



REPRESENTATIVE FOR  
CHILDREN AND YOUTH

Exhibit: National Inquiry into Missing and  
Murdered Indigenous Women and Girls  
Location/Phase: Parts 2/3 Winnipeg  
Witness: Mary Ellen Turpel-Lafond  
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Add'l info: P02-03 P03 P04 01  
Date: OCT 04 2018

Initials

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# Final Progress Report on the Implementation of the Recommendations of the BC Children and Youth Review ("Hughes Review")

November 29, 2010







REPRESENTATIVE FOR  
CHILDREN AND YOUTH

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Nov. 29, 2010

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 the Progress Report on the Implementation of the Recommendations of the BC Children and Youth Review to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 20 (2) (b) of the *Representative for Children and Youth Act*, which allows the Representative to make special reports to the Legislative Assembly.

Sincerely,

Mary Ellen Turpel-Lafond  
Representative for Children and Youth

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

Ms. Joan McIntyre  
Chair, Select Standing Committee on Children and Youth





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## Part One – Overview

### Background

In 2005 the Honourable Ted Hughes, QC, was asked by the provincial government to examine aspects of the child-serving system and make recommendations for improvement. The *BC Children and Youth Review: An Independent Review of BC's Child Protection System* (the "Hughes Review") was released in April 2006.

A key Hughes Review recommendation called for the creation of a new position and the appointment of a Representative for Children and Youth – an Independent Officer of the Legislature. The mandate of the Representative, as set out in the Hughes Review, was to include monitoring the child welfare system, reviewing child injuries and deaths and advocating on behalf of individual children and families and the systems that serve them.

Government endorsed all of the Hughes Review recommendations, and the Legislature appointed the first Representative on Nov. 27, 2006. The Office's oversight role came into force April 1, 2007.

This report marks the third time since being appointed that the Representative for Children and Youth has examined government's progress on implementing the Hughes Review recommendations. The purpose of these reports is:

- to determine what has been accomplished in repairing the system
- to compare what the Hughes Review recommended, with the reality of what has been achieved
- to look at "what is and what can be."

This ongoing monitoring of progress on Hughes recommendations looks closely to see if actual change is taking place – change that responds to the key areas identified in the Hughes Review. In other words, is government actually improving the system by addressing the issues raised in the Hughes Review?

Over the course of the Representative's four years of monitoring and assessment of progress on the Hughes recommendations, all but five of the 47 recommendations initially assessed as not complete have received two thorough assessments.





## 2007 Progress Report

In the Representative's first progress report, all 62 Hughes Review recommendations were reviewed. Fifteen were assessed as complete or fully operational, leaving 47 to be further assessed.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Insufficient information provided
62	15	3	11	8	22	3

## 2008 Progress Report

In the second progress report, the Representative re-examined 15 recommendations that had been previously assessed as not yet complete, leaving 32 to be further assessed.

These 15 recommendations were specifically chosen for evaluation in 2008 because the Representative believed them to be at the very core of the essential work required to improve and enhance the way the Ministry of Children and Family Development (MCFD) functions in serving B.C.'s vulnerable children and youth. These recommendations relate to the decentralization of MCFD, quality assurance and accountability, and MCFD's complaints processes.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Insufficient information provided
15	0	1	5	7	2	0

## 2010 Progress Report

This third progress report re-examines 27 recommendations that had been previously assessed as not yet complete, leaving five to be further assessed. MCFD was given the opportunity to review and comment on the Representative's assessments on two occasions – first in December 2009 and again in July 2010 – as part of the administrative fairness process.

These recommendations relate to case reviews, modern approaches to child protection, communication, information-sharing and privacy, and the external oversight role.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	No progress or limited progress	Implementation unsatisfactory
27	12	3	0	1	0	11

Five other recommendations will be evaluated in an upcoming broader review of services to Aboriginal children and families.





## Moving Away from Hughes

When the Hughes Review was released, it was enthusiastically received throughout the province and by both government and the opposition. In the 2006 government budget, a significant infusion of new money was earmarked for the implementation of the Hughes recommendations and enhancements to child protection and family support services. In April 2006, the path ahead seemed very clear.

The Hughes Review is widely acclaimed as an incisive, accurate and thoughtful look at the challenges facing B.C.'s child welfare system, with the identification of practical, clear means to improve it. Mr. Hughes described his review as a blueprint "to allow for full repair of a system that has in recent times been battered on stormy seas." Many agreed then and many, including the Representative, agree to this day.

By mid-2007, MCFD had introduced their new *Good Practice Action Plan*. In Sept. 2007, MCFD's Deputy Minister reported to the Select Standing Committee on Children and Youth that the ministry's new action plan was "not a response to the Hughes recommendations or the Hughes report."

Unfortunately, in the 4½ years since the Hughes Review, there has been at times a lack of sustained action on the agenda that Mr. Hughes provided, and at other times outright government dismissal of the Hughes recommendations.

This Hughes progress report will be the last dedicated to examining progress on specific recommendations from the Hughes Review. The decision to make this the final Hughes progress update is not because the Hughes Review recommendations have been adequately addressed.

A new way of assessing progress is necessary because MCFD has now moved on to using other frameworks for change. To address this reality, a new approach to measuring progress is required in order to provide the public with an independent assessment of whether B.C.'s children and youth are better served today than when Mr. Hughes tabled his report.

Unfortunately, due to the immense amount of time and resources required to properly assess progress on each recommendation, it is not possible to definitively answer the key question: How many of the 62 Hughes Review recommendations are now complete? The Representative estimates that less than half of them are complete or fully operational. The disappointing reality is that far too many Hughes recommendations have never received the attention they deserve, and at this point likely never will.



Although the Representative will move to different methods of assessing improvements to the child welfare system, the Hughes Review and its recommendations will remain at the core of such work. A "touchstone" is defined as an excellent quality or example used to test the excellence or genuineness of others. The wisdom of the Hon. Ted Hughes and the Hughes Review will always be touchstones in the continuing work of the Representative.

### **A Detailed Look: MCFD's Response to Hughes**

As mentioned, the Hughes Review was a plan for action – a comprehensive blueprint for legislative, policy and practice changes to improve the child-serving system. Instead of actively engaging in implementing the essential changes put forward in the review, MCFD's overall response has been the creation of alternative plans that make high-level reference to the Hughes Review yet offer no detailed information on the specific recommendations.

The Representative notes that these plans have a vague quality and a noticeable absence of detailed operational or budget documentation to support them, including information about the specific allocation of funding for new initiatives and means to achieve the vision of the alternative plans. There is no clear path involving legislative, policy or standards reform directed at measured improvement for children and youth.

After 4½ years, the opportunity to fundamentally change the child-serving system has not been realized. In July 2007, MCFD released the draft *Good Practice Action Plan* and then, in April 2008, released *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth*. These plans received qualified support from the Representative in prior updates. However, the concerns noted in 2007 and 2008 are still present – the plans remain, to this day, high level and aspirational. Concrete strategies for implementation are lacking. These alternative plans do not adequately embrace or address the Hughes Review recommendations, and the Representative does not consider them to be satisfactory substitutes.

The Hughes Review updates provided within the *Strong, Safe and Supported* document are brief and lack substance. The status updates for each recommendation are limited to a few sentences and do not contain sufficient detail or analysis of practice change. The Representative reviewed these updates and held back this report for a period to give MCFD the opportunity to showcase their achievements. The Representative's approach was one of encouragement, and it was openly stated on many occasions that the intent of the current update was to profile the ministry's achievements in effecting positive change for children.

The Representative repeatedly requested further information regarding the nature and extent of the service transformation approach that MCFD put forth as a response to the Hughes recommendations. The Representative and senior staff were provided a briefing on the



"practice framework" by the Deputy Minister. Unfortunately, this briefing failed to answer the fundamental questions of what exactly the transformation exercise is intended to accomplish, what will change, how it will be implemented and what outcomes it purports to address. Subsequent requests for this detailed information or further briefings about this important change initiative were rebuffed by MCFD. After a great deal of effort, the Representative was eventually provided with a binder containing "all the available information" concerning the new practice and assessment process.

Careful review showed that the binder was mostly material already provided to the Representative or publicly available on the MCFD website. Information about the practice framework was entirely conceptual, described in diagram rather than containing detailed information that would allow a careful and thorough analysis. This is an initiative that has been promised for more than four years. It is the cornerstone of the transformation approach, guided by MCFD's Deputy Minister. It is reasonable to expect that such an initiative could be succinctly described and that the written material would be readily available. The Representative is concerned that such a major government policy approach appears to have a weak foundation and has heard repeatedly from MCFD staff, service providers and related professionals that a considerable degree of confusion and frustration exists around transformation.

Implementation and effective change management are always central challenges of large transformation efforts in the public sector. Based on the material and briefings provided to date, the Representative sees no evidence that the practice framework exists beyond broad aspirational statements, even though specific policy changes that will impact hundreds of children and their families are premised on its existence. For example, see the Representative's recent report, *No Shortcuts to Safety: Doing Better for Children Living with Extended Family*, an audit report on the ministry's Child in the Home of a Relative (CIHR) program and kinship placements.

Only a limited amount of information was provided to the Representative that would showcase achievements of the ministry regarding either the transformation agenda or implementation of the Hughes recommendations. Today less than half of the Hughes recommendations are considered complete or fully operational. Major themes such as quality assurance, organizational learning, public accountability and decentralization continue to be inadequately addressed or are said to be restructured with lack of clarity about what will be measured or improved. Public reporting must be more consistent and detailed, particularly in the area of critical injuries and deaths.



The Representative is concerned that MCFD is now in a position, having moved off the Hughes recommendations, of promising great things but showing no evidence of improved outcomes. There is insufficient evidence of appropriate budgeting, workforce management or clarity around expectations for non-governmental service providers. All of this is compounded by recent budget pressures and new priorities on fiscal restraint.

The Representative is not expecting MCFD to achieve a standard beyond reach. There is no such thing as a perfect child welfare system. But an effective system has some essential characteristics, and these were articulated clearly in the Hughes Review. A well-functioning child welfare system meets the obligations established in legislation by:

- establishing a clear mandate
- guaranteeing children and families equitable and consistent access to core services
- establishing service expectations and standards to ensure consistency
- establishing effective structures and systems to support the services, including adequate supervision and ongoing training
- allocating appropriate resources, including adequate and qualified staff
- achieving reasonable outcomes
- reporting on outcomes achieved at the level of the child, particularly for children at risk
- maintaining transparency in the delivery of services, and
- monitoring performance and using data to improve services.

These are the fundamental elements of the system that the Representative will continue to monitor in the interests of transparency and public accountability. The Representative is not confident that these components are currently in place given the level of reporting and accountability the ministry has provided.



## Part Two – Observations

This section examines a number of systemic concerns that have not been addressed, as well as ongoing barriers to the creation of real and sustainable change. These same concerns were noted in the Hughes Review itself, and it is unacceptable that none of these have been resolved to a satisfactory level. In Part Three of this report, the Representative looks at 27 specific recommendations.

### MCFD Decentralization

The Hughes Review recognized that decentralization had the potential to better meet the diverse needs of children and youth across the province. The review supported the ministry's efforts to be innovative and to be responsive to local contexts. However, the review stressed the importance of regional practice and variations in service delivery occurring within a strong provincial framework of standards and oversight. Monitoring at a provincial level is essential to the delivery of consistent, high-quality services across all regions. As the Hughes Review noted, MCFD headquarters carries out a vital function in overseeing the regional operations of the ministry and in ensuring consistent delivery and availability of services across B.C.

MCFD remains committed to a form of regionalization. The Representative is concerned that this approach leads to inconsistency, reduced accountability for decision-making and a critical lack of oversight.

A number of frameworks and structures have been created to support the decentralized model, including the Integrated Case Review Framework; the Child and Family Support, Assessment, Planning and Practice framework; the Regional Executive Director (RED) Council; the Integrated Quality Assurance Team; and the Continuous Quality Improvement Strategic Working Group. The Representative is concerned that these frameworks lack the depth and the detail to adequately guide practice. In addition, insufficient evidence has been provided to illustrate that the provincial teams, councils and committees have held or can hold the regions accountable for practice deficiencies or non-compliance.

When a serious issue or conflict arises, will the collective and collegial style of MCFD's decentralized model be sufficient and effective? The ministry's recent review of the RED Council identified this same problem. It was noted in material provided by MCFD<sup>1</sup> that some Assistant Deputy Ministers (ADMs) were concerned that the council was not addressing issues of regional isolation and inconsistencies with defined provincial approaches.

<sup>1</sup> Ministry of Children and Family Development. *Regional Executive Director Council Review*. January 2009.



Furthermore, the question was raised as to how the Council would regulate itself. The Representative had serious reservations about that same question. The Representative is not clear on how the recent elevation of REDs to ADMs and the dissolution of the RED Council will address the need for consistent provincial oversight of regional practice and variations in service delivery. The Representative requested, but did not receive, information on how the oversight responsibilities previously ascribed to the RED Council were now being handled by either the MCFD Leadership Team or the new REDs. In fact, with the newest organizational structure, less detail is available on how the ministry monitors and enforces consistent practice than there was during the review period and the existence of the RED Council. Rather than addressing the concerns expressed about the potential ineffectiveness of the RED Council to police itself, yet another structure has been created in its place and, in the Representative's view, without an analysis of what is needed to adequately address regional inconsistencies and practice concerns.

### Quality Assurance and Accountability

A decentralized model requires increased attention to accountability. The Hughes Review noted MCFD quality assurance suffered with the transfer of this function to the regions. A number of changes have occurred since that time, including:

- the creation of the Integrated Quality Assurance Team in headquarters and the Integrated Quality Assurance and Improvement Framework
- the initiation of the Integrated Practice Analysis Tracking (IPAT) system and the first Provincial Aggregate Analysis of Recommendations from practice audits and case reviews.

Despite these developments four areas of concern remain:

- an inherent conflict of interest between regional service delivery and regional responsibility for oversight and monitoring
- potential for uneven quality assurance practices across the regions depending on differences in resources and skill sets
- a lack of clarity about the roles, accountabilities and authorities of regional versus headquarters staff
- no agreement or direction at this point on what will be measured, by whom, at what intervals and to what end.

The overriding concern is how non-compliance or deficiencies in performance are identified and addressed. Insufficient evidence was provided of the provincial oversight role. Systems and structures are in place, but MCFD did not submit adequate documentation of monitoring the quality of regional practice or completed trend analyses that have led to knowledge transfer and system improvements.



### Public Reporting

The Hughes Review called for clearer, more open public reporting. Increased transparency helps boost public confidence and provides a context for serious issues when they arise.

The changes made in public reporting have met neither the letter nor the intent of the Hughes Review, and in fact, the information publicly posted now is not as useful as it has been in the past. Prior to April 2008 MCFD posted aggregate reports that collated and analyzed information for all case reviews for the year. These reports used to include findings, areas in need of improvement and recommendations. Currently, information about case reviews is posted on a case-by-case basis.

The information on the website lacks important details such as timelines, updates on the achievement of recommendations, trend analysis and updates on changes to the system.

### Provincial Director of Child Welfare

The oversight role of the provincial office to ensure accountability and performance management has been further compromised by the elimination of the position of a single Provincial Director of Child Welfare. With this change there has been a loss of important checks and balances. MCFD has also lost an important leadership perspective that not only takes into account the broader provincial context but also provides the objectivity that rises above regional interests and viewpoints. The Representative does not advocate for a hierarchical model characterized by micro-management and burdensome reporting requirements. However, some aspects of oversight are necessarily hierarchical as there needs to be that ultimate authority to oversee compliance, impose consequences and command practice change.

The multiple roles and structures created to support regionalization do not fill the gap left by the loss of a Provincial Director. They are a complex and confusing alternative to what was a pivotal position. The lines of authority within a child welfare organization cannot be unclear or administratively complex. The decisions are too important and sensitive to leave room for confusion or uncertainty. Changing administrative and delegation arrangements does not change the legal aspects of designation. Delegation of the Provincial Director's authority involves a sharing of the powers, duties and functions in the Act, not a transfer of authority. The sharing of such roles and responsibilities automatically increases the risks of inconsistency, non-compliance and conflict. MCFD has fallen short of creating a robust central role for overseeing regional performance in a decentralized system.





These concerns about a consistent standard of service, accountability and a fixed point of responsibility were articulated in Hughes Review Recommendation 21:

"That the Ministry retain at its headquarters, the authority it needs to set and ensure compliance with provincial standards and to meet its responsibility for public accountability."

The Representative has identified ongoing concern about accountability in other reports released by the Office, including *Amanda, Savannah, Rowen and Serena: From Loss to Learning* April 2008; *Housing, Help and Hope: A Better Path for Struggling Families* July 2009; and *Honouring Christian Lee – No Private Matter: Protecting Children Living with Domestic Violence* September 2009.

The Representative's concern about MCFD's failure to move forward over the past 4½ years is well illustrated by the issue of measuring results. The Hughes Review highlighted in Recommendation 23 the importance of measuring actual results to give the ministry and the public a clear understanding of children in care and the impact programs and services had on their lives:

"The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time."

In the Sept. 4, 2007, meeting of the Select Standing Committee on Children and Youth (SSCCY), a committee member questioned the ministry's progress in measuring important outcomes for children, youth and families. He raised the same important concern that Mr. Hughes did:

"The question I have is around measuring success with regards to the delivery of services by those organizations within communities, making a real difference for children, making a real difference in families, showing that the services they're providing are actually making progress in the life of the child that's being impacted. What are your plans with regards to that kind of measurement or those kinds of goals, if you want to call them, in terms of success on the ground?"<sup>2</sup>

<sup>2</sup> Report of Proceedings (Hansard), Select Standing Committee on Children and Youth, Victoria, Tuesday, Sept. 4, 2007, Issue No. 7



In response, the Deputy Minister promised to address this area:

"Once we have those standards clear for the entire continuum of services, we will be putting quality assurance processes and measures in place so that we are able to have a look at outcomes related to children, to family and to communities."<sup>3</sup>

However, the Representative's 2007 and 2008 Hughes progress reports noted that little progress was made in achieving this recommendation. The progress that was noted in 2007 was the creation of "draft plans for the development of an integrated quality assurance system by December 2008." In 2008 the Representative commented on MCFD's development of various lists of performance measures. The lists lacked the continuity and substance needed for effective accountability of a child welfare system. The Representative observed that the:

"examples show that MCFD's performance measures change regularly and vary from document to document. As well, only a few of these current measures address the 'real and long-term impacts of its programs and services on children, youth and their families,' which the Hughes Review encourages in performance measures."

In *Strong, Safe and Supported*, MCFD again articulates a commitment to service development that is based on evidence gathered through a strong quality assurance system. One of the key actions identified in the fifth pillar of this plan is to increase reporting on important indicators of quality assurance and child and youth outcomes. Ministry updates on progress in this area are brief and lack substance.

In MCFD's *Progress Report – February 1, 2009 to May 30, 2009* brief mention is made of a new model being developed for the evaluation of child and youth outcomes. No detailed information is provided; nor are any actual measurements reported. In an update received after the data gathering phase of this progress review, MCFD reports that the ministry is a member of the Federal/Provincial/Territorial Child Welfare Outcomes Coordinating Committee, a national group with a goal to create and report on a common set of child welfare measures. MCFD currently reports on eight of the 10 National Child Welfare Outcomes Indicator Matrix ("NOM measures"). Consensus has not been reached by the participating provinces and territories on definitions of the remaining two measures. MCFD has reported on some of the common NOM measures in its service plans.

<sup>3</sup> Report of Proceedings (Hansard), Select Standing Committee on Children and Youth, Victoria, Tuesday, Sept. 4, 2007, Issue No. 7



In addition, some of the NOM measures or partial NOM measures were included in MCFD's first report that brings together all of the ministry's current measures into a single public document – inclusive of their service plan – the March 2010 *Public Reporting of Performance Measures*.

In the Representative's April 2008 report, *From Loss to Learning*, it was once again determined that comprehensive measures were not yet formulated. Robust and regular reporting on the safety, education status and well-being of children in care remained a serious concern. The type of regular public reporting that the Representative views as essential includes:

- data on the number of children in care
- continuing custody orders and Youth Agreements per region
- the percentage of plans of care that are up to date
- visits with guardianship workers, and
- educational outcomes for all children in care, not only those with continuing custody orders.

In *From Loss to Learning* the Representative made a specific recommendation on public reporting that built on the Hughes Review. Recommendation 7(a) addressed key timelines and specific reporting elements, including important child outcomes and practice standards.

MCFD did produce two reports – the first in December 2008 and the second in March 2010.

The December 2008 document was called *Report on Children in Care of the Ministry of Children and Family Development in the North*. The Representative applauded this move, as did a leading Canadian expert on child welfare. Professor Nico Trocmé of McGill University praised the ministry in the media for reporting on outcomes and posting the data on the public website of the ministry, with a commitment to continue to report.<sup>4</sup>

Trocmé identified the importance of following this data over the next few years to identify trends and issues. This was the purpose and intent of the Hughes recommendation, as reformulated again by the Representative. This was the ministry's first public report on the safety and well-being of a population of children in care in one region of B.C. The Representative expected the ministry to continue to report (at least twice a year) and to extend this to all children in care throughout the province, including those transferred to delegated Aboriginal Agencies.

<sup>4</sup>"Northern B.C. has higher rate of recurring child abuse:" News article, *Victoria Times Colonist*, March 30, 2009



On March 11, 2010, the second Children in Care in the North report was posted only on MCFD's internal intranet site. While the Representative is pleased to see a continuation in the monitoring of important child outcome measures in this region, this report falls short of the recommendations in *From Loss to Learning* in significant ways:

- The Representative recommended that the North region publicly report on key measures semi-annually. The timing of the second report suggests that reporting may be only on an annual basis.
- Important measures recommended by the Representative – participation in early childhood education, health status, advocacy services sought and received and measures of sustaining Aboriginal identity and connection to community – have still not been included.
- The measure regarding completed Comprehensive Plans of Care changed between the 2008 and 2009 reports. This can limit comparability and can be misleading in terms of understanding trends or changes.
- The Representative recommended that the ministry prepare a similar report for children in the care of delegated Aboriginal Agencies. This type of reporting has not occurred.
- In its 2008 report MCFD notes that it "will be producing similar material that is region specific on a regular basis." Reports have not been produced for other regions nor is there a mention of this plan in the 2009 report. In November 2009, the Representative was informed by MCFD via a brief email that in fact this additional reporting would not occur.

Building on the 2006 Hughes Review, the Representative made the recommendations in *From Loss to Learning* in 2008, with the realistic expectation that adequate reporting would be an entrenched practice by 2009.

In the Representative's view, the importance of reporting on children in care has resulted in a single report from one region and not a commitment to genuine and regular reporting on outcomes. More than four years after the Hughes Review and following specific recommendations to the point, with many commitments in ministry documents and plans, it has not launched even this basic level of regular and province-wide reporting. This is not acceptable in a ministry that remains badly in need of rebuilding public confidence.



## Current Context

The very heart of the child protection system is the strong and compassionate people doing such essential work for B.C.'s children – child protection workers and others on the front line. The Representative echoes the word of the Hughes Review in expressing deep appreciation to them. The Hughes Review applauded their "toughness, warmth, intelligence, compassion, decisiveness and determination."

These people must be thanked, repeatedly and genuinely, for their continued commitment to protecting and nurturing our province's most at-risk children, youth and families. These skilled individuals address the devastating results of poverty, addictions and violence and make difficult, life-changing decisions every day. The Representative's Office hears frequently from members of the public, service providers and MCFD staff that today's hard economic times are making this difficult work even more challenging and that much more must be done with much less.

The Representative's Office has also heard from ministry staff that to their frustration, they lack a clear understanding of where the ministry and its transformation agenda are heading. For example, they've been told that they will have less paperwork to do in the future, but they know little more today about what that means than they did in 2006.

Important forward-looking initiatives such as the Integrated Case Management (ICM) system have been delayed. In the 2008 Hughes progress report the Representative provided positive recognition of the ministry's work in this area:

"This is an important development and deserves acknowledgement as a positive indication of movement in the direction suggested by Mr. Hughes. To some, information systems may not seem important to children and youth. However, better accountability for what is done and more evaluation of the effectiveness, responsiveness and universality of programs and services is crucial to a strong, well-functioning child-serving system."

Two years later, the government is only in the first phase of a five-phase process. Phase 1 is slated to be completed at the end of 2010, with some assessment and planning functionality being implemented for MCFD staff during this time. It is reported that the majority of case management functionality for MCFD is to be implemented during Phase II and Phase III. Since ICM is portrayed as the lynch-pin of many other changes, the protracted pace of development is a significant concern, and the Representative encourages a full and timely implementation without further delays.



The ministry has fallen short of achieving the performance targets articulated in their service plans – targets set for increasing placements with extended families and reducing the recurrence of abuse and neglect. It will be an ongoing struggle to meet service plan goals given decreased budgets and potentially fewer staff. New measures are reportedly in progress. However, even though performance measures are at the core of the Representative's monitoring role, no consultations have been held with this Office on this vital topic.

Difficult economic times can mean harsher realities for many of B.C.'s families. Poverty will deepen for some, unemployment rates may climb, and previously successful families may struggle. Social services may be required more often, and community supports may disappear. Stagnant or decreasing budgets will not be able to address the needs of additional children and families.

The 2009/2010 overall government budget and the projected budget freezes for the next two fiscal years create a challenge for the system to adequately meet current needs and respond to anticipated increases in caseloads. MCFD has made some significant investments in staff training and knowledge transfer in previous years, and it is important to maintain these efforts.



## Part Three – Analysis and Evaluation

This progress report is the third examination of the implementation status of Hughes Review recommendations to improve the child-serving system. The Office of the Representative has been systematically examining the progress of government in making the important changes and improvements in legislation, policy and practice called for in Hughes' recommendations.

This progress report considers the status of 27 of the recommendations that were assessed to be incomplete in the 2007 update. These recommendations relate to:

- MCFD's review of child injuries and deaths
- modern approaches to child protection
- communication, information-sharing and privacy
- external oversight.

MCFD was given the opportunity to review and comment on the Representative's assessments on two occasions – first in December 2009 and again in July 2010 – as part of the administrative fairness process.

Two of these areas, the internal injury and death review process and information-sharing and privacy, were highlighted in the 2007 review and profiled to the Select Standing Committee on Children and Youth as important areas that had not yet received the leadership from MCFD that was required.

The Hughes Review offered a "new approach to the issue of child death reviews" and called for improved consistency, clarity, timeliness and accountability. Little evidence was provided in 2007 of progress towards achieving these improvements, and the Representative remains concerned about limited change or the quality of the changes in this area.

The competing interests of the protection of privacy and the importance of sharing sensitive information were tackled in the Hughes Review. Recommendations were made for amendments to legislation and improvements to public reporting. As with case reviews, little progress was noted in 2007 in this area. Although key legislative changes have been implemented since then, the nature of public reporting is still an issue and cultural barriers to sharing information are still evident.





## Methodology

The methodology used in this third progress report is consistent with the two previous reviews – a follow-up audit approach to measure the activity that has occurred towards implementation and the progress made in achieving the recommendations. The Representative's review procedures included document review, enquiry and discussion.

The Representative worked with MCFD in the process of gathering evidence for this update. Over 200 documents were submitted or referenced by MCFD during the conduct of this review. The ministry's Interface Team within the Integrated Quality Assurance Team was accommodating and well-organized in their response to requests for information, and the Representative is appreciative of this. The team also facilitated a number of meetings between MCFD and the Representative's Office to discuss and clarify information.

The key documents that were reviewed are listed in the Resource List: Documents and Sources section. Numerous documents were also accessed electronically and reviewed, including examples of training materials, information-sharing protocols, budget and staffing summaries, case review summaries and practice guidelines. The Representative's intent in conducting this review is to showcase, where possible, areas of accomplishment, in addition to challenges and any lack of progress.

The information received was evaluated against the standards of:

- sufficiency – was there enough evidence to support a conclusion that the recommendation had been addressed?
- relevancy – was the evidence logically related to the recommendation?
- competency – was the information valid and reliable?

As in previous reviews, verbal and written summary statements alone were generally not considered conclusive and needed to be supported by primary sources of information. Documentation and other evidence were reviewed to determine if the required change or improvement addressed in the recommendation:

- was made
- met the intent and spirit of the recommendation
- is being consistently implemented in practice.



Each recommendation was assessed on a six-point scale. This scale is the same scale used in the two previous reviews, with one change. The rating "insufficient information provided" has been deleted, and a new rating has been added – "implementation unsatisfactory." Previous RCY progress reports have measured the extent of the implementation of the recommendations. In this review the Representative is addressing not only the amount of activity related to implementation but the quality of the implementation and the actual change in practice. This new rating is used to address instances where MCFD determines the implementation to be complete but the Representative judges the quality of the implementation or the utilization of the changed practice to be insufficient or inadequate.

### Rating Scale for Assessing Implementation

Rating	Definition
Limited or no progress	No documentation is available to indicate that work is being done towards implementing the recommendation. Generating informal or general draft plans is regarded as limited progress.
Planning underway	Specific plans for implementing the recommendation are being developed, and appropriate resources and a reasonable timetable for implementing the plans have been addressed.
Implementation underway	Activities beyond the planning underway process are occurring, such as hiring staff or putting in place the structures necessary to fully implement the recommendation.
Substantial implementation	Significant results have been achieved in implementing the recommendation, and full implementation is imminent.
Complete or fully operational	All actions required to satisfactorily implement the letter, spirit or intent of the recommendation are completed; structures and processes are operating as recommended and implemented fully in all intended areas of the organization.
Implementation unsatisfactory	Actions have occurred to achieve the letter of the recommendation, but those actions are insufficient to achieve the spirit or intent of the recommendation, are of a questionable quality or are not being fully implemented in practice.



## Assessment Overview

Twenty-seven recommendations made in the Hughes Review and discussed in this progress report are assessed to determine how much progress has been made since the review was released in April 2006 and the sufficiency of the progress.

Of these, 12 are complete or fully operational, three are substantially implemented, one is underway and 11 are unsatisfactorily implemented.

Total	Complete or fully operational	Substantial implementation	Implementation underway	Planning underway	Limited or No progress	Implementation unsatisfactory
27	12	3	-	1	-	11

## Case Reviews

(Recommendations 31–38, 40, 41, 48–53)

The task of examining and making recommendations to improve the ministry's system of reviewing child deaths was an important element of the mandate of the Hughes Review. In addition, the Hughes Review examined and made recommendations to improve the public reporting of child deaths. The issue of child death reviews was acknowledged by the Hughes Review as the most contentious aspect of the review. In this progress report the Representative continues to find this area to be significantly lacking in terms of the quality of the implementation of the recommendations.

The Hughes Review identified two important purposes for injury and death reviews:

- continuous improvement in policy and practice such that future injuries or deaths can be prevented, and
- public accountability to ensure British Columbians that the ministry has met its responsibilities.

A number of the specific recommendations addressed these two purposes, and in addition, the detailed recommendations addressed the need for clarity and consistency in the definition and conduct of case reviews.

MCFD has determined that the recommendations with respect to case reviews have been substantially implemented. This determination is based on the introduction of the 2008 Integrated Case Review Framework (ICR Framework) and the review of case review processes for all program areas. However, the Representative finds the 2008 framework and current practice to be inadequate in meeting the intent of the Hughes Review in the key areas of continuous system-wide improvement, public accountability, and clarity and consistency.



1. The opportunity for continuous learning and practice improvement is hampered by the structure of the review process. The abolishment of the Provincial Director of Child Welfare and the absence of a more robust provincial oversight role has created gaps in terms of objectivity and consistency. The important elements of a system-wide perspective and province-wide checks and balances have been weakened, and there is greater risk of regional variances. It is clear to the Representative that not enough is being done to benefit from the learning that is possible from the systematic review of child injuries and deaths.

The ministry's recent review of all recommendations from case reviews for the period of June 2006 to November 2008 is limited. It falls short of a complete aggregate analysis of case reviews and as evidence that the ministry has acted upon the results of such an analysis. With respect to the new Continuous Quality Improvement Strategic Working Group, it is too early to judge the impact of this committee on quality improvement at a provincial level.

2. Changes to public reporting of case reviews fail to meet the Hughes Review's call for greater emphasis on public accountability in a decentralized system. The publicly posted case review information is inadequate:
  - reports on the achievement of timelines are not included
  - updates on the achievement of recommendations are not included
  - analyses of themes across reviews or updates on improvements to the system are not included.
3. The Hughes Review called for a review process that is "timely, thoughtful and impartial." In addition, it made specific recommendations to improve clarity and consistency. The introduction of the new ICR Framework and the continuation of existing standards and language for other reviews during a transition phase have not achieved this goal. There is still no comprehensive guide for all case reviews that clearly defines when to conduct a review, what type of review to conduct and how to conduct it.

In assessing this group of recommendations, a considerable amount of material was submitted to and reviewed by the Representative, including the 2008 ICR Framework, existing standards, examples of integrated case reviews, information-sharing protocols, staff training materials and a range of other regional materials. In addition, information was accessed from MCFD's intranet and website and the Representative's internal tracking systems.



Hughes Review Recommendation 31	2007	2010
<i>That the Ministry adopt a common review tool to guide the conduct of case reviews across all program areas that are relevant to the life of a child who has died or been seriously injured.</i>	planning underway	implementation unsatisfactory

The ICR Framework partially meets this recommendation in that the framework:

- requires the participation of all program areas involved with the child's life, including child welfare (child protection, family development, guardianship and adoption), delegated Aboriginal Agencies, Children with Special Needs, Child Care, Child and Youth Mental Health, Youth Justice and Provincial Services
- requires a review when a child is involved in more than one program or service at the time
- guides case reviews of both deaths and critical injuries.

However, this is a framework and not a common tool as specified by the Hughes Review. In the framework MCFD says there will be "subsequent, standard, policy, guideline and tool development, within the context of the framework, to reflect the specific services each area provides." Given the separate and potentially disparate guidelines, policy and criteria for program areas, it is the Representative's opinion that the development of a coherent review process has not been accomplished.

The specific concerns the Representative has with the framework are:

- the absence of clear criteria for when to go beyond an initial review or preliminary examination of an injury or death and conduct a case review
- a lack of clear criteria as to which type of review to conduct – file or comprehensive
- a role of provincial oversight that is unclear and limited.

The Representative is also concerned that the ICR Framework was established to define and guide "integrated" case reviews only, where the child is or was involved in more than one region or program area. As such, it is not a broader guide for all case reviews in all program areas. As of July 2009 the public postings of case review information utilized the language of the ICR Framework – "comprehensive" and "file" for all case reviews despite the more limited definitions for these terms contained in the ICR Framework.



As noted above, the framework defines integrated reviews for situations where the child was involved in more than one region or program area. The internal documentation and examples provided illustrate gaps, inconsistencies and the use of old and new language and terms (e.g., comprehensive, file, Director Review and Deputy Director Review), and there is a need to look in several places, including the ICR Framework and Quality Assurance Standard 2, to piece together a more comprehensive description of and guidelines for case review practice.

The Provincial Director of Child Welfare position was abolished and the Regional Executive Director Council created, yet the ICR Framework references the Provincial Director in many places. This is confusing, and the Representative questions why the language and processes in the framework were not amended to reflect these important organizational changes and to be as current and clear as possible.

Four examples of integrated case reviews were submitted to the Representative. Only two of these reviews clearly contained all elements of the new framework and demonstrated an integrated review practice. The Representative notes that four examples represent a very limited implementation of the framework over a 16-month period (March 2008 – June 2009).

Although the ministry reports that the provincial office reviews all case reviews, will provide feedback and may add further recommendations, there was little evidence that it monitors the consistency and the quality of the regional processes. In conducting this progress report review and through the Representative's critical injury and death review function, the Representative has observed that many of the case reviews routinely submitted by MCFD lack sufficient oversight in both the conduct and the content of the reviews. Many of the reviews are seen as limited in the analysis of circumstances and practice and do not identify or encourage understanding of broader issues. These limitations compromise the value of case reviews as a tool for accountability and for system learning.

In a review of the Regional Executive Director (RED) Council, MCFD identified the potential for regional variances and isolation resulting in the absence of a common approach. However, MCFD was confident that those could be dealt with through discussion and consensus building. The Representative's Office is not as confident in the capacity of a collegial and supportive approach to address serious concerns inherent in case reviews. The Representative shares a concern expressed in the ministry's review of the council that the purpose and roles of the RED Council might take on a personality consistent with its current members, as opposed to being more formally established. Notwithstanding that MCFD has since disbanded the RED Council and appointed regional Assistant Deputy Ministers, the Representative remains concerned about the ministry's approach to non-compliance and practice concerns. The approach appears now to be comprised of an increasing level of ambiguity with no evidence of a fixed point of accountability.



Hughes Review Recommendation 32	2007	2010
<i>That the Ministry adjust its timelines for its internal reviews, ensuring timeliness but taking account of current capacity. Once established, the timelines should be made public.</i>	implementation underway	implementation unsatisfactory

The Integrated Case Review Framework partially meets this recommendation in that it establishes adjusted timelines for both levels of *integrated* reviews – 11 months to complete a comprehensive review and six months to complete a file review. Existing standards – Quality Assurance and AOPSI standards – contain the unchanged timelines for reviews that are not integrated. The adjusted timeframes for integrated reviews are not identified on MCFD's website, where case reviews are defined and the summaries of individual reviews are posted. The adjusted timelines are found on the Hughes Update appended to the *Strong, Safe and Supported* update. Complete information is difficult to locate, and the Representative questions why all relevant information isn't found in one place, in one document. MCFD does not publicly post the achievement of timelines for individual case reviews and never has.

The Representative's Office tracks timelines achieved for the completion of case reviews and notes that the majority do not achieve the timelines – old or new. MCFD does not provide the Representative's Office with any details on what factors delayed the completion of specific case reviews, and therefore it is not possible to comment on what percentage were delayed as a result of criminal investigations, autopsy findings or court proceedings. In the end, the concern noted in the Hughes Review about establishing and then seldom meeting timeframes is still a significant issue. Although the provincial office monitors timelines on its electronic tracking system, there was no evidence of holding regions accountable for timelines not achieved and requiring follow-up action, nor is there a provincial mechanism for accomplishing this.

Hughes Review Recommendation 34	2007	2010
<i>That the Ministry rename its internal injury and death reviews and clarify the scope of each.</i>	planning underway	implementation unsatisfactory

The ICR Framework partially meets this recommendation in that the framework renames two types of *integrated* reviews – comprehensive and file. MCFD reports that it will use the existing standard and definitions for reviews that are not integrated until Quality Assurance Standard 2: Case Review is amended. In practice, however, the terms and language currently used are inconsistent and confusing. In many places MCFD has adopted the language of the ICR Framework – “file” or “comprehensive” – even though these terms have not been defined outside of the ICR Framework.





The Representative recognizes that this is a period of transition but sees the framework as an inadequate tool to manage the transition. The framework has created more confusion than it has resolved. A time of change demands more precision in language. The Representative was not informed of the June 1, 2009 change in the naming of all case reviews until March 2010. This change occurred without any changes to the supporting framework or standards.

In the ICR Framework the scope of each type of integrated review has been defined, including timelines, guidelines for methodology and content, dissemination of results, feedback to participants and the specifications for extracting best practices and what has been learned. The framework does not establish clear criteria that guide a decision as to which level of review to conduct – a comprehensive or a file review. Criteria that should be included but are not are the nature of the incident, the seriousness of the injuries and the length of involvement with MCFD. It appears that the decision as to which type of review to conduct is left to the discretion of the region.

A commitment is made in the framework for each region and the provincial office to establish a mechanism to decide to conduct a review and ensure the most appropriate type of review is conducted. The Representative is concerned about the loss of consistency across all regions and programs and the degree of regional and program discretion. In a decentralized system, strong and clear criteria must be in place to guide decisions when these decisions are being made by the same managers responsible for the oversight of services delivered when an injury or death occurred. There must also be a system of checks and balances in place to ensure that regional decision-making is consistent with provincial intent.

This Hughes recommendation was intended to accomplish clarity and simplicity in the practice of case reviews. This has not been achieved. The ICR Framework document lacks detail and clarity. Without a more comprehensive document that defines and delineates all reviews including criteria, content, methodology and oversight, guidance of the practice of case reviews is anything but clear, simple and rational.

Hughes Review Recommendation 36	2007	2010
<i>That the Ministry develop clear criteria to guide the decision as to whether to review the death or critical injury of children who are receiving or have received Ministry services.</i>	implementation underway	implementation unsatisfactory



The Representative is very dissatisfied by the work done in this area. Clear criteria have not been established in the ICR Framework to guide the decision as to whether to conduct a case review or not. The Representative sees the framework as a step backwards in this regard. MCFD reports that each region and the provincial office will establish a mechanism to decide to conduct a review and ensure the most appropriate type of review is conducted. The Hughes Review's intent was for a standard, high level of practice across all regions and programs. This level of discretion concerns the Representative with respect to consistency in practice.

The concern expressed in the Hughes Review that there is "no clear direction to the regions as to when to undertake a review and the level of review to be undertaken" has clearly not been addressed.

Hughes Review Recommendation 33	2007	2010
<i>That the Ministry undertake reviews of critical injuries and deaths of children receiving services from any of its program areas.</i>	planning underway	implementation unsatisfactory

Hughes Review Recommendation 35	2007	2010
<i>That the death or critical injury of a child who is in care always be subjected to a review, regardless of the circumstances.</i>	implementation underway	implementation unsatisfactory

Hughes Review Recommendation 37	2007	2010
<i>That the Ministry review injuries and deaths not only of children who were receiving Ministry services at the time of the incident but also of children who had received Ministry services during the 12 months preceding, and in exceptional circumstances, going back even further.</i>	limited or no progress	implementation unsatisfactory

MCFD reports full implementation in that all critical injuries or deaths are initially reviewed through a Reportable Circumstance Report, and the ICR Framework guides decision-making about whether an additional review is warranted. A number of sample protocols were submitted to substantiate the requirement to report a critical injury or death, including new protocols with the Coroners Service and an updated process with Vital Statistics. MCFD also reports that the IQA team reviews all Reportable Circumstance Reports.



In contrast to the ministry's assessment of compliance with these recommendations, the Representative is concerned about two serious gaps in implementation. MCFD acknowledges that policy, standards and procedures regarding the notification of reportable circumstances vary across program areas and that there are different criteria for reporting in different areas. The new framework does not address these variations, and the Representative is troubled by the persistence of differences in the requirement for an initial review across program areas.

The second area of concern is the framework itself. The ICR Framework partially meets these three recommendations in that the criteria for an *integrated* review include:

- program areas/service providers that fall within the categories of Child and Family Development, Aboriginal Regional Support Services, Provincial Services, Children and Youth with Special Needs and Community Living
- the death of a child in ministry care
- injuries or deaths that occurred in the preceding 12 months.

The language in the ICR Framework is not as precise as the criteria suggested in the Hughes Review. For example, although the framework's criteria covers all children receiving services, the framework does not specifically address critical injuries of children in care. The Hughes Review noted that the province is the guardian of a child in care, and like any caring parent, the ministry should have all questions answered about a critical injury. In addition, unusual circumstances are mentioned in the framework, but the criteria miss the point made in the Hughes Review in terms of including the discretion to review injuries or deaths when the child has not been involved with the ministry beyond the 12-month period, when circumstances warrant.

The framework does not include clear criteria to guide the decision to proceed to a case review. The written framework document is missing many important details – details more clearly defined in existing standards documents. The Representative is not convinced that the ministry is adequately ensuring that all regions appropriately review all injuries and deaths as recommended by the Hughes Review.

Hughes Review Recommendation 38	2007	2010
<i>That the Regional Executive Director be responsible to decide whether a review should occur; record the reasons for that decision; establish the terms of reference for the review; decide who will do the review; and finally, sign off on the recommendations that result.</i>	implementation underway	implementation unsatisfactory



The ICR Framework partially meets this recommendation in that it outlines a process where a number of different senior staff members, including the Regional Executive Director (depending on the program areas involved), could be responsible to:

- make the decision to conduct a review
- establish Terms of Reference for a review
- decide who will conduct the review
- sign off the recommendations.

However, the framework is confusing in regards to more complex situations. The Assistant Deputy Minister of integrated quality assurance, the director of a provincial program or the director of children's services with Community Living BC may be consulted regarding a decision to conduct a case review, but the framework does not speak to how the decision gets made. Decisions about case reviews for children and youth served by a delegated Aboriginal Agency are to be made by the Deputy Director Aboriginal Services and the Provincial Director – a position that no longer exists. Although Community Living BC no longer has jurisdiction for children with special needs and the Representative has been told that the First Nations Director has assumed the responsibilities of the former Provincial Director role as it relates to delegated Aboriginal Agencies, RCY is not aware of any updates or amendments to the ICR Framework that clarifies these changes in decision-making responsibility for ministry staff members.

The Representative highlights an important gap in the process: the requirement to record the reason(s) for the decision to conduct a case review or not. Although some regions submitted evidence of a regional documentation process, the practice is not formalized or consistent.

Hughes Review Recommendation 40	2007	2010
<i>That the Ministry provide required orientation, training and mentoring for practice analysts who will conduct reviews; and maintain a list of qualified reviewers.</i>	planning underway	complete or fully operational

MCFD provided documentation and samples of the various ways it supports practice analysts. Practice analysts tend to be senior, experienced staff members, and much of their training tends to be one-on-one mentoring. The IQA team hosted three two-day practice forums for provincial and regional analysts in 2008. There was broad participation in the forums, and good feedback was received from participants. In addition, practice analysts participate in regular teleconferences for support and new information. MCFD also submitted examples of follow-up training provided to practice analysts.



A bid for qualified reviewers was held in 2007. MCFD reported that there were 10 qualified external bidders to do case reviews in 2004, and 10 in 2009. In addition, there are 17 practice analysts on MCFD staff teams across the province.

Hughes Review Recommendation 41	2007	2010
<i>That the Ministry make use of multi-disciplinary teams in its child injury and death review process.</i>	limited or no progress	substantial implementation

There is no specific reference in the ICR Framework for the requirement for a multi-disciplinary team. In MCFD's *Strong, Safe and Supported* update, the ministry reports that the new framework and current practice are consistent with this recommendation, given that often many professionals and agencies are involved in a child's life. In three of the four integrated case reviews submitted there was sufficient evidence of a multi-disciplinary approach. In addition, a number of the regional submissions described the use of a multi-disciplinary approach in their practice. Compliance with this recommendation would have been clearer had the new framework been more explicit in this regard.

Hughes Review Recommendation 48	2007	2010
<i>That the Child, Family and Community Service Act, which sets out powers and duties of the Provincial Director, be amended to include the power to produce reports of internal child death reviews and to state that although the main purposes of the report is learning, public accountability is a purpose of these reports.</i>	planning underway	complete or fully operational

From a legislative point of view, there is substantial compliance with this recommendation. The creation of an express power to produce reports of internal child death reviews took place in two stages. Stage 1 was the enactment of s. 93.2 of the *Child, Family and Community Service Act (CFCSA)*, effective March 29, 2007. Stage 2 was the enactment of s. 19.1 of the *Child, Family and Community Service Regulation*, effective June 21, 2007.



Hughes Review Recommendation 49	2007	2010
<i>That the Child, Family and Community Service Act be amended to allow the Provincial Director to make information-sharing agreements with other agencies for the purpose of multi-disciplinary child death reviews.</i>	limited or no progress	complete or fully operational

Although an amendment was not made as recommended, other amendments were made that, combined with already existing powers, are adequate to achieve the legal purpose of this recommendation to ensure information-sharing agreements among public bodies. The collective effect of these provisions is to make it legally permissible for public bodies as defined in the *Freedom of Information and Protection of Privacy Act (FOIPPA)* to engage in meaningful participation on an internal child death review without fear that their information disclosures would be unlawful.

MCFD did not report any issues with using these legal provisions to their full extent in practice.

Hughes Review Recommendation 50	2007	2010
<i>That the Child, Family and Community Service Act be amended to require the Provincial Director to give, on a confidential basis, a complete copy of the final child death review report to all agencies that participated in the multi-disciplinary Child Death Review Team.</i>	limited or no progress	implementation unsatisfactory

There is partial compliance with this recommendation. Section 79(g.1), (g.2) and (k) of the *CFCSA*, added on March 29, 2007, confer discretion on the Director but do not *require* him or her to disclose the full and final report to participating agencies. The Director has discretion to refuse to do so. These provisions are also unclear as to whether release is intended to apply only to public disclosure or whether it was intended to apply to all outside agency participants on the internal review. If the ministry takes the position that s. 79(g.2) applies to the agencies too, then disclosure of the final report is not only discretionary but prohibited if the "unreasonable invasion of third-party privacy" test in *FOIPPA* is met. From a legal point of view, compliance with this recommendation is partial, as disclosure is not mandatory and may well be prohibited depending on how the ministry is interpreting and applying s. 79(g.2).



Hughes Review Recommendation 51	2007	2010
<i>That in its annual reports the Ministry of Children and Family Development provide a statistical report on its reviews of deaths and critical incidents as well as the recommendations that resulted from those reviews, and a progress report on their implementation.</i>	planning underway	implementation unsatisfactory

MCFD reports that the ministry's required format for an annual report is a standard government format and does not allow for this type of unique reporting. As an alternative to including this information in an annual report, MCFD posts a summary of each case review on its website. Although these postings include the recommendations for individual reviews, this alternate reporting format does not meet the recommendation in that:

- it is not a statistical or aggregate reporting that lends itself to comparisons to prior periods or that identifies trends
- it does not include progress reporting on the implementation of recommendations.

Prior practice (2007 and before) was to post annual summary reports. In this format information for all case reviews for the period was collated and analyzed, including trends in intakes, findings, recommendations and areas in need of improvement. This format provided more useful information.

Hughes Review Recommendation 52	2007	2010
<i>That twice a year the Ministry of Children and Family Development publicly release a summary of each child death review it has completed during the previous six months. The summaries would contain no names, dates or places.</i>	implementation underway	complete or fully operational

As noted above, MCFD posts summaries of all individual child death reviews every six months. These postings meet the recommendation in that the summaries:

- are released in a timely manner
- are publicly released
- contain no identifying information but sufficient detail for the public to know what happened and on what basis the recommendations were made.





Hughes Review Recommendation 53	2007	2010
<i>That if the death of a child who was in care or known to the Ministry has already been disclosed by police, a court or the Coroner, the Ministry be permitted by the Child, Family and Community Service Act to disclose the child's name and relationship to the Ministry and the contents of the Ministry's case review, to the extent necessary for accountability but without unreasonable invasion of privacy.</i>	limited or no progress	complete or fully operational

Sections 79(g.2) of the *CFCSA* and s. 25.1 of the Regulation comply with this recommendation.

### Modern Approaches to Child Protection

(Recommendations 42, 45 and 46)

The Hughes Review acknowledged and supported the "service transformation" undertaken by the ministry to move away from traditional child protection work to more out-of-care options and alternate dispute resolution processes. The newer approaches were viewed as having significant potential to keep children safe within their families, achieve better outcomes and reduce costs over the long term. The Hughes Review cautioned that the fundamental change in practice required by the transformation must be supported up front with adequate resources and training. The need for an initial investment in the service system was repeated in the recommendation to revitalize the campaign for foster and adoptive parents.

Little or no progress in this area was noted in the 2007 update. At the time, the Representative received mostly draft plans, and there was limited evidence of changes in practice or skill sets.

In MCFD's recent progress report the recommendations in regards to modern approaches were rated as substantially implemented. In the conduct of this review the Representative notes significant progress and investment in the newer approaches and agrees with the ministry's evaluation. In addition, MCFD demonstrated that feedback from line staff was used to evaluate service options and to guide the reinvestment and redesign of resources and training.

There remains a significant risk that much of this progress and investment will be lost during current and anticipated periods of fiscal restraint. MCFD reported that staff development activities were curtailed during the last fiscal year, and the Representative is aware that auxiliary full-time equivalents (FTEs) have been lost. It was highlighted in the Hughes Review that



service transformation was introduced during a time of constant change and budget reductions in the ministry and that the implementation of new approaches suffered as a result. The Representative has not seen any evidence that the ministry has plans in place to safeguard the current status of these new approaches in the face of budget constraints.

In assessing this series of recommendations for the present review, a great deal of material was submitted and reviewed, including documentation of funding, staffing and training increases, curricula and documentation of program utilization rates.

Hughes Review Recommendation 42	2007	2010
<i>That government provide sufficient funding, staffing and training to support its newer approaches to child protection work.</i>	limited or no progress	complete or fully operational

  

Hughes Review Recommendation 45	2007	2010
<i>That government provide training for current social workers and recruit individuals with the necessary mediation and counselling skills to support the service transformation initiative.</i>	limited or no progress	complete or fully operational

Detailed evidence was provided to document ministry increases in funding, staffing numbers and training to support modern approaches over the 2006–2009 period. These investments were made in alternative dispute resolution processes, support to families and out-of-care options. Program utilization rates were provided that documented growth in these important strategies. There is also evidence of the critical analysis of these investments in terms of the utilization rates, staff feedback and barriers to utilization. MCFD used these analyses to change practice and adjust training opportunities.

Front-line staff positions increased modestly but consistently between June 2006 and June 2009 – from 2,868 FTEs in 2006 to 3,247 in 2009, an 11 per cent increase over the three-year period. A significant amount of staff training occurred during this time to improve staff understanding and use of the targeted approaches. Many examples of training materials and conference packages were submitted, as were detailed attendance records. MCFD reports



that in 2007/2008 the ministry delivered more than 1,000 distinct learning events – a total of over 40,000 training days to approximately 4,000 ministry and 1,500 partner staff members. Training opportunities were open to staff from delegated Aboriginal Agencies and contracted service providers. The Representative commends MCFD for this work.

Staff feedback on the training was routinely sought, and samples of these evaluations were provided. The core child welfare practitioner training has elements of modern approaches, as does the new competencies system that was introduced in 2007. MCFD also provided a copy of the curricula review of child welfare specialization in B.C. post-secondary institutions.

As previously noted, it will be a challenge to sustain adequate levels of staff training during a time of budget restraints and cuts. The ministry is currently utilizing and planning to expand alternative staff training methods based in adult learning research, including webinars for supervisors, videoconferencing, e-learning, mentoring and coaching.

Hughes Review Recommendation 46	2007	2010
<i>That the Ministry reinvigorate its campaign to recruit foster and adoptive parents and ensure that it is funded so that it can respond to public interest and participation.</i>	implementation underway	substantial implementation

Children belong in families, and when they cannot live with their family of origin, an adoptive or foster family establishes permanence and important life-long relationships. The recruitment of foster and adoptive parents requires ongoing reinvestment and reinvigoration to maintain and, it is hoped, increase the number of families available.

MCFD submitted evidence of funding for recruitment campaigns in 2006/2007 and 2007/2008 and examples of recruitment efforts. Although money and resources have been invested, evidence was not provided that outcomes for children and youth have improved. It is unfortunate to note that neither the adoption numbers nor the foster home numbers showed any real growth over the reporting period.

The Representative knows that this will continue to be an issue and calls for the ministry to rise to the challenge and find more creative and successful strategies to meet the demand for permanency.



## Communication, Information-sharing and Privacy

(Recommendations 57, 60–62)

The Hughes Review noted the inherent tension and complexity in achieving the protection of individual privacy, the sharing of vital but sensitive information, and public accountability in the work of the ministry. This is a particularly difficult balance in a field such as child welfare where public interest is high and the information is personal and often very troubling. The review called for improved communication and coordination between all individuals and organizations involved in service provision.

In their most recent progress report MCFD reports that three of the outstanding recommendations in regards to information-sharing and privacy have been substantially implemented. The Representative agrees with this assessment.

Hughes Review Recommendation 57	2007	2010
<i>That the Ministry of Children and Family Development, in collecting linked data from other public bodies for the purpose of decision making about individuals, ensure that the absolute minimum information is collected and that each linking is necessary to enable the Director to deliver mandated services, and that the highest privacy standards are met.</i>	limited or no progress	complete or fully operational

MCFD submitted and referenced a range of documents and resources that addressed information-sharing and privacy. These included regulations, guidelines, staff training materials and information-sharing agreements. These submissions met the recommendation by addressing the following principles:

- Information is shared on a need-to-know basis in that the requestor has a very definitive purpose for knowing the information.
- Information requested is necessary for the Director to carry out a function or perform a duty that is mandated.
- When information is gathered about a person, it is protected, stored and disposed of properly.
- No more information is collected than is necessary.

In addition, the Privacy Impact Assessment Template that will be used for the Integrated Case Management system was submitted, and a Risk Assessment for the new system will be developed.



Hughes Review Recommendation 60	2007	2010
<i>That the Ministry of Children and Family Development review the statutes that govern it to ensure that there are no statutory barriers to disclosure of information among program areas.</i>	insufficient information provided	complete or fully operational

The Hughes Review called for the ministry to ensure that no legislative barriers remained to block the sharing of information across its program areas. The Representative is of the opinion that the legislative provisions are fully adequate to ensure that there are no statutory barriers to disclosure of information among the ministry's program areas. The important thing is for the ministry to fully and effectively use the legal authority it has. MCFD acknowledges the existence of staff behaviours and program cultures that are still barriers to sharing information between program areas. The Representative has observed these barriers during investigations of critical injuries or deaths. Clear and comprehensive policy can be in place, but if practice is not consistent with the policy, opportunities to provide the best service or supports are lost due to inadequate information-sharing.

Program areas can exchange information among themselves in accordance with *FOIPPA*. The only time this principle does not apply is where the particular statute has a provision expressly overriding *FOIPPA*. Provincial program areas can also exchange information with federal program areas where the relevant federal statutes make provision for this in their statutes, as with the *Youth Criminal Justice Act*, or where a written agreement regarding disclosure has been entered into *FOIPPA*.

Hughes Review Recommendation 61	2007	2010
<i>That the Ministry of Children and Family Development review its privacy policy documents to ensure that they are current, accurate and easily useable by employees.</i>	limited or no progress	complete or fully operational

This recommendation is viewed as complete based on the review of the following MCFD documents:

- Confidentiality and Disclosure of Information
- The Privacy Charter
- Information Sharing and Privacy – A Framework for Decision Making
- Segment 8 of the Child Welfare Practitioner Training – Child Welfare Legislation and Standards.



These resources were identified as current, and the Representative's Office found the materials to be readable and easy to use.

Hughes Review Recommendation 62	2007	2010
<i>That the Freedom of Information and Protection of Privacy Act be amended to incorporate the "unreasonable invasion of privacy" test in s. 33.2, which authorizes public disclosure of personal information under certain conditions.</i>	limited or no progress	planning underway

*FOIPPA* outlines to whom and for what purpose disclosure may take place, and the discretion to disclose is fairly broad. There is no "unreasonable invasion of a third party's personal privacy" provision written in that would forbid a public body disclosing information to another public body if it would be an unreasonable invasion of a third party's personal privacy. The Hughes Review recommended that there should be such a provision.

To date, this change has not been made, and *FOIPPA* remains "non-compliant" with this recommendation. The Representative questions whether this recommendation should be implemented as to do so might conflict with other key Hughes recommendations about the critical importance of avoiding cumbersome legal requirements and ensuring easy information-sharing between program areas as long as the information so disclosed is protected (which is required under *FOIPPA*, the *CFCSA* and the *RCYA*).

MCFD reports that these matters are "under consideration" by the Ministry of Citizens' Services. The Representative proposes that this recommendation be carefully studied before it is implemented to ensure it does not undermine the good progress that has been made in ensuring easier disclosure between program areas.

### A New Plan for External Oversight

(Recommendations 16, 54, 56 and 58)

The 13 recommendations established in the Hughes Review for external oversight defined the framework for the Office of the Representative for Children and Youth. These recommendations were substantially complete in 2007, with four minor updates required for this report.



Hughes Review Recommendation 16	2007	2010
<i>That at least one of the three senior positions at the new Representative for Children and Youth be held at all times by an Aboriginal person; and that the Representative actively recruit some Aboriginal staff at all levels of the organization.</i>	substantial implementation	complete or fully operational

The situation in the RCY Office with regards to Aboriginal leadership is the same as was reported in the 2007 progress report: the Representative is a First Nations person from the Muskeg Lake Cree Nation. The Associate Deputy Representative (responsible for Advocacy, Aboriginal and Community Relations) is a member of the Nisga'a Nation. Two other staff members are of Aboriginal ancestry. A number of temporary or co-op staff members have been Aboriginal, and in some cases Aboriginal candidates have been specifically recruited for these positions.

Typically, RCY postings for permanent and short-term positions (at every level of the organization) include the phrase "preference may be given to applicants who are of Aboriginal descent." This encourages Aboriginal candidates to apply and allows RCY to take this into consideration when evaluating applicants.

The implementation of the recommendation is complete, but the Representative views this work as an ongoing commitment. The work of the Representative's Office includes outreach to many Aboriginal communities to increase awareness about the Office and encourage the engagement of children, families and other community members.

Hughes Review Recommendation 54	2007	2010
<i>That the Representative for Children and Youth Act contain an authority to collect information that is at least equivalent to s. 11 of the Office of Children and Youth Act; provisions to ensure that the records it requests are delivered promptly and without charge to the Representative; and to permit public disclosure of personal information if it is in the public interest, necessary to support the findings and recommendations, and not an unreasonable invasion of privacy.</i>	substantial implementation	implementation unsatisfactory



There has been compliance with this recommendation except insofar as the Hughes Review recommended that government should be under an express duty to deliver records "promptly" and without charge. This has not been written into the legislation. The drafters likely considered these requirements to be unnecessary, since records would in fact be free and the ministry would be prompt in practice. An express legislative requirement to act promptly would assist in the administration of the *Representative for Children and Youth Act (RCY Act)*, and therefore the Representative concludes that there has been non-compliance with this part of the recommendation.

Hughes Review Recommendation 56	2007	2010
<i>That the Representative, in collecting linked data from Ministry of Children and Family Development and other public bodies for the purpose of fulfilling its monitoring role, develop policies and practices to ensure that all identifying information is removed from public reports and that the highest privacy standards are met.</i>	implementation underway	substantial implementation

The Representative's Office drafted and implemented a policy to comply with this recommendation, and information-sharing agreements are in place as necessary. RCY ensures all identifying information is removed from public reports, unless permitted by legislation, and that all applicable privacy standards are met. RCY will continue to refine internal procedures as the work with linked data from other public bodies expands.

Hughes Review Recommendation 58	2007	2010
<i>That the Representative for Children and Youth Act contain a provision similar to s.9 of the Ombudsman Act, requiring that information collected by the Representative be kept in confidence, with a limited right of disclosure.</i>	substantial implementation	complete or fully operational

Section 23 of the *RCY Act* fully complies with this recommendation. The small differences between s. 23 of the *RCY Act* and s. 9 of the *Ombudsman Act* flow either from recommendations made by the Hughes Review or the need to ensure that child protection comes first.





## Concluding Remarks

This third and final progress report on the Hughes Review accomplishes three goals:

- It provides an update on 27 of the recommendations that were assessed as incomplete in the first progress report.
- It provides a review of the ministry's overall achievement in addressing the Hughes Review recommendations.
- It sets direction for future reporting by the Representative.

The Representative's assessment of government's progress in achieving specific recommendations is once again a mixed review. The good news is that 15 of the group of 27 recommendations specifically reviewed in this report are complete or substantially complete, and one recommendation is considered to be underway. Unfortunately, 11 have been judged to be implemented at an unsatisfactory level.

While MCFD sees all of these recommendations as complete, the Representative questions the quality of the implementation or does not see consistent utilization of the improvement in ministry practice.

Of greatest concern to the Representative is the lack of progress in improving the ministry's case review practice. The new Integrated Case Review Framework does not address all of the issues noted in the Hughes Review, in terms of clarity and consistency. As well, practice has not achieved the high professional standard called for by the Hughes Review in the areas of uniformity, timeliness and continuous learning.

Stepping back to again take a look at the full Hughes Review, the ministry's lack of overall success in meeting the aim of the review remains a major concern. Less than half of all the recommendations are judged to be fully implemented and major systems issues are not addressed to a satisfactory level. Oversight and quality assurance measures are insufficient. The development of a number of provincial frameworks and senior level councils and working groups do not demonstrate the required degree of monitoring and practice management to ensure a consistent quality of service across all programs and regions.

The Hon. Ted Hughes spoke clearly in his review of "the need for equilibrium and stability." He noted that the constant turnover in leadership, multiple changes in practice direction and budget cuts all took "a toll in terms of staff morale and the ministry's ability to set directions, frame goals and make progress." More than four years later, there is little to show that the ministry has learned to address these issues.



The ministry's executive team, for example, has been restructured several times since Hughes, with Assistant Deputy Ministers (ADMs) coming and going through the "revolving door" that Mr. Hughes urged should stop spinning. Currently there are 28 people on MCFD's "leadership team." Responsibility and accountability are divided for many programs – child care has three different ADMs, for example. The Representative has met with staff at all levels of the ministry and hears regularly of the frustration and unease caused by promises of change disconnected from the reality of the day-to-day experience and policy expertise of MCFD staff.

Stability from steady executive governance, detailed and meaningful planning, and adequate resources were of the essence if the Hughes recommendations were to be completed and this ministry's success ensured. Much has been promised and little delivered along the path of implementing the Hughes recommendations.

The Representative has been told by MCFD senior executives that transformation is more comprehensive and meaningful than Hughes, and will yield more significant improvement for children. Yet there is very little evidence on the ground in the form of new standards, practice or outcomes to support that ambitious claim, more than 4½ years after the Hughes Review. The Representative is left questioning the ministry's commitment to important changes to practice and, regrettably, has lost confidence in the ministry's capacity to achieve the intent and vision of the Hughes Review.

The systematic review of the Hughes recommendations has been an important undertaking. The Hughes Review stands as an excellent critical analysis of the child-serving system in B.C. While some of the issues or gaps have been dealt with and are essentially off the table, others are unresolved and must be monitored on an ongoing basis. These elements and others are identified and form the foundation of the Representative's monitoring and reporting work on a go-forward basis. The Representative's Office will continue to address issues such as consistency, outcomes, quality assurance and equity.

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Since first assessing progress on the Hughes recommendations in 2007, the Representative has expressed concern about shifting priorities and timelines at MCFD. This concern has not diminished in subsequent years. The ministry must be responsive and effective in serving the children of British Columbia, with its activities and outcomes for children continually reported on for accountability purposes and also to ensure that its operations are improving over time in all places. The ministry has significant responsibilities to British Columbians and has entered a period of change that is incredibly ambitious and is certainly experimental.

Given the ambitious change agenda pursued, and the ministry's move away from the Hughes Review, the Representative would have preferred an open and transparent commitment to



explaining practice change, prevention work, and how it will ensure improvement to the situation of B.C.'s children and families, especially those at risk. Ambitious change agendas require vigorous management of change, sufficient resources for stability and increased scrutiny and reporting.

Unfortunately, this has not been possible on many fronts as the level of detail, reporting and evaluation by the ministry of its ambitious program is inadequate. The Representative has been rigorous in attempting to provide oversight, but has been unable to evaluate the "transformation" agenda because it lacks detail and proper explanation of what it means for service to children, especially vulnerable children.

Front-line staff are trying to respond to requests for service, although they too express their confusion and concern. They are unsure about what is happening with standards and operations, and they report that there is a lack of effective prevention services to respond to the presenting problems that families experience. They tell the Representative and her staff that they are concerned that high-level talk is not relevant to their tasks and expect more for the families and children they serve.

Youth, parents, front-line staff and an oversight body should not be left guessing and speculating. It must be shown, by quantitative measures, that this initiative will not only respond to, but will actually address the challenges faced by children and families.

Change is required, and those leading the change must demonstrate that this approach is working, or will work, through explaining how families are actually better served, and how children's risk is reduced. By failing to provide information, the ministry's leadership demonstrates they do not appreciate what Mr. Hughes called for — a new accountable approach, with full cooperation with oversight.

The failure of the ministry to provide such information is a failure in its duty to the children and youth of B.C., and others are urged to join the Representative in calling for change. Political leaders from both sides of the Legislature must demand a level of public accountability and regular reporting that permits rigorous scrutiny. Sadly this has not been the approach, but it is hoped this will change. This rigour is essential due to the immense impact these projects and initiatives have on the daily lives of B.C.'s children and youth.

The Representative will continue to monitor and comment on the issues of service transformation, child safety and accountability through regular reports, presentations to the Select Standing Committee on Children and Youth and public discussion. The Hughes Review themes will provide guidance for public reporting, even if such reporting out is not directed at specific recommendations.



The child-serving system remains a vital area of public service. Government has made ambitious commitments to "prevention" – without much analysis of what is causing the risk to children – largely to suggest that the system *itself* is the cause of risk to children, due to systemic approaches that are too intrusive and not necessarily "strengths based."

The Representative believes that this government approach requires an even higher level of accountability, to ensure that effective services are preventing children from risk, thus justifying a diminished focus on child protection. Given recent reductions in services, it is not clear that a new prevention focus, or a new practice framework, has yet been launched at the operational level. The presenting issues continue to challenge front-line staff – the very issues that families struggle with and that place children at risk – poverty, addictions, mental health concerns, and domestic and other violence.

Building on the blueprint provided by the Hughes Review, on the recently released *Growing Up in B.C.* report, and on specific recommendations made in her past reports, the Representative will implement a new reporting process. The focus will be on examining actual outcomes that make a real difference in the lives of children.

One of the ways to measure progress is through regular measurement of outcomes achieved. The Representative will use the strong work of the federal/provincial/territorial committee on child welfare outcomes to report on commonly accepted measures for child welfare.

The Hughes Review, as it does with many complex issues, articulates a straightforward vision of why we must measure progress – and the incontestable desired end result: "When programs and policies are introduced, the ministry and the public need to understand the expected results for children; and after implementation, they need to be able to tell whether those results are being achieved."

The Representative remains keenly committed to working with MCFD and others to set and understand expected results, to critically analyze if these are being achieved, and to help realize the successes that B.C.'s children and youth deserve, as envisioned in the Hughes Review.



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REPRESENTATIVE FOR  
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