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30th day of March 20 12

BC Children and Youth Review

Honourable Ted Hughes OC, QC, LL.D. (Hon.)

An Independent Review of BC's Child Protection System

April 7, 2006

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April 7, 2006

Honourable Stan Hagen
Minister of Children and Family Development
The Province of British Columbia

Dear Minister:

I am pleased to submit the BC Children and Youth Review final report.

I was appointed to conduct an independent review of British Columbia's child protection system. As per my Terms of Reference, this report includes recommendations to improve:

- Monitoring and publicly reporting of the government's performance in protecting and providing services for children and youth in British Columbia,
- Advocacy for children and youth,
- The system for the review of child deaths, including how the reviews are internally addressed, and
- The public reporting of child death reviews to ensure that it balances the need for public accountability with the privacy interests of the families and others involved.

The safety and well-being of B.C.'s children, youth and families are at the centre of this report. I ask that you and all Members of the Legislative Assembly give positive consideration to what is being recommended.

Sincerely,

Honourable Ted Hughes, OC, QC, LL.D. (Hon.)
Victoria, British Columbia

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Honourable Ted Hughes
OC, QC, LL.D. (Hon.)

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1. First Words

I was told when I accepted this assignment that it would be a straightforward task, easily accomplished in the space of a few weeks. That turned out to be hugely mistaken. What I have discovered in the past four and a half months is that child welfare is a many-faceted system, complex in each of its parts. And I have learned from the many knowledgeable people who agreed to be interviewed and the nearly 300 more who wrote and phoned, that there is no great consensus awaiting my discovery.

I have done what I could to live up to my mandate but am mindful that there is much more to say. This report may not be as comprehensive as some would have wished, but in the time allotted and within my terms of reference I have tried to address the most pressing issues and to suggest ways of moving forward.

The strongest impression I have gleaned from this inquiry is one of a child welfare system that has been buffeted by an unmanageable degree of change. There has been a revolving door in senior leadership positions; emphasis in practice has shifted between child protection and family support; functions have been shifted out to the regions and then pulled back to centre; new dispute resolution processes have been introduced. And much of this has gone on against a backdrop of significant funding cuts, even though it is commonly understood that organizational change costs money.

To illustrate, within the Ministry for Children and Family Development, between mid-2002 to mid-2003:

- New programs, intended to keep more children at home with their families, were introduced amidst budget cuts to the services that support families and youth in crisis; social workers received no training to help them implement these new programs.
- Five new regional Directors of child welfare were appointed where historically there had been one Provincial Director.
- The Ministry was at work planning for transfer of service delivery and support for children and adults with developmental disabilities to a new Community Living authority, and a sixth Director of child welfare.
- Governance planning absorbed Ministry energy as 11 regions were collapsed into five and work began on moving to regional authority boards.

- A joint Aboriginal management committee began planning for eventual establishment of five Aboriginal authorities.
- The Ministry met stringent budget reduction targets through an almost 12% cut to services for children and families, and a 55% reduction (since 2001/02) in executive and support services, including quality assurance.
- Case review and audit functions were transferred to the regions, with insufficient staff left at head office to ensure that they were being carried out: in fact, practice audits were suspended during this time.

Each of these changes, taken alone, posed challenges to the organization. Taken together they created a climate of instability and confusion that could only detract from the Ministry's work on behalf of children. The need for equilibrium and stability is a central theme of this report.

Any organization has a finite capacity for managing change, particularly in a climate of budget restraint, and this Ministry has been stretched far beyond its limits.

In the 10 years since 1995, the Ministry has been led by no fewer than nine ministers, eight deputy ministers, and seven directors with lead responsibility in child protection. This turnover has taken a toll in terms of staff morale and the Ministry's ability to set directions, frame goals and make progress. The revolving door has got to stop.

At this time, the positions of Deputy Minister for Children and Family Development, Associate Deputy Minister, and the Provincial Director of child welfare all are being filled by acting appointments. Every effort should be made to recruit the most competent candidates as soon as possible and once hired, and barring serious and unforeseen circumstances, the new appointees should be left in office for a minimum of four years. Five would be better.

Child welfare practice itself has been subject to cyclical patterns. Looking at statistics over the years on children being taken from their families and into care, we see the numbers decline for several years and then begin to climb, sometimes quite suddenly.

For example, there was a spike in the number of apprehensions during and after the Gove Inquiry in 1995 when child safety concerns were brought to the fore. More recently, the numbers have gone down as social workers are asked to use alternative arrangements where possible, rather than bringing children into care.

I hope that some of the recommendations in this report can help to achieve a balance so that the pendulum can return to equilibrium.

What will be required, more than anything, is a spirit of cooperation and collaboration among the leadership in our child welfare system, not only in the Ministry of Children and Family Development, but in other ministries and government agencies as well.

Front and centre among those whose cooperation I invite, are the elected Members of the Legislative Assembly. I am recommending a key role for them in leading the way towards changes I see as essential to the safety and well-being of our children and youth—our leaders of tomorrow.

1.1 WHAT LED TO THIS REVIEW?

In an ideal world, all children would be cared for in their homes, with nurturing adults to keep them safe and care for them. That is the reality for most children in British Columbia, but some children have needs that surpass a family's ability to cope; some parents suffer from the effects of unrelenting poverty, substance abuse, or other afflictions; some families are unwilling to care for their children; and sometimes children are left with no family at all to stand between them and the world.

Government has long played a role in protecting children who are at risk for any reason, but has always struggled to find the right balance between respecting families' autonomy and privacy on the one hand, and intervening to protect vulnerable children on the other.

From the appointment of BC's first Superintendent of Neglected Children in 1919, the scope and delivery of child welfare services have evolved to meet changing conditions and to reflect a general growing awareness of child abuse and neglect and of the rights of children and families.

A new chapter in British Columbia's child protection history began in 1994 when Judge Thomas Gove was appointed to head an inquiry into the death of Matthew Vaudreuil, a little boy who was killed by his mother while he was a client of the province's child protection system. Over the next 18 months the Gove Inquiry looked at the policies and practices of the child protection system and other services provided to children and youth by government ministries and agencies.

A perhaps unintended result of the inquiry itself was a shift in child protection practice towards removing more children from their homes rather than offering support so that families could stay together: feeling attacked by the adverse publicity surrounding the inquiry, social workers were afraid of leaving children in situations where there was any possibility that they might come to harm.

In the summer of 1995, before Judge Gove had issued his report, the government responded to public consultations conducted in the early 1990s about BC's child protection system and appointed the province's first Child, Youth and Family Advocate.

Once the Gove report was received, government was quick to adopt it and appoint a Transition Commissioner to study its recommendations and develop an implementation plan.

Fundamental changes resulted, including:

- creation of a new Ministry of Children and Family Development, which was to integrate child, youth and family programs and services from the former ministries of Social Services, Education, Health, Women's Equality, and Attorney General, under one umbrella ministry; and
- creation of the Children's Commission to review child deaths and oversee the activities of the new ministry.

The Commission undertook the task of reviewing, in one way or another, every child death in the province[1] and making recommendations that were usually aimed at the Ministry of Children and Family Development. It was also charged with reviewing the plan of care for every child in care.

[1] The Gove Inquiry had recommended only that reviews be done of deaths of those children who died while in care or who had received Ministry services within the preceding 12 months.

Meanwhile, the Child and Youth Advocate was providing advocacy services to children and families who were having difficulty dealing with the Ministry.

The new government's Core Services Review in the summer of 2001 looked at the range of agencies involved in the child welfare system including the Children's Commission, the Child and Youth Advocate, the Coroners Service, the Ombudsman, and the Public Guardian and Trustee. The Review concluded, and government agreed, that there were overlaps and duplication of services. The plan was that the Coroner would assume a child death review function that it had not had before, but which would be more limited than that carried out by the Children's Commission; the Ombudsman would continue to monitor fairness issues; and a new Child and Youth Officer, reporting to the Attorney General, would replace the two former children's agencies as the external oversight body for the child welfare system.

During this period, budgets were being cut across government and the Ministry's child protection services were significantly affected. About the same time, the Ministry was engrossed in transferring responsibility for quality assurance, audit, and practice reviews (including child deaths and critical injuries) to the five regions; significant reorganization was undertaken in anticipation of regional governance; the Community Living Authority, an independent body responsible for services and support to children and adults with developmental disabilities, was created; and major program shifts (referred to as "service transformation") which focused on options to in-care placements, were rolled out to the regions with little or no training, planning, consultation, or follow up.

In early 2004, a group of people in the child protection system felt unable to communicate with the government about the impact these budget cuts were having on children. They turned to Dulcie McCallum (former Ombudsman), Joyce Preston (former Advocate for Children, Youth and Families), and Cindy Morton (former Children's Commissioner) and asked them to use their influence to bring these concerns to the attention of the Premier.

In June, 2004, these individuals wrote to the Premier, pointing out the absence of an independent voice for children and youth who have concerns about the care or services being offered or denied to them. They also noted the lack of public accountability in the Ministry, with no vehicle for informing British Columbians about the resolution of difficult cases, or about the overall performance of the child protection system.

After receiving no response, they released their letter publicly in March, 2005. The media and the Opposition seized on the issue and Premier Campbell committed to meeting with the group.

(There was some confusion as to whether the Premier himself had received the letter.) That story made headlines for a few days and then the deaths of two Aboriginal children who had been receiving services from the Ministry became associated in the public's mind with the issues raised in the letter.

In September, Joyce Preston and Cindy Morton met with the Premier and Minister Stan Hagen and suggested that these most recent deaths illustrated the need for a single office that could conduct a comprehensive review in such cases.

The Ministry came under intense criticism after it released its internal review of the death in Port Alberni of a Nuu-chah-nulth child. Media reports followed about other children who had died in suspicious circumstances: the Ministry's internal reviews had not yet been released, nor had there been a review by the Coroner's Service such as would have been done by the Children's Commission. (See Chapter 2 for a description of this process.) When it became clear that the second-stage reviews that the Children's Commission would have done, did not take place on hundreds of files due to the transition, the government's decision to transfer the death review function to the Coroner's Service came under fire.

These concerns ultimately led the Minister of Children and Family Development to ask me to undertake this review.

1.2 MY REVIEW

My Terms of Reference

The Minister of Children and Family Development appointed me to do an independent review of the child protection system in British Columbia and to report to the Minister and to the public.

I was asked to examine and make recommendations to improve:

- the system for reviewing child deaths, including how these reviews are addressed within the Ministry,
- advocacy for children and youth, and