Report to the Attorney General of British Columbia under Section 6 of the *Office for Children and Youth Act* on the Director's Case Review Relating to the Nuu-chah-nulth Child Who Died in Port Alberni on September 4, 2002

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February 15, 2006

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AG 06020 02/24

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A. Introduction

On September 4, 2002, a 19-month-old Nuu-chah-nulth girl died in Port Alberni as a result of injuries sustained at the hands of her male caregiver. He was charged with manslaughter in June 2003, pled guilty, and was sentenced in October 2004 to ten years in prison.

The late Nuu-chah-nulth child's caregivers were members of her extended family. At the time of her death, she was living in their home as a result of a "kith and kin" agreement facilitated by the Nuu-chah-nulth Tribal Council's family and child service program, Usma Nuu-chah-nulth Community and Human Services ("Usma"). Usma (meaning "precious ones") is a part of the Nuu-chah-nulth Tribal Council. The Nuu-chah-nulth Tribal Council, through Usma, is one of a number of Aboriginal agencies in British Columbia with delegated authority to undertake protection and guardianship responsibilities on behalf of the provincial Director under the *Child, Family and Community Service Act* ("CFCSA").

During the fall of 2002, in accordance with its policy, the Ministry of Children and Family Development ("MCFD") undertook a Director's case review relating to the late Nuu-chah-nulth child. The initial terms of reference for the case review were developed in September 2002. They were changed in November 2002. On May 11, 2005, the then provincial Director under the CFCSA signed off the completed Director's case review, and a summary of it was publicly released on July 21, 2005.

This report is not an investigation into the circumstances surrounding the child's tragic death. That is the task of the Coroner's public inquest. Nor is it an investigation into questions of legal responsibility, including responsibility for the child's death, that are the functions of other forums. What this report addresses is why were the terms of reference for the Director's case review changed? Why did it take more than two and a half years to complete the case review? What is there to be learned from this experience about how to improve the Director's case review process? It addresses each of these matters in the context of my function under section 3(1) of the *Office for Children and Youth Act* to provide independent observations and advice to government about the state of government-provided or funded services to children and youth in British Columbia.

To get answers to these questions, the Attorney General requested me in September 2005 to undertake this investigation and report under section 6 of the *Office for Children and Youth Act* (See Appendix 1). My terms of reference as of November 10, 2005, were as follows:

> With respect to the Director's Case Review of the death of [the late Nuu-chah-nulth child] on September 4, 2002, I request that you investigate and report to me by **December 31, 2005**:

1. The timelines involved in the writing, completion and release of that Review;
2. Why the terms of reference for that Review were changed;
3. To review the policy concerning a Director's Case Review, including those where a Kith and Kin [Agreement] has been applied, and make any recommendations necessary as a result; and
4. Any other matter you deem relevant to a full consideration of the Director's Case Review process in that case.

If, in the course of conducting this investigation, you determine that the timelines, the change in terms of reference, or any defect in the Director's Case Review, may have materially affected the outcome of the Review, I request you to review whether the outcome was materially affected and make recommendations by **March 31, 2006** to address any such impacts.

During the fall of 2002, MCFD was also considering another issue relating to the late Nuu-chah-nulth child: the continued placement of children in the caregivers' home. This issue will be the subject of a further investigation and report by me under section 6 of the *Office for Children and Youth Act*.

I conducted this investigation by reviewing relevant documentation and carrying out over 60 hours of interviews under oath of 18 individuals (See Appendix 2). The documentation I considered included email correspondence, notes of meetings and the relevant files in the possession of Usma, MCFD, and Nicholas Simons, the individual who was contracted by MCFD to conduct the fact finding and analysis part of the Director's case review.

Collecting and sorting through the documentation proved a challenge.[1] Not everything was available at the time of the initial interviews and consequently some individuals were interviewed more than once. In the time frame under which I worked, it was not feasible to require or expect MCFD, Usma or the reviewer to do exhaustive audits of the files that they produced for me. Having said that, I am satisfied that the documentation I received was substantially complete for my purposes.

Those I interviewed had sometimes different recollections concerning the same event, particularly about dates or because they understood the event from differing perspectives. However, I detected no indications that anyone fabricated or withheld information from me.

My investigation is not a public inquiry. The *Office for Children and Youth Act* provides that I communicate the results of my investigation in a confidential report to the Attorney General. The Attorney General can decide whether or not the report should be made public.

On December 19, 2005, the Attorney General extended the date for completion of my report to January 31, 2006, to enable me to give individuals and organizations that might be adversely affected by it an opportunity to make representations to me before the report was concluded. I asked for a further extension to February 15, 2006, to allow me sufficient time to consider and incorporate the representations I received.

The Director's case review relating to the late Nuu-chah-nulth child, including the time taken to set it up, covers almost a three-year period and, depending on how you count, at least 25 drafts of the case review. The scale and time frame of my investigation did not permit me to get to the bottom of each and every thing that I heard about from those I interviewed. I have not reported on the myriad of details of the many drafts of the case review that were circulated. I have summarized the relevant substance of what I heard and read (including in the written representations that were made to me before I completed the report). I have related the perspectives on key points of those who were most significantly involved. Consistent with my mandate, my objective throughout has been to observe how this Director's case review process unfolded and based on these observations to advise government how it might improve the Director's case review process in the future.

Overall, my observation is that the story of this Director's case review is not a story of conspiracy and cover-up, but rather one of organizational failure.

It is also a story that can only be understood in the context of the organizational fluidity and dynamics within MCFD between September 2002 and July 2005, the complex relationship between MCFD and Aboriginal agencies with delegated authority under the CFCSA, and the purpose and policy behind Director's case reviews.

For this reason, in Parts B, C and D of this report I provide background information about the relevant organizational context within MCFD, the relationship between MCFD and Aboriginal delegated agencies and MCFD policy for Director's case reviews. In Parts E and F, I recount the details of what happened. Part G contains my observations about what happened, and in Part H, I consider the Director's case review process and give advice about how it could be improved in the future.

In their Director's case review procedures, MCFD referred to the individual doing the fact-finding and analysis as the "Practice Analyst". MCFD also frequently described this role as the "reviewer". The term "reviewer" has the potential to create confusion between the respective responsibilities for a Director's case review of the Practice Analyst doing the fact-finding and analysis and the Director under the CFCSA in whose name and office the case review is conducted. Nonetheless, because Nicholas Simons was described as the "reviewer" in the terms of reference for the Director's Case Review and on its front page, I have also used that term in my report to describe his role.

Numerous provincial and regional MCFD officials, the reviewer, and a number of Nuu-chah-nulth Tribal Council officials were involved in the Director's case review. For ease

of reference, these individuals are listed by name and position over time in Appendix 3, Key Officials.

B. Organizational Context

1. MCFD priorities during the relevant time

In 2002, MCFD had three major items on its agenda: a move to regional governance (Aboriginal and non-Aboriginal); transformation of its service delivery system; and budget reduction. All three items were substantial organizational initiatives and engaged the attention and energy of the senior managers both at the provincial and regional levels of MCFD.

The individuals I interviewed did not raise budget cuts as a direct explanation for why the case review relating to the late Nuu-chah-nulth child took such a long time to complete. It was, however, a reality that impacted MCFD during this time period. The provincial operations of MCFD were being down-sized because of the intended devolution of authority to the regions and the desire to minimize the impact of budget cuts on front-line services. Also, the issue of how to manage the budget cuts took priority for senior managers, particularly starting in the summer of 2003. The regular monitoring information received by the executive was focused on this issue, not on such issues as whether Director's case reviews were being completed within the timelines set by the standards.

The move to regional governance was a particular focus in 2002 and through to the summer of 2003. It also had direct implications for the role of Director under the CFCSA and, in particular, the role of the Director's case review function, which I will explore below.

2. Regional governance and decentralizing/centralizing forces

As long as there has been a provincial ministry responsible for child protection services in British Columbia, tensions have existed between the "front-line" and the provincial "centre" in Victoria. This tension is not unique to the child protection ministry; it is, no doubt, in part a result of the geographical realities of the province.

There are particular reasons, however, why these tensions are accentuated in the ministry responsible for child protection services. The pull to decentralization relates to the nature of the work. Whatever the current organizational structure of MCFD, protection work remains essentially the same: that is, making difficult judgment calls in particular interactions with children, youth and families, in crisis. Of necessity, the core work of the ministry takes place at the local level. Local conditions, which the "front-line" will always believe are misunderstood by the "centre", are highly relevant. This reality suggests the good sense of a decentralized model, as I have stated elsewhere.

The opposing tendency to the centralization of authority relates in part to the seriousness of the consequences when child protection services fail and the highly political nature of this area when crises occur. Every right-thinking person is horrified at the thought of a child being harmed. The natural response when that occurs is to want to hold someone responsible. In a political system of ministerial and executive responsibility, it is those at the centre who are held responsible. Those who are held responsible quite naturally want a corresponding authority to avoid mistakes.

Historically, MCFD and its predecessor ministries, in response to these tensions, have tended to undergo, in the balancing of the bureaucratic authority for front-line operations, pendulum swings from centralization to decentralization and back. This phenomenon played itself out over the course of the Director's case review relating to the late Nuu-chah-nulth child and is important context for understanding aspects of what happened.

In September 2002, the pendulum within MCFD was swinging towards decentralization. It remained headed in that direction until the summer of 2003, when the move to regional governance was put on hold and the pendulum began to swing back towards centralization, accelerating in that direction during 2004, with a change of minister and deputy minister early that year, and the tightening of budget control from Treasury Board.

Having made that observation, I hasten to add that regional governance is still the stated MCFD policy, and many of the organizational changes made to support increased regional operational responsibility have remained.

Related to the decentralize/centralize debate was a debate about the extent to which policy should be directive and prescriptive. Again this is a debate that has gone on within MCFD for many years, with the decentralizers tending to favour higher level, less prescriptive standards that leave discretion to the workers in the field to use their professional judgment, and the centralizers preferring more directive policies.

3. Role of the Director under the *Child, Family and Community Service Act*

The move to regional governance had an impact on the role of Director under the CFCSA (called the "Superintendent" under previous legislation). The Director, who must be designated by the minister responsible for the CFCSA, has statutory responsibility for the protection and guardianship of children. For most of the history of a provincial ministry responsible for child protection, the Director's statutory responsibilities as protector and guardian of children have been separated from managerial responsibility for front-line operations. This has resulted in two lines of responsibility for front-line workers and supervisors who have delegated authority from the Director under the CFCSA.

This division of responsibility has been justified on the basis that in making judgments about what is in the best interests of a given child, the Director under the CFCSA needs

to be unfettered by bureaucratic pressures. It leads, however, to tensions within MCFD senior management that may find expression in conflicting messages to front-line staff.

Until mid-2002, there was only one Director under the CFCSA. On July 2, 2002, as a step in the imminent move to regional governance, five further Directors were designated by the Minister, one for each of the five regions into which MCFD operations were organized at the time.

In September 2002, operational responsibilities, including those for services and functions under the CFCSA, rested with the senior regional managers who previously had the title Regional Executive Director and had recently been given a new title of Interim Chief Executive Officer. The Interim Chief Executive Officers did not report to David Young, who was the provincial Director under the CFCSA.

The Interim Chief Executive Officer for the Vancouver Island region was also the Director under the CFCSA for that region.

In July 2003, Jeremy Berland became both the provincial Director under the CFCSA and the Assistant Deputy Minister responsible for regional operations and for the Children and Family Development Division. Under his leadership, effective April 1, 2004, the positions of regional Director under the CFCSA and Regional Executive Director were separated. (The Interim Chief Executive Officer title had by this time been changed back to the Regional Executive Director title.) The ministerial designations of the regional Directors under the CFCSA added a requirement for them to follow the policies and standards set by the provincial Director under the CFCSA.

4. Devolution of the Director's case review function to the regions

Those I interviewed were not clear about the exact state of devolution of the Director's case review function to the regions in September 2002. The Quality Improvement Branch[2], responsible for dealing with audits and case reviews, was in the process of being dismantled and regional personnel were to be trained to take on this function.

In September 2002, it was reasonably clear that if the incident triggering a Director's case review involved MCFD services, the relevant Director under the CFCSA would be the regional Director, not the provincial Director. However, no regional Director's case review had yet been done, nor had the regional capacity to conduct such case reviews been developed. There was some level of concern at the time, especially among those I interviewed who were involved in the quality improvement branch when it was dismantled, that the expertise which had developed centrally in investigating and writing Director's case reviews would be lost by the decentralization of the function.

C. Aboriginal Delegated Agencies

While guardianship and protection responsibilities of the Director under the CFCSA were being devolved to the regions, the provincial Director retained responsibility under

the CFCSA to the extent that those responsibilities were delegated to Aboriginal agencies.

Some level of Aboriginal autonomy in the area of responsibility for Aboriginal children has been part of British Columbia child welfare history for 25 years. Delegation to the Nuu-chah-nulth Tribal Council took place in the 1980s. Throughout the 1990s, more and more Aboriginal delegated agencies were created. There are now 23 such agencies with varying degrees of delegated authority under the CFCSA.

Historically, there has been a level of mistrust between MCFD and its predecessors and the Aboriginal agencies serving First Nations children on reserves. The First Nations were wary of acknowledging the authority of the provincial government. They saw their relationship to be with the federal government as nation to nation. The notion that the provincial Director under CFCSA had statutory authority that was delegated to agencies attached to First Nations, was not universally accepted in the context of First Nations' jurisdictional and constitutional perspectives.

In September 2002, new relationships were being developed provincially at the political level, particularly between the then Minister of Children and Family Development and some of British Columbia's key Aboriginal political leaders. In September 2002, an historic Memorandum of Understanding was signed between the provincial government and the then four major provincial Aboriginal organizations (the First Nations Summit, the Union of British Columbia Indian Chiefs, the United Native Nations and the Métis Provincial Council of British Columbia).

This Memorandum of Understanding affirmed joint responsibility of Aboriginal communities and the provincial government for Aboriginal children in British Columbia and a partnership between the provincial government and the Aboriginal political organizations in fulfilling that responsibility. It envisioned setting up, in each of the five MCFD regions, a non-Aboriginal authority and an Aboriginal authority to provide governance for services to children, youth and families.

This "partnership" relationship was in its early days in the fall of 2002. Not all Aboriginal delegated agencies were comfortable with the idea of regionalization in general, or of the setting up of regional Aboriginal authorities.

Having said that, I was told by all concerned that the relationship between Usma and MCFD was relatively good in September 2002. Supervisors from Usma and the local MCFD offices in Port Alberni reported that they worked well together. The provincial MCFD had confidence in Usma's ability to carry out its delegated responsibilities. Usma and the Nuu-chah-nulth Tribal Council were not opposed to the development of Aboriginal regional authorities and were not considered to be particularly adversarial in terms of their relationship with the provincial government.

The relationship between the provincial Director under the CFCSA and the Aboriginal delegated agencies was, in 2002, different than the relationship between the regional

Directors under the CFCSA and the workers to whom a regional Director has delegated statutory responsibility. In the regions, the social workers with delegated responsibility are MCFD employees of the provincial government**.** The social workers in an Aboriginal delegated agency are the employees of the agency, or the tribal council of which the agency forms a part. In the case of Usma social workers, they are employees of the Nuu-chah-nulth Tribal Council. This affects the control that the provincial Director under the CFCSA has over the social workers to whom he has delegated statutory responsibility.

The relationship between MCFD and Aboriginal delegated agencies is governed by delegation agreements. The delegation agreement that was in place in September 2002 between the Nuu-chah-nulth Tribal Council and the "Superintendent of Family and Child Services" had been signed under the previous legislation in November 1985 (See Appendix 4). The agreement covered all children within the Indian Reserve boundaries of the Nuu-chah-nulth Tribal Council and any Nuu-chah-nulth members in care. It was two pages and had ten clauses, which provided, among other things, that:

- Subject to negotiation, the Superintendent [now the provincial Director] would delegate powers, duties, functions and capacities "agreeable to both the Superintendent and the Tribal Council".
- Those persons delegated would be subject to the direction of the Superintendent.
- The Tribal Council would develop and maintain child protection services, and would supply information for monitoring purposes "satisfactory to the Superintendent".

Negotiations for an updated agreement (See Appendix 5) commenced in 2000 and were still in progress in 2002. A key issue for the Nuu-chah-nulth Tribal Council in those negotiations was to extend the service to all Nuu-chah-nulth children, whether on or off reserve. The preamble of the 2004 agreement states that the Nuu-chah-nulth Tribal Council intends to seek designation of a Nuu-chah-nulth Director under the CFCSA.

A key issue for the provincial Director under the CFCSA was the inclusion of standards in the agreement. In 1999, in consultation with the Aboriginal delegated agencies, the Aboriginal Operational and Practice Standards Indicators had been developed. In the 2004 agreement, the Nuu-chah-nulth Tribal Council committed to follow those standards although the agreement also provides that, with the exception of MCFD policies regarding reportable circumstances, the Nuu-chah-nulth Tribal Council may develop its own standards provided the provincial Director approves them.

The wording of this 18-page agreement was essentially resolved in 2002, but the agreement was not finalized until April 2004 when the federal government, in recognition of its funding relationship, also became a signatory by means of a memorandum of understanding between the provincial and federal governments that is an appendix to the agreement.

Funding for children who are on reserve comes from the federal government, and is based on "eligible" children, who are defined in the agreement as children in care. Funding for "non-eligible" children is the responsibility of the provincial Director under the CFCSA, who also agrees to provide and fund training of Nuu-chah-nulth Tribal Council staff, and to negotiate other costs, made necessary by legislative or policy changes.

Section 10.1 of the 2004 agreement specifically provides for the inclusion of case reviews conducted by the Director in respect of any "reportable circumstance resulting from child and family services delivered by the [Nuu-chah-nulth Tribal Council] at the time of the reportable circumstance".

Around the time of the death of the Nuu-chah-nulth child, another child also died who had received services from an Aboriginal delegated agency. These were the first two deaths to come under the MCFD Director's case review policy that directly involved Aboriginal delegated agencies.

D. Director's Case Review Policy

Section 93(3) of the CFCSA requires the Director to have review procedures. It provides as follows:

> 93(3) A director must, in accordance with the regulations,
>
> (a) establish a procedure for reviewing the exercise of the director's powers, duties and functions under this Act, and
>
> (b) ensure that information about the review procedure is available to any person on request.

Case reviews are one of the procedures followed by MCFD for the review of the exercise of Director's powers, duties and functions. There are two kinds of case reviews: Director's case reviews and Deputy Director's case reviews.

A Director's case review is different from a Deputy Director's case review in that the former involves interviewing key witnesses to obtain additional facts and perspectives beyond what is obtainable from the written record. In contrast, a Deputy Director's case review is a paper review, based on the relevant file or files. Given the extensive nature of MCFD files, including a running record with detailed information about events and file decisions, a Deputy Director's case review can be extensive, and it can be an alternative to, or the first step in, a Director's case review.

The death of a child in care or a child who received MCFD services in the previous 12 months is a "reportable" incident that triggers a case review. The Nuu-chah-nulth child's

death fell within the latter category; it had to be reported to the provincial Director under the CFCSA and the case review that was done was a Director's case review.

In 2002, the MCFD procedures for Director's case reviews were undergoing modification. Julie Dawson, the then Director of the quality improvement branch, told me that an earlier draft of what became MCFD "Case Review Procedures – June 2003", was in effect in the fall of 2002. Many of those I interviewed identified the June 2001 MCFD "Protocol between the Director's Office and BCGEU for the Director's Case Review Process" (See Appendix 6) as the procedure that was in place at this time.

It was the June 2001 protocol that was referred to in the 2002 initial and the revised terms of reference letters for the Director's case review relating to the late Nuu-chah-nulth child. However, the conduct of the case review clearly went on well past the June 2003 date of the succeeding procedures.

The June 2001 protocol and the June 2003 case review procedures (See Appendix 8) were, in any event, similar, the main difference being that the 2003 procedures took into account the designation of regional Directors under the CFCSA in 2002. Because of their similarity and the lack of clarity about which document applied, I will generically describe the process document as the "Director's case review procedures" unless it is relevant to the facts to distinguish between them.

According to the Director's case review procedures, the purpose of a Director's case review was to examine the facts concerned and determine whether MCFD had adequately fulfilled its legislated mandate. The primary, though not exclusive focus, was case practice, and the stated principles and objectives of a Director's case review were the same in both documents:

REVIEW PRINCIPLES

- The review will embrace the principles of fairness, timeliness, openness, and accountability.
- The review will be respectful of individuals and will be guided by the best interests of the child.
- Information gathered through the review process will be relevant and factual.
- There will be organizational accountability.
- Confidentiality will be adhered to throughout the review process.

REVIEW OBJECTIVES

- To promote excellence in case practice as well as confirming good case practice.
- To assess and examine case practice in relation to the fulfillment of delegated powers, duties, and functions under the *Child, Family and Community Service Act*, specifically as they relate to practice standards.

- To inform case practice at an individual case level and at a systemic level.
- To identify those case practices where additional services to the child or family are required.
- To identify barriers to providing an adequate level of service.

The appropriate scope of a Director's case review was not defined. The June 2001 protocol said (and the June 2003 procedures contained a very similar statement**)** that:

> Having determined that a Director's Case Review is warranted, the terms of reference are established by the Director's office in consultation with Regional Management. The terms of reference include the scope, focus, and issues to be examined (the methodology for the review is confirmed at the same time).

From the answers I received on the subject, varying opinions exist on the extent to which all practice relating to a family should be reviewed in a Director's case review, regardless of its potential impact on the child death or other serious incident involved.

The Director's case review procedures provided that the Director would designate a practice analyst to do the Director's case review. At different times, practice analysts were either MCFD employees or on contract to MCFD. A more senior MCFD employee supervised the reviewer.

The Director's case review procedures set out a seven-stage process. The following summarizes those stages:

1. **Notification:** The Director gives written notification to MCFD staff and the British Columbia Government and Service Employees' Union (BCGEU). A notification meeting follows. Staff are provided with written information that includes the decision to conduct a case review, the identity of the reviewer, the terms of reference, and the case review procedures. They are also informed of staff rights under the collective agreement and the name of the designated manager involved.

2. **Preparation:** Files under review are collected and the reviewer examines all the written material related to the case. The reviewer prepares a chronology and identifies those who will be interviewed.

3. **Information gathering and fact verification:** Interviews are conducted with MCFD staff, clients, family members and community collateral witnesses, workers and supervisors with information about the issues identified in the terms of reference. Facts obtained through the interviews are summarized and provided to the individual for fact verification. If, as the review proceeds, the reviewer identifies relevant issues not included in the terms of reference, these issues will also be explored.

4. **Work in progress:** The reviewer is expected to synthesize and analyze the information gathered about the chronology of events and the significant incidents, from which analysis, the reviewer is to produce clearly stated findings, both positive and negative. These findings are to reflect case practice relative to the terms of reference, which are then measured against the practice standards, policy, best practice, and sound clinical judgment. The term "Work in Progress" is given to the reviewer's list of issues, verified facts (in chronological order) and analysis with the findings for moving on to the recommendation stage. The director may suggest edits to the chronology of events section but does not change or alter the findings of the review.

5. **Recommendation development:** The recommendation process is a consultative phase in which key individuals from the regional management group develop recommendations relevant to the findings in the Work in Progress. The reviewer is also included in this stage. Recommendations could include, but are not limited to, practice, policy, administration, training, legislation, delegation, audit, and/or professional development plans.

6. **Submission of the Director's case review report to the executive audit and review committee (called the integrated review committee in the June 2003 procedures):** This committee, made up of senior representatives from all divisions of MCFD, reviews the Work in Progress to ensure it adequately addresses the issues identified in the terms of reference, and to assess whether the recommendations are adequate relative to the findings in the report. Once approved by this committee, the Work in Progress becomes the Director's case review report.

7. **Final report, précis and distribution:** For the purpose of promoting openness to quality improvement of practice, a non-identifying précis or summary version of the Director's case review report is prepared for wide distribution, including to participants in the case review. As appropriate, family members are invited to a meeting to discuss the report.

The June 2001 protocol stated that a Director's case review took approximately **four to six months** to complete the entire process. The June 2003 procedures stated that the approximate time to completion was **two to six months**, depending on the scope, methodology and availability of staff.

E. Setting Up the Director's Case Review: September to December 2002

1. Complex reporting relationships

A number of provincial and regional MCFD officials were involved in establishing and overseeing the Director's case review relating to the late Nuu-chah-nulth child. The responsibilities and reporting relationships of these officials were inter-related. Some wore more than one hat or reported to more than one supervisor. All came, left, or changed their positions between September 2002 and July 2005 (See Appendix 3, Key Officials).

In 2002, David Young was the provincial Director under the CFCSA and also Assistant Deputy Minister responsible for the Children and Family Development Division, which included the Aboriginal services branch[3]. The Aboriginal services branch had responsibility, among others things, for practice support to Aboriginal delegated agencies. Jeremy Berland, the Executive Director of that branch, though not an assistant deputy minister, reported directly to the Deputy Minister.

Catherine Reznechenko was provincial Deputy Director under the CFCSA. She had delegated responsibility for Aboriginal children from David Young. She was also a manager in the Aboriginal services branch where she had supervisory responsibility for the practice analysts, and thus had a dual reporting relationship to David Young and to Jeremy Berland.

The provincial quality improvement branch, also part of the Children and Family Development Division, had been responsible for all quality assurance and improvement activities, including audits, case reviews and delegation of responsibilities, except with respect to Aboriginal delegated agencies, which came under the auspices of the Aboriginal services branch. Julie Dawson, the Director of the quality improvement branch, reported to David Young.

In the fall of 2002, the functions of the quality improvement branch were being devolved to MCFD regional operations. At that point, although the quality improvement branch was not responsible for quality assurance and improvement activities for the regions or Aboriginal delegated agencies, it continued to provide audit and case review support services to both the regions and the Aboriginal services branch.

In late 2002, Jane Cowell was the Interim Chief Executive Officer with operational responsibility for the Vancouver Island region. She was also the Director under the CFCSA for that region and delegated much of the day-to-day responsibilities related to the statutory role to Thomas Weber, the Assistant Director for the region.

2. Two different approaches

David Young, until he left MCFD in mid-2003, and Jeremy Berland, throughout, had significant provincial operational responsibility for Director's case reviews involving

Aboriginal delegated agencies. They had differing approaches, personalities and focuses.

In or around December 2001, when David Young was promoted to provincial Director and Assistant Deputy Minister, the major priority of MCFD was to implement the devolution to regional governance and service transformation. David Young saw his position as provincial Director under the CFCSA as transitional, both on the non-Aboriginal and the Aboriginal side. The Assistant Deputy Minister role, in itself, had a large mandate, and, unlike some previous incumbents in the Director/Superintendent role, he did not feel, for the most part, the need to be engaged in day-to-day child welfare issues. He was more focused on governance, which was generating a lot of activity at the time. In that context, he had particular sensitivities around acknowledging the emerging authority of the regions. He described his approach to the Director's role as "collaborative and respectful". Because he had worked in the field for a long time, he did not believe that the provincial MCFD could effectively manage cases at a community level. He told me:

> One reason I supported the [regional] directors is you had people who could make decisions and provide direction that were closer to the individuals actually providing services and the communities actually being served.

David Young's inclination was to give the regions the tools to do the job and to trust them to do it. Once the regional Directors were designated, and he remained the Director only with respect to Aboriginal delegated agencies, he saw himself as having no involvement in individual cases, except in regards to Director's case reviews. Even then his involvement was in the context of the responsibility of the Aboriginal services branch to manage the relationship and practice issues with the agencies, and therefore to manage the review.

Jeremy Berland had, and has, a different perspective and approach. Before July 2003, as Executive Director of the Aboriginal services branch, his major focus was strengthening relationships with the Aboriginal delegated agencies and developing their capacity to take over increasing responsibility for services to Aboriginal children and youth. In September 2002, when he was still Executive Director of the Aboriginal services branch, and even more so after July 2003 when he replaced David Young as the provincial Director and Assistant Deputy Minister, Jeremy Berland saw himself as being in the middle of an accountability/autonomy issue between the provincial Director and the Aboriginal delegated agencies. The provincial government, of which he was the representative with respect to this issue, was becoming more directive about the application of standards to the Aboriginal delegated agencies. This was a trend he approved of, although it created conflict with the agencies with which he dealt. He observed to me:

> So the question of oversight of the agencies and the way in which the agencies are overseen is important.

> And, as with all things, it's based on maintaining a positive and good relationship with the agencies, so that you always have a vehicle for going and having that conversation about a difficult issue.
>
> And if you don't have a relationship, then you don't get the information. They don't tell you. And if they don't tell you, … you have limited ways of finding out – short of being there all the time, you know, having an analyst located in their office.

Jeremy Berland was, and is, by all accounts, including his own, a senior manager with strong opinions about various issues, including practice issues, based on his many years in the field as a protection worker and supervisor. He described himself to me as "pushy" and acknowledged that some within MCFD find him "a little bit overbearing". In September 2002, he was openly in disagreement with the prevailing view among other members of the MCFD executive in favour of decentralizing authority to the regions. As he put it, in a system of parliamentary democracy, with ministerial responsibility, "somebody has to advise the minister on how to proceed". While Jeremy Berland believed that he had a pretty good relationship with David Young, he felt that in the area of child welfare he had the superior background and skill set to David Young.

It was in this context that the Director's case review relating to the late Nuu-chah-nulth child arose.

3. The decision to do the Director's case review

The Nuu-chah-nulth child died on September 4, 2002. On September 5, 2002, the responsible Usma worker submitted the required report to MCFD to the attention of the "Director of the Aboriginal Services Branch". The report was required, because the child was, at the time of her death, subject to a kith and kin agreement facilitated by Usma and had received services from Usma in the 12 months prior to her death.

Preliminary reports indicated that the child had died in her caregivers' home, in which she had been placed under a kith and kin agreement, as a result of falling and hitting her head when her three year-old brother allegedly pushed her.

By September 11, 2002, an updated MCFD briefing note stated that preliminary autopsy results indicated injuries not consistent with the explanation given by the male caregiver; that a further RCMP investigation was underway; and, that this was the second death of an infant in the male caregiver's home. (MCFD file information on the earlier death was that the medical examination of that child found no evidence of abuse and the coroner had confirmed that the child died from an intestinal condition not caused by abuse.)

By September 19, 2002, Kellie Kilpatrick, a Practice Analyst in the quality improvement branch, had done a file review, a standard procedure with a reportable incident, based on the electronic version of the caregivers' files. The Usma files related to the child's immediate family were not at that time on the MCFD electronic system.

Kellie Kilpatrick's experience was considerable, having conducted and written or assisted in writing or managed close to 50 Director's case reviews and over 100 Deputy Director's reviews. She compiled a chronology of the intakes on the files under the caregivers' names and distributed it to David Young, Jeremy Berland, Julie Dawson and Jane Cowell. An intake occurs when a report (verbal or written) of concern for the safety of a child is made to a social worker. The initial information received, additional information gathered and the action taken, if any, are recorded. Among the intakes Kellie Kilpatrick reviewed were some that indicated past, potential protection concerns related to the caregivers. Others were related to the late Nuu-chah-nulth child's mother, rather than the caregivers. The child's mother lived with the caregivers from time to time. Following the death of the child, Jack Colmer had also noted the intakes to Monty Montgomery.

At some point in September, based on this information, it was decided that a Director's case review would be undertaken. It is not clear who made this decision.

The decision to do a Director's case review relating to the late Nuu-chah-nulth child was made around the same time as a decision to do a Director's case review related to another death involving a delegated Aboriginal agency.

4. Consultation by MCFD with Usma

Jeremy Berland took the lead in meeting with Usma about the decision to do a Director's case review. He told me that, while it was clear to him that a Director's case review would be done, he was conscious of the importance of not getting into an adversarial relationship with Usma over it; and that if the Director's case review was to be useful they would have to get off to a good start, which included being clear about the reasons for doing the case review and the structure for how Director's case reviews work.

On September 24, 2002, Jeremy Berland and Monty Montgomery traveled together to Port Alberni to meet with Charlotte Rampanen and Darlene Thoen. On the way, they discussed the terms of reference for the case review and touched base with Julie Dawson, who gave them her input. Her notes indicate three core areas to be looked at: was the investigation of the child's family leading to the kith and kin agreement adequate; was the kith and kin agreement the appropriate plan for this child; and, did Usma follow the written guidelines in developing the kith and kin agreement?

Jeremy Berland told me he spoke with Jane Cowell by telephone on the way to Port Alberni. He recalled her acknowledging that the case review would to some extent cover MCFD practice in the region, and that the region would therefore be participating in some undetermined way. On his way to Port Alberni, Jeremy Berland also contacted Jack Colmer and asked him to attend the meeting. Jack Colmer did attend, although he told me that he was unclear about his role at the meeting.

At the meeting in Port Alberni, the idea of doing a Director's case review was discussed and accepted by Usma. Jeremy Berland outlined what might be included in the terms of

reference, with the idea that Monty Montgomery would subsequently draft them. He made a point about the need to go back and look at earlier intakes related to the family, both MCFD and Usma intakes, suggesting that the time frame be from the birth of the first child in the family (1999).

Reference was made to the case review being done "jointly" and "in a spirit of partnership", and that the partnership would involve Usma, the Vancouver Island region (Jane Cowell's name was given as the regional contact) and the provincial Aboriginal services branch. In this spirit of partnership, Usma agreed to contribute to the cost of the case review. Jeremy Berland recalled to me that he was surprised at how well the meeting went, and that Usma seemed so willing to have a Director's case review done.

5. The initial terms of reference

Following this meeting at Port Alberni, and without any further consultation with the Vancouver Island region or Usma, Monty Montgomery prepared the October 1, 2002, terms of reference letter from David Young to Charlotte Rampanen at Usma (See Appendix 11). This letter stated that the purpose of the Director's case review was:

> to examine the extent and nature of the involvement of the Usma Nuu Chah Nulth Community and Human Services agency and the Ministry of Children and Family Development in the case of … the children of [the mother] to ensure that policy and practice requirements regarding the provision of child protection services were met.

It also set out the following terms of reference for the case review:

1. Was the response of Usma Nuu Chah Nulth Community and Human Services to the child protection concerns associated with the [child's] family consistent with established standards?

2. Was the response of the Ministry of Children and Family Development to the child protection concerns associated with the [caregivers'] family consistent with established standards?

3. Was the decision to facilitate the entering of a *CFCSA* s.8 Kith and Kin Agreement between [the female caregiver and the children's mother] in the children's best interests?

4. Did Usma Nuu Chah Nulth Community and Human Services agency staff follow the July 2002 Draft "Practice Guideline for Section 8 Agreements – Aboriginal Agencies"?

5. Was the information sharing process between the Ministry for [*sic*] Children and Family Development Vancouver Island region and the Usma Nuu Chah Nulth Community and Human Services agency adequate to ensure the safety of the children in the Kith and Kin placement?

A similarly worded letter addressed to the MCFD Community Service Manager responsible for the intakes related to the caregivers was prepared and sent to the Vancouver Island regional office for the signature of Jane Cowell.

6. Selecting Nicholas Simons as the reviewer

Kellie Kilpatrick recalled that she was initially considered to do the Director's case review. However, Jeremy Berland and others felt that it was important to develop the capacity among the delegated Aboriginal agencies for undertaking Director's case reviews, and the idea of using Kellie Kilpatrick was rejected in favour of asking someone from or connected with the Aboriginal delegated agencies.

Several names for reviewers were considered at the meeting in Port Alberni. Jeremy Berland suggested Nicholas Simons because he was the Director of another Aboriginal delegated agency. In addition, Jeremy Berland was aware of Nicholas Simons' social work experience and had confidence in him because of past experience with his work. Nicholas Simons had not done a Director's case review before but, in addition to being Director of an Aboriginal delegated agency, he had a Master's Degree in Criminology, had been lecturing in that field, and had been a child protection worker.

Under MCFD policy, David Young had the authority to select a reviewer. He accepted the recommendation from Jeremy Berland that it be Nicholas Simons, being familiar with Nicholas Simons and having confidence in his ability.

Jeremy Berland telephoned Nicholas Simons shortly after the Port Alberni meeting to ask him to take on the job. Nicholas Simons agreed. He told me that, during the telephone conversation, he and Jeremy Berland also discussed Nicholas Simons' requesting some time off his regular job (he recalled two weeks) to do the case review. Nicholas Simons also told me that his request for time off was turned down and those at MCFD were aware that he worked on the case review in addition to his regular job as Director of an Aboriginal delegated agency.

Kellie Kilpatrick told me that in the past a new reviewer would first train in tandem with an experienced reviewer and, when she was told that she was no longer going to be doing this Director's case review, she had concerns which she told me that she communicated to her manager, Clara Robbins, and to Julie Dawson, and possibly to other colleagues as well:

> I thought it was a very good idea that the work of the agency was being examined. They're delegated practitioners, they serve kids and families, so I thought that part was very good.
>
> I had some concerns about a director's review, which is the most comprehensive type of review, being assigned to individuals who had not done a review before.
>
> ***

> It's a very comprehensive piece of work, and I would have had reservations about anyone, whether they were from an aboriginal agency or a region or headquarters, conducting one when they hadn't done it before, without some sort of training and orientation process.
>
> ***
>
> The decisions has [*sic*] been made, and we will be going forth, and you will be available to coach and mentor.
>
> And I did feel strongly, because in the past I had trained and felt very strongly that there was a way of training reviewers to do the work.
>
> So if you were a new reviewer, you would watch me do one first; the second one we would do together; the third one you would do, and I would shadow. So I felt very strongly about that work.

On October 1, 2002, Kellie Kilpatrick met with Nicholas Simons and the reviewer for the Director's case review of the other death involving an Aboriginal delegated agency. Although originally the plan was to meet for two days, they only met for one. Kellie Kilpatrick's expectation was that she was providing orientation and training, which would be followed by ongoing mentoring, coaching and support. Nicholas Simons understood that he was attending a meeting about what his responsibilities were and what would be expected of him. He did not consider it a "training" session. He had full confidence in his abilities and believed that he had been selected because of his competence.

Kellie Kilpatrick told me that examples of case review format were provided to the new reviewers. Nicholas Simons recalled that he was given some templates and samples of previous case reviews, but understood that these were guidelines only. He believed that the discretion about how to conduct the case review remained with him. As he said to me:

> If I remember correctly, they [the templates] were for the purposes of our comfort and to assist us in the process, there was a template, but I never got the impression that we were required to follow a template.
>
> …at the time I never had really an impression that they were confining me at all. I never had the impression that they were going to dictate any aspect of the review, but they were providing assistance.

The material Nicholas Simons received included a document called, "May 2002 Suggested Template for Director's Case Review" (See Appendix 7). This 11-page document is organized under nine headings: Purpose of the Review, Terms of Reference, Background, Circumstances Related to the Child's Death, Current Status, Findings, Summary, Recommendations Arising From the Review, and Executive Audit

and Review. Under each heading there is commentary. Under many of the headings, there is also sample narrative.

The commentary under the Background heading included the following:

> The chronology should include key events in the child's life…
>
> If reviewing the adequacy of intake, assessment and investigation, the chronology should include the steps that were taken at each risk decision point. The information should be described in a consistent manner for each intake…
>
> Limiting the scope of the review allows you to focus on more current practice concerns and can be more relevant for staff. This does not preclude the reviewer from examining earlier intakes. You may wish to build your own chronology intake by intake or summarize earlier ones.

And later under the same heading:

> The chronology is the fact pattern. The analysis is based on information included in the fact pattern. The practice is measured against the standards, policy, mandate of the ministry and current clinical wisdom. Description of each intake or case work activity should be described succinctly and consistently using language that is plain, informative and non-judgmental. The chronology will include information contained in files and information acquired during interviews.

Under the heading Findings, the template suggested that the findings, or each finding if the findings were separated into more than one part, were followed by "Analysis/Discussion", and the commentary about this included the following:

> The analysis section discusses the practice based on the chronology of services. Each activity/step is measured against the policy/standards of the day. The discussion focuses on what did happen, what did not and what should/could have happened. The tone of this section is important in that it should be neutral, with a strong clear voice. The discussion should not individualize the criticism but rather point to "this step was missed" or "flawed" as opposed to saying "the social worker should have done this or that".
>
> You will be viewing the practice as a whole process which is defined as work completed by the social worker, supervisor, manager in the region. The practice may also be viewed within the context of other factors. These may include local resources, workload, cultural issues and relationships between ministry staff, the community and the family. You will be identifying gaps in the service delivery model, access to supervision, policy and other systemic issues. It is important to contextualize the practice by understanding the work environment.

Shortly after the session with Kellie Kilpatrick, Nicholas Simons also received a copy of the David Young's October 1, 2002, initial terms of reference letter addressed to Charlotte Rampanen (See Appendix 11). In addition to the five specific terms of reference, it included information about the procedure, the June 2001 protocol, and the purpose of the case review:

> For your information, the process to be followed in the conduct of the review is consistent with the document "Protocol Between the Director's Office and the BCGEU for the Director's Case Review Process" dated June 2001, a copy of which has been made available to you. I recognize that the process outlined in this document has not been adopted for use with First Nations Child and Family Service Agreements at this time, however I ask you to consider that this review be conducted "in the spirit" of this Protocol. I am aware that sections of the June 2001 protocol that specify the role of the BCGEU are not relevant to the Usma Nuu Chah Nulth Community and Human Services program. However, "in the spirit" of the Protocol, I recommend that you meet with your staff to review the procedural steps outlined in the Protocol, share with them the established terms of reference, and provide them with information about the reviewer who will be conducting the review.
>
> ***
>
> The purpose of the review is to examine the extent and nature of the involvement of the Usma Nuu Chah Nulth Community and Human Services agency and the Ministry of Children and Family Development in the case of [the child and sibling] to ensure that policy and practice requirements regarding the provision of child protection services were met.

7. Changing the initial terms of reference

On October 9, 2002, the letter about the terms of reference for the case review that Monty Montgomery had prepared for Jane Cowell's signature was faxed to Thomas Weber. When Thomas Weber saw the draft letter, he was surprised and annoyed on two fronts. Primarily he was annoyed that the terms of reference had been developed without any real consultation with the region. He also thought that the scope of the terms of reference was too wide, and that it made no sense to go back to 1998 to look at the practice behind each of the intakes related to the caregivers. His view was that the focus of the case review would be Usma's decision to enter into the kith and kin agreement and the only relevance of MCFD practice to the death of the Nuu-chah-nulth child was MCFD's failure to communicate to Usma all relevant information related to the caregivers. At the time, he reviewed the MCFD intakes that would have been covered by the second term of reference and concluded that they did not warrant a review separate from any relevance they might have to the issue of information sharing.

Thomas Weber expressed his views to Jane Cowell, who in turn raised the issue with Jeremy Berland. Jeremy Berland has no recall of this conversation (or any conversations about any changes to the terms of reference) but it is clear from the email

exchanges that he was aware of the issue at the time and that, consistent with his strongly held view that case reviews should be wide in scope, he was opposed to any change in the terms of reference. In any case, the authority to determine the terms of reference was not his as he was not at that time a designated Director under the CFCSA.

Jane Cowell also took her objections to David Young, who ultimately agreed with her that the terms of reference should be changed. He told me:

> What I've seen from the e-mails show there's some discussion happening at a regional level, and eventually that came to me, and I believe there was a conversation with Jane [Cowell] and maybe others, and I made the change…In retrospect I look at it and I don't understand why it was ever included. ...The issue at hand, from my perspective was ... what [were] the activities associated with the placement of this child, and so that is what we needed to review and consider.

David Young and Jane Cowell saw it as a matter to be negotiated between equals: that is, between Jane Cowell as the Director under the CFCSA for the Vancouver Island region, responsible for the practice of MCFD regional workers with delegated authority under the CFCSA, and David Young as the provincial Director, responsible for the practice of Aboriginal delegated agency workers. David Young had no direct line of authority over Jane Cowell. From both their perspectives, establishing the terms of reference for the case review, so far as it related to regional practice, was within Jane Cowell's authority.

Their joint decision was to change the terms of reference in a way that was consistent with Thomas Weber's view that the final term of reference pertaining to information sharing was sufficient to address the relevant MCFD practice. This decision was conveyed to Catherine Reznechenko and Monty Montgomery, who exchanged emails with Thomas Weber about the exact wording of the changes.

Catherine Reznechenko had been on holidays during the month of September when the original terms of reference were worked out. When she returned to work on October 1, 2002, she took over the responsibility for managing this Director's case review, as well as the one involving the other Aboriginal delegated agency. Neither she nor Monty Montgomery felt that they were in a position to question the decision to change the terms of reference.

I found no indication that MCFD consulted anyone from Usma or the Nuu-chah-nulth Tribal Council about the decision to change the initial terms of reference.

A December 2, 2002, letter from David Young to Charlotte Rampanen (See Appendix 13) that was received by the Nuu-chah-nulth Tribal Council on December 13, 2002, set out the changed terms of reference. The following second term from the October 1, 2002, initial terms of reference was deleted:

> Was the response of the Ministry of Children and Family Development to the child protection concerns associated with the [caregivers'] family consistent with established standards?

The last term of reference about the breakdown of communication was changed to read (emphasized words were added):

> Was the information sharing process between the Ministry for [*sic*] Children and Family Development Vancouver Island region and the Usma Nuu Chah Nulth Community and Human Services agency **with particular respect to the sharing of information regarding the [caregivers'] family** adequate to ensure the safety of the children in the Kith and Kin placement?

A letter setting out the revised terms of reference, dated November 8, 2002, (See Appendix 12) had also been sent from Jane Cowell to the MCFD Community Service Manager responsible for the intakes related to the caregivers.

Charlotte Rampanen was away from work for much of December 2002 and January 2003. Darlene Thoen, who took over for her, remembered being aware of the letter changing the terms of reference. Her recollection was that she saw the letter likely in the early part of 2003 because the Nuu-chah-nulth Tribal Council shut down over the Christmas period. She recalled asking Charlotte Rampanen about the changes and was told that a term of reference was deleted because it was not relevant.

Monty Montgomery recalled speaking to Charlotte Rampanen about the changes in the fall of 2002 or early 2003, before he left the Aboriginal services branch in February 2003, and that she was unhappy about them.

Charlotte Rampanen remembered first becoming aware of the changes of the terms of reference on March 30, 2004, when Julie Dawson took over responsibility for managing the Director's case review after Catherine Reznechenko retired. She had no recall at all of a conversation with Monty Montgomery. As for the discussion with Darlene Thoen about her concerns about the changes, she recalled that that conversation took place when she spoke to Darlene Thoen about them in March 2004.

Regardless of diverging recollections about exactly when Charlotte Rampanen became aware or alert to the changes in the terms of reference, it is clear that in late March 2004 the changing of the terms of reference emerged as an issue of concern for Charlotte Rampanen and others at Usma.

8. Views on the scope of the terms of reference

There was a general consensus among those I interviewed from MCFD that the purpose of a Director's case review arising from a death was to examine practice that may have contributed to the death, to highlight areas that need attention and to learn

from the experience about how to improve practice. This is consistent with the "Review Objectives" set out in the Director's case review procedures.

There were different views, however, as to what would be the proper range of a Director's case review both generally and in these circumstances. Jeremy Berland and Kellie Kilpatrick shared the view that case reviews were an opportunity to look at practice, and that practice issues should be looked at whether or not they related directly to the death or critical injury. Jeremy Berland believed that in this case review a fuller picture of the family would result from looking at the full story, which included the intakes related to both the immediate family and the caregivers' family. From his perspective of concern for relationship building with Usma, there was an added issue of how it could be explained to Usma that it was necessary to go back and look at their past practice, but not the past practice of MCFD.

Jeremy Berland also expressed the view to me that the exact wording of the terms of reference was not necessarily important:

> The terms of reference for these things are fairly standard, the sort of obvious questions to ask and then sort of more broad questions. But the fewer the better in terms of not making it too complicated, so you can kind of really zero in on what the issues are. … You can have one question and the right reviewer and have all the questions answered.

The notion that the reviewer has the scope to deal with issues that come up was shared by those more experienced with case reviews, and is expressly stated in the Director's case review procedures under the Information Gathering and Fact Verification section:

> As the review proceeds, if the [reviewer] identifies relevant issues not included in the terms of reference, these issues will also be explored.

Not all those with experience considered that the scope of reviews should be very broad. Clara Robbins told me that "scope creep" was always a concern and the terms of reference could be too broad. She thought that to go back to look at the practice issues relating to old intakes would be "a real fishing expedition". Specifically, she expressed the view that the question of how a 1998 intake relating to the caregiver's family was handled, was not properly within the scope of this case review. At the same time, she believed that, given that there were known to be some risks inherent in the caregivers' home and some information that MCFD should have conveyed to Usma, a term of reference should have been included to allow the reviewer to look at what MCFD should have known and conveyed to Usma.

Julie Dawson also expressed the view that the scope of the case review should be related to outcome:

> I believe that it's looking at anything that might be relevant in terms of what happened to a child, whether it was a fatality or critical injury of a child, that it's

> any involvement of the service delivery agent, the Ministry, or the agency that's relevant to that child's – to the outcome for that child.

David Young clearly shared the view that the scope of the case review should be focused on the practice associated with the placement of the child.

9. The "spirit of partnership" and "joint review"

David Young's October 1, 2002, initial terms of reference letter stated (emphasis added):

> It is anticipated that this review will be conducted in a **spirit of partnership** and with the full support of the Ministry of Children and Family Development, Vancouver Island Region, the Usma Nuu Chah Nulth Community and Human Services agency and the Ministry of Children and Family Development Services to Aboriginal Children and Families Division (on behalf of myself as the Director of Child Protection Responsible for Aboriginal Agencies).

A similar paragraph was included in David Young's November 8, 2002, revised terms of reference letter that was directed to the MCFD Vancouver Island region.

The December 2, 2002, revised terms of reference letter referred to the "spirit of partnership" in this way (emphasis added):

> My earlier correspondence in this matter indicated that the Terms of Reference for the review had been identified. However upon further discussion with the Vancouver Island region of the Ministry of Children and Family Development, several revisions were made to the Terms of Reference that better reflect the **spirit of partnership** within which this review is to be conducted. It is my belief that the revisions will not substantially impact components of the review that pertain specifically to the practice of the Nuu Chah Nulth Community and Human Services staff.

The November 8, 2002, revised terms of reference letter to the region also referred to the case review itself as a "Joint Director's Case Review". Neither the initial terms of reference letter (October 1, 2002) nor the revised terms of reference letter (December 2, 2002) that were sent to Charlotte Rampanen used this language.

As it turned out, "spirit of partnership" meant different things to different people, as did "joint review".

Jeremy Berland explained the partnership concept as applying to the relationship between MCFD and the Aboriginal delegated agencies. He said that partnership is:

> a way of making sure that we do our work hand in hand and that we don't end up with two separate systems running parallel. These are systems that have to work…. in a completely inter-connected way. And so the partnership is, we're

> going to do this, but we're going to do it with you. We're not doing something to you.

His view was that this partnership responsibility still recognized the accountability of the provincial government for child protection. In the context of the case review, the basic approach would be the same whether or not a delegated Aboriginal agency was involved. However, the reviewer selected might be different, or the way of constructing the process might be different by involving more negotiation than if the case review was done completely within MCFD. He anticipated that Usma would participate in the development of the terms of reference.

Monty Montgomery told me that "partnership" referred to the relationship between the province and the Nuu-chah-nulth people.

Catherine Reznechenko told me that she was not really clear about what it meant to be working in "partnership" on the review, but that she thought that "partnership" included the region, the Aboriginal services branch and Usma and that they "would all be working together to find out what wrong [*sic*] in this case and what we could learn from it."

The statement in David Young's December 2, 2002, revised terms of reference letter to Charlotte Rampanen that the changes "better reflect the spirit of partnership" suggests that, for him, the partnership concept included not only the Aboriginal delegated agency but also the Vancouver Island region.

With respect to the term "joint", Jane Cowell and Thomas Weber believed that the case review was to be "joint" in the sense of belonging to both the provincial and the regional Directors. At roughly two or three month intervals, Thomas Weber would telephone or email to ask how this case review was going. He told me that he assumed that it would be a joint Director's case review, until the fall of 2004 when Julie Dawson, who had taken over responsibility for managing the case review from Catherine Reznechenko in March 2004, informed him that the region was not going to be involved.

Jeremy Berland told me that to him "joint" meant that the same reviewer would look at both Usma and MCFD practice. He assumed, however, from the beginning, that the Director's case review was the case review of the provincial Director. When he became provincial Director in July 2003, he continued to understand himself to be the sole "Director" whose case review this was. He also told me that he assumed throughout his involvement as provincial Director that the terms of reference for this case review had not been changed, and that the case review continued to be "joint" in his original understanding of that word.

Charlotte Rampanen understood that "joint" and "spirit of partnership" meant the same thing and that there were three partners to the case review: Usma, MCFD Aboriginal services branch, and MCFD Vancouver Island region. She said she assumed that when Usma's portion was done, they were going to get together with the Aboriginal and the non-Aboriginal side of MCFD (David Young and Jane Cowell) and that all three of

them would sign off. It was not until March 2004 that she realized it was not going to happen. In Charlotte Rampanen's words to me:

> And so it was – I was waiting for a conversation that was never going to happen and realized the major decision-maker for some time had been Jeremy [Berland].

F. Producing the Director's Case Review: December 2002 to July 2005

The Director's case review procedures anticipated six months as the outside time for completion of a Director's case review. I was told, however, that it was not unusual, for various reasons, to exceed that time frame. The other Director's case review relating to the death involving a different Aboriginal delegated agency that commenced around the same time was completed by September 2003 and the summary was publicly released that November. It would not have been considered untoward had the Director's case review relating to the late Nuu-chah-nulth child been completed by the end of 2003. But, of course, that did not happen.

In fact, it took until May 2005 for the case review to be signed off by the provincial Director (then Jeremy Berland) and until July 2005 for a summary of the case review to be publicly released.

Having immersed myself in the detail of what happened, I have stepped back and seen that the events from December 2002 to July 2005 can be grouped into five phases.

The five phases of events are as follows:

1. The interviews and initial drafting from December 2002 to April 2003.
2. The redrafting action and inaction from April 2003 until March 2004.
3. The redrafting efforts to bring the case review to completion from March to August 2004.
4. The action and inaction from September 2004 to January 2005.
5. The final phase from February to July 2005.

1. Interviews and initial drafting: December 2002 to April 2003

Catherine Reznechenko was responsible for managing the case review process until she retired from government on March 17, 2004. She told me that in the initial stages she left Nicholas Simons to get on with the case review. She was aware that matters were taking up his time at his regular work but she herself was busy with the Director's case review related to the other Aboriginal agency and with her other responsibilities. She was not concerned with Nicholas Simons' timelines for doing interviews and the initial drafting of the report.

Nicholas Simons, having read the Usma file related to the late Nuu-Chah-Nulth child and her immediate family, conducted interviews in December 2002 and January 2003. He interviewed Charlotte Rampanen and Darlene Thoen, as well as the two Usma workers involved in the recent intakes with the child's family and with the decision to place the child with the caregivers, and Jack Colmer. Nicholas Simons also spoke to the police constable and the local coroner. He did not interview members of the child's extended family who worked for Usma, or some of the workers involved in the earlier intakes. Nicholas Simons began drafting the report in January 2003. He sent Catherine Reznechenko an email on April 2, 2003, with attached documents, which collectively he regarded as his "final first draft".

2. Redrafting action and inaction: April 2003 until March 2004

a. MCFD feedback on the "April 2003 first draft"

Catherine Reznechenko received the April 2, 2003, email from Nicholas Simons, forwarded it to one of the practice analysts in the Aboriginal services branch, and together they provided feedback by way of email to Nicholas Simons later in April 2003.

Catherine Reznechenko told me that when she received the "April 2003 first draft", she was disappointed and it was not what she expected at all. Her April 11, 2003, feedback email to him, however, had some positive things to say about the work he had sent to her:

> Hi Nick, thanks for our conversation today, I appreciate the extensive work that you have done on this tragic death of the innocent child and I know it is not an easy thing to do for many reasons.
>
> In general Nick I have to say your writing is a pleasure to read. Can you put the grammer [*sic*] in the past tense, what was done and what was reviewed.
>
> ***
>
> …Thank you so much for this Nick, your work is very valuable and will provide a great deal of learning for hopefully many people providing service within Aboriginal Communities.

The email continued with a few points to summarize what Catherine Reznechenko and Nicholas Simons had discussed. Some were minor. Some were fundamental, such as:

> Section 1 is really a summary of the child protection concerns associated with the family. In general I think you could shorten this section a great deal by providing more of a summary of the intakes with respect to their nature. I think many of them were of a similar nature so you could examine those of a similar nature and summarize how they were dealt with. This first part is a summary of the facts gleaned from the file review and clarified by interviews of the social workers and

> supervisors involved in making the decisions. It should flow in chronological order.
>
> The finding(s) generally come at the end of all the facts, however because you are looking at two sets of families and their respective files you could lay this out in the sections as you have keeping the families files separate like this, however, I suggest that you consider placing all the facts together in light of the planning for the children of this family. This isn't really a review of the kith and kin family and how intakes were or were not handled but it is a review of this family and the decision made to utilize them as a resource for these children. The fact that the information was missing for the agency to have made a better informed decision is important, how that came about will support your findings on this point as well as any recommendations made with respect to information sharing between MCFD and the agency and what this means for other agencies….

Nicholas Simons told me that he remembered being a little bit surprised by the feedback. He realized there was more work that he had to do. A further email from Catherine Reznechenko to Nicholas Simons, dated May 23, 2003, stated:

> I am looking forward to seeing your next draft. Let me know if you are struggling and if there is any assistance you need. I know these things can often get to a place where it is difficult to move them any further and another set of eyes or discussions can help. I think its called "writers block". Take care Nick.

b. The "August 2003 final draft"

When Catherine Reznechenko followed up in mid-June, Nicholas Simons emailed that the revisions were coming along, and apologized for the delay. Two days later, in a June 18, 2003, email, he made the following request:

> Regarding the review, what I need to do is come to Victoria for a couple of days to finish the review where I would have an opportunity to consult with you while the changes are being made. I cannot get much accomplished in this atmosphere but I have made attempts. What do you think?

Catherine Reznechenko replied the same day, saying that he was welcome to come to her office and use a spare office and computer there.

Nicholas Simons did indeed go to Victoria on July 17 and 18, 2003. Catherine Reznechenko told me that she was very concerned about the calibre of the draft material she had received to that date from Nicholas Simons. She explained this to me as follows:

> …because there was no fact pattern, there was no chronology, what he had to say was clearly his opinion, not based on any facts.

> He made statements. Like, he would say "Clearly", you know, and then a statement of opinion. Well, it wasn't clear to me. It might be clear to him, but I don't know why it was clear to him.
>
> So I know what Nick was told. And I know in my opinion a review needs to always be able to be read so that the reader can follow the logic pattern of what the reviewer has written, and that the logic makes sense to the reader, that it follows in a chronological kind of way.
>
> The analysis is based on facts. It's not based on opinions. And if it is an opinion, then the reviewer would say "in my opinion", not just state -- make a blanket judgment with no supporting rationale for why the judgment was being made.

Catherine Reznechenko told me that she spoke about her concern to both Jeremy Berland and Nicholas Simons:

> …I did tell Jeremy that I was really disappointed with what I was getting from Nick. And I met with Nick and went over in detail with him what I expected and what the issues were with what he had given me, and I thought he understood.
>
> He seemed to understand. He seemed like he was saying, Oh, you know, I get it now. Absolutely no problem, Catherine. I understand what you mean. I see what you're getting at. And he went away with that information.
>
> And I expected that the next draft would be a complete draft and would have a chronology in it and a fact pattern.

Catherine Reznechenko also told me that around that time she had been working very hard guiding the reviewers on the other Director's case review involving an Aboriginal delegated agency. For that case review, the new reviewer was working with an experienced reviewer. She told me that working with an experienced reviewer was offered to Nicholas Simons at the outset, and he had declined, and this was offered to him again in July 2003.

Nicholas Simons denies that he was offered, and declined, any assistance in doing the Director's case review or that MCFD staff or officials raised to him, at any time, any concerns about his research, analysis or writing. He told me that he did not recall sitting down and meeting with Catherine Reznechenko, as such. He remembered dropping in and saying hello and chatting, and as he told me:

> …I don't think she ever told me that my analytical content was not up to her standards. I don't remember anything at all negative about the report except its length and the structure wasn't familiar to her, having read previous report. I don't remember anything specific, I don't remember meeting with her more than having a chat with her.

And later:

> …I remember early on in this stage that one of the first things that I ever did was a chronology, one of the first things, so that I could establish the sequence of events. That's what any reviewer would do. And I – I did chronologies, I had them figured out. I had timelines, and quite frankly July 2003, having received new information about the case, it seemed to be an evolving, an evolving report. I think – I think there was possibly – on the part of Catherine there was some expectation that I would fit my report into a particular style, and it was never required of me and it was never – there was some stylistic things that I thought – you know, I was writing the report.

On August 14, 2003, Nicholas Simons sent an email to Catherine Reznechenko with some attachments that he considered a final draft. I was not able to establish if and when this email was received by Catherine Reznechenko, as the original email was neither in the printed off emails I received from MCFD nor in Nicholas Simons' file. However, a forwarded version of the August 14, 2003, email with its attachments was in a February 2004 email from Nicholas Simons to Catherine Reznechenko.

I saw no indication of activity on the part of either Catherine Reznechenko or Nicholas Simons on the case review until February 2004. It appears that during this time each was waiting for the other to take the next step. Nicholas Simons was waiting for comments from Catherine Reznechenko on the material attached to his August 14, 2003, email and she was waiting for further work from him.

c. The push for completion in February and March 2004

Contact between Catherine Reznechenko and Nicholas Simons resumed in February 2004 and they were set to meet on February 12. Catherine Reznechenko sent an email to two MCFD practice analysts asking them to read over the draft case review prior to the meeting, but what she attached to that email was not the attachments to the August 14, 2003, email, that is, the "August 2003 final draft", but instead previous drafts of some sections of the case review. Catherine Reznechenko sought confirmation from Nicholas Simons that what she had sent was his latest draft. Nicholas Simons replied that it was not and forwarded to her his August 14, 2003, email with the attachments that together made up the "August 2003 final draft".

Catherine Reznechenko told me that at the meeting on February 12, 2004, she once again spoke to Nicholas Simons about her concerns with the case review as written to that point. By this time, she was getting concerned that he was not prepared to say anything critical about the practice of the Usma workers because her impression was that, rather than evaluating or analyzing the extent of compliance, he wanted the case review to focus on criticism of the kith and kin policy itself. She told me that at the meeting she attempted to convey to Nicholas Simons that, while finding fault with policy was fine, it was also necessary to look at the practice of the Usma workers. As she put it:

> …you know, I certainly believe and certainly said to him that there's a place for your comments with respect to the clarity in the policy, absolutely, in the review.
>
> But you have to answer the key question: Was policy followed? How did they [the social workers] evaluate his [the caregiver's] criminal offences with, Is this a safe place for the children? You have to answer that question when you're making evaluation of the placement with someone who has a criminal past.
>
> And to my way of thinking, someone who has recent criminal charges of spousal assault and… I think there's another assault in here, an unprovoked assault. At the time he was on current probation for unprovoked assault, of whom I don't know. Is that not a violent home? Or is that a violent home? Would you not assess that as a violent place to be for children?

And later:

> So then this was the comment around Section 4. This to me was a very important section. It was regarding the information-sharing process between the Ministry of Children and Families, Vancouver Island Region, and Usma, with respect to sharing information about the family to ensure it was adequate for – to ensure the safety of children in the placement.
>
> So my comments were similar. Again, the information needs to go into the chronology section with your findings and analysis specific to the question.
>
> So he does a lot of analysis, but… A lot? I don't call it analysis. He does a lot of – gives a lot of information, but it isn't an analysis about the adequacy about the information-sharing process between the ministry and the agency.

I asked Nicholas Simons about Catherine Reznechenko's recollection that at the February 12, 2004, meeting she was trying to say it was important to look at practice, not necessarily to the exclusion of criticisms about policy, but important to look at the practice. He responded as follows:

> That's interesting that she remembers that. I often take issue with a structural analysis of policy and its application because what it doesn't address is the myriad of other factors that lay in the social worker's decision-making, as a consequence of that I think she might have thought that I was being defensive of social workers when I said that I could find fault with practice according to the practice guidelines, but I could not find blame and associate that with the result of this case. I think my discussions with Catherine were – and I have to say all my discussions with all Ministry people were always very positive, the relationship has never been bad. And the same thing with the agency, which I might add was supposedly the co-sponsor of this review. And at no point was any direction given me from the Nuu-chah-nulth. So when the Ministry was making these suggestions, recommendations, and all the other things they wanted, I think that

> my perception was that I had to be sure that it was fair, and that if Nuu-chah-nulth didn't have the capacity or resources to take equal part in this contract, that I would just make sure that I was boring as possible and sort of unaffected as possible, and I think that my discussions with Catherine – well, I don't remember disagreeing with her really, except to say that her emphasis on specific practice guidelines, which were clear in my first draft, didn't capture the whole story. I wonder if that's where my "Context" section came in. I don't know.

And later:

> I was feeling like there was going to be a finding of inappropriate – or a finding that standards were not adhered to, and I was wanting to make sure that I could easily say, yes, standards were not adhered to, but that is not what this report is supposed to really determine, because that to me – there was an attempt to find technical fault with practice, and I was finding fault, more systemic fault, and I had to put it into my report. I have to say the terms of reference would not have been those terms of reference if I wrote them.
>
> ***
>
> …I probably spoke about them [the terms of reference], but I didn't say this is bad terms of reference, because within the terms of reference that I was given I felt I had the mandate to explore practice standards within context.

After that meeting, Nicholas Simons again went back to make changes, some of which he sent to Catherine Reznechenko on February 20, 2004. Catherine Reznechenko replied by email on March 1, 2004, with extensive commentary and substantial edits on virtually every page. She was clearly making an effort before her last day of work on March 17. As she put it in her email:

> …well, I've made some substantial edits. I just found it was quite difficult to follow and so very different in style from the format that is usually followed. So I took the liberty to go through it….

In her commentary on his February 20, 2004, draft, Catherine Reznechenko asked a number of questions about facts that were not in the case review. These were interspersed with suggested edits. She questioned the "contextual factors" as being too general and based on opinion rather than the facts about the case. With respect to the intake section, she suggested that he include where the facts come from, whether they were on the file or from an interview with the social worker. She again suggested that the entire fact pattern be laid out first, followed by the questions from the terms of reference answered relying on those facts. She then made the statement:

> Even though I have made a lot of comments on the above intakes, I am tending to think these should be summarized as they do not directly lead to the Section 8 [kith and kin] decision.

She also acknowledged in the email that Nicholas Simons may not be able to answer all the questions as he did not interview the social workers on those intakes that were done before March 2001. With respect to the intake that led to the kith and kin agreement, Catherine Reznechenko also asked a number of questions:

> Please identify the process that lead to the Section 8. What happened? When? Who was there? Was the supervisor involved? How? Was the local MCF office? Again, what happened? What are the facts? What decisions were made? Who made them? Who approved them? What plans were made? And what was actually done? Then were all those things following the standard or not?

She suggested that in the chronology of events all the circumstances leading to the kith and kin agreement should be included, in particular all the discussions with the family about the placement.

She repeated this line of questioning in the section on whether the placement in the Section 8/kith and kin home was in the child's best interests, asking:

> Did they or did they not approve this home as a Section 8 home? Did they follow the steps necessary in order to make the assessment that this was an appropriate home for a Section 8? I have serious concerns about the assessment of the home if they approved it. This would not be a home I would approve and my concerns lie in the list of offences.

Nicholas Simons told me that he was surprised by the extensiveness of Catherine Reznechenko's comments:

> What I remember from this period of time is that it seemed to me that I was supposed to start over. I remember thinking – thinking, "What suddenly changed that there are so many changes being recommended", and…includes so many comments that could have been addressed earlier…

He also recalled:

> You know, it almost – I remember thinking they've almost changed it back to my original draft, my first draft.

In her March 1, 2004, email, Catherine Reznechenko tentatively set March 11 to meet with Nicholas Simons and Charlotte Rampanen to go over the recommendations. The meeting did not happen as neither Nicholas Simons nor Charlotte Rampanen was available on that day and on March 12, when Charlotte Rampanen was available, Nicholas Simons was not. In further emails on March 4 and 8, Catherine Reznechenko asked Nicholas Simons about how revisions were coming and pressed him to get a draft back to her before her last day of work.

On March 15, 2004, Nicholas Simons sent Catherine Reznechenko an email with attached tracked draft versions of two sections of the case review. His email stated:

> I know you are probably packing but I thought I'd give you a version of the intake and investigation history in an early draft form (it will need slimming, and you probably want all the "findings" in one section). If you have a chance to look it over, that would be great. I have read your comments carefully, and believe that that this is more in line with your expectations.

The changes to the "Intake" section were drawn, mostly if not entirely, from Nicholas Simons' "April 2003 first draft". The changes answered some of the questions that Catherine Reznechenko had posed. Under each intake, he distinguished the facts from the analysis, by including a "discussion" section. He did not lay the entire fact pattern out first, as Catherine Reznechenko had suggested.

Nicholas Simon summarized his recollection of his involvement at this time as follows:

> …as far as I was concerned by then it was a question of if they wanted to cut and paste and put things in different sections, that was what they were doing. I didn't – I don't remember being involved in rewriting anything at that point.

On March 16, 2004, Catherine Reznechenko sent to a number of people, including Julie Dawson and Jeremy Berland, the rewritten intake and investigation sections that Nicholas Simons had sent to her the day before. She expressed her regret that the case review was not complete and was a very major task that she had to leave behind**.**

Catherine Reznechenko's final email to her MCFD colleagues went on to state her assessment as follows:

> I have had further discussion regarding this review (Nick's latest piece attached) with all of you. I am very sorry to say that this review is not in any shape to take to Usma to set the recommendations. Nick has now sent a summary of the intakes following my meeting with him and extensive edits. What he has sent is only part of the review and he expects to send more shortly. I have told him that a full review should really not be more than 30 – 35 pages. I have also told Nick that Dawn will be his contact.
>
> Next steps: Dawn and Ray will review this rendition and discuss with Clara who has graciously agreed to assist in getting this review to final. It may well be that we have to cut our losses and pull it together ourselves. Nevertheless see what he has given us and hopefully he will send the remainder soon.

Nicholas Simons was also not satisfied with what was happening with the case review, but for different reasons. He recalled for me his perspective of the process at this time:

> It was a frustrating process I remember because I felt like I was rehashing a lot of things that I had done already and, you know, I say I don't get distressed, but the case dragged. It was – like I'd done the work on it and I thought, you know, this was – I didn't want to have to go and dig back into things that I had already done, because it's not a pleasant subject and I felt I had done my – I had done my work.

3. Efforts to bring the case review to completion: March to August 2004

With Catherine Reznechenko's retirement, responsibility for managing the Director's case review fell to Julie Dawson. The idea of starting from scratch, raised by Catherine Reznechenko, was considered by Julie Dawson in consultation with Jeremy Berland. He told me:

> Well, I felt trapped really. We had started down a path with Nick. We'd started to have this review done. He had done all the fact-gathering. It needed to be finished. I didn't want to start a new process and end up having, you know, it taking even longer. … I just thought it needed to get done, and I didn't really have a whole lot of time for sort of fussing around about why it wasn't getting done. I just wanted it to be finished.

Initially, Julie Dawson considered assigning the work of managing the completion of the case review to a practice analyst within the Aboriginal services branch. When that analyst was not available, Julie Dawson decided that she needed to take over direct responsibility herself.

a. Issues between MCFD and Usma

Usma had been led to believe that the Director's case review would be completed within six to twelve months. From September 2003, there were regular emails on file from Charlotte Rampanen inquiring about the status of the case review. By March 2004, Charlotte Rampanen and the Usma workers were already very concerned at how long the process had gone on, and how many people from the provincial MCFD office had been involved with it.

On March 30, 2004, a teleconference was held between MCFD staff, including Julie Dawson, and Charlotte Rampanen and other Usma staff. Usma staff expressed concerns about continuity because of the different MCFD staff that had been assigned to the case review and questioned why it was taking so long. They were informed that the practice analyst would change again and that the case review might have to be redone, by a different reviewer, because its structure was not consistent with other case reviews. Usma staff were very upset with this news.

Charlotte Rampanen was disturbed enough by what was said in the March 30, 2004, teleconference with Julie Dawson to send Simon Read, Director of Nuu-chah-nulth Community and Human Services, an email about her concerns. Although Charlotte

Rampanen reported to Simon Read, he did not have delegated authority under the CFCSA and therefore did not involve himself in case issues. His role, from Charlotte Rampanen's perspective, was with political issues. In her email, she raised with him the possibility of Usma withdrawing from participation in the Director's case review. She also raised the issue of whether Julie Dawson's suggestion of involving Usma staff in developing the recommendations might lead to a legal attack on the objectivity of the case review.

Following up on this email, Charlotte Rampanen spoke directly with Simon Read. For the first time, they spoke about the changing of the terms of reference for the Director's case review and Simon Read stated that it was important that something be put on record right away to protest the changes and the delay in the case review.

These discussions between Charlotte Rampanen and Simon Read led to an April 1, 2004, email from Charlotte Rampanen to Julie Dawson that set out the chronology in the change in the terms of reference and expressed concerns about the delay and lack of the promised partnership in the process. A request was made for a direct meeting to discuss further actions to bring the process to a quick conclusion. A teleconference was arranged that very day between Julie Dawson and Simon Read, Charlotte Rampanen and other involved Usma staff. Julie Dawson agreed to go back and look at the material produced by Nicholas Simons. The Usma workers explained that the fact verification process had not yet happened and Julie Dawson said that she would arrange for Nicholas Simons to do it before the requested meeting. Julie Dawson told me that she also acknowledged the need for closure and conveyed her hope that the case review would be completed by the end of May 2004.

b. The "April and May 2004 drafts"

Julie Dawson met with Nicholas Simons in Victoria on April 6, 2004. They went over her concerns about the state of the draft case review that Catherine Reznechenko had sent out in her concluding email on March 16, 2004, plus some additional parts that Nicholas Simons brought with him to the meeting. Nicholas Simons agreed to do a rewrite in time for the meeting with Usma staff, which was set for April 13, 2004. Julie Dawson told me that she believed Nicholas Simons was very receptive to her suggestions for restructuring the document and that she was left feeling confident he was going to make the necessary changes.

Nicholas Simons produced an April 9, 2004, draft that, with formatting and minor stylistic changes made by MCFD, was taken to the April 13, 2004, meeting with Usma staff in Port Alberni. Julie Dawson, Nicholas Simons, Charlotte Rampanen and Darlene Thoen attended. Charlotte Rampanen and Darlene Thoen pointed out some factual inaccuracies in the draft. Darlene Thoen suggested that more information should be included about the lack of adherence to practice standards in the early intakes in which Usma was involved. She pointed out that this would provide a contrast to the improved practice in the later intakes and would thereby substantiate the reviewer's comment that there had been an improvement over time in Usma's adherence to standards.

Nicholas Simons took notes from the April 13, 2004, meeting. Once again, it was suggested in the meeting that the detailed intakes, up to the one leading to the kith and kin placement decision, should be put in an appendix, with a brief summary in the text of the case review. Following the meeting, Nicholas Simons created a May 2004 draft that he sent to Julie Dawson on May 4, 2004.

c. The "June to August 2004 drafts"

When Julie Dawson received Nicholas Simon's May 2004 draft, she decided to assign a new practice analyst to assist with the Director's case review and the process for preparing recommendations. She informed Charlotte Rampanen of this in late May 2004. Charlotte Rampanen expressed concern that, contrary to prior agreement, yet another person was being brought in at that late date.

Karen Blackman had done quality assurance work in the past, more on the audit than the review side. Soon after she started working in the Aboriginal services branch, she was absent on a four-week course returning toward the end of June 2004. From that time to August 9, 2004, when she left the branch sooner than expected to go to a new MCFD job in the north, she worked primarily on the case review drafts.

Karen Blackman was told that the process had gone on too long, and it would be too disruptive to go back and start again, and that her role was to work with the reviewer and get the case review "out the door". She was not to re-work the whole thing; it was an editing piece.

Karen Blackman's first step was to go through the case review and pick out anything that was glaringly a problem with the language used. She understood that she was to go with the format that was in place even though it was not the same as the case reviews she had read in her audit work. A new draft, titled the "June Draft", with Karen Blackman's edits, was sent to Nicholas Simons on July 6, 2004, for his review.

Nicholas Simons' recollection was that Karen Blackman took an active role in writing and rewriting and that,

> She got into this whole issue long after I had completed numerous first drafts, numerous final drafts in my mind, and this was a point where it was – like it was getting ridiculous.

Karen Blackman and Nicholas Simons met for the better part of a day on July 9, 2004, and discussed the facts in the case review and the recommendations. She told me that her dealings with him were quite cordial and their meeting was not contentious. She was left with the impression that he was fine with her changes.

Nicholas Simons told me that his interactions with Karen Blackman were most civilized, even though dealing with questions he had been through for two years was an irritation for him. He described the July 9, 2004, meeting as follows:

> We were going through the report, and just what I had been doing for three years is going through the report, underlining words, saying elaborate here, shorten there, put this in the appendix, put this out of the appendix, the same thing.

He told me he was frustrated at this point and "wondering whose report is it". As he also put it to me:

> …I would have said in the report if I felt there was direct interference, but there was certainly like, you know, a thousand cuts, you know, that my report underwent a thousand cuts. It was – at a certain point it's like, "Okay, well, we can shave off the mandate, we can cut down the jurisdiction that I have over this report until there's nothing left," because the truth of the matter is there's no template for a director's review. There's suggested format, which I think is specifically for the ease of the reader. My report was very easy to read. I've never had any negative comment about my style or my format, and so I found there was – I found there was unnecessary intervention in my report. And then when it came to the recommendations when I found out that I don't write the recommendations, when it came to writing the précis, the summary, that I don't write the précis. I got a précis back from the Ministry that didn't reflect my work, and I found that was offensive at that point.

The June 2004 draft, in which the intake descriptions relating to the child's family were put back into the main text of the case review, was sent to Usma on July 14, 2004, and a meeting with Usma took place the next day. The meeting included Nicholas Simons, Julie Dawson, Karen Blackman, Charlotte Rampanen and Darlene Thoen. Its purpose was to check some of the facts and begin discussion about recommendations.

At the July 15, 2004, meeting, Charlotte Rampanen and Darlene Thoen pointed out a few, not many, concerns with the accuracy or implications of statements in the draft. Julie Dawson told me that she felt some sense of frustration that facts were still not clear at this late date, and hearing from Charlotte Rampanen and Darlene Thoen brought greater clarity to her about what had happened than she was able to glean from reading the draft case review.

For example, it became clear that Usma workers knew about the male caregiver's criminal record at the time that the decision was made to proceed with a kith and kin agreement, and that they did not think it precluded the placement. An earlier draft had not been clear on this point. After the sessions in July 2004, Karen Blackman went back and made changes, tracking them on the June 2004 draft. The tracked changes were then circulated again.

The overall impressions of Charlotte Rampanen and Darlene Thoen were that this revised draft was an accurate reflection of the facts. The changes to be discussed at the meeting were understood by all participants to be purely for the purpose of getting the facts correct.

The revised draft sent out by Karen Blackman was reviewed in a subsequent teleconference held on July 23, 2004, that included Karen Blackman, Julie Dawson, Gary McDermott, Charlotte Rampanen, Darlene Thoen and Nicholas Simons. Based on some further comments, Karen Blackman prepared a "Final Draft" in which more information was added about practice issues in the early intakes and modifications were made to the background section. Karen Blackman and Usma staff assumed that the factual part of the case review was now complete, and that finalizing the recommendations was all that was left for a completed Director's case review.

As it turned out, when Nicholas Simons read the "Final Draft" prepared by Karen Blackman, he had some concerns and came back with a number of additional suggested changes.

The most substantial change suggested by Nicholas Simons in late August 2004 concerned the summary in the kith and kin section of the case review. On September 1, 2004, he left a voicemail for Julie Dawson about his unhappiness with the cuts made by Karen Blackman to this summary, and sent her his original version. Julie Dawson had some concerns about the wording of this version and did a redraft. Julie Dawson and Nicholas Simons exchanged further emails on the redrafted section in early October and it was put in the January 19, 2005, draft of the case review.

d. Developing the recommendations

In his "April 2003 first draft", Nicholas Simons had included 21 recommendations (See Appendix 14). Catherine Reznechenko had ignored them as being premature. The Director's case review procedures envisioned that recommendations would not be done until the fact finding and analysis had been completed, and then they would be developed through a collaborative, consultative process. The June 2001 protocol, which was referred to in the terms of reference letters for the case review, said this:

> The Manager of Case Review will coordinate the participation of key individuals to develop recommendations relevant to the findings of the *Work in Progress* (i.e. Regional Executive Director, Regional Child Protection Manager, Practice Analyst, and Division Representatives).

Toward the end of July 2004, with the facts and analysis more or less complete, the focus turned to the development of the recommendations in the case review. The July 23, 2004, teleconference between MCFD, Usma and Nicholas Simons was intended to begin the process of collaboratively developing the recommendations. On July 13, 2004, Karen Blackman had produced three draft recommendations and on July 19, 2004, Nicholas Simons faxed to the teleconference participants 21 draft recommendations, most of which had been contained in his "April 2003 first draft".

Jeremy Berland told me that MCFD's criteria for case review recommendations are:

- They must be based on the findings in the case review.

- They should be something new that is not already in policy ("follow policy" is not an acceptable recommendation).
- They should be achievable within the area of responsibility of MCFD.
- They should be directed to a person to do something within whose area of responsibility that "something" is.
- They should be understandable so that people could grasp why, in relation to these facts and these findings, that recommendation should be enacted.

Nicholas Simons' 21 draft recommendations did not, for the most part, meet these criteria. He told me that he never fully accepted the criteria, although he was told about them during the recommendation development process in July and August 2004, and later when the final version of the recommendations was settled on in April 2005.

Nicholas Simons explained to me that he had been under the impression that in doing the case review he was also responsible for making the recommendations. His explanation for this is that, "he was never provided with the Director's case review policy". He told me, in his interview:

> Well, I assumed I'd write the recommendations absolutely. I mean, I'm the one that did the review. How else could it be? The explanation to me was, "Well, we take the recommendations out of the report. They come directly from the report." And I say, "Well, even the order of the recommendations should be up to the reviewer." And they were changing – the order of recommendations were changed. The number of recommendations was changed. In fact some with my consent and some without my consent.

At the July 23, 2004, teleconference, Nicholas Simons' recommendations were "stream-lined". It was agreed that some were "observations" rather than recommendations, although Nicholas Simons was not happy about this categorization of what he felt were his "systemic recommendations". The following are two examples of Nicholas Simons' recommendations that were considered to be more observations than recommendations:

> 1. Complex tri-partite financial and policy arrangements exist between the Federal, First Nations and Provincial government that may lead to confusion over which level is legally and financially responsible for various practice decisions.
>
> 5. Criminal investigations are secondary to child protection investigations and as such all professionals and government agency representatives, including coroners and law enforcement officials must be reminded of their Section 14 obligations in order to prevent children from remaining in obviously dangerous situations.

Other recommendations were questioned because it was not clear who would be responsible for their implementation as neither MCFD nor Usma had the authority to do so. For example:

> 4. Comprehensive funding to support new initiatives should be a consideration when enacting new legislation, new standards are implemented or when new policies are approved.
>
> 15. Family support workers who are not employees of Agencies but who work in communities without full-time delegated workers should be required to undertake delegation training.

Following the July 23, 2004, teleconference, Karen Blackman circulated further progressively revised drafts of the recommendations on July 27, July 29, August 3 and August 9, 2004.

Two recommendations appear in these drafts that were considered by provincial MCFD staff as "standard" for Director's case reviews. They were drafted by Karen Blackman on July 13, 2004, and were not in Nicholas Simons' "April 2003 first draft" recommendations. They were:

1. The Agency will review with their staff the Aboriginal Operational and Practice Standards and Indicators related to investigation specifically Standards #4 -#20 of level 15 delegation.

2. The Agency will review their protocol with MCFD to ensure that there are no barriers to good communication between the Ministry and Agency.

Usma staff had questioned one of Nicholas Simons' recommendations in the July 23, 2004, teleconference because of their concern about how its implementation would be funded. It read:

> Social workers should request a medical examination as a matter of course for all children who have been subject of child protection concerns or are living in a home where domestic violence or persistent alcohol abuse is likely.

This recommendation was changed to:

> MCFD should review policy regarding out of care options to determine whether medical examination should be completed on all children living in out of care placements as a result of a child protection intervention.

The recommendation requiring social workers without delegated authority under the CFCSA or family care workers to take social worker training was changed to:

> The Ministry and the agencies should develop training for family support workers regarding reporting responsibility and working with delegated agencies.

In her August 9, 2004, email, Karen Blackman asked for immediate feedback on the, by that time, 12 recommendations and said that the final revisions for the case review would be sent out in the next day or two. On August 10, 2004, Nicholas Simons responded with another draft of the recommendations in which he changed their order slightly and added a thirteenth one:

> Where the *Child, Family and Community Service Act* (*CFCSA*) is in conflict with any other legislation the CFCSA shall take precedent.

In his email of August 10, 2004, Nicholas Simons commented that he thought he "should maintain discretion over this" and said that he would be reviewing the entire document shortly.

4. Action and inaction: September 2004 to March 21, 2005

a. Expectations at the end of August 2004

The expectation of all those working on the changes to the Director's case review and its recommendations in the summer of 2004 was that they were essentially complete by the end of August. In the later part of that month, in response to a question from Darlene Thoen about the remaining process, Gary McDermott set out his expectations for the timelines. He said that the draft recommendations would go to Jeremy Berland for his signature, the draft case review including the recommendations would then go for review by the MCFD Executive Audit Committee and would become final. He expected these steps to be completed by the end of September, at which point the recommendations would go to Usma and it would be given 30 to 40 days to formally respond to them.

b. Minimal activity from September to December 2004

These steps were not followed within the time frame suggested in Gary McDermott's email. (The review by the MCFD Executive Audit Committee never occurred.) In fact, there was not much activity between September 2004 and January 2005. I was not able to establish a clear reason for this.

On October 5, 2004, Julie Dawson did the first draft of the summary. On the same day, the male caregiver, who had pleaded guilty, was sentenced in the death of the child. Jeremy Berland told me that it would have been inappropriate to publicly release the case review summary until after the sentencing had been complete and the appeal period had expired. In any event, the Director's case review was not completed or signed off nor was the summary prepared by early October.

On October 26, 2004, Julie Dawson and Gary McDermott met and one of the topics for discussion was the recommendations for the Director's case review.

At the beginning of November 2004, Julie Dawson sent the latest draft of the case review to Thomas Weber for his feedback. He suggested minor changes, some of which were incorporated.

In an email dated December 2, 2004, responding to an email inquiry from Charlotte Rampanen, Julie Dawson, after apologizing for the delay, told her that the recommendations were with Gary McDermott who would be forwarding them to Jeremy Berland for his review. Charlotte Rampanen sent another email in early January 2005 wondering what was happening. Again Julie Dawson apologized for the delay and said that the case review was with Jeremy Berland.

c. The Executive Audit Committee step

With respect to the Executive Audit Committee step, the Director's case review procedures referred to a review of the "Work in Progress" (the reviewer's list of issues, verified facts and analysis with findings) by the Child, Family and Community Service Executive Audit and Review Committee, made up of senior representatives from all divisions of MCFD. The purpose of this step was to ensure that the case review adequately addressed the issues identified in the terms of reference and to assess whether the recommendations were adequate relative to the findings. Once approved by that committee, the "Work in Progress" becomes the Director's case review.

At the end of September 2004, Julie Dawson had a discussion with Jeremy Berland about sending the Director's case review to the Executive Audit Committee. He told her that it did not have to go through that step. The reason given by Jeremy Berland was that it had no mental health or youth justice or broader implications, but was essentially dealing with issues within the MCFD Children and Family Services Division, which was his area of responsibility.

Jeremy Berland told me that by this time, an Executive Audit Committee review was no longer part of the Director's case review process. According to him, that process, when it was used, was seen not to work well. The Executive Audit Committee review had not been done in the case review involving the other Aboriginal delegated agency either. In fact, there had been very few Directors' case reviews during this time period.

d. January to March 21, 2005

A further draft of the case review was created dated January 19, 2005, and Julie Dawson and Jeremy Berland had a meeting on January 24 in which this draft was discussed. Jeremy Berland told me that this was the first version he had seen and that by this time he was feeling the pressure of the deadline of getting the matter out before the provincial election in May 2005. He had told at least one reporter that the case review summary would be released in late 2004. Although he was not entirely happy with the contents, he felt that the "January 19, 2005" draft was "reasonably okay".

In the meeting with Julie Dawson, Jeremy Berland gave her direction to follow up with Nicholas Simons on one item of concern for him in the draft. He considered the conclusion in the case review to be wrong that the kith and kin policy was introduced to reduce costs. In this context, Jeremy Berland and Julie Dawson raised an issue that they had discussed many times before about whose review a Director's case review was. How does a Director under the CFCSA deal with findings or recommendations that he does not agree with, given that the case review is his and he has to sign it? They also discussed the inclusion of some of Nicholas Simons' earlier systemic "recommendations" as "reviewer's observations" in an appendix to the case review. This would be a way of not discarding them but taking them out of the recommendation section, which was more geared to specific recommendations to specific officials. In this way, Jeremy Berland would not have to sign off on them, but they would be included in the case review document.

The "January 19, 2005, draft" was sent to Usma on January 26, in time for a teleconference the next day that included Gary McDermott, Nicholas Simons, Charlotte Rampanen and Darlene Thoen. Julie Dawson did not participate because she was away at the time. This draft reflected the changes that were made in July and August 2004, including Nicholas Simons' feedback. It also included the 12 recommendations and the reviewer's observations. Some minor changes were suggested at the January 27 teleconference.

At their meeting on January 24, 2005, Jeremy Berland and Julie Dawson also discussed the steps necessary for finalization of the case review and the public release of a summary. These steps included discussing the completed case review with Usma and preparing Usma staff for the public release of the summary; sharing the summary with the family and preparing them for its public release; and, making arrangements with the Nuu-chah-nulth Tribal Council for a joint public release event.

The meeting of Jeremy Berland and Julie Dawson with Usma staff to discuss the completed case review and go over the plans for public release of the summary did not occur until March 22, 2005. When I asked Charlotte Rampanen what she understood was happening between the end of January and the March 22 meeting, her recall was that people were away. She told me that she was away for 10 days, Darlene Thoen was also away for a time during that period, and she thought people from the MCFD office were away as well. Jeremy Berland told me that he was on holidays for the last part of February and then at a conference in the beginning of March.

On February 24, 2005, prior to his holidays, Jeremy Berland met again with Julie Dawson and they discussed the Director's case review and themes it raised that reflected issues within some remote and isolated communities, such as: lack of adequate investigation; lack of consideration of historical information; lack of ability to deal with prevailing problems of mental health, substance abuse and family violence; lack of follow up; and, lack of communication.

By early March, the changes from the January 27 teleconference had been incorporated and Jeremy Berland had approved but not signed the new draft. It was circulated on March 4, 2005. Arrangements were made for Jeremy Berland and Julie Dawson to go to Port Alberni to meet with Usma on March 22, 2005.

5. The final phase: March 22 to July 21, 2005

a. Meetings between MCFD, Usma and Nuu-chah-nulth Tribal Council officials

Julie Dawson told me that her impression was that Usma staff were looking forward to the March 22, 2005, meeting and that they were prepared to accept responsibility for errors in practice on their part and move forward from there.

The meeting included Simon Read, Charlotte Rampanen, Darlene Thoen and other staff involved in the case. By all accounts, it was not an easy meeting. Jeremy Berland did most of the talking. He told me that he felt that Usma staff needed to be prepared for the kind of criticism that was likely to come when the case review summary was released. His words were received as being highly critical of Usma's practice (much more so than was the Director's case review itself). He made a statement to the effect that, in other situations like this, "heads would roll". Usma staff took this as an implication that they should have been disciplined. Jeremy Berland expressed his unhappiness with the case review itself, making negative comments that Usma staff had not heard from MCFD staff throughout the two and a half years that the case review had been underway. He also spoke about some of the themes that he and Julie Dawson had discussed at their February meeting. Charlotte Rampanen, Simon Read and perhaps others who were present took some of Jeremy Berland's remarks to be disrespectful of Aboriginal communities. Jeremy Berland said that he would be talking to the Aboriginal provincial leaders about these issues.

There was a discussion at the meeting about supporting the late Nuu-chah-nulth child's family and advising them about the public release of the case review summary. It was suggested that Usma staff meet with the family first, and Jeremy Berland offered to speak to the family after that if they wanted. Some of the questions that would be raised publicly were discussed. Jeremy Berland raised the fact that the public release of the case review summary had to be before April 19, 2005, when the provincial election was to be called.

Simon Read recalled to me that Jeremy Berland stated his preference to release the case review summary before the election, if that was possible, and Simon Read's reaction to this was that it was a very busy time for their office as it was the fiscal year end and it would be difficult to do all the briefing and media preparation in such a short time. Charlotte Rampanen raised the difficulty of notifying the child's family properly in that time frame. Jeremy Berland recalled that more issues were raised that suggested to him this was not the best time, from the family's perspective, for public release of the case review summary.

Charlotte Rampanen told me that the March 22, 2005, meeting was very upsetting for her and Usma staff. She said that she tried to respond to Jeremy Berland at the time, but did not think that she was getting through to him.

Jeremy Berland told me that he was fairly pleased with the meeting when he left it. He knew that he had been blunt about the fact that what had happened was an example of poor practice, but he felt that he had balanced this with acknowledging that Usma's practice had improved over time. He told me that he was deliberately hard in what he said in order to prepare Usma staff for the tough questioning of their practice that would follow the public release of the case review summary.

Julie Dawson told me she was surprised by the strength of Jeremy Berland's statements at the meeting. On the way back to Victoria, she told him that he had been too hard on Usma staff. Jeremy Berland listened to her and suggested that perhaps they should make arrangements to go back. That evening he called Charlotte Rampanen to say that he would like to meet again because he thought what he had said had not come across the way he meant it.

The next day Charlotte Rampanen spoke to Simon Read about this request. Usma staff were somewhat resistant to the thought of another meeting with Jeremy Berland. Charlotte Rampanen contacted Shawn Atleo to say that the staff would not feel comfortable having such a meeting unless he, Shawn Atleo, were present. Since May 2003, Shawn Atleo had been one of the three co-chairs of the Nuu-chah-nulth Tribal Council and he was the chair with particular responsibility for community and human services, including those provided by Usma. He also had experience as a facilitator.

Around this same time, Usma staff requested and were granted a meeting with Florence Wylie, Executive Director of the Nuu-chah-nulth Tribal Council. The staff wanted to respond to the statements made by Jeremy Berland. Shawn Atleo was brought into that meeting. Charlotte Rampanen was not present because she was away. Usma staff went over their concerns about the meeting with Jeremy Berland. Shawn Atleo told me that he felt supportive of Usma staff on the basis of what they told him at the meeting. He described being quite concerned about what he perceived was not a healthy two-way communication between MCFD and Usma. It seemed to him that MCFD officials lacked appropriate respect in the way that they had handled the Director's case review. He felt he had a responsibility to do what he could to facilitate a more respectful and collaborative relationship.

Arrangements were made for a return visit of Jeremy Berland and Julie Dawson to Port Alberni on April 1, 2005. Florence Wylie and Shawn Atleo attended, in addition to the participants at the first meeting. Shawn Atleo facilitated the meeting and set a respectful tone. Julie Dawson described it to me as something of a reconciliation meeting. At the beginning, Usma staff were not present and Jeremy Berland went over the Director's case review in detail with Simon Read, Florence Wylie and Shawn Atleo. They discussed difficulties around using professional judgment and knowing when to make hard decisions; the need to have training and experience and knowledge of the

family history and dynamics, alcohol and drug issues and violence, as well as policy and standards; and, the issue of how much to allow decision-making by parents whose capacity for making good decisions was at issue.

When Usma staff joined the meeting, they expressed their distress at what Jeremy Berland had said at the previous meeting. Jeremy Berland explained why he had said what he said and made some conciliatory statements, including that he saw no grounds for disciplinary action against the staff. After the meeting, Jeremy Berland and Julie Dawson attended a lunch held by the Nuu-chah-nulth Tribal Council to honour foster parents. Shawn Atleo had made a particular point of inviting them to the lunch as an opportunity to be welcomed and to spend time with Usma staff. To Jeremy Berland's surprise, he was given the gift of a print.

b. The provincial election

Minister Hagen, Deputy Minister Alison MacPhail and Jeremy Berland all told me that with respect to the Director's case review, Minister Hagen dealt directly with Jeremy Berland.

Jeremy Berland told me that he came to the meetings with Usma with the perspective, shared by the Minister, that they had to "get it [the case review] out" as soon as it was appropriate to do so even if that was before the election. He also told me that at no time he felt pressure to delay this case review for political reasons.

Minister Hagen told me that his specific recollection of this Director's case review did not begin until the time arrangements were being made for the public release of the summary. He said he may well have been briefed about the case review by Jeremy Berland at earlier stages, but does not recall it was an issue requiring his attention until about a month or so before the public release of the summary in July 2005.

At the March and April 2005 meetings attended by Jeremy Berland and Julie Dawson in Port Alberni, Charlotte Rampanen and Simon Read both expressed the view that getting the child's family and the Nuu-chah-nulth Tribal Council ready for public release of the Director's case review summary by April 19, 2005, was going to be too rushed. So by the beginning of April, the idea of a public release before the provincial election campaign began was dropped.

Jeremy Berland was very clear to me that public release of the Director's case review summary in the middle of a provincial election campaign was not an option he was prepared to consider. He told me that it was a basic operating rule for senior public servants that ministerial actions had to be kept at a minimum during an election campaign, as ministers were no longer members of the Legislative Assembly and their ministerial duties were expected to be restricted to essential things that have to be done in order to keep the province running. It was particularly important not to involve ministers in anything overtly political that could wait until after the election. In Jeremy Berland's opinion, there was nothing urgent about this public release.

Jeremy Berland told me that it would have been inappropriate for him, as a senior public servant, to decide to drop what might be a political "bombshell" into the middle of the election campaign. Even though the public announcement of the Director's case review in the lead up to the election might have had the same effect, at that point the minister had full responsibility and authority, and therefore the potential effect on an election campaign would not be a relevant factor.

Deputy Minister Alison MacPhail agreed that public release of the case review summary should not be done in the midst of an election. She provided me with an April 19, 2005, memorandum that she wrote to all MCFD staff. She explained that this was a standard memorandum that all deputies sent to their staff. It reads, in part:

> Through this election period, Cabinet ministers remain in office as caretakers and act only in emergencies. All deputy ministers have the power to act for their respective ministers, with the exception of the ability to enact regulations. MLAs vacate their seats and are no longer MLAs….
>
> Ministries are restricted from making announcements or new financial commitments during the election period….

c. The finalized case review and summary

After the meeting on April 1, 2005, in Port Alberni, at Jeremy Berland's suggestion, Julie Dawson did some further work on the recommendations in the case review so that the person responsible for implementation, either the provincial Director (Jeremy Berland) or the Director of Usma (Charlotte Rampanen) was clearly stated in relation to each recommendation. She circulated these revised recommendations on April 14, 2005.

Nicholas Simons, by an email to Julie Dawson, objected to the deletion of the recommendation that he had added on August 10, 2004:

> Where the *Child, Family and Community Service Act* (*CFCSA*) is in conflict with any other legislation the CFCSA shall take precedent.

This recommendation did not fit the case review recommendation criteria, as it was a restatement of the law, and did not appear in the final Director's case review recommendations (See Appendix 15).

Also, another draft of the summary of the case review was done, at Jeremy Berland's request, to make it more concise. Julie Dawson sent this revised summary to Nicholas Simons who provided feedback. As a result, some cuts were reinstated, in particular a list of reasons why Usma chose the kith and kin agreement option. Nicholas Simons told Julie Dawson that he thought the list was incomplete. At the same time, Jeremy Berland was asking Julie Dawson to make the summary less detailed. The final version described the reasons for choosing the kith and kin option as including:

the belief by the agency that there was no history of child protection involvement with the caregivers; the placement was a "less intrusive" measure than removal but would still have allowed social workers to monitor the situation; and the family supported the plan for a placement with the caregivers.

The final version of the case review was dated April 26, 2005, and Jeremy Berland signed off on May 9, 2005. The election was on May 23, 2005, and the Director's case review summary was publicly released on July 21. Jeremy Berland acknowledged to me that it sat on his desk for a couple of weeks because he did not want to sign off until the summary was near to public release.

d. Comparing the final product with earlier drafts

Nicholas Simons told me he wanted to make it clear that no changes were made to the Director's case review without his knowing, but he did not necessarily agree with those that were made. He saw the changes that were being suggested by MCFD as primarily structural and stylistic. At the same time, he told me that he thought the final product watered down some of the points he wanted to make, particularly the systemic ones.

The following compares and contrasts the final product with the early drafts in April and August 2003:

- The structure is more or less the same in that no narrative chronology or section on facts followed by a section on analysis was ever developed. (Nicholas Simons believed that the chart chronology, which he developed early on and which he included as an appendix in his "April 2003 first draft" and his "August 2003 final draft", met the requirement of a chronology. It was not attached to the final case review.)

- The commentary on the fact that three of the caregivers' intakes were actually about the child's mother, and were therefore misfiled by MCFD, was deleted from the final product on the basis that it was a comment outside the terms of reference which, in their final form, did not include review of MCFD intakes on the caretakers' files. A summary of each of these intakes was included in the finalized case review as an appendix, with sufficient information for a reader to pick up this point.

- Missing from the discussion in the final product of each intake related to the child's immediate family are Nicholas Simons' comments about the other factors that might have had an impact on the worker's decision even though not noted on the documentation, and his comments about the difference between determining compliance with standards and assessing what factors may effect practice rendering it "good" or "bad" practice in the circumstances. Much of this appears in the "context" section of the final product.

- Missing from the final product is Nicholas Simons' critique of the kith and kin policy, which he continued to have doubts about as a policy. The rationale for deleting this section was that the purpose of the case review was to look at practice in relation to accepted policy; the kith and kin policy was an accepted policy and the reviewer was not being asked to question the policy.

- The final recommendations were specifically directed at the provincial Director or the Director for Usma, and the generalized ones were not included. Some of Nicholas Simons' original "systemic" recommendations were moved to an "Observations" section in the final product.

- The part about cost saving to MCFD being a factor was included in the final product, despite Jeremy Berland's objection to it, which he told me he dropped because he did not want to cross the line of what was appropriate interference on his part as director with findings of fact of the reviewer.

e. Public release of the case review summary

In September 2003, when the completion of the Director's case review relating to the other Aboriginal delegated agency was publicly announced, there was a joint press conference of Gordon Hogg, the then Minister of Children and Family Development, Jeremy Berland, the provincial Director under the CFCSA, and a spokesperson from the First Nation involved. Given the tensions around the Director's case review relating to the late Nuu-chah-nulth child, the Nuu-chah-nulth Tribal Council and Usma were initially not certain that they wanted to work with the government in this way, but they decided to go ahead and that Shawn Atleo would be their spokesperson.

It was clear to me from documents I reviewed and from what a number of individuals, including Minister Hagen, told me in their interviews, that the time between the appointment of a new minister on June 16, 2005, and the public release of this Director's case review summary, was attributable to difficulty in finding a date that worked for both Minister Hagen and Shawn Atleo. Shawn Atleo's role as Regional Chief of the Assembly of First Nations meant that he was often traveling outside British Columbia. He was in fact out of the province in the days preceding the joint press conference on July 21, 2005.

G. Observations About the Director's Case Review

One of the functions of the Child and Youth Officer under section 3(1) of the *Office for Children and Youth Act* is to provide independent observations and advice to government about the state of services provided or funded by government to children and youth in British Columbia. One of the means by which my mandate to observe and advise is accomplished is through investigations and reports under section 6 of the *Office for Children and Youth Act*. With respect to the Director's case review relating to the late Nuu-chah-nulth child, the Attorney General requested me under section 6 to

conduct an investigation and report to him with respect to the following specific terms of reference:

1. Why the terms of reference for the Director's case review were changed.
2. The timelines involved in the writing, completion and release of the Director's case review.
3. Review the policy concerning a Director's case review, including those where a kith and kin agreement has been applied, and make any recommendations necessary as a result.

My terms of reference were expanded, at my request, to include any other matter I deemed relevant to a full consideration of the Director's case review process relating to the late Nuu-chah-nulth child. When information came to my attention that I deemed relevant but was not necessarily strictly tied to the changing of the terms of reference or the timelines, I incorporated it into my narrative and observations.

My terms of reference also requested me to consider whether the timelines, the change in the terms of reference, or any defect in the Director's case review may have materially affected its outcome and, if so, to review whether the outcome was materially affected and make recommendations to address any such impacts. This part of my terms of reference will not be addressed in this report as I asked not to report on it until March 31, 2006, so I could take into account any relevant information that might come out in the Coroner's public inquest into the death of the Nuu-chah-nulth child, which started on February 6, 2006, and is still underway at this time.

My report has now recounted, based on what I saw and heard in my investigation, the substance of the story of this Director's case review and the perspectives of those involved in it. In this section, I turn to providing my observations to government about the Director's case review process as it unfolded in relation to the late Nuu-chah-nulth child. In the section that follows this one, I conclude my report by making recommendations for MCFD's Director's case review process.

My overall observation is that the story of this Director's case review is one of significant organizational failure to accomplish what was intended. I heard and reviewed nothing that indicated conspiracy or cover-up by anyone involved. I did, however, observe a process, which many well-intentioned individuals recognized was of great importance, that went far off track and produced, after more than two and a half years, a final product that did not really satisfy anyone involved and was not dramatically different than a draft produced by the reviewer in August 2003.

How, despite the considerable resources put into it, could the Director's case review process so little fulfill its purpose for efficient organizational learning from the tragic circumstances of the death of the Nuu-chah-nulth child? Why did MCFD not recognize and adapt a lot earlier to the reality that its view of the case review purpose and process was not the same as the reviewer's? In April 2004, when MCFD more or less decided to

go with the reviewer's work, and not to take control itself or start again, why was the final product still such a long way off? What went wrong from an organizational point of view?

1. Changing the initial terms of reference

a. The changes made

The second term in the initial terms of reference for the Director's case review, which asked whether MCFD's response to child protection concerns associated with the caregivers' family was consistent with established standards, was deleted in the revised terms of reference. The effect of the deletion was that the reviewer did not undertake a practice review of the historical intakes related to the caregivers' family and involving MCFD Vancouver Island region. (For an explanation of what an intake is, see page * of this report.) Nevertheless, the reviewer was aware of those intakes, noted them in the case review itself and took them into account with respect to the term of reference for the case review regarding information sharing between the MCFD Vancouver Island region and Usma.

The last term in the initial terms of reference asking whether the information sharing process between the MCFD Vancouver Island region and Usma was adequate to ensure the safety of the late Nuu-chah-nulth child and her sibling in the kith and kin placement, was revised to add the words "with particular respect to the sharing of information regarding the [caregivers'] family". Nothing in my investigation suggested that the addition of this phrase had any effect on the case review.

b. Authority to make the changes

Two Directors under the CFCSA, David Young, the provincial Director and Jane Cowell, the regional Director for Vancouver Island, together made the decision to revise the initial terms of reference, not long after the initial terms of reference had been conveyed in a letter from David Young to Usma.

To the extent that this Director's case review was going to look at regional MCFD practice, the relevant Director under the CFCSA was Jane Cowell, the Director for the region. To the extent that it was going to look at the practice of Usma, the Aboriginal delegated agency, the relevant Director was David Young, the provincial Director.

Given that the terms of reference for this Director's case review were intended to cover all relevant issues related to the death of the Nuu-chah-nulth child and that those issues covered both Usma practice and MCFD practice within the Vancouver Island region, the wording of the terms of reference was appropriately a joint decision of the provincial and regional Directors under the CFCSA.

c. Role of Usma

The MCFD Director's case review procedures stated that terms of reference were established by the Director's office in consultation with regional management. There was nothing in the procedures about how this consultation would be conducted when an Aboriginal delegated agency was involved. Aboriginal delegated agencies do not have the managerial layers that exist within MCFD so the reference to consultation with regional management was not helpful.

Jeremy Berland's efforts in September 2002, on behalf of the provincial MCFD, to involve Usma in discussions about the terms of reference were a consultation that was consistent with the spirit, if not the words, of the Director's case review procedures. This consultation was also consistent with prevailing MCFD policy and the Memorandum of Understanding between the provincial government and Aboriginal organizations within the province, which recognized a joint responsibility for the protection and care of Aboriginal children.

Although there was no indication of active intention to exclude Usma, the failure to bring Usma into discussions about the changes to the terms of reference made something of a mockery of the "spirit of partnership" words in both of the terms of reference letters to Usma. There was nothing wrong with reconsidering the terms of reference in response to a legitimate issue raised by the region. However, to do so without consulting Usma was an organizational failure to carry through with the steps that had been taken to consult Usma in the first place.

d. Reasons behind the changes

The decision to change the initial terms of reference was a judgment call by three very experienced child protection officials. Specifically, the changes to the initial terms of reference were made at the suggestion of Thomas Weber, the regional manager with day-to-day responsibility for the delegated exercise of the regional Director's authority under the CFCSA, and with the agreement of the provincial and regional Directors, David Young and Jane Cowell.

Thomas Weber had not been given an opportunity to express his views on the initial wording of the terms of reference until after the letter confirming them had been sent to Usma. His assessment was that their scope was unduly broad with respect to looking at MCFD practice within the region. He made that assessment after looking at the MCFD summary of each of the region's intakes related to the caregivers' family. He concluded that the practice surrounding those historical intakes, on their face, had no direct causal connection with Usma's decision to place the child in the caregivers' home and, therefore, did not warrant specific inclusion in the terms of reference for the Director's case review. He recognized that the question of information sharing between MCFD and Usma about these historical intakes was relevant and made a judgment that the final term of reference was adequate for consideration of those intakes.

The Director's case review procedures said nothing about the appropriate scope of the terms of reference. The varying views I heard on the subject suggest that there is no single "right" answer to how broad in scope terms of reference for a Director's case review should be. There is good sense in the notion that the terms of reference should focus the case review on the practice related to the outcome in the case. The argument against "scope creep" is also compelling.

The changes to the initial terms of reference resulted in less scrutiny of the practice surrounding MCFD past interactions with the caregivers' family. A judgment that this scrutiny was not directly relevant to what should be the focus of the case review, and that the relevant issue of information sharing between the region and Usma was addressed by the final term of reference, was reasonable in the circumstances. There was no indication in what I saw or heard that protecting MCFD from scrutiny was a factor in the changes to the initial terms of reference.

e. Better-designed terms of reference

While deletion of the second term in the initial terms of reference resulted from professional judgment based on reasonable considerations, the question remains whether the final terms of reference were designed well, in their entirety, to focus the case review on the relevant facts.

The first and second of the initial terms of reference were parallel and, as Jeremy Berland pointed out, it is difficult to see the justification for deleting the second term of reference and leaving the first one in as it was. What applied to the relevance of the practice related to MCFD's historical intakes with the caregivers to Usma's decision to place the children, would also apply to the relevance of some of Usma's historical intakes with the child's parents. When MCFD reconsidered the initial terms of reference, they could and should have considered changes that would have better focused the whole case review. Better-designed terms of reference would have deleted both the first and the second terms of the initial terms of reference and reframed the remaining terms to ensure a focus only on MCFD and Usma practice that had potential relevance to the outcome in the case.

I agree with Jeremy Berland that the fewer terms of reference the better. Simply stated terms of reference allow the reviewer to zero in on the core practice issues that relate to the outcome in the case. For this case review, a generalized question about the practice (both MCFD's and Usma's) that affected the kith and kin placement decision would have directed the reviewer to assess the relevance of past intakes of both MCFD and Usma. As he learned more in the course of his investigation, the reviewer could then have looked in depth at the practice surrounding those intakes if, but only if, that practice was potentially relevant to the outcome.

The changes that were made to the terms of reference only partly dealt with the lack of relevant focus of the initial terms of reference. Better-designed terms of reference would have resulted if the consultation leading to the change had included Usma staff,

as well as more of those within the provincial MCFD who had considerable experience and expertise in case reviews and who so forcefully expressed to me their opinions about the appropriate scope of the reviews.

2. Timelines in producing the Director's case review

My first observation about the timelines for producing the Director's case review is that more than two and a half years is an unconscionably long time for a process the primary purpose of which is to provide organizational learning about case practice. No one I interviewed was satisfied with the time it took to produce this Director's case review. No one told me that that much time was required or was acceptable. So why was a case review that was expected to be done in the spring or summer of 2003, December 2003 at the outside, not ready for sign off until April 2005 and a summary not publicly released until July 2005?

My second observation in this area is that, in all that I reviewed and heard, there was no indication of anyone's intention to sabotage the efficient completion of the Director's case review and release of the summary. The only decision that was truly intended to delay the process was the decision, made as the case review was finally ready for sign off, not to make a public release about it during the election campaign. That decision was made to comply with government policy concerning public announcements during an election. So, if, with that one exception, there was no active intention to delay, how can the time taken be explained? How did things get so far off track? I observed, and will now discuss in turn, a number of causes that, except for the election period, were interrelated:

- Uncertainty over "ownership" of the Director's case review
- Poor communication of MCFD's expectations of the case review structure
- Inadequate training and supervision of the reviewer by MCFD
- Cross-purposes of the reviewer and MCFD
- Periods of minimal productive work
- Turnover of MCFD managers
- The 2005 fixed-date provincial election

a. Uncertainty over "ownership" of the Director's case review

Nicholas Simons, who MCFD had contracted to do the information gathering, fact verification and writing up and analysis of the facts, believed that the Director's case review, including the recommendations, was "his" case review. As reviewer, he saw himself in a role with considerable independence from MCFD. Over time, he came to believe that the way MCFD was managing the case review was becoming an interference with "his" review. This view of reviewer ownership of the case review,

including the recommendations, was not consistent with MCFD's concept of the Director's case review process.

The very name the "Director's case review" conveyed that the case review was the Director's.

Having said that, even in the Director's case review procedures and within MCFD, there was considerable uncertainty surrounding the question of who owned a Director's case review. The case review procedures, for the most part, referred to the individual doing Nicholas Simons' job as the "practice analyst". However, the term "reviewer" was used in the suggested template that Nicholas Simons received, in some places in the 2003 procedures, in the terms of reference letters, and to identify Nicholas Simons on the front of the final case review. There is a potential for confusion in the use of the term "reviewer". "Practice analyst" suggests a limited role and one focusing on the review of practice, more consistent with what MCFD officials told me they were expecting from the reviewer in this case. "Reviewer" leaves an impression of an element of ownership of the case review in combination with, or even to the exclusion of, the Director.

Uncertainty existed on the part of various MCFD managers about the appropriate level of involvement of the Director and his staff in the work of the reviewer. That uncertainty was also reflected in parts of the Director's case review procedures. On the one hand, the practice analyst/reviewer worked under the supervision of an MCFD manager; on the other hand, the procedures said that the Director could suggest edits to facts but could not change or alter the findings of the case review. When does supervision end and interference with findings begin? How useful is an internal review if the Director cannot ask hard factual questions of the practice analyst/reviewer or challenge the factual underpinnings or logic of the factual analysis?

With respect to who makes the recommendations, the Director's case review procedures were clear that their development was a collaborative process, but less clear about whose recommendations they were. The distinction in the procedures between the "Work in Progress" and the "Director's case review" implied that it was the practice analyst/reviewer's responsibility to do the "Work in Progress" and the Director's responsibility to sign off on the recommendations after input from the managerial level within MCFD. It was not clearly stated that the recommendations were the Director's as the official with statutory responsibility.

The differing understanding of MCFD and the reviewer with respect to the development of the recommendations did not, in itself, significantly extend the timelines, as Nicholas Simons did not resist MCFD's leadership in the recommendation development process. It did, however, increase his concern that MCFD might be trying to water down "his" case review, and it fuelled the overall climate of miscommunication. As I observe below, this climate of miscommunication, which was frustrating all round, contributed significantly to the time it took to produce this Director's case review.

Lack of clarity about ownership of the Director's case review also contributed to MCFD managers being less direct, and less directive, than was warranted with the reviewer about their expectations of his work. This protracted the writing of the case review. It also, somewhat astoundingly given all the dialogue, meetings, suggestions, comments, drafts and redrafts that happened with respect to the facts, analysis and findings in the case review, contributed to an ultimately hands-off approach by MCFD to all but the recommendations in the final product.

b. Poor communication of MCFD's expectations of the Director's case review structure

This lack of directness and direction by MCFD was one aspect of another cause of delay: the poor communication of MCFD's expectations of how the case review should be constructed with transparent analysis. Nicholas Simons believed that it was for him, as an independent reviewer, to decide how to conduct the case review, provided he stayed within the terms of reference. He considered the suggested template given to him as a guide, and not a reflection of any strict approach that MCFD expected its reviewers to follow.

The provincial MCFD staff I interviewed had strongly held views about the proper analytical content for Director's case reviews. The persistent theme that the case review should start with a chronology was really another way of saying that the reviewer needed to demonstrate how he reached his conclusions by setting out the relevant facts in an orderly way before moving on to logical analysis of those facts and clearly stated findings that flowed from the facts and the analysis.

The series of MCFD staff assigned to this Director's case review never managed to get across to Nicholas Simons that their concerns about the case review were about substance, not just about form. They never successfully conveyed to him that the chronological chart which he had included as an appendix in the early drafts of the case review was not, from their point of view, an adequate substitute for a systematic setting out of the facts, leading to the logical analysis of these facts and conclusions, and then to recommendations that were demonstrably connected in a logical way to the facts and conclusions.

This failed communication on such a central drafting issue led to redrafting exercises that exasperated everyone. From Nicholas Simons' point of view, MCFD was unduly obsessed with form. From MCFD's point of view, Nicholas Simons' redrafts did not accommodate the importance they placed on presenting, in the text of the case review, the synthesizing and analyzing of relevant information leading transparently to logical findings. Months on end were consumed in redrafting, without successful communication from MCFD about what the redrafting was all about.

c. Inadequate training and supervision of the reviewer by MCFD

The intention to develop capacity among Aboriginal delegated agencies to do case reviews was laudable. However, if the capacity that MCFD wanted to develop was the capacity to do Director's case reviews with the same purpose and analytical approach reflected in the Director's case review procedures, then for this case review MCFD did not provide the necessary training and supervision to meet that objective.

Nicholas Simons correctly believed that he had been chosen to do the case review because of his practice experience and ability to write reports. He understood that to mean that he was expected to apply his already-developed skills to the task, and to conduct the review in his own way. If MCFD was expecting something different from him, they needed, before he got started, to make sure that what they wanted was clearly understood and accepted by him, and if training and supervision in their expected approach was needed, that he had that training and supervision.

Nicholas Simons did not view the session that he and the other new reviewer had with MCFD in Victoria on October 1, 2002, as "training". MCFD staff called it a "training" session. Whatever the label, the session did not have the desired effect of impressing the new reviewer with the importance that MCFD attached to his following the Director's case review procedures or the suggested template. It did not dislodge his view that he should conduct the case review in the way he saw fit and that the recommendations in it would be his to develop. Nor did it leave him instilled with and accepting of the favoured analytical method of writing the case review.

I was told that the usual practice was for new reviewers to first observe and then work in tandem with an experienced reviewer, learning the expected approach to a Director's case review by observing and working with an "expert". Since this was one of the first two Director's case reviews involving an Aboriginal delegated agency, there was no pool developed from among those agencies. In these circumstances, I can understand why the conventional way of training and giving guided experience to new reviewers was varied. Otherwise, these new reviewers would only have been "observers" on their first time out. The fact that the new reviewers were both directors of agencies with considerable managerial responsibility justified speeding up the training process.

It is less clear, however, why Nicholas Simons was not paired with an experienced reviewer, when the other new reviewer was.

The obvious risk of misunderstandings about ownership of the case review, its purpose and analytical expectations could have been better-managed in this case review had Nicholas Simons been working alongside an experienced MCFD reviewer. If MCFD put so much value on the way Director's case reviews were to be done, it should have gone beyond offering, and instead have insisted on an experienced co-reviewer.

The lack of clarity about expectations and hands-on supervision played out in a cycle of mutual disappointment that was not a positive learning experience for anyone concerned and was a significant feature in the time that it took to produce this Director's

case review. If the level of training and supervision that was called for with a new reviewer, albeit an experienced practitioner and writer, had been in place, this cycle might well have been prevented.

d. Cross-purposes of the reviewer and MCFD

Nicholas Simons followed the directions given to him by the first of the final terms of reference and looked at each of Usma's historical interactions with the late Nuu-chah-nulth child's family, measuring Usma's practice in each instance against MCFD standards. His first and later drafts of the case review reflect this work. His interest, however, lay more with commenting on the kith and kin policy, and on the underlying systemic issues that explained Usma's practice in the circumstances. The generality of these policy and systemic reflections was not consistent with MCFD's expectation that a Director's case review should focus primarily on practice. From MCFD's perspective, while policy and systemic issues could be appropriately raised in a Director's case review, the foundation for the case review was the findings of fact and analysis about the practice.

This working at cross-purposes, MCFD staff and the reviewer each having a sense of righteousness in their own perspective, began to be looked at by MCFD and the reviewer as efforts of the other to undermine the proper purpose of the Director's case review. MCFD became concerned that Nicholas Simons was resisting laying out practice errors on the part of Usma. Nicholas Simons became concerned that MCFD, in their efforts to focus the case review more on Usma's practice issues than on the reviewer's reflections on policy and underlying challenges and problems with the system, was missing the context and interfering with his independence as a reviewer. From what I heard and saw, these respective concerns were not effectively expressed or resolved. The existence and lack of openness about these concerns added another dynamic to the frustrating redrafting activities that prolonged the production of this case review.

e. Periods of minimal productive work

Another significant factor explaining the timelines for this case review is that there were time periods when minimal productive work occurred and the ball was essentially dropped. Notably, these periods were:

- From April 11, 2003, when Catherine Reznechenko provided feedback to Nicholas Simons, to July 2003, when Nicholas Simons began his redrafting in earnest.

- From August 14, 2003, when Nicholas Simons sent his "final" draft, to February 2004, when Catherine Reznechenko followed up and arranged to meet with him.

- From early may 2004, when MCFD made the decision, despite concerns, to push through with the work Nicholas Simons had produced, to July 2004,

when the next step of meeting with Usma took place. (Some minimal activity took place during this time period, but the hope that the case review would be done by the end of May was not met.)

- From September 2004, when a near final draft was ready for Jeremy Berland's consideration, to January 2005, when Jeremy Berland for the first time read a draft of the report. (Some minimal activity took place during this time period, but the expectation at the end of August that the case review would be completed and the summary publicly released in the fall of 2004 was never realized.)

- From January 24, 2005, when Jeremy Berland and Julie Dawson met to consider next steps, to March 22, 2005, when they met with Usma in preparation for public release of the summary.

In every case (except for what happened to Nicholas Simons' August 14, 2003, email to Catherine Reznechenko), there were explanations for the gaps in time, the primary one being other demands on the time of those involved. Stepping back and looking at the pattern, however, leads me to observe that, overall, MCFD, as an organization, was not sufficiently aware of the delays. After a period of little or no activity, there was often a flurry of activity in recognition that things had been left too long, but during the lapses, no one was monitoring and systematically asking the question – what is happening with this case review? The result was that the weeks often turned into months when not much happened.

The MCFD procedures anticipated that a Director's case review would be completed in up to six months after the decision was made to do it. At the outside, this Director's case review could have been acceptably completed in 12 months, or even by the end of 2003. Bearing all this in mind, from the perspective of the march of time this case review was still reasonably under control until the summer of 2003.

As the hoped-for timeline for the case review passed (late spring or summer 2003) and then the acceptable timeline passed too (December 2003), the organizational response should have been more, not less, effective movement toward completion. This did not happen.

An organizational response to lapsed timelines is necessary to counter natural inertia that develops for individuals involved in a project that has gone on sporadically and for too long. There were certainly periods of time when the responsible person in MCFD took charge and this case review moved on somewhat, but the renewed momentum was not sustained. This was an organizational failure.

f. Turnover of MCFD managers

Delay begets delay. The more time that went by the greater was the likelihood that MCFD, or Usma personnel involved with this Director's case review, or the reviewer

himself would move on to other things, which would inevitably risk poorer communications and duplication of efforts on the case review going forward.

As it turned out, Usma had good reason to be concerned about the introduction of new MCFD managers into the process. Each time a new manager took over, they had to assess what was happening. This assessment grew more difficult over time as the situation to assess became more and more complicated by a long history of miscommunication and frustration. Despite best efforts, sometimes suggestions by a newcomer to the case review repeated ideas that had been introduced and responded to by others at earlier stages. These complications consumed time and undermined trust.

g. The 2005 fixed-date provincial election

Another factor contributing to the delay was the provincial election. My investigation revealed no indication of any efforts to delay the case review during the pre-election period, but plans to publicly release the summary were suspended from the time the election writ was issued on April 19, 2005, to June 16, 2005, when Minister Hagen was re-appointed as the Minister of Children and Family Development.

This delay was pursuant to established government practice for an election period and was outside MCFD's control. So too was the delay from June 16, when Minister Hagen was re-appointed, to July 21, 2005, when the summary of the case review was publicly released. This last delay was simply a matter of finding a time when Shawn Atleo was available for the media release.

The disturbing observation remains that the provincial election need not have been a factor, were it not for all of the avoidable delay that happened long before April 19, 2005.

H. Recommendations for the Director's Case Review Process

In this section, I conclude my report by making recommendations for the Director's case review process. My recommendations flow from my observations about what happened with the Director's case review relating to the late Nuu-chah-nulth child. They also flow from background work done by my Deputy, Fred Milowsky, and meetings with various officials of MCFD and Aboriginal delegated agencies. My Deputy made inquiries of MCFD about the current state of the Director's case review process and the thinking of senior managers with responsibilities related to it. He met with Aboriginal delegated agency directors to get their feedback on how Director's case reviews affected their organizations. He and I also met with MCFD Regional Executive Directors, Directors under the CFCSA, and provincial senior managers to hear their experience with, and perspectives on, Director's case reviews.

The Director's case review related to the late Nuu-chah-nulth child started in the fall of 2002 and was signed off in the spring of 2005. My recommendations in this section will

be most useful if they are given in the context of the current state of the Director's case review process. I will therefore begin by outlining aspects of the process as it is now.

I am also aware that my recommendations are made in the context of an anticipated creation of regional Aboriginal and non-Aboriginal governance authorities within MCFD. I have, therefore, framed them for application in the present MCFD set-up, but also so that they could be adapted when regional governance is implemented.

1. The current state of Director's case reviews

a. Case review policy updated

The MCFD case review policy is stated in MCFD "Quality Assurance Standard 2: Case Review", which came into effect in July 2004 (See Appendix 9). This standard covers both Director's case reviews and Deputy Director's reviews. The standard makes reference to, among other documents, the "Protocol between the BCGEU and the Directors for the Conduct of Case Reviews June 2003" and the "Case Review Policy and Procedures June 2003".

In July 2005, MCFD produced a three-page paper entitled "Improving Case Reviews and Audits" (See Appendix 10). Part of the stated background for this paper was that since responsibility for case reviews and audits was devolved to the regions, concerns have arisen in the following areas:

- Qualifications and criteria for selecting contractors to conduct case reviews
- Quality of review and audits, particularly recommendations arising from reviews and audits
- Implementation of the recommendations arising from reviews and audits
- Tracking of recommendations to ensure implementation

The July 2005 paper stated that MCFD was taking a number of actions to address these concerns, including the following with respect to case reviews:

- Maintaining a provincial MCFD bidder's list that includes contractors to conduct case reviews and practice audits, and establishing qualifications and criteria for the selection of these contractors

- Reinforcing the need to conduct case reviews according to established standards and procedures

- Clarifying and improving, in policy, the recommendation development and sign off stage of case reviews, including:

    - Distinguishing between a "draft" report of the analyst/reviewer, that does not contain recommendations, and the "final" report that includes

recommendations developed by the relevant Director under the CFCSA and senior managers and the analyst/reviewer

- Increasing structure with respect to sign off by involved individuals at different stages, including a short time frame for MCFD executive to make additions to the recommendations related to provincial-level initiatives and practice issues, sign off by both the regional and provincial directors, and forwarding to the Child and Youth Officer and the Coroner

- Articulating a process for tracking recommendation implementation

- Creating a provincial forum (either provincial executive or designated Directors table) to which all reviews, audits and recommendations would be presented, and recommendation implementation would be reported on. The purpose of the forum would be consistency and quality in approach, and cross regional and provincial learning

- Making information about reviews, audits and recommendations available to the public through the MCFD web site

In the time frame available to me for this investigation and report, I was not able to explore or establish whether, or the extent to which, these proposed actions have been implemented by MCFD.

b. Purpose of case reviews

The intent of case reviews stated in the case review standard is to:

- Promote excellence in case practice as well as confirming good case practice
- Improve service delivery to children and families
- Ensure that the Director has complied with standards, policy and the legislative mandate under the CFCSA

In practice, case reviews typically gather and analyze the facts necessary to determine whether MCFD has adequately fulfilled its mandate under the CFCSA and whether practice standards have been met. The appropriateness of the practice standards, the underlying reason for non-compliance, and the broader context in which the practice occurs are not usually examined.

c. Deciding to do a case review

The case review standard says that a case review is undertaken when there is a death in suspicious circumstances, critical injury or other serous incident involving a child.

Insofar as child deaths are concerned, Directors under the CFCSA told me that they would do a case review whenever there was an unexpected death of a child and, for an

expected death, if they could not answer any practice issues on the basis of looking at the case file.

With respect to the choice between a Director's case review and a Deputy Director's review, the case review standard states that the decision to conduct a Director's case review is based upon "the severity of the occurrence or complaint, the potential link between case practice and the outcome, and level of response required for public accountability". There is no requirement for a Director to state the reasons for choosing between a Deputy Director's review and a Director's case review.

Directors said that their main consideration in deciding between the two kinds of case reviews was what information they needed to know, and whether interviewing those involved was required to provide that information. The public or media profile of a case also appears to be a factor in the decision to do a Director's case review.

I was provided with information about the number of Director's case reviews and Deputy Director's reviews in recent years. Since responsibility for case reviews was devolved to the regions in 2002, the ratio of Director's case reviews to Deputy Director's reviews has remained about the same, but the overall number has decreased.

From July 2002 to December 1, 2005, there were 69 case reviews completed, of which nine were Director's case reviews and six of those nine were fatalities. Explanations given to me for these numbers were that in 2001 a decision was made not to review natural deaths and that the number of non-natural deaths of children in care or receiving services from MCFD are small in absolute terms.

d. Time frames

With respect to the time frame for completing Director's case reviews, the case review standard states:

> A director's case review is completed as soon as possible and within eight months of the decision to conduct the review.

The time frame for a Deputy Director's review is 90 days from the decision to begin the review. I learned that these time frames are rarely met. Explanations given to me for this were:

- The few reviews that are being done are more comprehensive and therefore they take longer
- Not enough practice analysts are available to do case reviews
- Priority has not been placed on doing case reviews, particularly since the devolution of the responsibility for case reviews to the regions

The lack of availability of practice analysts was explained, in part, by competing priorities for the existing analysts, insufficient resources being put into this function, and difficulty in recruiting into these analyst positions.

e. Training and support

With respect to case review training and support since July 2002, I was told that Directors designated under CFCSA and Deputy Directors were given two days of devolution training in the summer of 2002. In 2005, Directors and Deputy Directors attended a two-day quality assurance seminar in January, and Deputy Directors and practice analysts were provided two days of case review-specific training in June. I was told that support for regional Directors under the CFCSA is provided through quarterly meetings and monthly teleconferences, and that case consultation from the provincial Child and Family Development Division is available for both Directors and practice analysts. I was also told that new practice analysts are "encouraged" to visit provincial MCFD on-site for orientation in quality assurance work.

f. Tracking and monitoring

Tracking recommendations is currently a regional responsibility and each region has a system in place to do this. I was told that MCFD capacity to track and monitor timelines and recommendations will be enhanced by a new information technology system that is planned for implementation this year.

The provincial MCFD has conducted no audits of how the regions are carrying out their case review responsibilities.

g. Case reviews across services, regions and agencies

The case review standard applies to case practice associated with the provision of services under the CFCSA; it applies, that is, to providing family, protection and guardianship services. MCFD's mandate also includes youth justice and mental health services for children and youth. The practice around these other services can also be a potential contributing factor to deaths and other serious incidents.

Child death reviews have been done in a couple of regions when youth justice or child and youth mental health services, in addition to services under the CFCSA, were involved. A process for integrating case reviews in more than one area of service has not been worked out.

The process for inter-regional case reviews and for case reviews involving delegated Aboriginal agencies has been determined on a case-by-case basis. Typically, the region with the case file at the time of the child death or other reviewable incident takes the lead and involves the other region. In the very few cases to date involving an Aboriginal delegated agency, the provincial Director has assumed the lead role.

Approximately, 80 percent of the MCFD budget goes to contracted agencies that provide services within MCFD's mandate. How contractors will be involved in case reviews is not stated anywhere in the MCFD case review standard for case reviews. The responsibility of contractors to comply with recommendations arising from case reviews and the funding for compliance also do not appear to have been considered.

For Aboriginal delegated agencies and contracted agencies, there is an issue about their capacity to participate in case reviews, which can be very time-consuming for staff, and it has not been addressed.

When external agencies, other than delegated or contracted agencies, are involved and MCFD has no authority to direct them, those agencies have not been involved in the case review and development of recommendations, no matter how important their involvement was in the incident. Directors have dealt with this limitation by including in the case review a recommendation to the local MCFD manager to develop a protocol with the external agency.

2. The primary purpose of case reviews

Lack of clarity about the purpose of case reviews creates false expectations and leads to less effective reviews. Before setting out my recommendations, I want to first explore what the primary purpose of case reviews should be. Many of my recommendations flow from my thoughts on this issue.

In broad terms, four purposes that may be served come to mind: organizational accountability through public transparency; monitoring of organizational compliance with practice standards; disciplinary accountability for poor practice; and organizational critical self-examination and improvement. These purposes are not mutually exclusive, but they can be quite different and potentially conflicting, and it is important to be realistic about the prospect of successfully reconciling all of them into a single process.

The kind of uninhibited reflection that makes critical self-examination valuable and healthy for an organization can be hard to do, even impossible, in the glare of a public spotlight.

The public and external agencies may be skeptical, for good reason, of the effectiveness of unsupervised organizational self-monitoring for compliance with normative standards.

Disciplinary accountability proceedings may trigger defensiveness and procedural requirements that are not conducive to candid organizational self-examination or to public transparency.

Monitoring for organizational compliance with practice standards may be more effectively done through audits than case reviews because audits are more systematic

in their approach. Case reviews tend to turn too much on their own particular facts to be overly helpful from a monitoring of compliance with standards perspective.

A case study, which is really what a case review is, can provide important opportunities for organizational critical self-examination, that other processes cannot provide. It has the advantage of being grounded in experience that allows individuals to reflect on what worked and did not work in practice, to extrapolate from that a vision of what good practice is, and to come up with practical recommendations for how practice can be improved.

My advice is to make organizational learning and improvement the primary purpose of MCFD case reviews, to be clear about that purpose, and to think through the implications of that purpose for how the process should be structured and should function. That optimum structure and functioning may not lend itself entirely to public transparency, systematic compliance monitoring or disciplinary accountability.

A case review should be an exercise in organizational self-examination and creative thinking about organizational improvement. As such, it should fully engage those individuals whose practice is being reviewed and who have responsibility for that practice at all levels of the organization. It should be designed to encourage, among its participants, frank and open dialogue about what works in practice, what should have been done differently, and how to improve practice in the future. In that way, participants will learn and the resulting recommendations will be informed by experience and will have the support of those responsible for their implementation.

3. Recommendations

The following are my recommendations for the MCFD case review process. I recognize that some may already be part of MCFD's established policy or its proposed plans:

1. Expand case reviews to cover deaths and critical incidents not just of children in care or children known to the MCFD under the CFCSA, but also of children and youth who have received services under MCFD's broader mandate, when those services and the practice related to them may have significantly affected the outcome of the case.

2. When more than one area of practice or service is involved, conduct an integrated case review, with joint responsibility for terms of reference and recommendations resting with the responsible managers. Involve practice analysts with expertise in the relevant areas of practice.

3. In consultation with Aboriginal delegated agencies, and with agencies contracted to provide services within MCFD, develop mutual and clearly stated expectations of respective roles in case reviews when the agencies' services and employees' practice are being reviewed, including in:

- the development of the terms of reference
- the fact gathering and practice analysis
- the development, implementation and monitoring of the recommendations
- the funding and human resource support for the agencies during the case review process

4. Set out MCFD's case review process in one document that clearly states the following:

   a. The case review is the review of the manager responsible for the practice and services under review, with guidelines as to how that manager is to be determined.

   b. If more than one manager is responsible for the practice and services under review, the case review is a joint review of those responsible managers, with the terms of reference and the recommendations being jointly agreed to, and one of the managers, by agreement, being designated to take the lead.

   c. The primary purpose of a case review is organizational self-examination and improvement.

   d. The decision to conduct a case review is the judgment of the responsible manager.

   e. A case review can be of two types, a file review alone or a file review and interviewing of individuals involved in the incident. The decision as to which type of case review will be conducted is also the judgment of the responsible manager, who should take into account the following factors:

      - the severity of the outcome of the case
      - the extent of the link of case practice to the outcome
      - how information is best obtained in the circumstances
      - other processes related to the same case
      - the extent to which a case review is likely to further organizational learning

   f. The responsible manager is required to record reasons for the choice of case review to be conducted.

   g. The terms of reference of the case review should focus the practice analyst's fact-finding and analysis on the practice that could have affected the outcome of the case, and be broadly enough stated to allow the practice analyst free range in pursuing potentially relevant information.

   h. While the case review is a review of practice, contextual or systemic issues that significantly effect practice in the particular case should be noted.

i. The recommendations coming out of the case review are the recommendations of the responsible manager and should be:

- Based on the facts and analysis set out in the case review;
- Directed at those who have the authority within the mandate of MCFD to carry them out;
- Achievable within the resources and responsibility of the manager to whom they are directed.

5. With respect to the practice analyst:

a. Be clear that the role of the practice analyst is to objectively determine the relevant facts, synthesize them in an orderly fashion, analyze them from a practice perspective, and set out the facts and the analysis in a written report.

b. Enhance the current provincial MCFD list of practice analysts, from which responsible managers can choose, by clarifying the experience, skills and abilities required for case reviews, and making those requirements a condition of being on the list.

c. Provide practice analysts with mandatory training in, and orientation to, the type of analysis expected for case reviews and in the development of writing skills, including on-the-job training and working with another practice analyst experienced in case reviews.

d. Provide supervision of practice analysts conducting case reviews by a designated MCFD staff member, probably at the provincial level, who has particular expertise in practice analysis and case review.

e. Be clear to the practice analyst and the manager responsible for managing the case review that hands-on supervision is appropriate.

f. Be clear that the case review is the responsible manager's case review, not the practice analyst's case review, and that it is appropriate for the responsible manager to challenge the fact-finding or analysis of the practice analyst.

g. Make certain that the facts are verified by those involved in the case, and that disputes about key facts are highlighted and different perspectives noted in the practice analyst's written report.

6. With respect to the development of the recommendations:

a. Develop them collaboratively involving those whose practice is being reviewed and the supervisors and managers who have responsibility for the practice and for implementation of the recommendations.

b. Encourage full and frank discussion of all issues and consider using a facilitator.

c. Experiment with participation by external agencies involved in the case and with whom MCFD works in partnership.

7. Consider whether special safeguards need to be in place respecting the use of disclosure of information gathered in case reviews, to foster and protect their primary purpose as a process for organizational self-examination and improvement.

8. Clarify the provincial MCFD role to set standards, including acceptable timelines and expectations of when and how case reviews should be conducted.

9. With respect to timelines, create a realistic standard, listing factors that may reasonably lead to delays, including the impact of other processes such as police and coroners' investigations.

10. Recognize the provincial MCFD role in monitoring compliance with the case review standard. Conduct provincial MCFD audits of case reviews. Put in place a provincial MCFD tracking system for:

- All reportable incidents by region
- Responsible managers' decisions, with reasons, to do or not do a full case review with interviews of those involved in the incident
- Timelines for case reviews
- Responsible manager's explanations for going beyond those timelines
- Recommendations arising from case reviews
- Implementation of those recommendations, with clarity that a recommendation stays on the tracking system until it is implemented, and not just until a plan for implementation has been developed.

4. Conclusion

a. Organizational self-examination

Conducting a case review when there has been a serious incident that raises questions about practice, is itself good practice. An organization, if it is to achieve the goals it sets for itself, needs to take the time for critical self-examination. It needs to ask how it is doing at putting into practice its plans to achieve its goals.

A good way to start that process in a particular case is to engage an experienced practitioner to critically examine the practice involved, find out what happened and assess what happened against the organization's expectations of itself. Because the subjectivity that comes from direct involvement with an incident can cloud critical analysis, it helps if that experienced practitioner was not part of the incident under review. A good critic does more than hunt out bad practice. A good critic distinguishes the good from the bad and identifies for others which is which.

The self-examination process should not end with critical analysis of the practice under review. To be most helpful, the process needs to move on to reflection on what happened by those responsible for that practice, at all levels of the organization. Having individuals reflect on the practice in a case in which they were involved, has the advantage of rooting the organization's self-examination in experience.

Individual reflection, rooted in experience within the organization, is an excellent building block for creative thinking about how to improve performance in the future. This creative thinking about organizational improvement is the final step in the self-examination process. Without it, the exercise risks becoming self-congratulation or self-flagellation, sometimes both.

Critical self-examination of an organization's role in a tragic incident requires a lot of people. In the Director's case review relating to the late Nuu-chah-nulth child, many individuals invested time and commitment to the process, despite strong emotions evoked by the tragedy. That MCFD has a policy to conduct reviews in these cases is right and, in my experience, uncommon among agencies responsible for delivering government-funded services.

b. Adaptation to change

This Director's case review was entered into with good intentions all around but I have concluded that, as the process unfolded, it became an organizational failure. At the centre of that failure was a lack of clarity about what case review was all about, its core principles and how case review fit within MCFD's organizational objectives.

This Director's case review took place in a period of intense change for MCFD. Elsewhere, I have said that the course of transformative change of British Columbia's child welfare system is the right course, the one that holds out the promise of truly making a difference for our children and youth. The managers involved in this Director's case review were simultaneously engaged on moving forward with that transformative change. They were doing so in a context of budget cuts that were seeing their numbers significantly reduced. A case review process that may have worked well in the past did not keep pace with the changes that MCFD was undergoing.

Organizational self-examination is particularly important in times of change. If the case review process is to be a useful instrument for organizational improvement, it needs to be re-examined and refocused. It needs to adapt to the way in which services for children, youth and families are being delivered today and are planned for tomorrow.

The challenge for MCFD is to take case review, a good practice that was developed successfully over many years, and build on that success. MCFD needs to make the case review process work in the changing environment that has been, is, and will continue to be, the prevailing environment for the government ministry charged with the responsibility to protect and promote the well-being of the most vulnerable of British Columbia's children and youth.

[1] I am grateful for the work done in obtaining and organizing documents by Kellie Kilpatrick from MCFD. Parts of the electronic files were not available. Some email correspondence was eventually retrieved from archives, but only after the interviews had been commenced. The reviewer's files were not received until November 8, 2005, again after some of the interviews had already started. The numbers of drafts of the case review, or parts of the case review, many of which appeared in more than one file, and the lack of clear labeling of the dates of the drafts made it difficult to track the various versions.

[2] The name of the provincial branch responsible for audits and case reviews was changed from the Quality Assurance Branch to the Quality Improvement Branch some time in 2001 and 2002. The terms quality assurance and quality improvement are used within MCFD essentially interchangeably. In 2002, the concept of continuous quality improvement was embraced by MCFD senior management. It reflects more of the idea of monitoring as one step in a continuous organizational learning and planning cycle directed at improving services. The term "quality assurance" is a more static monitoring concept, fitting more within an "accountability" framework. In the last few years, the "quality assurance" terminology has returned in provincial MCFD documents. Throughout this report, I refer to the provincial branch responsible for audits and case reviews as the "quality improvement branch".

[3] The MCFD branch or division responsible for services for Aboriginal children and families had different names from 2002 to 2005. In September 2002 it was called the Services to Aboriginal Children and Families Branch. Throughout this report, I refer to it as the "Aboriginal services branch".

This report is my own, but the assistance of my staff has been invaluable to me. I would like to acknowledge in particular my Associate Jeannie MacPherson whose work supported me throughout the investigation and my Deputy Fred Milowsky for his work in providing background regarding the Director's case review process generally. I also want to acknowledge the valuable advice and assistance of my legal counsel, Susan Ross.