

# Overview of the Child Critical Injury and Death Investigation and Review Process in British Columbia

February 2008

<b>Exhibit: National Inquiry into Missing and Murdered Indigenous Women and Girls</b>		
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Prepared by The Children's Forum:

- BC Coroners Service
- Ministry of Children and Family Development
- Ombudsman
- Public Guardian and Trustee
- Provincial Health Officer
- Representative for Children and Youth



# Overview of the Child Critical Injury and Death Investigation and Review Process in British Columbia

## February 2008

The purpose of this document is to summarize the roles and responsibilities of the Coroners Service, the Ministry of Children and Family Development, the Ombudsman, the Provincial Health Officer, the Public Guardian and Trustee and the Representative for Children and Youth in the review of critical injuries and deaths of children in British Columbia, and to describe how these public agencies collaborate to strengthen the system of supports for vulnerable children and youth.

### Introduction

In British Columbia, several agencies examine the critical injuries or deaths of vulnerable children and youth. The BC Coroners Service (BCCS), the Ministry of Children and Family Development (MCFD), the Ombudsman, the Provincial Health Officer (PHO), the Public Guardian and Trustee (PGT) and the Representative for Children and Youth (RCY) all have legislative mandates related to reviewing critical injuries or deaths of children. Until recently, these agencies have acted largely independently of one another.

In the 2006 BC Children and Youth Review (the Hughes Review), the Honourable Ted Hughes found that the independence of these public bodies largely precluded the kind of cooperative relationships proven to yield systemic change and improvements to service delivery. He suggested that improved cooperation and collaboration between these public bodies could improve the system of supports and strengthen public accountability.

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.

The Hon. Ted Hughes, QC  
BC Children and Youth Review

The Hughes Review recommended that "the Ministry establish a forum or council, including the new Representative for Children and Youth, the Coroners Service, the Ombudsman and the Public Guardian and Trustee, that will meet regularly to review developments and issues of common concern" (BC Children and Youth Review, p. 108) in order to facilitate the collaborative relationships required for systemic reform.

In December 2006, MCFD held the first meeting of the Children's Forum with the Chief Coroner, the Ombudsman, the Public Guardian and Trustee and a representative from the Ministry of Health. In that meeting, it was recommended and agreed that the Representative for Children and Youth would be the most appropriate Forum Chair. The Representative chaired her first meeting in March 2007, and the Forum, comprising all of its recommended representatives, has been meeting quarterly since then.

## **The Ministry of Children and Family Development (MCFD)**

MCFD provides services, including child protection services, through its regional offices, delegated Aboriginal agencies and contracted agencies. *The Child, Family and Community Service Act* (1996) provides the statutory authority for critical injury and death review and reporting.

The ministry provides and/or funds programs in the areas of youth justice, child and youth mental health, special needs as well as child welfare, which includes the guardianship of children in care. Each of these program areas have policy, including procedures for reporting and reviewing critical injuries and deaths of children and youth in care and/or receiving services.

MCFD policy requires staff to report a critical injury and/or death of a child who has been in care or received service through a ministry program within the 12 months preceding the injury or death. The policy related to each program area differs slightly, and different types of review and investigative processes can be undertaken in different program areas. MCFD is moving toward a process that is more standardized and integrated.

For children served by child protection services, it is the Director of Integrated Practice for the region or the Provincial Director of Child Welfare who must decide whether a further review of the critical injury or death should be conducted. In the child welfare and guardianship program area specifically, reviews are usually conducted when the injury has been determined to be non-accidental or unexpected. The Director must also indicate reasons for not conducting a further review of the incident. In June 2007, *Child, Family and Community Service Act* regulations were amended to mandate a review when the injury was deemed to be due to maltreatment and/or neglect.

Recommendations resulting from the review process are implemented by senior staff and community managers and these recommendations are tracked until they are completed. Public reporting includes the posting of fatalities, audits and case review summaries. The ministry's case review model is moving toward being more coordinated and integrated across program areas, as recommended in the Hughes Review.

**Contact information:**

The Ministry of Children and Family Development  
PO Box 9970 Stn Prov Govt  
Victoria, BC V8W 9S5  
Ph, Victoria: (250) 387-7027  
Ph, BC: 1-877-387-7027  
E-mail: MCF.CorrespondenceManagement@gov.bc.ca

## **The Public Guardian and Trustee (PGT)**

The Public Guardian and Trustee is a corporation established under the *Public Guardian and Trustee Act* (1996). Among its many roles regarding children, the PGT is the guardian of the estate of children who have been placed in continuing care. When a critical injury occurs and is reported to the PGT, a review of the circumstances of the injury is carried out to assess whether compensation may be available through civil action or other means. If so, the PGT may bring civil action for the injury. This may occur relatively soon after the injury or the legal proceeding may be postponed in order to more thoroughly consider the long-term impact on the life of the child so that appropriate compensation can be determined. If the injury is compensable, the PGT acts on the child's behalf and represents the child's legal interests. This particular role of the PGT is generally only applicable to children in continuing care.

**Contact information:**

The Public Guardian and Trustee of British Columbia  
700 - 808 West Hastings Street  
Vancouver, BC V6C 3L3  
Ph: (604) 660-4444  
Fax: (604) 660-0374  
E-mail: mail@trustee.bc.ca

## The BC Coroners Service (BCCS)

The BC Coroners Service is a public agency within the Ministry of Public Safety and Solicitor General. In British Columbia, all child deaths are reported to the Chief Coroner under Section 2 of the *Coroners Act* (2007). This includes all sudden and unexpected deaths as well as those deaths believed to be natural and expected.

On receipt of a report of child death, a Coroner will conduct an investigation and will determine who the child was, and how, when, where and by what means the child died. In the case of a natural and expected death, this investigation may be concluded shortly after the death occurred. In cases where the death was sudden, unexpected or unexplained, the investigation may take longer to complete. At the conclusion of an investigation, the Coroner will make a report to the Chief Coroner. The report may include recommendations or in some circumstances, the Chief Coroner may direct that an inquest be held.

At the conclusion of an investigation or inquest, the child death will be referred to the Child Death Review Unit (CDRU) of the BC Coroners Service. All child deaths are reviewed by case review specialists within the CDRU. During the course of the review, CDRU members may exercise the powers of investigation set out in Section 11 of the *Coroners Act* as if the member were a Coroner conducting an investigation.

Following each review of a child death, the CDRU will make a report to the Chief Coroner with findings respecting the circumstances related to the death and any recommendations respecting the prevention of similar deaths.

The Chief Coroner may establish a child death review panel to conduct further reviews of individual child deaths or a cluster of deaths. The child death review panel will provide the Chief Coroner with advice related to medical, legal, social welfare and other matters that may impact public health and safety and the prevention of child deaths.

The CDRU and child death review panel may make recommendations to the Chief Coroner respecting the protection of the health, safety and well-being of children generally but must not, in a report, make any finding of legal responsibility or express any conclusion of law.

### **Contact information:**

The Chief Coroner's Office  
Metrotower II Suite 800 - 4720 Kingsway  
Burnaby, BC V5H 4N2  
Ph: (604) 660-7745  
Fax: (604) 660-7766  
E-mail: BC.CorSer@gov.bc.ca

## The Ombudsman

The Ombudsman is an independent officer of the Legislature operating under the *Ombudsman Act* (1996). The Ombudsman can investigate complaints about administrative decisions, actions, omissions and procedures by public authorities including the Ministry of Children and Family Development, the Office of the Public Guardian and Trustee, the Provincial Health Officer and the Coroner's Service. Normally this is done after internal dispute resolution processes have been fully utilized.

Ombudsman investigators work in a consultative manner to develop, wherever possible, a fair resolution to a complaint and identify ways to improve administrative systems. The Ombudsman can make findings that administrative decisions, actions, omissions, or procedures are contrary to law, unjust, oppressive, improperly discriminatory, arbitrary, unreasonable, unfair, done for an improper purpose, negligent, result in undue delay or are otherwise wrong, and recommend solutions. The Ombudsman can also issue public reports. The Office of the Ombudsman may review complaints about public authorities' handling of a critical injury or death and look at systemic issues that adversely impact service delivery to children and youth.

### **Contact information:**

The Office of the Ombudsman  
2nd Floor, 756 Fort Street  
Victoria, BC V8W 9A5  
Ph, Victoria: (250) 387-5855  
Ph, BC: 1-800-567-3247  
Website: [www.ombudsman.bc.ca](http://www.ombudsman.bc.ca)

## The Provincial Health Officer (PHO)

The Provincial Health Officer collects and analyzes data on all child deaths that occur in BC. The analysis informs improvements to the child serving system in order to improve the health and social outcomes of all children.

The PHO's role is to provide a larger context for population health and well-being trends and for the causes of child fatalities. The PHO educates and recommends prevention strategies to improve children's health and brings profile to the health issues that arise for children generally and for vulnerable children in particular.

### **Contact information:**

The Office of the Provincial Health Officer  
4th Floor, 1515 Blanshard Street  
Victoria BC V8W 3C8  
Ph: (250) 952-1330  
Fax: (250) 952-1362  
Email: [Andrea.Berkes@gov.bc.ca](mailto:Andrea.Berkes@gov.bc.ca)

## The Representative for Children and Youth (RCY)

The Representative for Children and Youth, who is an independent officer of the Legislature, has a multifaceted mandate that includes advocacy, review and investigations of critical injuries and deaths, and the monitoring of the child serving system.

The Representative has a statutory mandate to review and investigate the non-accidental critical injuries and deaths of children who received designated government services (in areas such as youth justice, mental health and/or child protection) in the 12 months prior to the incident. The Select Standing Committee on Children and Youth (SSCCY) may also make referrals to the Representative to review and report on deaths, injuries or other matters pertaining to children in British Columbia.

The *Representative for Children and Youth Act* (2006) provides that the Representative must wait until a criminal process has been completed for the investigation to begin. If no criminal process arises following the child death or injury, then the Representative waits for MCFD and/or the Coroner Service to complete their work before commencing an investigation. The Representative is required by law to allow these agencies up to one year following the critical injury or death to complete their work before engaging in an investigation. Where no such reviews are conducted, the Representative's work can commence before the one-year period.

The RCY process is to collect the relevant documentation and conduct a preliminary review in order to determine whether the circumstances of an incident raise service delivery issues or present opportunities to consider strengthening the system of supports for vulnerable children and youth in British Columbia. The Representative then monitors the file until other reviews are completed. The Representative analyzes the file and circumstances and determines whether circumstances cited in Section 12 of the *Representative for Children and Youth Act* (service delivery issues and/or self-harm and/or suspicious circumstances) were involved in the incident and thus whether a full investigation, analysis and report are required.

Following the investigative process, the Representative may seek the advice of a multi-disciplinary team. This team, as established by the Representative's Office, comprises health and child welfare experts and community professionals who review the findings of the investigation and provide input on recommendations to improve the system.

The Representative reports findings and recommendations to the Select Standing Committee on Children and Youth of the BC Legislature, and to the public.



**Contact information:**

The Representative for Children and Youth  
4th Floor, 1019 Wharf Street  
PO Box 9207 Stn Prov Govt  
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Ph, Victoria: (250) 356-6710  
Ph, BC: 1-800-476-3933  
Fax: (250) 356-0837  
Email: rcy@rcybc.ca

**Collaboration**

Each of the offices and agencies involved in the Children's Forum interact extensively, as is appropriate, given their respective roles and responsibilities.

Where fatalities are concerned, a Memorandum of Understanding (MOU) between MCFD and the Coroners Service, in place since 1996, outlines the information-sharing process between the two organizations. If a child or youth dies, MCFD notifies the Coroner if the child has had involvement with the ministry or was in care in the 12 months preceding the incident. The same notification process is carried out by MCFD to the RCY. MCFD must also report critical injuries to the RCY. MCFD and the PGT also have a MOU that outlines how information is shared between them regarding children for whom they share guardianship. This includes delivery by MCFD to the PGT of all critical incident reports involving children in continuing care.

Upon completion of the MCFD review process, the review report is provided to the Coroner (in the case of a death) and to the RCY in order to facilitate their respective review and investigative processes.

On occasion, child deaths that have been referred to the Child Death Review Unit for a final review are subsequently referred to the RCY. Referrals to the RCY fall into two categories. The first category are those child deaths that occurred during the 2002-2007 transition period where there are unexamined child welfare issues. The second is where the death was intentional or occurred in extraordinary circumstances, where service or other systemic issues have been identified and it is in the public interest for the death to be further reviewed.

The RCY also has memoranda of understanding with MCFD and other organizations. These MOUs ensure that information-sharing protocols are in place to allow the RCY to accomplish its mandate while working collaboratively to strengthen the system of supports for vulnerable children and youth.

## Conclusion

The child critical injury and death review process in British Columbia is undergoing significant changes to improve collaboration and cooperation among various review bodies in an effort to better protect the safety, health and well being of vulnerable children as well as improve their system of support. The Children's Forum and the individual members of the Forum look forward to their continued partnership on behalf of children.

## Appendix: Resources

British Columbia. *Child, Family and Community Service Act*. R.S.B.C. 1996, c. 46.

British Columbia. *Coroners Act*. S.B.C. 2007, c. 15.

British Columbia. *Ombudsman Act*. R.S.B.C. 1996, c. 340.

British Columbia. *Public Guardian and Trustee Act*. R.S.B.C. 1996, c. 383.

British Columbia. *Representative for Children and Youth Act*. S.B.C. 2006, c. 29.

Canada. *Criminal Code of Canada*. R.S.C. 1985, c. 2 (1st Supp.)

Hughes, T. (2006). *BC children and youth review: An independent review of BC's child protection system*. Victoria, BC: Ministry of Children and Family Development.



