



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Amanda, Savannah, Rowen and Serena:
From Loss to Learning

April 2008

April 16, 2008

The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria BC V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting *Amanda, Savannah, Rowen and Serena: From Loss to Learning* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services. In this instance, the report deals with the April 26, 2007 referral made by the Select Standing Committee on Children and Youth.

Sincerely,

A handwritten signature in black ink, reading "melturpellafond". The signature is written in a cursive, lowercase style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Ron Cantelon, MLA
Chair, Select Standing Committee on Children and Youth

Mr. E. George MacMinn, QC
Clerk of the Legislative Assembly

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Executive Summary

In April 2007, the Select Standing Committee on Children and Youth asked the Representative to investigate the deaths of four Northern B.C. children who died between 1999 and 2005. Amanda Simpson, Savannah Hall, Rowen Von Niederhausern, and Serena Wiebe were all between the ages of seven months and four years at the time of their deaths. Each had a family history of involvement with the child welfare system.

Their names are used in full in this report because all were the subject of coroner inquests in 2007. However, their names also form the title of this report to focus us all on the heart of this investigation – four young B.C. lives whose voices are no longer heard.

The death of a child affects everyone, whether as a personal loss or a collective sadness. As individuals or as a concerned community, we not only ponder *how* and *why* a child died, we also ask if there is anything that could have been done to prevent it.

That essential question drives this child death investigation. By looking closely at the lives and deaths of a number of children, the Representative's report moves from a detailed look at individual cases towards overall analysis of system of supports, whether significant improvements have been made in the years following their deaths, and eventually to what remains to be improved. It serves a crucial public accountability function.

The Representative's role is not one of fault-finding. In this report there are occurrences where it is clear that errors or misjudgements by individual service providers or their supervisors are a crucial part of the unfolding story. There is no easy way around this, nor should there be. However, where this arises, the greater good can be served by also assessing broader issues of supervision, quality assurance and operation of the child protection system.

The work of the men and women on the stressful front lines of the child protection system must always be honoured. When a child dies who has been involved with the system, people at all levels of the system experience a deep emotional impact and sense of loss. We owe them all a genuine commitment to acknowledge the challenges and complexities confronting families and professionals, while at the same time ensuring death reviews are allowed to be a respectful opportunity for learning. The surviving siblings, parents and extended families require our compassion and support. Ensuring that the death of their loved ones not be invisible may be one of our most effective expressions of that compassion.

...the primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented...

A secondary purpose...is one of public accountability...the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right.

– Honourable Ted Hughes, QC, *BC Children and Youth Review*

The Representative's investigation has determined that the system failed these Northern B.C. children on numerous levels. This knowledge must drive us to seek out the enduring lessons for today's practitioners. The silencing of these children's voices must stir us to move from loss to learning.

This report is the first external, independent and completely comprehensive investigation relating both to the services these children and their families received, and the circumstances relating to their deaths.

Although these deaths occurred before the creation of her new independent office, the Representative determined – and the Select Standing Committee agreed – that these particular deaths raised questions around systemic issues that warranted further investigation.

Given the time span of the involvement in the child-serving system of the children and their families (in excess of a decade), the Representative's office conducted extensive evaluation of the practice and policies during the entire period. Specific efforts were made to identify shifts in policy and practice, where the system has improved and strengthened, and where ongoing challenges remain.

The Representative's process examines broad issues, for example (but not limited to) child protection practice issues during the child's life, and communications between parties involved in the child's life and after the death. These can include police, the medical community, the Aboriginal community, teachers, child care workers, coroners, and the government.

The first stage of this investigation involved a review of all records for each of the four children and their families. Materials and transcripts from the coroner's inquests were analyzed, and Ministry staff interviewed. Experts on the Representative's Multidisciplinary

Team then analyzed data and provided valuable advice for the Representative with respect to recommendations. The investigation also involved looking at the patterns, trends and risk factors which may have contributed to the deaths. Themes identified by the review of material, interviews and investigation, as well as those highlighted by the Multidisciplinary Team, were explored.

In addition, the Representative met with family members who wanted to discuss the death of their relative. Siblings, parents and other relatives of these children maintain a profound and personal interest in seeing improvements to B.C.'s child serving system. The Representative is deeply honoured by the trust some family members have placed in her, by their honesty and willingness to share their pain.

Issues identified in the lives and deaths of these four children that present challenges in current child and youth practice include:

- assessments of the children's safety falling below accepted standards
- significant guardianship practice deficiencies
- lack of thorough medical assessments for vulnerable children
- weaknesses in clinical supervision and case consultation
- lack of cultural planning for Aboriginal children in care, and cultural context in assessing safety
- insufficient communication between the Ministry and professionals in the community
- human resource challenges impacting the ability to provide safe and effective child welfare services
- uneven quality assurance practices not sufficiently focused on outcomes/results for children.

Examining these four deaths does not provide information to make sweeping conclusions on the child welfare system. It does identify systemic failings and cracks these children and their families fell through at the time, which leads us to examine progress to the current situation.

The detailed analysis that follows in this report focuses on identifying those enduring lessons that can be used to inform improvements to the child serving system and child protection.



1. Introduction

On April 26, 2007, the Select Standing Committee on Children and Youth referred the deaths of four children to the Representative for Children and Youth. The children are:

- Amanda Simpson (1994–1999)
- Savannah Hall (1997–2001)
- Rowen Von Niederhausern (2001–2002)
- Serena Wiebe (2004–2005).

The deaths of these four children occurred between 1999 and 2005. The Ministry was involved with the oldest of the children starting in 1997, and with her mother as early as 1991. For each of the children there was a history of parental involvement with the child welfare system. All four of the children were from the northern part of the province.

The Office of the Representative for Children and Youth was created by statute in November 2006. The Representative was appointed in December 2006 and the statute was amended and proclaimed in force on March 31, 2007. The Representative's statutory responsibility to review and investigate deaths or critical injuries of children receiving reviewable or designated services came into effect on June 1, 2007, with the proclamation of Section 4 of the *Representative for Children and Youth Act*. (Relevant sections of the Act are included in Appendix A.) These deaths were referred to the Representative by the Select Standing Committee on Children and Youth despite the fact that they occurred before the Act was proclaimed, because they were ongoing child death matters being evaluated by the Coroners Service.

The cause of death for each of these children had not been determined when the cases were referred to the Representative's Office, and internal reviews by the Ministry had not been released to the public or to the families. In the interest of public accountability, it was important to review the circumstances of the children's deaths.

Review of child deaths always presents significant opportunities – both to consider what was learned at the time and what may be learned now. Learning opportunities in reviewing these four children's deaths were even more significant because they died in an era when independent oversight for child deaths had been discontinued. Some of the cases had lingered in the system for many years without public bodies being engaged to determine how the children died or whether their deaths could have been prevented.

In the *BC Children and Youth Review*, the Honourable Ted Hughes recommended that the Representative for Children and Youth conduct reviews of critical injuries and deaths of children in care or receiving services from the Ministry of Children and Family Development. Mr. Hughes articulated his reasons for recommending this independent oversight and review of child injuries and deaths as follows:

This review has brought me to the belief that the primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented. I recognize that not every injury or death is preventable, but it is important to take advantage of every opportunity to learn about possible improvements to policy and practice. The systematic review of deaths and injuries is one such opportunity.

A secondary purpose for reviewing children's injuries and deaths is one of public accountability. The death of a child who is in the care of the Ministry or receiving Ministry services is a rare but tragic event and the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right (Hughes, 2006, p. 89).

In conducting a review or an investigation, the Representative is obliged to await the outcome of other processes, such as coroner's inquests, criminal proceedings or internal Ministry reviews. While these processes, with the exception of criminal proceedings, must be given one year to be completed before the Representative steps in, the role of the Representative's Office is a broad one. This allows the other processes to take place, but also enables the Representative to evaluate them and to consider whether the system of supports for children is adequate or whether improvements are to be recommended in addition to any that may have been identified by others. The Representative also has the benefit of tracking those improvements. The cases of the four children whose deaths are the subject of this investigative report were sent to inquest by the Chief Coroner in 2007. The last of the inquests was completed in November 2007.

In implementing the Honourable Ted Hughes's recommendations in 2006, the legislature directed the Representative to "conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives." The legislation also provides that, in some cases, a fuller investigation of a child's critical injury or death may be warranted. This could entail hearing witnesses and compelling their testimony. This report describes the results of such an investigation.

The Representative's role is neither fault-finding nor forensic. In the Representative's reports there may be cases when it is clear that errors or misjudgments made by individual social workers and their supervisors, or by other service providers, played a crucial part in the unfolding story. There is no easy way around this, nor should there be. The Representative recognizes that hindsight is of value but that it is not reasonable to look backward and question every decision and assess whether it met the perfect standards of practice. The basis for the investigation was to determine whether conduct and actions were reasonable and diligent in the circumstances.

In this process, the Representative acknowledges that the important work of social workers and others on the front-lines of the system requires making many delicate decisions under very difficult conditions. Assessing safety and well-being of children is not a mechanical process and judgment, professionalism, teamwork, and other factors will play a role in this work. The operative question is not whether the actions of individuals were ideal from our position looking backward, but whether they were reasonable in the circumstances at the time. The motivation for this investigation is to find the enduring lessons for the future and ensure that these can be brought to the front lines of the system. It is clear from the many discussions the Representative has had with front-line workers throughout the Province, that they are unwavering in their commitment to improve the system for children and are seeking opportunities to learn and improve the system of supports for vulnerable children.

The Representative's reviews of child deaths are rooted in a systemic approach. As recognized by international leaders in this area:

A systemic approach to reviewing a child's death provides a change of focus from the conduct of an individual social worker to the more complex factors and interrelationships that invariably surround a child at risk. Child death reviews, regardless of their focus, can be used to improve services or they can be misused to search for a scapegoat....

Rethinking our responses to child homicide has the potential to increase understandings of the dynamics that place children at risk, and to foster a culture of service improvement. It could be that using a systems framework of review that places practice in a wider context is more likely to contribute positively to the strengthening of services for children overall (Connolly, M., Doolan, M., 2007, p. 10).

The system approach requires a close analysis of broader issues of supervision, quality assurance and operation of the child protection system. The important work of those on the front lines of the child protection system must always be recognized. They have one of the most challenging roles in public service and they can function well only when they are supported, clear supervision is available, and coherent policies, practices and sufficient

resources underpin their efforts to keep children safe from maltreatment, abuse and neglect. The Representative has benefited enormously from discussions with front-line social workers in the preparation of this report and applauds their individual dedication and commitment.

In keeping with this sentiment, the Representative has not sought to attach blame for individual actions or inactions that may have been pivotal in the deaths of the four children. In three of these deaths, the system failed the children on numerous levels.

With the loss of these four children, the enduring lessons for today's practitioners must be found and tomorrow's system improvements made to ensure that those lessons have been learned.

In this report, and in those to follow, the emphasis will be placed on identifying those enduring lessons that should inform improvements to practice and help to secure better outcomes for the children and youth served by British Columbia's system of supports and services, especially for the most vulnerable children and youth, such as those who are abused or neglected or in state care.

The Representative is guided by the United Nations *Convention on the Rights of the Child* (1989) which guarantees every child personal safety and healthy conditions for their development (Article 3), the support of the state when their parents cannot meet their responsibilities (Article 18), or in those rare instances when children are intentionally maltreated and harmed or neglected, the certainty that the state will protect them with an effective and responsive child welfare system (Article 19). These important rights to personal safety and healthy development at the international level are not limited by exceptions based on geography, ethnic identity, or other circumstances.

Of the four children whose deaths are the focus of this report, three were Aboriginal. Their unique circumstances and the vulnerability of Aboriginal children, particularly in northern British Columbia, will be a necessary focus in improving the system. The system of supports for vulnerable children must extend fully to Aboriginal children, as it does to non-Aboriginal children. Important lessons may be drawn from this aspect of the lives of three of the four children.

The report

The report begins with a brief description of the investigative process and methods accepted by the Representative's Office for the preparation of reports on the circumstances of child deaths and injuries. Chapters 3 to 6 present narrative accounts of the four cases. An analysis of the issues identified in the investigation is provided in Chapter 7, and the findings and recommendations resulting from the investigation are detailed in Chapter 8. Technical terms used in the report are defined in the glossary.

Ministry names

The events covered in this report take place over the course of a 15-year period in which child protection and other services for children and families were delivered by three different ministries:

- Ministry of Social Services, 1992–1996
- Ministry for Children and Families, 1996–June 2001
- Ministry of Children and Family Development, June 2001–present.

In the interest of consistency and readability, the report refers to the “Ministry” throughout.



2. Methodology and Context

The review and investigation of child deaths and injuries must be thorough, analytical and fair. As complete an understanding as possible of the system and the events and circumstances in each instance must be developed, so that improvement, where appropriate, can be suggested. To that end, investigations must be informed by appropriate principles and statutes.

The work of the Office of the Representative for Children and Youth is guided in a general and over-arching manner by the United Nations *Convention on the Rights of the Child*. Article 3 of the Convention provides that the best interests of the child will be primary in public and social welfare services, that the child's well-being must be protected, and that "the institutions, services and facilities responsible for the care of protection of children shall conform with the standards established by competent authorities."

In evaluating the system of supports and services for vulnerable children, the *Child, Family and Community Service Act* also provides a touchstone. This statute and its regulations provide the basis for both mandated and voluntary services offered by the Ministry. It is also the platform upon which Ministry policies are based. Those policies, as well as any practice standards in effect to implement them appropriately, also provide an evaluation framework. Similar instruments are applied in reviewing service delivery on the part of other agencies and organizations involved with vulnerable children. In some instances it may be that the policy or practice guidelines are inadequate or in need of development. Child-serving systems, like all significant systems of support, exist to support vulnerable people when their families cannot or will not do so through incapacity or other circumstances. Continual evaluation and improvement in these systems is a hallmark of good governance for civil societies around the world.

Principles of administrative fairness are also of critical importance in providing objective and fair analysis. Administrative fairness requires that the subject of the review have the opportunity to be heard and to review and identify inaccuracies, in an atmosphere of respect and general fairness. To that end, Ministry staff members have been consulted throughout the process, including the Regional Executive Director and the Provincial Director, and drafts of this report have been shared with the Ministry and other organizations for the identification of inaccuracies. Careful attention has been paid to confirming source data and ensuring that all available data has been considered. Where information included was in the form of opinion or general statements, some corroborating evidence of circumstances supporting the opinion or statement was sought, both in consultation with the Ministry and independently.

The Representative's investigation

This investigation by the Representative's Office was completed in three stages.

The first stage involved a review of all records for each of the children and their families. This included all Ministry file materials, including the Deputy Director's reviews for two of the children and Director's case reviews for the other two children. In addition, other relevant records, including medical, legal and police records, were reviewed. (A complete list of documents reviewed is provided in Appendix B.) A review of current research on child abuse and maltreatment, assessment of child safety and medical assessment of neglect and abuse was also conducted. Relevant practice standards and policies that were in effect at the time the children and their families were served were also reviewed and considered.

Following the coroner's inquests into the four deaths, which were completed in November 2007, materials and transcripts from the coroner's inquests were reviewed and analyzed. Ministry staff were interviewed, and consultations were conducted with the North region management team and focus group interviews with front-line and supervisory staff. Ministry practice audits and critical injury and fatality case review documents were analyzed. A final confirmation of available documents and data was also carried out to ensure that all relevant materials were provided, and where not provided, that such information was not available or retrievable.

At the conclusion of the first stage of the investigation, the material was summarized and presented to the Representative's Multidisciplinary Team. The Multidisciplinary Team is a group of experts in the field of children's services. The team provides guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children. (Multidisciplinary Team terms of reference and membership are provided in Appendix C.) The team's discussions produced valuable advice for the Representative with respect to recommendations to improve the child welfare system.

During the second stage of the investigation, the themes identified through the review of material and interviews, as well as those highlighted by the Multidisciplinary Team, were further explored. Given the length of time during which the children and their families were involved in the child-serving system (in excess of a decade), it was important to conduct further evaluation of the practice and policies from the entire period. The themes identified include:

- assessment of child safety
- medical assessment of vulnerable children, including children in care
- coordination and sharing of information by the Ministry and other service providers and community partners
- clinical supervision of child protection workers

- quality assurance standards and practices
- changes in practice over time.

Following the advice of the Multidisciplinary Team, further analysis was undertaken to investigate trends and practice standards in the region over the period and to evaluate the Ministry's quality assurance and improvement model. Specific efforts were made to identify shifts in policy and practice, human resources and quality assurance, and to consider whether the system has been improved and strengthened since the children's deaths or whether ongoing challenges remain.

The third and final stage of the investigation process was the preparation of findings and recommendations. Before these were finalized, information about other deaths and injuries in the North region during the same period was also reviewed, to determine whether they showed similar patterns of evidence or if they provided objective indications of change in the system. This ensured that the findings were based on the best available evidence.

At the conclusion of the third stage, efforts were made to meet with family members who might wish to discuss the deaths of their children. The privacy interests of families must be respected and these meetings will therefore not be reported on, except to indicate that the siblings, parents and other relations of these children take a strong interest in seeing improvements made to the child-serving system in British Columbia. The Representative has assured them that British Columbians also share this view, and that the independent oversight role was created to play a part in that process.

How this investigation differs from others

Prior to the Representative's investigation, each of the four children's deaths had been through three separate and distinctly different processes: police investigation, Ministry review and coroner's inquest. Each of these processes looked at the circumstances of the specific child's death. However, because of their nature and purpose, they do not apply the systemic approach the Representative is able to use in looking at the strength of the child-serving system as a whole. For example, in none of the four inquests was the full Director's case review or Deputy Director's review put into evidence for the jury. However, it was open to counsel in their examination of witnesses to refer to those reviews to test the credibility or reliability of direct evidence of those witnesses.

Police investigations were conducted into all four of the deaths and no criminal prosecutions were undertaken in the end.

Ministry internal review processes were also conducted in all four of these cases: Director's case reviews were completed in two of them, and Deputy Director's reviews were completed in the other two. These internal reviews were limited to analysis of case

practice against expected standards. The two Deputy Director's reviews were simply file reviews involving no extraneous interviews or inquiries.

The coroner's inquests involved more broadly based evidence, including testimony from family members, Ministry staff, medical professionals and experts, and police officers. However, jury members are not in a position to review all Ministry file materials, medical information or police investigation files. The inquest process aims to establish a classification of death, and by nature, does not focus on an exhaustive analysis of all available information. The nature of these processes is that the evidence must be provided through the direct testimony of witnesses and not through documents such as internal Ministry reviews.

The Representative's investigation had the benefit of a review of all known file materials, interviews with key staff witnesses and other Ministry staff from the period and the present day, and review of the coroner's inquest transcripts and materials sought to be filed but not received into the record at the inquests. Practice audits of child protection and guardianship work in the region, along with the reviews of all fatalities and critical injuries from 1999 to the present, were also evaluated.

Following the complete file review and staff interview process, the investigation plan was expanded to include more detailed questions about how the risk assessment model was implemented in 1997 and about utilization of the risk assessment model by child protection workers. The quality assurance models in place at the time were considered. The tools used in practice by child protection workers were a matter of considerable interest.

In order to explore in more detail the issue of assessing child safety, the investigation team developed a series of questions for child protection workers and supervisors with respect to the way they utilize the risk assessment model, barriers to its use, communication between child protection workers and supervisors, and how collateral issues like inexperience and staffing shortages affect their work. The questions were asked of a small group of six front-line child protection workers in each of Smithers, Terrace and Prince George. A group of six team leaders was interviewed in Prince George, and a smaller group of team leaders was interviewed in each of Smithers and Terrace.

The investigation also consulted with individuals who were involved in the training and implementation of the risk assessment model, the North region management team, and current Ministry executive officers regarding social work and child protection practice.

The North region

All four of the children who are the subjects of this report lived in what is currently the Ministry's North region. In order to fully understand the context within which these children and their families were provided with services, it is necessary to consider that the characteristics that distinguish the North region from the other regions of the province.

At just under 925,000 square kilometres, the North region encompasses 66.7% of British Columbia's land mass. With a population of 289,793 (2006 census), it accounts for 6.7% of the province's total population (4,320,255). In addition, the population of the North region is young: an estimated 8.2% of the province's 0–19 age group lives in the region.

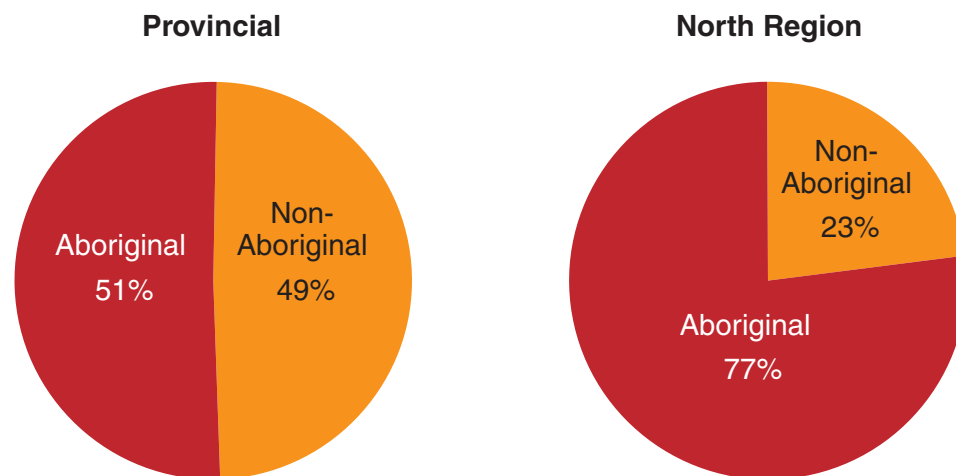
The Ministry provides services from local offices in 18 communities: Prince George, Quesnel, Terrace, Fort St. John, Dawson Creek, Kitimat, Mackenzie, Prince Rupert, Fort Nelson, Chetwynd, Vanderhoof, Fort St. James, Burns Lake, Smithers, Dease Lake, McBride, Hazelton and Queen Charlotte City. There are six delegated agencies in the North region, representing 35 of the 51 First Nation bands in the region.



There are unique challenges in delivering services in a large number of small and often isolated towns, villages and First Nations communities across an area of this geographic size. These include staffing in isolated communities, doing child protection work in small communities, and the amount of time that can be taken up in travel. In the case of First Nations communities, there can also be jurisdictional issues between the federal and provincial governments.

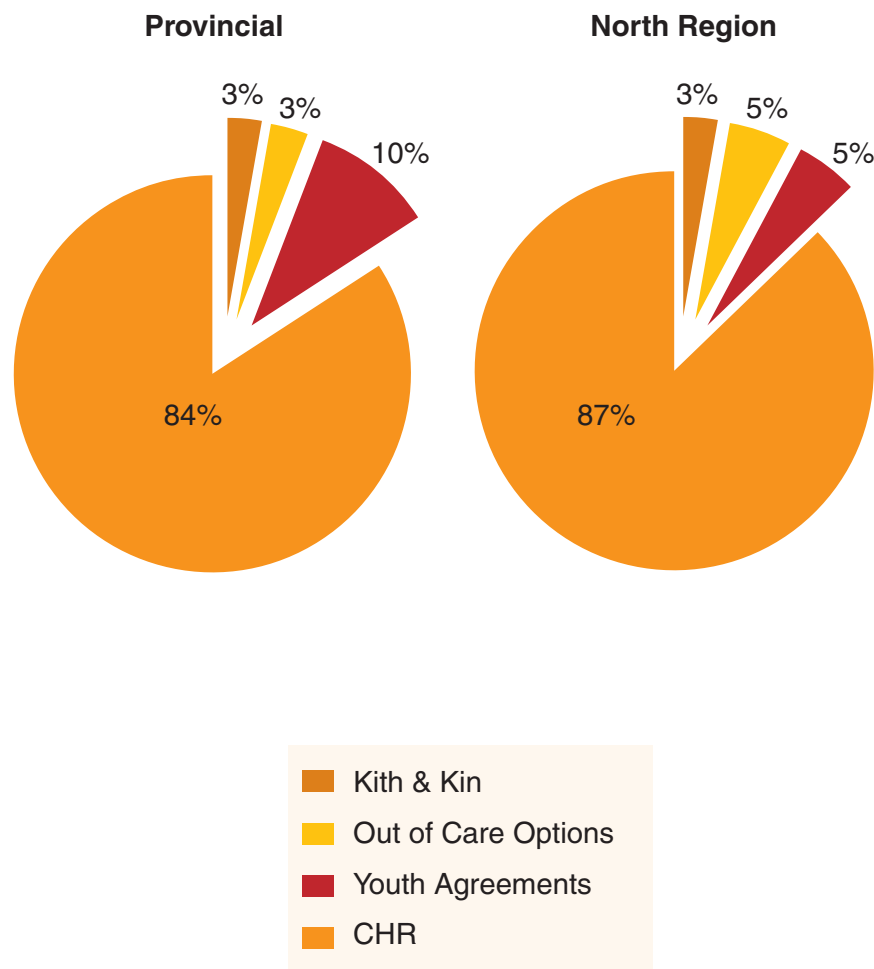
There are 51 First Nations bands in the North region, and 16.6% of the region's total population is Aboriginal, compared with 4.5% of the province's total population. Even more striking is the difference in the 0–19 age group population, of which 24.1% is Aboriginal, compared with 7.7% for the entire province (2006 census). At the end of February 2008, there were 1,023 children in care in the North region. The proportion of children in care in the North region who are Aboriginal is much higher than for the province as a whole (Figure 1).

Figure 1: Children and youth in care



In other ways, the North region more closely resembles the rest of the province. For example, a similar proportion of children and youth in the North are in living arrangements outside of their parental homes, not in the direct care of government but receiving provincial government services (Figure 2).

Figure 2: Children and youth out of parental home



Changes in the Child Welfare System

The period in which the events described in this report occurred was a time of constant change in the child welfare system in British Columbia. A major event in the history of child protection services in British Columbia was the release of the *Report of the Gove Inquiry into Child Protection* in November 1995. In 1996, in keeping with recommendations made in that report, children's services from across government departments were amalgamated in the new Ministry for Children and Families. The Children's Commission was established and given a mandate to provide oversight for services for children and youth, which included reviewing deaths and critical injuries.

In 1996, the Ministry began a process of regionalizing its services, starting with 20 regions and eventually collapsing them into five regions in 2002. There were many resulting changes in organizational structures and leaders. At the same time, there was considerable change in policies and practice standards. Notable developments included a new formal risk assessment process and more effort in the areas of practice audits and case reviews. In addition, Aboriginal agencies grew in number and assumed more responsibility for service delivery.

Further significant changes occurred in 2002, with a review of services and programs initiated by a new government, as well as targeted budget reductions and greater emphasis on alternatives to the removal of children from their families. During this period, oversight of the system was changed, and specific reviews of deaths and critical injuries of children involved with government services or the child welfare system were no longer conducted as a separate activity.

In the fall of 2005, when public concerns were raised following the death of Sherry Charlie, a young Aboriginal child, the Honourable Ted Hughes, QC was asked to conduct the *BC Child and Youth Review*, examining issues related to child protection, advocacy, and the monitoring and reviewing of services, including review of child deaths. Mr. Hughes spoke of his concern about the strategic shifts in the Ministry and whether they supported better outcomes for children or served a narrower set of administrative or political objectives. Mr. Hughes's trenchant observations regarding the need for stability and the strengthening of practice, with better evaluation of outcomes for children and stronger public accountability, are notable. Child safety has been a concern on the ground in the child protection system for many years and various strategies have been employed in the senior ranks of the Ministry to address better practice for children in British Columbia. In some instances, these have been laudable, but were dismantled before they became

functional, while in other instances, they were never committed to. In some cases, the work has started but is not evaluated regularly with public accountability. Mr. Hughes identified the keys to success: outcome measures for children, evaluations, and quality assurance and continual improvement through thoughtful, evidence-based change. There is much work to be done, and the Representative's Office wants to support the Ministry in succeeding in that work.

It is within the context of this changing system and its ongoing challenges in serving and supporting vulnerable children that the deaths of the four children are examined in this report. The timeline on pages 20-21 identifies the main strategic shifts and developments in the Ministry and social work practice during the lives of Amanda, Savannah, Rowen and Serena.

Timeline of Significant Events

