MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
INFORMATION NOTE

DATE: December 11, 2020 **DATE OF PREVIOUS NOTE** (if applicable): N/A
CLIFF#: 255957 **PREVIOUS CLIFF #** (if applicable): N/A

PREPARED FOR: Honourable Mitzi Dean, Minister of Children and Family Development

ISSUE: Public Posting of Case Review Summaries for December 2020

BACKGROUND:
In the *BC Children and Youth Review*, the Honourable Ted Hughes recommended that twice a year the Ministry of Children and Family Development (ministry) publicly release a summary of each child death review it completed during the previous six months. In June 2011, the ministry revised its process for posting summaries to include all critical injury reviews as well. The summaries are posted in June and December each year and provide a narrative description of the review. The public disclosure of summary reviews considers privacy issues and confidentiality in accordance with the *Child, Family and Community Service Act.*

DISCUSSION:
There are 18 summary reviews for posting in December 2020.

Of the 18 reviews:

- All reviews were of file information only
- 12 of these reviews were fatalities
- 6 of these reviews were critical injuries

12 of the 18 reviews were regarding fatalities, and of the 12 children who died:

- 5 children were of Indigenous ancestry
- 7 children were in care and 5 children were not in care
- 1 child was served by a Delegated Aboriginal Agency (DAA) and 11 children were served by MCFD
- the coroner determined 2 of the deaths were natural, 7 were accidental, 1 was undetermined, 1 was suicide and 1 was homicide

7 of the 18 reviews were regarding critical injuries and of the 8 children injured:

- 6 children are of Indigenous ancestry
- 3 children were in care and 5 children were not in care
- All were served by MCFD

The practice concerns identified in the reviews were addressed through action plans developed in collaboration with DAAs and Service Delivery Area (SDA) leadership where the children were served. Themes of the practice concerns were:

- issues with joint case management and case transfer processes
- collaboration by social workers with parents, families, communities and service providers;
- using Structured Decision Making tools consistently and taking the required steps in responding to child protection concerns;

- utilizing the Aboriginal Policy and Practice Framework and involving Indigenous communities in assessment and planning.

In the reviews that noted positive practice themes these included placement stability as a strength, careful consideration and collaboration of end of life planning decisions and medical needs; and consistent assessment and planning occurred in relation to guardianship responsibilities.

It is the responsibility of each SDA and DAA to complete the action plans. The Quality Assurance Branch monitors the completion of every action in the action plans by following up with those responsible for the actions until they are completed. Overdue actions require an explanation, as well as the expected steps and timeframe for completion; these may be brought to the attention of the responsible Assistant Deputy Minister.

Next Steps:
Once approved, these summaries will be posted to the ministry's internet page for public viewing.

ATTACHMENTS:

A. Table for Summary Posting December 2020
B. 247708 FR Summary
C. 250122 FR Summary
D. 241774 FR Summary
E. 246453 FR Summary
F. 248096 FR Summary
G. 248938 FR Summary
H. 244749 FR Summary
I. 249982 FR Summary
J. 245399 FR Summary
K. 244732 FR Summary
L. 245304 FR Summary
M. 244327 FR Summary
N. 247196 FR Summary
O. 244884 FR Summary
P. 246243 FR Summary
Q. 247714 FR Summary
R. 239344 FR Summary
S. 246255 FR Summary
T. Background for Case Review

Contact Assistant Deputy Minister:	**Alternate Contact for content:**	**Prepared by:**
Cory Heavener *Office of the Provincial Director of Child Welfare and Aboriginal Services* *(778) 698-5126*	*Trisha Myers* *Director, Quality Assurance Branch* *(778) 698-4964*	*Lynn Black* *Practice Analyst, Quality Assurance Branch* s.17

Table for Summary Postings: December 2020

#	Ref #	In Care	Critical Injury /Fatality	Type of Fatality	Fatality Incident	Indigenous	MCFD or DAA	Type	# Actions	Actions Completed	Actions Overdue
1	247708	Yes	Fatality	Natural	s.22	No	MCFD	File	0	0	0
2	250122	Yes	Fatality	Natural		No	MCFD	File	0	0	0
3	241774	Yes	Fatality	Accidental		Yes	DAA	File	4	4	0
4	246453	Yes	Fatality	Accidental		No	MCFD	File	2	2	0
5	248096	Yes	Fatality	Accidental		No	MCFD	File	1	1	0
6	248938	Yes	Fatality	Accidental		No	MCFD	File	0	0	0
12	244327*	Yes	Fatality/Cr Injury	Homicide		Yes	MCFD	File	2	2	0
13	247196	Yes	Critical Injury	N/A		Yes	MCFD	File	2	0	0
14	244884	Yes	Critical Injury	N/A		Yes	MCFD	File	3	3	0
15	246243	Yes	Critical Injury	N/A		No	MCFD	File	3	3	0
7	244749	No	Fatality	Accidental		Yes	MCFD	File	8	7	0
8	249982	No	Fatality	Accidental		Yes	MCFD	File	0	0	0
9	245399	No	Fatality	Accidental		Yes	MCFD	File	3	3	0
10	244732	No	Fatality	Undetermined		No	MCFD	File	2	2	0
11	245304	No	Fatality	Suicide		No	MCFD	File	1	1	0
16	247714	No	Critical Injury	N/A		Yes	MCFD	File	4	4	0
17	239344*	No	Critical Injuries	N/A		Yes	MCFD	File	7	7	0
18	246255	No	Critical Injury	N/A		No	MCFD	File	3	0	0
							TOTALS	Type	45	40	0

* These case reviews relate to a sibling group of two.
** Coroner service is still investigating.

BRITISH COLUMBIA

Ref #: 247708
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Director in 2020

Circumstances of the Fatality

The review examined the case files of a child who died from complications related to a medical issue. The director was providing guardianship services to the child at the time of their death.

Findings

Assessment and planning were consistent with the child's needs, particularly in relation to permanency planning and placement considerations. Collaboration occurred with the parents, extended family and the child's care team, and an extended family placement was being considered at the time of the child's death. End of life decisions were carefully considered and involved the child's family. Family connections were preserved, and information was shared between the child's family, the director and the medical staff to address issues as they arose.

Actions

No actions were required to address the findings of the review.

The review was completed in October 2020.

BRITISH COLUMBIA

Ref #: 250122
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Director in 2020

Circumstances of the Fatality

The review examined the case files of a child who died. The director was providing guardianship services to the child at the time of their death.

Findings

The child was brought into the care of the director soon after child protection concerns of neglect were identified. The director collaborated with the family and medical professionals to appropriately address the child's safety and well-being, particularly as it related to the child's health needs.

Actions

No actions were required to address the findings of the review.

The review was completed in November 2020.

BRITISH COLUMBIA

Ref #: 241774
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth in the Care of the Director in 2019

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died. The director was providing guardianship services to the youth at the time of their death.

Findings

The director worked to address the youth's needs, with a specific focus on cultural and relational permanence. The youth was engaged in services to meet specific needs; however, there were challenges with assessments and communication between service providers.

Prior to the case review being finalized, information sharing, and training occurred to address the concerns about assessment and communication between service providers.

Actions

No further actions were required to address the findings of the review.

The review was completed in December 2020.

BRITISH COLUMBIA

Ref #: 246453
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth in the Care of the Director in 2019

Circumstances of the Fatality

The review examined the case files of a youth who died while in the care of the director. The director was providing guardianship services to the youth at the time of their death.

Findings

The youth experienced health issues throughout their time in care. The director collaborated extensively with the youth's parent and community service providers to support the youth. The director arranged several Family Group Conferences to address the youth's safety and well-being, as well as their changing needs. The director did not complete child protection responses in a timely manner and did not utilize assessment tools to guide their decision-making for the youth and their family.

Prior to the case review being finalized, the involved staff completed specific overdue children protection responses. Additionally, the Directors of Operations and Practice met with the involved staff to review the importance of completing child protection work in a timely manner. A plan was developed for the team leader to continue to address timelines, documentation and completion of assessment tools in regular supervision with staff; these consultations would be documented on the file.

Actions

No further actions were required to address the findings of the review.

The review was completed in September 2020.

BRITISH COLUMBIA

Ref #: 248096
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth in the Care of the Director in 2020

Circumstances of the Fatality

The review examined the case files of a youth who died. The director was providing guardianship services to the youth at the time of their death.

Findings

There was a delay in assessing the report of neglect. Once the report was assessed, there was a determination there were concerns of neglect, and planning occurred to address the youth's safety. Numerous consultations and significant collaboration occurred to support a plan for the youth to remain with their parent. The youth was eventually brought into the care of the director due to an escalation of the ongoing concerns for their safety and well-being; however, they refused to stay at their placement and returned home to their parent. Significant supports were put in place to regularly assess the youth's safety while in their parent's care, and the director worked with the youth and their parent to develop plans to address the identified concerns. Soon after being placed in the director's care, the youth died.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to have a discussion with the child protection team leaders focusing on providing services to children throughout the director's involvement; this includes the timeliness of response to reports.

The review was completed in November 2020. The above action plan was fully implemented in November 2020.

BRITISH COLUMBIA

Ref #: 248938
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Director in 2020

Circumstances of the Fatality

The review examined the case files of a child who died. The director was providing guardianship services to the child at the time of their death.

Findings

The child experienced stability while in the care of the director in relation to their placement and family connections. Assessment and planning were thorough and consistent to meet the child's needs. After their accidental injury, the child was hospitalized for a month before dying. During that time, family connections were honored and supported. The director collaborated regularly with the child's caregivers, family and medical team to address the child's medical needs before they died.

Actions

No actions were required to address the findings of the review.

The review was completed in September 2020.

BRITISH COLUMBIA

Ref #: 244749
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Director in 2019

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died. The director provided services to the youth within the 12 months prior to the youth's death.

Findings

The youth had been in care from a young age and maintained a single placement for many years before they moved to another placement; this disruption resulted in significant instability in subsequent placements. During their time in care, they had health challenges that impacted their daily functioning; however, the director and community professionals supported them with services that addressed these challenges, including accessing other Ministry of Children and Family Development programs. While the director provided the youth with information about their Indigenous culture and community, a cultural plan was not on file and the Indigenous community was not involved in development of the Care Plan.

Prior to the case review being finalized, the Service Delivery Area leadership implemented several changes to improve service to Indigenous children and youth, including the creation of a new Indigenous-focused child protection intake team and increasing the number of Indigenous Elders available to support Indigenous children and youth.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the involved staff and caregivers to receive information on how youth can access specialized training and to document when youth have received this training.

The review was completed in July 2020. The above action plan was due for full implementation in October 2020.

BRITISH COLUMBIA

Ref #: 249982
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Director in 2020

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died. The director provided services to the youth within the 12 months prior to the youth's death.

Findings

The youth had been in the director's care for a short period prior to their death. During their time in care, the youth had significant health needs that impacted their daily functioning. The director and community professionals supported the youth with services that addressed these needs. The youth was aware of their Indigenous identity throughout their time in care. The director collaborated with a Delegated Aboriginal Agency, as well as other service providers, to confirm the youth would be supported after they left the care of the director.

Actions

No actions were required to address the findings of the review.

The review was completed in November 2020.

BRITISH COLUMBIA

Ref #: 245399
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Director in 2019

Circumstances of the Fatality

The review examined the case files of an Indigenous child who died from an undetermined cause. The director was providing services to the child and their family at the time of the child's death.

Findings

Shortly before the child's death, the director obtained a supervision order returning the child to their parent's care. When the file was transferred to a new social worker, there was no indication the family was monitored for the remainder of the order. The director also received multiple reports about neglect but did not screen these to determine whether a child protection response was required. While the director completed assessment tools that identified areas of concern for the parent, these tools were not completed in collaboration with the parent.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the involved staff to receive training on the guidelines for problematic substance use and the Child Protection Response Policies, particularly around collaborating with families in completing assessment tools. Additionally, the involved staff will conduct monthly meetings with families who are being monitored through a supervision order.

The review was completed in July 2020. The above action plan was fully implemented in July 2020.

BRITISH COLUMBIA

Ref #: 244732
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Director in 2019

Circumstances of the Fatality

The review examined the case files of a youth who died from an accidental injury. The director was providing services to the youth and their family prior to the youth's death.

Findings

The youth had specific needs and parenting concerns were not addressed. The director did not respond to child protection reports and did not view the youth's home, meet with the youth, or coordinate information from other sources. Consultation to guide practice was not consistent and tools used to guide decision making were either not completed or inaccurately completed.

Actions

The involved Service Delivery Area (SDA) leadership and the Quality Assurance team developed an action plan to review the Child Protection Response Policies related to concluding a child protection response with the involved staff. This included a focus on the importance of completing interviews, home visits, collateral information gathering, consultation points, and Structured Decision Making tools. The SDA leadership also led a review of the Good Recording Guide with the involved staff.

The review was completed in October 2020. The above action plan was fully implemented in November 2020.

BRITISH COLUMBIA

Ref #: 245304
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Director in 2019

Circumstances of the Fatality

The review examined the case files of a youth who died while in their parent's care. The director was providing services to the youth and their family at the time of their death.

Findings

The director made consistent offers to support the family in addressing the youth's health needs prior to their death. The family declined these offers, as they were involved with a care team of community professionals who collaborated regularly to address the youth's needs. Reports about critical injuries the youth experienced prior to their death were not submitted; these would have provided leadership an opportunity to consider what support and assistance could have benefitted the family and assisted in meeting the director's legal obligation to inform the Representative for Children and Youth.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to organize a discussion with the involved staff focused on when to submit Reportable Circumstance Reports, particularly in coordination with other involved program areas.

The review was completed in July 2020. The above action plan was fully implemented in October 2020.

BRITISH COLUMBIA

Ref #: 244327
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Director & Critical Injury of a Child Known to the Director in 2019

Circumstances of the Fatality and Critical Injury

The review examined the case files of two Indigenous children who were siblings. One child died and the other was critically injured. The director was providing guardianship services to one child at the time of their death and was providing services to the other child and their family at the time of their critical injury.

Findings

One of the siblings had been in care prior to the incident but was returned to the parents' care. Planning occurred to support the return of the child; however, information from community partners working with the family was not gathered to inform assessment or planning for either child. When additional concerns of neglect arose, the director did not complete the required steps of a child protection response. Upon learning the children had been critically injured while with their parents, they were brought into the care of the director and medical treatment was obtained. One of the children subsequently died from their injuries.

Actions

The involved Service Delivery Areas and the Quality Assurance team developed an action plan to review policy that guides assessments, collaboration with other service providers, and gathering collateral information. Additionally, a plan was developed to review how to identify and invite key stakeholders to Family Group Conferences. The involved staff were to review the practice directive on Case Transfer and Joint Case Management.

The review was completed in September 2020. The above action plan was fully implemented in October 2020.

BRITISH COLUMBIA

Ref #: 247196
Date: December 2020

SUMMARY: FILE REVIEW
Of the Critical Injury of a Youth in the Care of the Director

Circumstances of the Critical Injury

The review examined the case files of an Indigenous youth who was critically injured while in the care of the director. The director was providing guardianship services to the youth at the time of their critical injury.

Findings

The director responded in a timely manner to address the youth's guardianship needs and, in collaboration with others, developed a plan for the youth to reside with their extended family. The youth's Indigenous community was not included in the planning, and the assessment of whether the youth's placement could provide for their safety and well-being was incomplete.

Prior to the case review being finalized, the director engaged with representatives of the youth's Indigenous community in planning, and the youth was moved to a placement approved by the director.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide training to staff related to the policies and procedures for screening Out of Care placements, and the best practices for planning with Indigenous children and youth, particularly in regard to engagement with Indigenous communities.

The review was completed in November 2020. The above action plan is due for full implementation in January 2021.

BRITISH COLUMBIA

Ref #: 244884
Date: December 2020

SUMMARY: FILE REVIEW
Of the Critical Injury of a Youth in the Care of the Director in 2019

Circumstances of the Critical Injury

The review examined the case files of an Indigenous youth who was critically injured. The director was providing guardianship services to the youth at the time of their critical injury.

Findings

Although extended family members were involved in some planning, there were no assessments completed to support a family placement for the youth. The youth's Indigenous identity was not explored or supported, and there was a lack of permanency planning for the youth. Increased collaboration with involved service providers may have provided opportunities to support the youth with their health needs.

Prior to the case review being finalized, the involved staff initiated conversations about how to support the youth's Indigenous identity, services to address the youth's health needs increased, and the youth's care team became more involved with collaboratively supporting and planning for the youth.

Actions

No further actions were required to address the findings of the review.

The review was completed in October 2020.

BRITISH COLUMBIA

Ref #: 246243
Date: December 2020

SUMMARY: FILE REVIEW
Of the Critical Injury of a Youth in the Care of the Director in 2019

Circumstances of the Critical Injury

The review examined the case files of a youth who was critically injured. The director was providing guardianship services to the youth at the time of their critical injury.

Findings

The youth resided with an extended family member. The director did not fully assess the family member as a caregiver and did not implement a plan to support the placement. Some assessment to inform permanency planning occurred; however, the director did not develop a permanency plan, there was no record of how some specific needs of the youth were being addressed and the youth's connection with other family members was not planned for.

Prior to the review being finalized, the involved staff participated in a workshop regarding Care Plans and permanency planning.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to track placements and payments to caregivers, as well as review policy regarding case transfers and joint case management.

The review was completed in June 2020. The above action plan was fully implemented in September 2020.

BRITISH COLUMBIA

Ref #: 247714
Date: December 2020

SUMMARY: FILE REVIEW
Of a Critical Injury of a Youth Known to the Director

Circumstances of the Critical Injury

The review examined the case files of an Indigenous youth who was critically injured. The director was providing services to the youth and their family at the time of the critical injury.

Findings

In the months preceding the critical injury, the youth's immediate safety was thoroughly addressed; however, assessments and planning related to the youth's likelihood of future maltreatment did not occur, and services to mitigate the concerns were not implemented. The director did not involve the youth's Indigenous community in planning.

Prior to the case review being finalized, the involved staff reviewed out of care options.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide the involved teams with training related to completing a protection response, Structured Decision Making Tools and safety planning. Additionally, training was provided to the involved management regarding the involvement of a Delegated Aboriginal Agency (DAA), Nation, and Indigenous community in the assessment of reports when applicable.

The review was completed in November 2020. The above action plan was fully implemented in November 2020.

BRITISH COLUMBIA

Ref #: 239344
Date: December 2020

SUMMARY: FILE REVIEW
Of the Critical Injury of Children Known to the Director in 2018

Circumstances of the Critical Injuries

The review examined the case files of two Indigenous children who were critically injured. The director was providing services to the children and their family at the time of their critical injury.

Findings

The director did not consistently complete records reviews when new child protection reports were received. As a result, some protection reports were screened as not requiring further action, when instead a child protection response was warranted. While the director correctly identified the family required ongoing supports to address the children's safety, the tools to guide decision making about what interventions were needed to address the children's needs were not used. Information was sought from a community partner regarding their involvement with one of the children's parents to assess risk to the children's safety. Additionally, the director did not implement the relevant guidelines on best practice approaches when assessing the children's safety.

Prior to the case review being finalized, the involved staff received further training on responding to high risk situations and the use of assessment and planning tools to guide decision making. Additionally, the process and purpose of completing Initial Record Reviews was highlighted in the involved office and was included as a specific component of training for newly hired practitioners.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review the following with the involved staff: the remaining Structured Decision Making tools (Strength and Needs Assessment, Family Plan, Vulnerability Reassessment and Reunification Assessment); the importance of completing both an Initial Record Review and Detailed Record Review; and, the need to interview all the children in the home, as well as the parents, when completing a child protection response.

The review was completed in July 2020. The above action plan was fully implemented in September 2020.

BRITISH COLUMBIA

Ref #: 246255
Date: December 2020

SUMMARY: FILE REVIEW
Of a Critical Injury of a Youth Known to the Ministry

Circumstances of the Critical Injury

The review examined the case files of a youth who was critically injured. The director was providing services to the youth and their family at the time of the critical injury.

Findings

The youth was temporarily in the care of the director and returned home to their parents' care once the safety concerns were addressed and support services were provided. Family members were engaged with services, and collaborative planning occurred between the director and community partners. The director's response to new child protection concerns was inconsistent in that some child protection reports were addressed while others were not. Tools to guide decision making were not utilized, risk assessments and safety plans were not completed, and an integrated service plan was not developed with the involved service providers.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review the following with the involved staff: the procedures for assessing new child protection reports, completing Structured Decision Making Tools, the family service practice cycle, using collaborative practices, the importance of completing mental health risk assessments and safety plans, and following the recommended evidence-based approach to therapy. A team leader forum is being arranged to discuss collaboration and integrated case management practices.

The review was completed in November 2020. The above action plan is due for full implementation in February 2021.

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT

OFFICE OF THE PROVINCIAL DIRECTOR AND ABORIGINAL SERVICES

APPENDIX 1

Background for Case Review

KEY MESSAGES:

- Case Reviews examine and learn from the facts surrounding a death, critical injury or, in some cases a serious incident, to improve practice and policy.
- When a Case Review identifies opportunities to improve policy, practice and service delivery, an action plan is developed to address the required improvements.
- Action plans are monitored for completion.
- The decision to conduct a Case Review is based upon an examination of the critical injury or death of a child using standard criteria:
    - the severity and nature of the incident;
    - the vulnerability of the person;
    - whether the incident occurred in a placement for which MCFD/DAA has responsibility;
    - the level of MCFD/DAA involvement with the person or their family;
    - the type of responsibility MCFD/DAA had for the person;
    - whether policy, practice or service provision contributed to the reportable circumstance;
    - whether there are opportunities for organizational learning and improvement; and,
    - the need for public accountability.
- There are two types of case reviews, a File Review and a Comprehensive Review.
- Timelines for completion are 3 months for a File Review, and 8 months for a Comprehensive Review.

- The Provincial Director of Child Welfare always conducts a Case Review when there is a fatality of:
    - A child or youth in the care of the director; or,
    - An adult up to 20 years of age, who was in the care of the director until turning 19 years of age.

The Case Review report is provided to the Representative for Children and Youth and a summary is posted on the ministry's website.

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
INFORMATION NOTE

DATE: December 8, 2020
CLIFF#: 255282

PREPARED FOR: Honourable Mitzi Dean, Minister of Children and Family Development

ISSUE: BC College of Social Workers Background – Social work oversight and possible Fall 2020 Board Appointment

BACKGROUND:

The British Columbia College of Social Workers (BCCSW) is the regulatory body responsible for overseeing the social work profession in BC. The BCCSW is established and governed under the Social Workers Act (SWA). The SWA establishes the mandate of the BCCSW: to serve and protect the public and to exercise its powers under the SWA in the public interest. The BCCSW's oversight role includes establishing and maintaining social worker registration requirements; establishing and upholding standards of practice and ethical requirements; dealing with complaints and discipline; and maintaining continuing competence and education processes.

BCCSW Board Appointments
The Ministry of Children and Family Development (MCFD) is responsible for administration of the SWA. As such, MCFD has certain responsibilities over the BCCSW, including the administration of appointment of public members of the BCCSW Board. Under the SWA, at least two members of the Board must be "public members" appointed by the Minister of Children and Family Development (Minister of CFD).

The Crown Agencies and Board Resourcing Office (CABRO) manages appointments to all Crown corporations, agencies, boards and commissions. As such, MCFD works with CABRO to facilitate BCCSW Board appointments.

Social Worker Oversight
MCFD is also responsible for BC's social work profession oversight framework – currently legislated through the SWA and implemented by the BCCSW. Under the SWA, anyone describing themselves as a social worker must register with the BCCSW unless exempt under the *Social Workers Regulation* (SWR). Exemptions include social workers employed by: MCFD and Delegated Aboriginal Agencies (DAA); Provincial and federal governments; Municipalities, regional districts or boards of education, and; First Nations.

The BCCSW – along with other groups – has long called for removal of the registration exemptions in the SWR[1], which would result in mandatory registration for all social workers in BC. MCFD has recently seen a renewed focus on this issue within the public domain, arising from (1) media coverage regarding a former MCFD employee who misappropriated funds from

[1] Include the BCCSW and the BC Association of Social Workers (BCASW), and Green Party leader (Sonia Furstenau).

children and youth in care, and (2) a recent Ministry of Health (MOH) review of BC health professional regulation[2].

DISCUSSION:

BCCSW Board Appointments

The BCCSW Board currently has one public member vacancy. In September 2020, representatives from MCFD participated in an interview panel to screen potential candidates. MCFD staff expects CABRO to brief Minister Dean soon (timing is TBC). Once the Minister provides direction on the appointment, MCFD will draft a Ministerial Order accordingly.

Social Worker Oversight

s.13

NEXT STEPS:

1. MCFD has certain administrative responsibilities over the BCCSW, including appointing public board members. MCFD staff expect CABRO to brief Minister Dean on the recommend candidate to fill the one board vacancy (timing TBC). Once the Minister provides direction on the appointment, PLL will move forward with drafting a Ministerial Order.

2. s.13

Contact **Assistant Deputy Minister:** *Carolyn Kamper* *Strategic Integration, Policy and Legislation Division* s.17	**Alternate Contact for content:** *Rhianna Begley, Director* *Strategic Policy, Research and Engagement* s.17	**Prepared by:** *Quinn Macdonald* *Strategic Policy, Research and Engagement* *(236) 478-3043*

[2] See August 2020 MOH Report: *Recommendations to Modernize the Provincial Health Profession Regulatory Framework*

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
INFORMATION NOTE

DATE: December 3, 2020 **DATE OF PREVIOUS NOTE (if applicable):** N/A
CLIFF#: 255911 **PREVIOUS CLIFF # (if applicable):** N/A

PREPARED FOR: Honourable Mitzi Dean, Minister of Children and Family Development

ISSUE: Jordan's Principle in BC and Canadian Human Rights Tribunal decisions.

BACKGROUND:
Jordan's Principle is a child-first principle that aims to ensure all First Nations children living in Canada can access the products, services and supports they need, when they need them. This requires the government of first contact to fund the available services for First Nations children and resolve funding disputes later. Jordan's Principle passed in the House of Commons in 2007.

In 2016, the Canadian Human Rights Tribunal (CHRT) ruled Canada had discriminated against First Nations children through the First Nations Child and Family Services Program and ordered Canada to immediately implement the full meaning and scope of Jordan's Principle. In July 2016, Canada announced $382.5 million in new funding for Jordan's Principle and created an interim three-year approach called the Child First Initiative. Initially this program was administered in BC through a partnership between Indigenous Services Canada (ISC) and the First Nations Health Authority (FNHA), with FNHA in a service coordination capacity. After the expiry of CFI funding in March 2019, another $1.2 billion investment was allocated to continue supporting Jordan's Principle.

A subsequent CHRT decision in 2017 set out an expanded definition of Jordan's Principle that includes who Jordan's Principle applies to (First Nations children both on and off reserve and not limited to children with disabilities) and requiring the government of first contact to determine if the provision of services should be provided to ensure substantive equality. The CHRT decision widened the scope of Jordan's Principle and has resulted in more complex requests that require coordination across multiple categories including health, education, mental health, infrastructure, social supports and child development.

On November 25, 2020, the latest CHRT decision expanded the definition again for children who are eligible to receive services through Jordan's Principle. The new criteria include a child who is recognized by their Nation for the purposes of Jordan's Principle, and children who are not eligible for *Indian Act* status themselves but have a parent who is. The order also sets out a process for confirming eligibility of a child recognized by their Nation for the purposes of Jordan's Principle and funding for expenses First Nations incur when confirming First Nations citizenship. The decision only relates to eligibility for Jordan's Principle and "explicitly avoids defining who is a First Nations child", recognizing the rights of First Nations to determine their own citizens (see Attachment C for synopsis of all related CHRT rulings).

DISCUSSION:

s.13; s.16

NEXT STEPS:

s.13; s.16

ATTACHMENTS:

- A: Common Briefing Note: Deputy Ministers Responsible for Social Services, December 2019
- B: Jordan's Principle ISC Information Summary
- C: Jordan's Principle: Timeline/overview of related CHRT rulings

Contact **Assistant Deputy Minister:**	**Alternate Contact** **for content:**	**Prepared by:**
Carolyn Kamper	Francesca Wheler, ED	Catherine May
Ministry of Children and	Child Welfare and	Child Welfare and
Family Development	Reconciliation Policy	Reconciliation Policy
778-698-7038	778-974-2164	s.17

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Withheld pursuant to/removed as

s.13 ; s.16

Attachment B to CLIFF 255911
Summary of Indigenous Services Canada's Jordan's Principle Data

On October 20, 2020 Indigenous Services Canada (ISC) provided data on Jordan's Principle requests and expenditures for 2019/20 nationally and for BC.

Key points:

- Approved requests and expenditures continue to increase nationally each year, with a 149% increase in approved requests from 2018/19 to 2019/20.

- **For British Columbia, approved requests *decreased* by 35% and expenditures decreased by 73% from 2018/2019 to 2019/20.**

- In 2019-20, BC had the third lowest number of approved individual requests (2,230) and the highest percentage of denied individual requests (26.3%).

- In 2019-20, BC had the lowest number of approved group requests (34) and the highest percentage of denied group requests (51.5%).

- ISC heavily attributes this to a "course correction" to align with national standards following the transfer of administration of Jordan's Principle to ISC from the First Nations Health Authority.

- ISC has not provided a breakdown of expenditures for each region.

Analysis

- The 2016 Census shows that BC has the second largest population of Indigenous Peoples in Canada (16.17%) after Ontario (22.37%).

- Funding in BC under Jordan's Principle has historically fallen below national trends.

- Given that funding under Jordan's Principle in BC has historically fallen below national trends, the 35% decline in expenditures in BC from 2018/19 to 2019/20 is significant, even with the course correction identified by ISC.

- Data may suggest service gaps in education, healthy child development, oral health (excluding orthodontics) and allied health.

- Further, nationally, mental wellness was the category with the highest group funding identifying a national service gap.

- 70% of requests in BC were beyond the normative standard, with variances across categories
    - This represents a significant difference from the national trend (33%) and could indicate that existing programs and services are better utilized provincially, regional differences in defining the normative standard or regional variations in administration.

Attachment C to CLIFF 255811 | Jordan's Principle: Timeline/Overview of Related Canadian Human Rights Tribunal (CHRT) Rulings

House of Commons	Original Motion
Motion-296 (Dec 12, 2007)	Private members motion: passed unanimously. Jordan's Principle is a child-first principle regarding jurisdictional disputes: the government department of first contact pays for the service and can seek reimbursement from the other government or department ***after*** the child has received the service, to prevent delay, disruption and/or denial of a goods/services for First Nations children on-reserve
Tribunal	**Notes on the decision**
2016 CHRT 2 (January 26, 2016) Original CHRT Ruling	- Landmark ruling about the funding discrimination against First Nations children living on-reserve. - The Tribunal found that the funding/access to service disparity between Indigenous children on reserve and non-Indigenous children amounted to discrimination on the grounds of race and national ethnic origin. This is because the funding formula (Directive 20-1) for First Nations Family and Child Services incentivized child removal, did not utilize least disruptive measures, and under-funded prevention programs. - The Tribunal found that the narrow interpretation of Jordan's Principle (as inter-governmental disputes in situations where a child has multiple disabilities requiring services from multiple service providers) resulted in service gaps, delays and denials for Indigenous children on-reserve. - The Tribunal ordered INAC to: • Cease its discriminatory practices regarded the FNCFS Program • Reform the FNCFS Program • Cease applying the narrow definition of Jordan's Principle; and • Take measures to **immediately implement the full meaning and scope of Jordan's Principle**: "Jordan's Principle is meant to apply to all First Nations children" (para 382), and to address service gaps (para 391) including mental health and dental services. - On substantive equality, the tribunal stated that "the Supreme Court has consistently held that equality is not necessarily about treating everyone the same. As mentioned above, "identical treatment may frequently produce serious inequality"" (para 399)
2016 CHRT 10 (April 26, 2016) Non-compliance order 1	**Panel ordered INAC to immediately consider Jordan's Principle as including all jurisdictional disputes (including disputes between governmental departments), involving all First Nations children (not only those with multiple disabilities), and that the government of first contact should pay for the service without delay (without need for policy review or case conferencing)** (para 30-34). - Ordered immediate remedies for, but not limited to: "the adverse effects related to the assumptions about children in care, families in need of services and population levels; remote and/or small agencies; inflation/cost of living and for changing service standards; and salaries and benefits, training, legal costs, insurance premiums, travel, multiple offices, capital infrastructure, culturally appropriate programs and services, and least disruptive measures" (para 20)
2016 CHRT 16 (September 14, 2016) Non-compliance order 2	- INAC continues to perpetuate discrimination by not acting *immediately* and issued further orders to ensure discrimination is eliminated immediately - INAC ordered to provide all First Nations and FNCFS Agencies with the name and contact information of the Jordan's Principle focal points in all regions, and to report/list the First Nations and FNCFS Agencies it has consulted with regarding Jordan's Principle. - The Tribunal again ordered the federal government to cease using a definition of Jordan's Principle that is more restrictive that the one formulated by the House of Commons in the original 2007 Motion. • "The Panel orders INAC to immediately apply Jordan's Principle to all First Nations children, not only those residing on reserve." (para 118) and to explain why it limited its definition of Jordan's Principle to children with "disabilities and those who present with a discrete, short-term issue for which there is a critical need for health and social supports" (para 119)
2017 CHRT 14 (May 26, 2017) Non-compliance order 3	- The process for accessing Jordan's principle has remained needlessly complicated and convoluted, which continues to contribute to delays, gaps, and denials of health and social services: "access to Jordan's Principle funding should be a priority, not be a last resort." (para 99) - Expanded Definition of Jordan's Principle: • Jordan's Principle "is **not** limited to First Nations children with disabilities, or those with discrete short-term issues creating critical needs for health and social supports or affecting their activities of daily living." (para 135) • It addresses needs by ensuring there are no gaps in government services to First Nations children (including but not limited to mental health, special education, dental, physical therapy, speech therapy, medical equipment and physiotherapy) • Where service is available to other children, the gov't of first contact pays without engaging in case conferencing/policy review; can seek reimbursement from another gov't/department

Note: Indigenous and Northern Affairs Canada (INAC) has been replaced by the Department of Indigenous Services Canada (ISC).

Attachment C to CLIFF 255811 | Jordan's Principle: Timeline/Overview of Related Canadian Human Rights Tribunal (CHRT) Rulings

	• Where service is not available to other children: gov't of first contact will "evaluate the individual needs of the child to determine if the requested service should be provided to ensure substantive equality in the provision of services to the child, to ensure culturally appropriate services to the child and/or safeguard the best interests of the child." Still, this process must be done without case conferencing/policy review, and the gov't/department can seek reimbursement where appropriate (para 135 iv) • A jurisdictional dispute is not a necessary requirement for the application of Jordan's Principle - Substantive equality: • "the emphasis on the "normative standard of care" or "comparable" services in many of the iterations of Jordan's Principle above does not answer the findings in the *Decision* with respect to substantive equality and the need for culturally appropriate services…To ensure substantive equality and the provision of culturally appropriate services, the needs of each individual child must be considered and evaluated, including taking into account any needs that stem from historic disadvantage and a lack of on-reserve and/or surrounding services." (para 69) - Orders: • Apply and publicise the provided definition/approach to Jordan's Principle and cease attempts to narrow it • Initial evaluation and a determination of the request shall be made **within 12-48 hours** of its receipt • Canada shall develop reliable internal systems to identify cases, track number of applications, reason for application, service requested, progression of each case, the result with reasons, and the timeline for resolving each case. • Canada must re-review applications that were denied from April 1, 2009 to ensure compliance with principles outlined, and denied request shall be informed of right to appeal the decision. Canada ordered to serve and file a report and affidavit materials detailing compliance with each order
2017 CHRT 35 (November 2, 2017) Non-compliance order 4	- Amendment to 2017 CHRT 14 - Order to Canada to cease relying upon and perpetuating definitions of Jordan's Principle that are not in compliance with CHRT orders 2016 CHRT 2, 2016 CHRT 10, 2016 CHRT 16 and 2017 CHRT 35 - Based Canada's definition and application of Jordan's Principle on key principles described in 2017 CHRT 14, with the following amendments: - When a gov't service **including a service amendment** is available to all children, the gov't of first contact will pay for the service (without engaging in administrative case conferencing) **before the recommended service is approved. Canada may engage in case conferencing to the extent that such consultations are reasonably necessary to determine the requestor's clinical needs** - Amendments also made to case tracking; Canada ordered to cease imposing service delays due to administrative case conferencing
2018 CHRT 4 (February 1, 2018) Non-compliance order 5	- Panel found that some of the same behaviours and patterns leading of systemic discrimination are still occurring: fully funding apprehension and maintenance, while not doing the same for prevention "perpetuates the historical disadvantages and the legacy of residential schools already explained in the *Decision* and rulings. It incentivizes the removal of children rather than assisting communities to stay together. Based on the findings and reasons in the *Decision* and subsequent rulings and the additional information provided to the Panel's questions, the Panel finds there is a need for further orders to eliminate the discriminatory practices explained above." (para 230) - Orders: • Cease discriminatory funding practice of not fully funding the costs of preventative/least disruptive measures, intake and investigation, building repairs and legal services, and to develop alternative system for fully funding actual costs for these services. (para 233) These costs must be analysed based on the real needs of First Nations agencies considering travel distances, case load ratios, remoteness, the gaps/lack of surrounding services and circumstances. (para 231) The costs are to be reimbursed retroactive to January 26 2016. • This methodology for alternative system for fully funding actual costs is to be created, including an accountability framework, in collaboration with AFN, the Caring Society, the Commission, the COO and the NAN. • Further Orders: o the Panel ordered Canada to cease its discriminatory funding practice of not fully funding, and to develop an alternative system for funding amounts for First Nations children and families on reserve based on actual needs, and to provide said funding retroactive to January 26, 2016 for the following: ▪ Child Service Purchase Amount -the Panel uncertain if increase from $100/child to $175/child was sufficient ▪ Small Agencies -300 children as lowest threshold for scaling funding does not support small agencies o Data Collection, Analysis and Reporting – Canada must provide reliable data collection, analysis and reporting methodology (respecting Indigenous intellectual property), and consult the other parties with how it will analyse collected information

Note: Indigenous and Northern Affairs Canada (INAC) has been replaced by the Department of Indigenous Services Canada (ISC).

Attachment C to CLIFF 255811 | Jordan's Principle: Timeline/Overview of Related Canadian Human Rights Tribunal (CHRT) Rulings

	○ Reallocation – stop unnecessarily reallocating funds from other social programs, especially housing, if it leads to apprehensions of Indigenous children, and do not reallocate funding until an evaluation shows such reallocation will not negatively impact Indigenous children ○ Ensure that any immediate relief investment does not adversely impact Indigenous children/families/communities ○ Analyse programs and fund actual costs of mental health services to First Nations children and youth in Ontario ○ Fund Band Representative Services for Ontario First Nations ○ Communicate clearly and consult with partners: First Nations Child and Family Services Agencies, the Commission, AND, Caring Society, COO, and NAN ○ Serve and file a report and affidavit materials detailing its compliance.
2019 CHRT 1 (January 7, 2019) Non-compliance order 6	- Motion filed over complaint that Canada failed in its disclosure obligations under CHRT Rules of Procedure to disclose 90,000 documents related to child and family service issues for First Nations families, resulting in a hearing delay and incurred costs for complainants (First Nations Child and Family Caring Society, AFN and Chiefs of Ontario) - Canada ordered to compensate complainants for costs incurred as a result of the failure to disclose documents prejudicial and relevant to Canada's case
2019 CHRT 7 (February 21, 2019) Non-compliance order 7	- Motion for interim relief - Discrepancy over terminology, namely the application of the term "First Nations Child" for the purposes of implementing Jordan's Principle (namely with regard to the issue of status) - Argument: First Nations children without status or otherwise status-ineligible is resulting in discriminatory practice against First Nations children in need of services - Several cases cited where First Nations children without status received inadequate service or did not receive needed services - CHRT Ruling: - Canada shall provide First Nations children living off-reserve who have **urgent and/or life-threatening needs but do not have and are not eligible for status** (as defined under the *Indian Act*) with the services required to meet those needs, under Jordan's Principle - This order applies to: ▪ First Nations children without status under the *Indian Act,* who live off-reserve but are recognized as members by their Nation ▪ First Nations children with urgent and/or life threatening needs, as assessed by a physician, health professional or other professionals involved in the child's assessment - This order does not decide the issue of Jordan's Principle eligibility based on status vs. non-status (focusing only on off-reserve non-status First Nations children with urgent and/or life threatening needs) - This is an interim order that will only apply until a hearing on the definition of a "First Nation child" under Jordan's Principle (what the term First Nations child will encompass). This hearing will be convened in the near future
2019 CHRT 39 (September 6, 2019) Non-compliance order 8 Current Status	- Tribunal found that Canada "wilfully and recklessly" discriminated against First Nations children and families via its inequitable First Nations child and family services program (including funding) and discriminatory approach to Jordan's Principle - The Tribunal ordered the maximum amount of compensation per child allowable under the Canadian Human Rights Act (40K per victim). - The Tribunal gives the Parties until December 10, 2019 to develop a process for the distribution of the compensation (para. 269). - 1) $40,000 for each child taken into care on reserve and in the Yukon for unnecessary removals (removals that may have been prevented if adequate services were available3) from January 1, 2006. [para. 245 (20K) + para. 253 (20 K) =40K] - 2) $40,000 for each child removed from their families on reserve and in the Yukon and then returned to immediate or extended family at a later date from January 1, 2006. [para. 246 (20K) +para. 253 (20 K) = 40K] - 3) $40, 000 to each parent or each grandparent caring for each child resident on reserve and in the Yukon who were unnecessarily removed from January 1, 2006. [para. 247 (20K) + para. 253 (20K) = 40K] - 4) $40,000 to each First Nations child who experienced abuse and were necessarily removed from their homes who resided on reserve and in the Yukon but were placed outside of their extended families and communities and thus did not benefit from prevention and least disruptive measures. [para. 249 (20K) + para. 253 (20 K) =40K] - 5) $40,000 to each First Nations child, living on or off reserve, who, as a result of a gap, delay and/or denial of services, was deprived of essential services and placed in care outside of their home, family and community in order to receive those services from December 12, 2007 to November 2, 2017. [para. 250 (20K) + para. 253 (20 K) = 40K]

Note: Indigenous and Northern Affairs Canada (INAC) has been replaced by the Department of Indigenous Services Canada (ISC).

Attachment C to CLIFF 255811 | Jordan's Principle: Timeline/Overview of Related Canadian Human Rights Tribunal (CHRT) Rulings

	- 6) $40,000 to each First Nations child, living on or off reserve, who was not removed from their family home and was either denied services covered under Jordan's Principle as defined in 2017 CHRT 14 or 35 (for example, mental health, and suicide prevention, special education, dental, etc.), or who received such services after an unreasonable delay or upon reconsideration ordered by the Tribunal. [para. 250 (20K) + para. 253 (20 K) = 40K] - 7) $40,000 to each parent or grandparent who, as a result of a service gap, denial and/or delay, were denied essential services and had a child removed from the home between December 12, 2007 and November 2, 2017. [para. 251 (20K) + para. 253 (20 K) = 40K] - 8) $40,000 to each parent or grandparent whose child was not removed from their home and was denied services covered under Jordan's Principle or received such services after an unreasonable delay or after reconsideration by order of the Tribunal. [para. 251 (20K) + para. 253 (20 K) =40K] - On October 3, 2019 Canada submitted a judicial review of the CHRT's decision to the Federal Court seeking an order to stop all financial compensation and a motion to put the CHRT order on hold until the Federal Court decided on the judicial review. - Hearing were held on November 25-26 at the Federal Court. Canda motion to stay the CHRT proceedings was denied, but an extension to the December 10 deadline to make submission on the compensation process was approved - to February 21, 2020. - All parties made submission to the CHRT on February 21, 2020 regarding a compensation process. The parties asked the CHRT to rule on three questions where consensus could not be reached, a decision was reached on March 16, 2020: - Age beneficiaries gain unrestricted access to compensation: Age of majority - Should compensation be available to children who entered care prior to January 1, 2006 but remained in care as of that date: Yes - Should compensation be paid to the estates of deceased individuals who otherwise would have been eligible? Yes, compensation should be paid to the estates of deceased First Nations children and parents or caregiving grandparents who have died waiting for Canada's discrimination to end.
2020 CHRT 20 (July 17, 2020)	- The Tribunal released a ruling on the groups of children eligible to receive services through Jordan's Principle. Canada has been ordered to immediately consider eligible for services through Jordan's Principle: - First Nations children who will become eligible for *Indian Act* registration/status under Bill S-3 implementation (aimed at elimination sex-based discrimination in the *Indian Act)* - The Tribunal found two other categories of First Nations children who will be eligible in the future following a further order from the CHRT: - First Nations children without *Indian Act* status who are recognized as citizens or members of their respective First Nations; and - First Nations children who do not have *Indian Act* status and who are not eligible for *Indian Act* status, but have a parent/guardian with, or who is eligible for, Indian Act status. - The Tribunal ordered the parties to consult regarding the criteria and mechanisms to identify these two categories of First Nations children and provide recommendations to the CHRT by October 19, 2020.
2020 CHRT 36 (November 25, 2020)	- The Tribunal considers the recommendations received from the parties further to 2020 CHRT 20 and orders that cases meeting any one of four criteria are eligible for consideration under Jordan's Principle. Those criteria are the following: 1. The child is registered or eligible to be registered under the *Indian Act*, as amended from time to time; 2. The child has one parent/guardian who is registered or eligible to be registered under the *Indian Act*; 3. The child is recognized by their Nation for the purposes of Jordan's Principle; or 4. The child is ordinarily resident on reserve (para. 56). - The order also sets out a process for confirming eligibility of "a child recognized by their Nation for the purposes of Jordan's Principle" (Annex A to the decision) and sets out funding requirements who incur expenses for confirming First Nations citizenship (Annex B to the decision).

Note: Indigenous and Northern Affairs Canada (INAC) has been replaced by the Department of Indigenous Services Canada (ISC).

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
INFORMATION NOTE

DATE: December 7, 2020 **DATE OF PREVIOUS NOTE (if applicable):**
CLIFF#: 255888 **PREVIOUS CLIFF # (if applicable):**

PREPARED FOR: Honourable Mitzi Dean, Minister of Children and Family Development

ISSUE: Plan for Implementing Recommendations in RCY report *Caught in the Middle*

BACKGROUND:
Released November 26, 2019, the RCY report *Caught in the Middle* is based on an investigation into the death of Romain (a pseudonym), a youth in care from Alberta. Romain was in B.C. under an inter-provincial agreement when he died of accidental overdose.

The RCY investigation found that confusion was created by lack of clarity in the Interprovincial Protocol that guides movement of children and youth in care between provinces. The RCY also identified inadequate coordination, tracking and oversight of interprovincial cases in B.C., as well as a lack of appropriate services and residential resources to respond to Romain's needs and his history of trauma.

The report contains 6 recommendations, all to MCFD.

RCY's recommendations process includes the Ministry developing an action plan for implementing a report's recommendations, the Ministry sending evidence of implementation of the plan to RCY on the anniversary of a report's release and RCY publicly posting an assessment of progress based on the evidence provided.

DISCUSSION:
In accordance with the RCY's recommendations process, MCFD sent RCY a draft action plan for *Caught in the Middle* recommendations in July 2020. The RCY assessed the draft plan and responded indicating that the deliverables in the plan, if implemented, would meet the intent of five of the report's six recommendations. The RCY indicated that the draft plan would not meet the intent of Recommendation 4.

The RCY clarified that the intent of Recommendation 4 is, in part, "…that MCFD has the ability to aggregate (e.g. roll-up) individual data to get a better sense of the self-identified ethnicity groupings/numbers to inform more specialized training, planning, service delivery, community engagement and to enhance capacity for culturally responsive care." In response, the Ministry has revised the deliverable for recommendation 4. An MCFD cross divisional working group will explore options for aggregating data on the ethnicities of children and youth in care.

NEXT STEPS:
The Ministry will send RCY the finalized action plan to RCY and evidence of the implementation of its deliverables. The RCY will assess the evidence provided and publicly post its assessment of progress on the recommendations.

ATTACHMENTS (if applicable):

A. *Caught in the Middle* Action Plan

Contact **Assistant Deputy Minister:**	**Alternate Contact** **for content:**	**Prepared by:**
Cory Heavener, ADM *Office of the Provincial Director and Aboriginal Services* *778 698-5125*	*Alex Scheiber* *Deputy Director of Child Welfare* *778 698-4966*	*Brian Hill* *Director of Monitoring* *Child Welfare Branch* *778 698-9414*

Representative for Children and Youth
Caught in the Middle – November 2019

MCFD Action Plan
December 2020

Recommendation #1: That the Ministry of Children and Family Development bring forward to the next review of the Protocol by the Directors of Child Welfare recommendations to address shortcomings. These include the addition of cultural planning to the Protocol; clarification that when a child arrives from another province or territory without notice, the dispute resolution process may be triggered; clarification about delegation of guardianship responsibilities; and an amendment to Interprovincial Agreement forms to allow for detail regarding financial expenditures and payment mechanisms.

Plan for Implementing Recommendation:

	Action	Target Date	Status
1	Initiate a request to the Provincial and Territorial Directors of Child Welfare to review and amend the Protocol with regards to IPAs. Formally recommend that the Protocol be reviewed and amended as required to address the concerns coming out of this report.	January 20, 2020	Complete

Recommendation #2: That the Ministry of Children and Family Development fully dedicate an Interprovincial Coordinator who will work together with an adequately resourced network of regional analysts to support, track and monitor interprovincial cases.

MCFD to put this network in place by December 2020.

Plan for Implementing Recommendation:

	Action	Target Date	Status
1	Dedicate a full time Interprovincial Coordinator position in MCFD	November 4, 2019	Complete
2	Develop tracking system of all Interprovincial Agreements.	December 31, 2020	On track
3	Establish monthly Inter-Provincial Community of Practice meetings to support collaboration with the Interprovincial Coordinator and a network of Provincial Practice Consultants and Practice Analysts to support, track, and monitor interprovincial cases.	April 9, 2020	Complete

Recommendation #3: That the Ministry of Children and Family Development create provincial practice guidelines or policies for interprovincial cases and develop an online training course that is required for staff who work on interprovincial cases.

MCFD to complete this work by December 2020.

Plan for Implementing Recommendation:

	Action	Target Date	Status
1	Enhance and adapt the current Interprovincial and Inter-territorial case practice guidelines.	December 31, 2020	On track
2	Develop a series of training materials and resources focusing on Interprovincial Placement Agreements (IPPA).	December 31, 2020	On track
3	Develop training and information regarding the Interprovincial Coordinator (IPC) role.	December 31, 2020	On track

Recommendation #4: That the Ministry of Children and Family Development direct staff to speak with children in care about their ethnicity and desired cultural supports/connections and record the child's self-identified ethnicity in the ministry's case management system.

Plan for Implementing Recommendation:

	Action	Target Date	Status
1	An MCFD cross-divisional working group will explore options for aggregating data on the ethnicities of children and youth in care.	March 31, 2021	On Track

Recommendation #5: That the Ministry of Children and Family Development ensure a trauma-informed method is implemented in resourcing decisions for children in its care who have experienced multiple adversities in their lives.

MCFD to have this trauma-informed method to resourcing in place by June 2021.

Recommendation #6: As part of the Ministry of Children and Family Development's overhaul of residential services, MCFD to assess the need for residential care and treatment resources across the province to accommodate children with complex needs and to create sufficient resources to meet the assessed need in a timely way.

Plan for Implementing Recommendation:

	Action	Target Date	Status
1	Develop and implement the Trauma Informed Guide	March 31, 2020	Ongoing, implementation underway

2	Develop and implement MCFD's In-Care Service Framework (In-Care Network)
	• The In-Care Network includes trauma-informed inclusive care planning to support resourcing decisions for children and youth in care.
	• The In-Care Network includes a re-examination of the role Contracted Residential Agencies (CRAs) centered on their provision of specific key services, and how they will be procured and overseen with consistency.
	• As part of this work, the Ministry will expand its continuum of care options including:
	  ○ Out-of care (extended family/community members)
	  ○ Foster care givers
	  ○ Short term residential stabilization
	  ○ Respite
	  ○ Emergency placements
	  ○ Long term specialized care
	• Long term specialized care will provide highly specialized care to children and youth for whom other care options are not feasible.
	• Placement in these care options will reflect integrated/inclusive care planning approaches that consider trauma, child strengths and needs, and community/family connections and permanency/reunification plans as part of every placement decision.
		Developed by Fall 2020
		
		Implement by October 2021
			On track

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
INFORMATION NOTE

DATE: December 8, 2020 **DATE OF PREVIOUS NOTE:**
CLIFF#: 255973 **PREVIOUS CLIFF #:**

PREPARED FOR: Honourable Mitzi Dean, Minister of Children and Family Development

ISSUE: On December 15, 2020, the Representative for Children and Youth (RCY) will release a report on youth transitioning to adulthood from government care.

BACKGROUND:
This RCY report examines data from B.C. and Canada on outcomes for young people in care transitioning into adulthood, as well as current B.C. policies and programs for youth transitioning from care. The report also examines the over-involvement of the child welfare system in the lives of First Nations, Métis, Inuit and urban Indigenous children and youth in care. The report includes case examples, case studies and a review of literature on the topics of promising practices for youth transitioning into adulthood, emerging adulthood, cost-benefit analysis, and policy and practice in other jurisdictions.

In the development of this report, the RCY held focus group consultations and one-on-one conversations with key stakeholders including youth from care, front-line service providers, foster parents, community service agency representatives, and staff representatives from the First Nations Leadership Council, Métis Nation and Delegated Aboriginal Agencies.

The report contains 7 recommendations[1]: five to the Ministry of Children and Family Development (MCFD); one to the Ministry of Mental Health and Addictions (MMHA) to lead in collaboration with MCFD and Ministry of Health (MOH); and, one to the Ministry of Attorney General and Minister Responsible for Housing (MAG).

DISCUSSION:
The report states that years of studies on youth leaving care consistently find that youth from care are forced to live independently much earlier than their peers and experience significantly worse outcomes, especially in housing, education, well-being and social exclusion.

The report provides information on post-majority supports currently available in B.C. for youth transitioning from care to adulthood, including Agreements with Young Adults (AYA), the Provincial Tuition Waiver Program, sponsorships and bursaries. It also notes that many youth transitioning from care to adulthood receive a Persons with a Disability (PWD) designation that enables long-term disability income support.

The RCY found that available post-majority supports are limited, have complicated and restrictive eligibility criteria, inequitable access across the province, disproportionately negative outcomes for Indigenous peoples, and insufficient resources to support the young people in most need. The report indicates that almost two-thirds of youth who have been eligible for AYA

[1] Based on draft recs provided by RCY Dec 8, 2020.

have not accessed the program and provides data showing that young adults who are male, First Nations, Métis or have not completed high school are less likely to access AYA support. It recognizes the Provincial Tuition Waiver program as a "bright spot" and a clear indication of government's belief in the potential of young people from care to succeed in post-secondary education. It concludes that existing supports for young people transitioning to adulthood are insufficient and not structured in a way that allows for easy access.

In the summary of research, the report finds that flexible and accessible services which prioritize youths' ability to choose and direct their lives and remain available for many years after the age of majority see successful outcomes. It's further noted that developing and maintaining natural relationships and expanding social connections are predictors of these successes.

Recommendations to MCFD are as follows (see Attachment B for full text of recommendations):

1. Extend and improve transition planning
2. Provide ongoing adult guidance and support by implementing dedicated youth transition workers through community agencies
3. Ensure Continuing Post-Majority Financial Support
4. Consider an extension of voluntary residential care beyond age 19
5. Collect Longitudinal Data and Evaluate Services

The recommendation to MMHA, to lead in collaboration with MCFD & MOH, calls for an enhanced range of trauma-informed and culturally appropriate mental health and substance use services for young people transitioning from care into adulthood. The recommendation to MAG calls for dedicated housing for youth.

ADVICE:
Some of these recommendations (i.e. 1-4) require legislative and/or regulatory amendments as there is no mandate to support young adults ages 19-27 beyond the agreements with young adults program which has restrictions.

The recommendation to collect longitudinal data may require a legislative amendment as the ministry currently has no authority to collect longitudinal data for young adults.

ATTACHMENTS:

A. Draft RCY Youth Transitions Report
B. Draft RCY Youth Transition Recommendations
C. Draft RCY Youth Transitions Data Appendix

Contact:	**Alternate Contact for content:**	**Prepared by:**
Cory Heavener *Assistant Deputy Minister: Office of the Provincial Director & Aboriginal Services Division* ***778 698-5126***	*Alex Scheiber* *Deputy Director of Child Welfare Office of the Provincial Director & Aboriginal Services Division* *778 698-9414*	*Brian Hill* *Director of Monitoring Office of the Provincial Director & Aboriginal Services Division* *778 698-9474*

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Withheld pursuant to/removed as

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MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT
INFORMATION NOTE

DATE: December 11, 2020 **DATE OF PREVIOUS NOTE:** June 3, 2020
CLIFF#: 255707 **PREVIOUS CLIFF #:** 250039, 246146**,** 243570

PREPARED FOR: Honourable Mitzi Dean - Minister of Children and Family Development

ISSUE: Public Posting of Deaths of Children in Care and Children Not in Care (Received Services)

BACKGROUND:
To provide statisical information on children who died between January 1 and June 30, 2020 that will be posted on the Ministry's public government website in late December 2020.

In 1996 the Ministry began publishing statistics on deaths of children in care and deaths of children who had received services within the past 12 months under the *Child, Family and Community Service Act* (*CFCSA*). Both types of fatality statistics are updated every six months and are publicly posted in June and December to promote public accountability.

A child in care means a child who is in the custody, care or guardianship of a director by court order or agreement under the *CFCSA.*

A child receiving services (not in care) means a child who is not in the director's custody, care or guardianship but is receiving ministry services. These may include: a child whose family is receiving protective or support services, (e.g. child care workers, respite or family counseling providers); child and youth mental health services; a youth on a Youth Agreement; a family receiving services to children and youth with special needs; and children placed in the custody of another person under the director's supervision.

DISCUSSION:
The Ministry works with the BC Coroner's Service (BCCS) to confirm its data[1] on child deaths before postings occur. The classification of a fatality may change as a death is investigated or new information becomes available. The classification of death information may change over time and the statistics are updated to reflect recent changes verified with the BCCS.

Children in Care Deaths:
From January 1 to June 30, 2020, 5 children in care died. The following classification of death is information *currently* provided by BCCS :

- 2 Natural;

[1] Current 2020 child fatality data was reviewed and reconciled by BCCS as of November 24, 2020.

- 3 Accidental[2];
- 0 Suicide;
- 0 Homicide; and
- 0 Undetermined.
- 2 of the accidental deaths were confirmed by BCCS as opioid/fentanyl overdoses;
- All 5 deaths proceeded to Case Review as required by policy - all file reviews. 3 of these are completed and 2 are in progress.
- The legal status of the 5 deaths is as follows: 2 under a Temporary Custody Order; 2 under Removal; and, 1 under a Voluntary Care Agreement.
- 1 of the 5 children was First Nations, Métis or Inuit.

Deaths of Children who Received Services (not in care) in the previous 12 months:
Between January 1 and June 30, 2020, 43 children who had received services died. The following classification of death is information *currently* provided by the British Columbia Coroner's Service:

- 26 Natural[3];
- 7 Accidental[2];
- 0 Homicide;
- 6 Suicide[4];
- 4 Undetermined - 2 with an Open BCCS investigation and 2 with a Closed classification;
- Of the 43 children who died 13 were First Nations, Métis or Inuit.
- 5 of the 7 Accidental deaths were children and youth who died of an opioid/fentanyl overdose, confirmed by BCCS; 3 of the 7 Accidental deaths were First Nations, Métis or Inuit.
- All fatalities were screened to determine whether a Case Review was required; 3 were screened in for a case review. All are File Reviews and in Progress.

SUMMARY:
Child fatality data from 2019 and 2020 (to date) reveals no significant variations from previous years.

FATALITIES OF CHILDREN IN CARE & RECEIVING SERVICES UNDER THE *CFCSA*

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[2] Accidental deaths may include motor vehicle accidents, drownings, choking, poisonings (including overdoses), unsafe sleeping practices, house fires or Opioid overdoses.

[3] The majority of children who died of Natural causes were receiving services from the CYSN program area; which comprises 61% of the total number of deaths of children receiving services for this time period.

[4] Suicide deaths - 3 of these 6 deaths were due to hanging; 1 was First Nations, Métis or Inuit. In consultation with the BCCS, it was determined that the number of children and youth who complete suicide by self-hanging is proportionate with provincial child fatality data.

Fatalities of Children in Care By Calendar Year

YEAR	NATURAL	ACCIDENT	HOMICIDE	SUICIDE	UNDETERMINED[5]		TOTALS
					OPEN	CLOSED	
2008	6	5	2	2	0	0	15
2009	8	1	0	1	1	0	11
2010	5	3	0	0	5	0	13
2011	6	1	0	2	0	1	10
2012	6	6	0	2	1	0	15[ii]
2013	2	2	2	2	0	1	9[ii]
2014[ii]	6	3	0	4	0	1	14[iv]
2015	1	4	2	3	1	0	11
2016	4	0	1	1	0	0	7[iv]
2017	4	5	0	0	3	0	12
2018[vi]	5	4	0	2	2	0	13
2019	5	7	1	1	0	0	15[iv]
2020	2	3	0	0	0	0	5

Fatalities of Children Receiving Services (Not in Care) By Calendar Year

YEAR	NATURAL[v]	ACCIDENT	HOMICIDE	SUICIDE	UNDETERMINED[i]		TOTALS
					OPEN	CLOSED	
2008	46	12	3	1	16	4	82
2009	44	11	3	3	15	2	78
2010	38	12	1	5	6	1	63
2011	40	16	2	2	6	2	69[iii]
2012	61	20	1	7	6	1	96
2013	53	10	2	7	0	8	80[ii]
2014[ii]	38	11	6	4	3	4	67[iv]
2015[ii]	70[v]	17	4	11	3	2	110[iv]
2016[iii]	54	17	1	9	15	0	97[iv]
2017	58	26	6	12	5	0	108[iv]
2018[vii]	60[iii]	22[ii]	2	7	7	2[ii]	101[vi]
2019	50[v]	18	3	11	2	5	91[iv]
2020	26[v]	7	0	6	2	2	43

[i] In the "Undetermined" category, "open" indicates a case is still under investigation by the Coroner; "closed" indicates the Coroner's investigation is complete and due to insufficient evidence or inability to determine, the death cannot reasonably be classified as natural, accidental, suicide or homicide.
[ii] Updated classification from the Coroner regarding cause of death.
[iii] Late report of death outside of six month bi-yearly report.
[iv] This total includes fatalities where there is no Coroner classification of death because the fatality occurred outside the province or country.
[v] Over 61% of the total number of deaths for January 01-June 30, 2020 were attributed to Natural causes.
[vi] These numbers represent data from January 1 to December 31, 2018 - bi-yearly report.
[vii] This total includes a child in care under the Adoption Act who received services within 12 months of death.

Appendix A – Supplemental information – attached.

Contact	**Alternate Contact**	**Prepared by:**
Assistant Deputy Minister:	**for content:**	
Cory Heavener	*Alex Scheiber*	*Claudine Fletcher*
Provincial Director of Child Welfare	*Deputy Director of Child Welfare*	*Practice Analyst*
Office of the Provincial Director and Aboriginal Services	*Office of the Provincial Director and Aboriginal Services*	*Office of the Provincial Director and Aboriginal Services*
250-698-5126	s.17	*250-812-0986*