March 30, 2006

Honourable Wally Oppal, Q.C.
Attorney General
Ministry of Attorney General
and Minister Responsible for Multiculturalism
Room 234, Parliament Buildings
Victoria BC V8V 1X4

Dear Mr. Attorney:

Re: Supplementary Report to the Attorney General Respecting the Director's Case Review Relating to the Death of the Nuu-chah-nulth Child in Port Alberni on September 4, 2002

On February 15, 2006, I provided you with a report, pursuant to Section 6 of the *Office for Children and Youth Act,* on the investigation I undertook at your request into the Director's case review of the death of the Nuu-chah-nulth child on September 4, 2002. My investigation had five terms of reference. I reported on:

- The timelines involved in the writing, completion and release of the Director's case review.
- Why the terms of reference for the Director's case review were changed.
- 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.
- The policy concerning a Director's case review, including those where a kith and kin agreement has been applied, and my recommendations with respect to that policy.

This letter report will complete the fifth and final term of reference for my investigation relating to the Director's case review:

- If, in the course of conducting my investigation, I determine that the timelines, the change in terms of reference, or any defect in the Director's case review may have materially affected its outcome, then review whether the outcome was materially affected and make recommendations to address any such impacts.

I deferred addressing this final term to take into account any relevant information that might come out in the Coroner's public inquest into the child's death held in Port Alberni from February 6 to 18, 2006.

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I have now had the benefit of the information that came out in the inquest and have reviewed documentation and some other information that was not considered, at all or in depth, in the inquest or the Director's case review. I have also conducted a further interview with the reviewer, Nicholas Simons, to canvas with him whether there are defects or new information that might have materially affected the outcome of the Director's case review.

1. Timelines in producing the Director's case review

The undue time that it took to produce the Director's case review was a material defect in the process. The reasons for delay and its effect on the case review were discussed at length in my February 15, 2006, report. Given the nature of this particular defect, it would make no sense to address it by reopening this case review, which already took too long. The way to address this defect will be by instituting measures that ensure a consistently timely process for future case reviews.

2. Change to the terms of reference

The second term in the initial terms of reference of the Director's case review asked whether MCFD's response to child protection concerns associated with the caregivers' family was consistent with established standards. In my February 15, 2006, report, I observed that the deletion of this term from the final terms of reference resulted in the reviewer not undertaking a practice review of MCFD's past intakes relating to the caregivers' family. I also concluded that the appropriate scope of the Director's case review was to look at practice that potentially impacted on the death of the Nuu-chah-nulth child.

The existence and circumstances of these intakes, which took place from 1998 to 2001, was relevant information that could and should have been available to Usma staff when they decided to place children with the caregivers. The MCFD practice underlying those intakes when they occurred was only tangentially related, however, to the circumstances surrounding the child's death. I therefore do not recommend going back at this time to review the past MCFD intakes relating to the caregivers from the point of view of whether practice standards were met.

3. MCFD information about the caregivers' family

The existence and circumstances of past MCFD intakes relating to the caregivers, and the communication and availability of that information to Usma, were relevant to the Director's case review.

a. Looking at this information and the terms of reference

The fourth term in the final terms of reference for the Director's case review addressed the issue of information sharing between the MCFD region and the Usma agency, particularly with respect to information regarding the caregivers' family.

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The reviewer, Nicholas Simons, was aware of the historical intakes relating to the caregivers. He was provided with computer printouts from the MCFD electronic file management system, known as SWS MIS. The intakes that were relevant were summarized by him in an appendix to the Director's case review, and were referred to and taken into account in the case review narrative itself.

Nicholas Simons believed, however, that it was not open for him, within the final terms of reference for the Director's case review, to go behind the SWS MIS computer printouts summarizing the MCFD intakes. He did not, therefore, request and review the more detailed underlying MCFD file material. He told me that he definitely would have taken this step had the terms of reference not been changed, as it would have been information he needed for a practice review of the MCFD intakes.

He might also have requested access to the underlying MCFD file material on past intakes with the caregivers, if the terms of reference had been better designed to focus him on Usma's placement decision. Similarly, he might have taken that step if the discretion of a reviewer, under MCFD's Directors' case review policy, to explore relevant issues even if not included in the terms of reference, had been successfully impressed upon him.

b. What the Director's case review said about this information

The Director's case review made references and findings related to the relevant MCFD historical intakes regarding the caregivers as disclosed in the SWS MIS computer printouts the reviewer received, and the sharing of information about them between MCFD and Usma, including the following:

- At the time the placement decision was made, delegated agencies, including Usma, did not use the SWS MIS system.
- Usma had for many years relied on the local MCFD office to fax the prior contact check computer printout from SWS MIS. These printouts listed the files, including family service files in which intakes and investigations were documented.
- Having administrative staff from an external agency research and print the prior contact check and then fax it to Usma left room for error.
- At the time of the placement decision, an incomplete printout was sent from the local MCFD office to Usma that did not include prior intakes or investigations related to the caregivers.
- This error was discovered after the child's death on September 4, 2002. A correct and complete prior contact check computer printout was forwarded by MCFD to Usma on September 26, 2002. Usma also eventually requested a SWS MIS printout of the MCFD past intake reports related to the caregivers.
- SWS MIS intake reports summarize the reporters' concerns and the social workers' response.

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- SWS MIS does not include all the information that would be in a case file. This additional information would have to have been requested from the local MCFD office, once Usma found out that there was a MCFD family service file involving a number of past intakes relating to the caregivers.
- It was impossible to speculate what the Usma decision would have been with respect to the kith and kin placement had Usma social workers had access to MCFD intake information regarding the caregivers at the time of the placement decision.
- Despite legitimate reasons for delegated agencies not using SWS MIS, access to this electronic file management system was essential for communications purposes.

One of the recommendations of the Director's case review was that all child welfare agencies in British Columbia be required to use an information-sharing computer database that interfaces with every other child welfare agency in the province. This recommendation has since been implemented.

c. New information about the caregivers and information sharing

My review of underlying MCFD file material for the 1998 to 2001 intakes relating to the caregivers and some other information, has led me to the conclusion that Nicholas Simons was unaware of information that was relevant to Usma's placement decision in August 2002. This information also was not considered at all or in any depth in the Coroner's inquest. I am satisfied that had Nicholas Simons been aware of this information, he would have incorporated it into the Director's case review. Any defect in the case review terms of reference or process that led to this information not being examined by the reviewer had, therefore, a material affect on the case review. The existence of this information raises the important issue of the extent to which Usma could, or should have had access to it.

d. Addressing this impact

This new information that was material to the Director's case review is also material to the circumstances surrounding the continued placement of the Nuu-chah-nulth's child's brother and other children in the caregivers' home after her death. These are circumstances that I am currently considering in my second investigation and report under Section 6 of the *Office for Children and Youth Act*.

I recommend that the impact of any defect in the Director's case review terms of reference or process that led to this relevant information not being examined by the reviewer, can and will be best addressed in the course of my investigation and report concerning the continued placement of children in the caregivers' home after September 4, 2002.

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4. Other new information

As would be expected given the scope of a Corner's inquest, some new information also came out at the inquest that would have been relevant to the Director's case review. Notably, a number of family members testified at the inquest and it emerged, apparently for the first time, that other adults, the Nuu-chah-nulth child's maternal great grandparents, were living at the caregivers' home when the children were placed there under the kith and kin agreement. This would have been significant information for the Usma social workers to consider. The fact that it was apparently not known by the Usma social workers would have been material for inclusion and discussion in the case review. It is not at all clear, however, that the case review process intended or could have brought to light this kind of new information.

Again, I recommend that any issues arising from this information about the initial and continued placement of children with the caregivers, can and will be best addressed in my second Section 6 investigation and report, or in the special report under section 8 that I have committed to issuing on systemic issues arising from the death of the Nuu-chah-nulth child and the decision to leave her sibling and other children in the home in which she died.

In summary, it is not necessary or productive to address material impacts that the change in the terms of reference and the lack of some relevant information had on the outcome of the Director's case review, by reopening or redoing the case review. The relevant information that was not available or known to the reviewer for consideration in the Director's case review is also relevant to the continued placement of children in the caregivers' home after the death of the Nuu-chah-nulth child. It can and will be incorporated as necessary into my upcoming Section 6 and 8 reports.

Respectfully submitted,

Jane Morley, Q.C.
Child and Youth Officer
Province of British Columbia

cc Allan Seckel, Q.C., Deputy Attorney General