credibility was established through triangulation of quantitative, interview and consultation group data. The consultation group process provided an opportunity to confirm and expand upon the trends developed in the analysis of the interview data, thereby enhancing transferability and confirmability (Creswell, 1998; Erlandson, Harris, Skipper, & Allen, 1993). Dependability or reliability was enhanced through the process of having one research team member conduct the interviews and record impressions, and then a second listen to the tapes for impressions prior to transcribing. Further the researchers worked collaboratively during the processes of open coding, axial coding and selective coding. Final results were then presented to large staff groups for discussion.

Results

A Child Dies

In the quantitative component of this study it was identified that the death of a child is the most emotionally distressing critical event encountered by child welfare workers, ranking above being physically assaulted and threatened (authors, in press). This is consistent with similar studies of police, fire and ambulance workers (Regehr, Hill & Glancy, 2000). However, unlike workers in those fields, child welfare workers often have ongoing relationships with both the victim and the perpetrator. Following the death, it was reported by some participants that they assisted the family in making funeral arrangements and dealing with the possessions of the deceased child. As a result, participants reported difficulties with sleeping, nightmares, depression and preoccupation with the event.

> I would try and push it out of my head and go to sleep, but somehow it crept into this dream in a very fitful waking up. …At about 3 or 4 o'clock in the morning, when your guard is down. That's when it hits you.

Taking Children into Care

While having a child die is extremely distressing, apprehending a child at risk is almost equally so. Participants described the experience of being threatened and assaulted during apprehensions. They described witnessing the emotional distress of both parents and children. Further, they described a sense of betrayal they felt when apprehending children.

> You build a relationship, the person starts to open up and they admit certain things about themselves and certain weaknesses. Then you use them in your affidavit.

Decisions to apprehend children are not easy. They are often made with insufficient information under the pressure of knowing that both failure to apprehend and unnecessary apprehensions involve significant risks to children (Steinhauer & Wilkes, 1996). Further, the legal liability associated with both apprehension and failing to protect adds an additional level of pressure (Alexander, 1993; Alexander & Alexander, 1995; Reamer, 1995).

The Impact of the Inquiry on Individual Workers

Respondents referred to inquiries following the death of a child as "horrendously stressful" events. This related to a number of factors including the experience of scrutiny and the all-consuming nature of inquiries. The first important element of individual experiences with inquiries is highly related to the previous section on the impact of a child dying. That is, workers involved in inquiries are re-exposed to the details of the tragedy. People identified difficulty with having to "relive this kind of work on the stand". "I questioned the reasons for showing us those photographs [of the autopsy]." One worker described the experience of the inquiry as having the scabs torn off the wound which resulted from watching a child die. This is consistent with literature on traumatic events in that emotional symptoms are re-experienced as a result of exposure to reminders of the

event (van der Kolk, McFarlane & Weisaeth, 1996). This exposure to traumatic material impacted workers in many ways.

> It has a tremendous impact on you emotionally. It took me a long time to get over that.

> It is not untypical for that type of information to play on one's mind and be taken home, to be regurgitated in so many ways … It can disturb anything and everything from sleep patterns to how you perceive the day, it can colour your outlook.

In addition, these events had long-term implications for workers.

> I had to testify [at one inquest] but I've also had other deaths and those things accumulate… Now that I [am older] I wonder whether I wish to continue or whether I want to walk into the sunset and do something different.

Another influence on individual workers is the critical nature of inquests and the manner in which the individual's personal and professional integrity is called into question. Conversely, it was identified that child protection workers are rarely acknowledged for the positive work that they do.

> "You feel very, very criticized about the work you've done and the decisions that you've made and your team made."

> You practice professionally to the best of your ability, not maliciously. When you're characterized as being other than professional, it really hurts. I have always practiced with children and families with their best interests in mind and I've never done anything to hurt anyone. I always felt that I was doing what I was expected of me, and probably at times going beyond that. When that is challenged, you feel that you are stripped of everything...they take everything away from you.

It was further noted that inquests could lead to isolation. One participant described a sense of discomfort that others had in dealing with those who were the subject of an inquest.

> I was struck by the number of people that I didn't hear from…there was a sense of dismay as they stepped back and watched the public and media display. I think they were quite uncomfortable with it, what to do, what to say. A lot of people didn't do anything.

Finally, the all-consuming nature of death inquiries and the length of time involved take their toll.

> [Inquests] create more pressure in day to day activities because your time and attention are turned to issues that are quite consuming from both a complexity perspective and an emotional perspective.

> I would say that it just sort of compounded the stress that I felt when the child died because you just sort of waited…waiting for two years to see if there would be an inquest. There was no let up in terms of it's over.

Radiated Distress

Inquiries into the death of a child do not only affect the workers involved. The stress and distress radiate throughout the agency.

> I sat in on the inquest for a few days and I felt that I was on the hot seat too. When they're critical of the agency, they're critical of me. So I feel it just as much as the person who is identified.

Workers described feelings of empathy for colleagues who were undergoing the process of inquiry. "Watching what happened to him was very painful. He was slaughtered by the papers." One worker described the experience of feeling the heat of the inquiries, even though they did not burn her directly. Radiated distress was particularly strong when the worker who was subject to review was a supervisee or a foster parent for the agency. "I sat in for days to support my staff, it was really difficult to hear." "I was conscious of the fact that this [foster] family had raised and loved the child – and they had to hear the gruesome details of what happened."

Empathy for others was mixed with a sense of awareness that it could easily be them on the hot seat. "I think that I would have made the same decision. There was no way of anticipating that this mother would have killed the child." "Lucky for me it wasn't my child."

Not only are child protection workers, supervisors and managers affected by the radiated distress of an inquiry. Clerical staff also indicated the extreme distress they experienced while transcribing gruesome and tragic details of the life and death of a child.

Media and public scrutiny

The media attention or "media frenzy" and public reaction had a significant impact on workers.

> They were jabbing these microphones in my face and everything and I was saying - Oh my God. I'll never be able to walk down the streets with my kids or do anything with them without these damn press people.

> I met a neighbour in the grocery store who knows I work for the Children's Aid and she said, "how dare you this" and "how dare you that". People were just staring. It feels like being accosted by strangers.

Workers also described how negative press about colleagues felt unfair. "You know how hard these people work. You know how much they care about kids." One worker lamented that all the negative public perceptions about child protection workers and their level of competence became a self-fulfilling prophecy.

> There has been so much negative publicity, so many people have left the field, so many good competent people, people have taken early retirement, people who show a lot of potential even if they're young are getting out because why would you want to do this work?

Not all press attention was negative however. Some workers felt supported by the press and subsequently the public.

> I was pleasantly surprised by this one article……I had a lot of people come up to me then with compliments and saying how tough the work appeared to have been and how grateful they were that there were actually some of us still on the front lines doing it. That was touching.

Further, it was identified that the media could be used as a means of educating the public. Conversely however, one participant suggested that no matter how much time was invested in placing a positive spin on the work and taking reporters along on the job, as soon as a problem arises, all the good will is abandoned.

Supporting One Another

Participants described a great deal of support within the agency. One aspect of this was the team of colleagues who worked together. Workers

who were not involved in the inquests routinely attended in order to offer support to colleagues. This was true at the front lines, and also within senior management.

> We pulled together, and it created a really strong spirit. Thank God we had one another and our own resources to rely on…[We said] we're going to pull through this together.

Front line workers and supervisors pointed to the importance of the support they had received from members of management. Other sources of support included the union and the Employee Assistance Program. Since the last inquest, the agency has also developed a Peer Support Team to assist workers faced with critical events.

Negative Changes

Subsequent to the inquiries there have been major changes to the delivery of services. Workers stated that in the past their work involved more than strictly protection. They believed that the work they formerly did positively contributed to children's lives beyond simply their safety. This resulted in a sense of loss and frustration for workers.

> Part is the change in law…trying to make adjustments after the inquest. Having to deal with all the children, changes in practice, as well as legislation, changes in technology. You name it. It all impacts on the front line. It means we don't get as much time to have direct contact…People come into social work for direct contact.

The focus on rules, standards and accountability is further seen to limit practice. Workers indicate that documentation and avoidance of liability are now at the forefront. "Everything we do now is driven by accountability." Yet as one worker indicates, there is an awareness that this is a false sense of protection. "We complied with the standards before. There can never be enough standards." Another participant cautions that there can be no quick fix.

> When you have something as volatile, public and political as the child death issue, all sorts of people jump in and say we need to fix it, we need to fix it tomorrow. Well it is far more complex than something that can be fixed in a day, a year or two years. It's taken years to develop and it's something that

needs careful planning and sequencing…. The challenge is to slow up the pace and change.

Positive Outcomes

While the process of death inquiries have been difficult, participants were able to identify positive outcomes emanating from the inquiries as well. Often this was in terms of learning how problems had occurred and the development of plans for future service delivery. This was particularly true for workers who were less directly involved with the inquest process. Problems identified by participants often related to failures in the child welfare system. It was stated that the government funder was not particularly interested in the system and avoided information regarding problems. Further, within the agency it was identified that coordination and teamwork was not always optimal, "[we could] see how we haven't always worked well together as a team for the benefit of children."

Table 2
Factors Contributing to Distress

Personal Distress
♦ The trauma of a child death ♦ Re-exposure to traumatic stimuli ♦ All consuming nature of inquiries (emotional and work related) ♦ Criticism of personal and professional integrity ♦ Isolation
Radiated Distress
♦ Empathy for colleagues undergoing review ♦ Scrutiny of agency ♦ Guilt by association ♦ Restrictive guidelines for practice
Weakened Public Support
♦ Negative and extensive press coverage ♦ Hostile public reactions ♦ Tainting of the agency and its workers

Consequently, the inquiries were viewed as a means of rectifying problems. "We are going to improve our practice as a result." One partici-

pant in referring specifically to internal reviews commented on the positive nature of the outcome. Nevertheless, it was clear that there is a limit to the efficacy of continued scrutiny.

> I found a certain amount of discomfort that goes with looking at everything in retrospect and under a microscope, but I honestly believe [the internal reviews] were very well done and that we've learned about as much as we could from them and the we've been able to implement ways of doing things better. So in the long run, it's been worthwhile. But I think we've had enough now, don't want anymore.

In the end, the learning and changes for the better are important, but do not come without costs to individuals directly involved.

> But it is still not without a great deal of cost both personally and professionally. You move through all sorts of situations, you grow, you learn, but you also pay. It takes its toll.

Conclusion

Public inquiries into child death have become a new phenomenon in which society attempts to deal with a serious issue that has lacked sufficient attention. At a time of prosperity in the western world, large numbers of children continue to be victims of neglect, abuse and ultimately murder. Nevertheless, addressing issues such as child poverty and societal structures, which limit the choices and opportunities available to some members, is overwhelming. In this environment, death inquiries become expedient ways to address public concern and guilt.

This study is a qualitative inquiry into the impacts of this form of social change on workers in one child welfare organization. In considering these findings, it is important to underscore that this is not intended to be representative of all staff in all child welfare organizations. This particular child welfare agency is a large organization in a major city that has been subject to two high profile coroner's inquests. The quantitative data represent a 33% response rate for all staff in the organization. The interviews were based on a random sample of those participants in the quantitative study who agreed to be interviewed. Thus there is a risk of a self-selection bias. Further, the results of this study may in part reflect the fact that this was one of the first times that staff were asked about the impact of

the work on them in the midst of a time of public outcry over child welfare. Thus, the comments may reflect a watershed of emotion that may not be indicative of everyday experience. Nevertheless, the findings do highlight many areas of concern.

In Ontario, coroner's inquests into child deaths and the subsequent media attention about the issue have raised public awareness regarding the plight of a small group of memorable children. Participants in this study further identified that the process of inquiry brought to light inefficiencies and inadequacies within the child welfare system. These findings support the efforts to re-evaluate and restructure child welfare services. Yet, while there are many productive facets to this, the process of evaluation and the subsequent changes have not come without costs. Costs have been incurred by individual workers and by the child welfare system as a whole. This study aimed to investigate the impact of inquiries into child deaths in a large child welfare agency in Ontario. The impact that was uncovered occurred at three levels. First is the distress experienced by individual workers, the second is the radiated distress throughout the agency and the third relates to weakened public and community support.

Several factors contributed to the distress experienced by individual workers in this study. The first factor was the re-exposure to traumatic stimuli regarding the death of a child. Participants described traumatic reactions as a result of having a child die for whom they had responsibility and with whom they often had a relationship. Repeated and prolonged exposure to the traumatic material throughout the inquiry process and through the media reports was described as the tearing off of a scab and reopening of a wound. The all-consuming nature of inquiries was the second factor. Participants described the intense emotional focus that occurred during an inquiry and intensive work required for preparation. Further, by definition, inquiries try to assess what went wrong. This results in a process of critique of the system and of individual workers within the system. Participants reported feeling that their personal and professional integrity was being called into question.

Distress regarding the inquiry process did not end with involved workers, rather it radiated throughout the agency. Participants described a feeling of empathy for colleagues, subordinates and managers who were encountering the process. They also reported discomfort with the scrutiny of the agency by the members of the inquest, and a feeling of guilt or blame by association. Further, the outcomes of the inquiry process resulted in an accountability-focused environment and strictly governed professional

practices. As a consequence, workers described less satisfaction with their jobs, as they no longer held many of the elements that attracted them to social work and specifically child welfare in the first place.

Finally, the experience of the inquiry into a child death was intensified by the concentrated media attention to the issue and the resulting public opinion. At times this was experienced positively, however several respondents experienced this as hostile and isolating. There was a sense expressed by participants that all members of the organization had become tainted by the death of a child and consequently the competence and integrity of all workers was being called into question.

In summary, public inquiries have become a necessary means of identifying societal problems and seeking meaningful solutions. Many of the recommendations emanating from the process can provide a useful beginning to altering and improving services to children in the child welfare system. Several participants cautioned however, that these changes cannot occur overnight and that systems change must be instituted in a thoughtful and careful manner. Failure to do so can result in a collapse of the system, much as what has been described in the experience of other jurisdictions (Brunet, 1998; Hill, 1990). Further, solutions must not focus on protection agencies alone.

> Responsibility for the care and protection of children must be shared by parents (who abuse children and conceal abuse), neighbours who fail to report, other professionals who see the results of abuse and fail to recognize and report it, mental health professionals who view their role too narrowly and are unprepared to assist CAS colleagues, judges who fail to protect children that appear before them, governments who cut budgets, media which exclusively targets CAS and fails to show the contribution of all participants in the tragic outcome. (Steinhauer & Wilkes, 1996)

Accountability and continuous improvement are important, necessary components of effective service delivery. The findings of this study however, suggest that we must continue to search for better ways to provide public assurances of a quality child welfare service, which do not unnecessarily contribute strain to an already stressful work environment. A rigid and inflexible system run by overburdened workers will not serve to better the lives of children and their families.

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