

Backgrounder

CHANGES TO REVIEWER'S ORIGINAL RECOMMENDATIONS IN ALBERNI CASE

1. Recommendation #1 regarding the complex tri-partite relationship between First Nations, the Province and the Federal government was removed and **changed into an "Observation"** in Appendix II of the final version of the Director's Case Review.
2. Recommendation #2 regarding the need for training to be provided for a new child protection policy was included in the final version as the **third recommendation, with weakened language.**
3. **Recommendation #3 on funding was removed outright.**
4. Recommendation #4 on the **need for non-Resource social workers to be trained before doing home studies was removed outright.**
5. Recommendation # 5 stating that **criminal investigations must be secondary to child protection investigations was removed outright, and language regarding the Section 14 duties of officials was also removed.** Softer language referring to communication and a good working relationship between MCFD and law officials was **included as an "Observation"** in Appendix II of the final version of the Director's Case Review.
6. Recommendation #6 regarding process for when there is **uncertainty over cause of death** was removed and **changed into an "Observation"** in Appendix II of the final version of the Director's Case Review.
7. Recommendation #7 regarding making **home study requirements the same for "kith and kin" as that demanded of restricted care was removed outright.**
8. Recommendation #8 regarding **the flawed kith and kin guidelines and incomplete checklist for criminal records check had the language changed to whitewash the government's error.** The whitewashed version appears as Recommendation #4.
9. Recommendation #9 regarding medical examinations in cases of suspected abuse had its language softened and appears as Recommendation #5.
10. Recommendation #10 regarding the need for an information-sharing computer database appears basically in the same format as Recommendation #6.
11. Recommendation #11 regarding case files of young parents is included in essentially the same form as Recommendation #7.
12. Recommendation #12 regarding file management policy was removed outright.
13. Recommendation #13 regarding file management policy was removed outright.

14. Recommendation #14 regarding the need for non-delegated social workers and family care workers to take Level 15 social worker training if they are expected to carry out delegated responsibilities was addressed in different wording by Recommendation #8.
15. Recommendation #15 regarding the need for non-delegated social workers and family care workers to take Level 15 social worker training if they are expected to carry out delegated responsibilities was addressed in different wording by Recommendation #8.
16. Recommendation #16 regarding file management (distinguishing protection files from others) was addressed in slightly different wording by Recommendation #9.
17. Recommendation #17 regarding file management of Family Services files was removed.
18. Recommendation #18 regarding the **need for social workers in remote areas to travel in pairs** was removed and **changed into an “Observation”** in Appendix II of the final version of the Director’s Case Review.
19. Recommendation #19 regarding **family members not being suitable for registering intakes** was removed and **changed into an “Observation”** in Appendix II of the final version of the Director’s Case Review.
20. Recommendation #20 regarding the need for clear communications protocol between agencies and police was included with different wording as Recommendation #11.
21. Recommendation #21 regarding Prior Contact Checks being done only by delegated social workers and not as a clerical function was included with different wording as Recommendation #12.

TEXT OF ORIGINAL RECOMMENDATIONS (APPENDIX 14 *Morley’s Section 6 Report*)

Confidential

Recommendations

- 1) Complex tri-partite financial and policy arrangements exist between the Federal, First Nations and Provincial governments that may lead to confusion over which level is legally and financially responsible for various practice decisions.
- 2) Before new child welfare legislation is enacted, new standards are implemented or new policies are approved, the director must provide all social workers with its associated training, especially in cases where the new legislation is central to how children are protected, such as Section 8,9 ,10 and 41.
- 3) Comprehensive funding to support new initiatives should be a consideration when enacting new legislation, new standards are implemented or when new policies are approved.
- 4) If child protection social workers are expected to conduct home studies of any kind – including Section 8 home studies, they should be undertaken by Resource social workers, accustomed and trained to conduct them.

- 5) Criminal investigations are secondary to child protection investigations, and as such all professionals and government agency representatives, including coroners and law enforcement officials must be reminded of their Section 14 obligations in order to prevent children from remaining in obviously dangerous situations.
- 6) When a child dies, and there is no immediate evidence available to confirm the cause of death, a team of pre-identified health and social service workers should be available to be consulted to determine the appropriate course of action (if any) to be taken with regards to any other child welfare concerns in the home. This team would be similar to that of the HARC (Health Assessment and Resources for Children) team, made up of a Pediatrician, two General Practitioners, a Psychologist, A social Worker, a half-time Nurse and one Administrator Position who respond in serious and complicated child protection matters.
- 7) Home Study requirements for Section 8 Kith and Kin Agreements should have the same requirements as those contained "Restricted" family care home studies.
- 8) Social workers should be given direction when entering into a Kith and Kin Agreement where a caregiver has a criminal record for an offence or offences that appear on a schedule of offences from the Criminal Records Review Act, Cited as Appendix "A" of the Practice Guideline for Section 8 Agreement-Aboriginal Agencies. The list should also be expanded to include alcohol and drug-related offences, as well as all crimes of violence so that domestic violence is included. The second option is to eliminate the list entirely and to allow social workers to use professional discretion and supervisory approval.
- 9) Social workers should request a medical examination as a matter of course on all children who have been the subject of child protection concerns are living in a home where domestic violence or persistent abuse is likely.
- 10) All child welfare agencies in British Columbia should be required to use an information-sharing computer database that interfaces with every other child welfare agency in the province. The SWS MIS system of file management and information sharing is one such database that should be available to all agencies in the province prior to *their achievement of* Level 15 (protection) delegation. Because social workers' tools are limited, knowledge of a family's previous history is essential for them to make informed decisions. The SWS MIS system lists any previous Ministry involvement with the child and family. Since all agencies go through a long and graduated process of achieving the highest level of delegation, the requirements that the information-sharing program be in existence prior to the Level 15 delegation would create undue hardship on an agency.
- 11) When social workers register intakes on young people who are parents or who are about to be parents and who are living away from their legal guardians with little or no likelihood of repatriation, they should identify the young person as the "key Player" on their own FS file even if they are living with family members or other de facto caregivers. This will lead to intakes on a mother being recorded in her own file rather than hidden in an old caregiver's file.
- 12) When opening or re-opening a file, social workers should take special care to identify the "key player", and that all other individuals are identified by their relationship to that "key-player."
- 13) All intakes should be part of a Family Service (FS) file with a constant file number associated with it. This does not mean that FS files should remain open, but each time it is opened, the entire file should remain intact with all previous contacts recorded. This will ensure that all intakes are kept with the file to which they associated.

- 14) Non-delegated social workers or family care workers should be required to take social worker training (Level 15) if they are expected to carry out any delegated responsibilities.
- 15) Family Support workers who are not employees of Agencies but work in communities without full-time delegated should be required to undertake delegation training.
- 16) All files should be clearly marked as “protection” or “request for family support services”. While the response of the social workers may not be affected by this classification because of their knowledge of the case, when the file is transferred to either; another social worker or another agency, proper classification is critically important.
- 17) Family Services (FS) files should be opened when the first intake is registered. They should not be used as a measure to reduce protection concerns, because in theory, every intake becomes a part of a FS file. The file should stay open if protection concerns are being addressed with specific involvement of the agency.
- 18) Social workers working in remote communities should be required to travel in pairs whenever carrying out delegated responsibilities. This additional travel cost and casework should be recognized in funding arrangements.
- 19) Family members should not register intakes on other Family Services files, whether they are “protected” calls or “request for family support services”.
- 20) A clear communications protocol should be developed and implemented between delegated social workers and local police detachments.
- 21) PCC’s should be accessed only by delegated social workers and should not be considered clerical functions.



CORONER'S COURT OF BRITISH COLUMBIA

held at PORT ALBERNI, British Columbia

VERDICT AT CORONER'S INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE INQUEST

INTO THE DEATH OF

CHARLIE

SURNAME

SHERRY LAURA ANN

GIVEN NAMES

TO: DIRECTOR, CHILD FAMILY AND COMMUNITY SERVICES ACT
TRAINING

- 1. That all delegated Social Workers should have access to the same training in the same time frame regardless if they are an agency or a Ministry worker.

SECTION 8 - KITH & KIN

- 2. That all conditions, that is, criminal record checks, prior contact checks and references, must be met pre-placement.
- 3. That three references be required including one each from the paternal and maternal sides of the family and one from a neutral person who knows the caregivers.
- 4. That during a first intake call, to inform parents that Kith and Kin Agreements can be made available.
- 5. That no discretionary power be given to Social Workers when any court order is in place.
- 6. That two audits be conducted within a three year time frame.

TO: THE DIRECTOR OF USMA AND THE NUL-CHAH-NULTH TRIBAL COUNCIL

- 7. That all employees of USMA must not compromise the integrity of the true meaning of 'USMA'.

TO: THE FIRE CHIEF, PORT ALBERNI FIRE DEPARTMENT

- 8. That members be reminded of their duty to report pursuant to section 14 of the CFCSA

TO: THE BCAS

- 9. That all employees be reminded of their duty to report pursuant to section 14 of the CFCSA
- 10. That all paramedics be required to document any external signs of injury such as bruises on their crew reports

TO: THE OFFICER IN CHARGE, 'E' DIVISION RCMP

- 11. That the officer investigating any child death should attend the postmortem examination so that there is direct discussion with the Pathologist regarding findings and their significance.
- 12. That when a child known to the MCFD or their designates has died, and other children remain in the home, autopsy findings are shared with social workers so that safe decisions can be made.



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TO: MEDICAL DIRECTOR, WEST COAST GENERAL HOSPITAL

13. That the attending doctor receive the pathologist report in any case of a sudden child death.
14. We suggest debriefing for staff who attend to the injured child who died.
15. That medical intervention apparatus from body be removed only by pathologist.

TO: CHIEF CORONER, BC CORONERS SERVICE

16. That Section 14 of the CFCSA be included in coroners' training.
17. That medical intervention apparatus only be removed by the pathologist.
18. That a method be put in place so new facts can be added to the Kimble Report for ongoing investigations.

TO: THE PREMIER OF THE PROVINCE OF BRITISH COLUMBIA

19. To re-instate the Children's Commission.