



REPRESENTATIVE FOR
CHILDREN AND YOUTH

Fragile Lives, Fragmented Systems:
Strengthening Supports for Vulnerable Infants

Aggregate Review of 21 Infant Deaths

January 2011

January 27, 2011
The Honourable Bill Barisoff
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, BC V8V 1X4

Dear Mr. Speaker,

I have the honour of submitting *Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants* to the Legislative Assembly of British Columbia.

This report is prepared in accordance with Section 16 of the *Representative for Children and Youth Act*, which makes the Representative responsible for reporting on reviews and investigations of deaths and critical injuries of children receiving reviewable services.

Sincerely,

A handwritten signature in black ink, reading "mecturpel-lafond". The signature is written in a cursive, lowercase style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

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

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

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Executive Summary

This review looks into the lives of 21 infants who died before the age of two years old between June 1, 2007 and May 1, 2009.¹ All of the infants' families were involved with the Ministry of Children and Family Development (MCFD).

This is an aggregate review – a collective look at deaths that occurred under similar circumstances. This is the Representative's first aggregate review, and it is different from any of the reviews or reports published to date. An aggregate review allows us to learn from these tragedies and see if there are ways to improve the systems that support vulnerable families in British Columbia.

As the Honourable Ted Hughes, QC, said in the 2006 *BC Children and Youth Review*: “The primary method of reviewing child injury and deaths will be to examine aggregated information and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives.”

As such, this is a more analytical, less personal report than others done by the Representative on the deaths of children. The nature of this type of review requires that all personal facts that could identify the infants be removed. However, to illustrate the life situations of some of the infants, case examples are provided throughout the report.

All of the infants in this review were born into families facing tremendous challenges. Many of the 21 families struggled with circumstances like serious poverty, inadequate housing and fragmented systems that failed to provide the supports they needed and failed to identify and respond to the risks that were in many instances obvious. Nine of the mothers were either single or very young parents. Five were first-time mothers. These families faced multiple risk factors that can have a significant impact on an infant's well-being. All of the 21 families had at least two significant risk factors, and the majority had four or more.

An alarming number of the infants – 15 of the 21 – were Aboriginal, and nine of these 15 were from Vancouver Island. The high proportion of Aboriginal deaths and the total number that occurred on Vancouver Island (13) are both areas of concern. The mortality rate for Status Indian infants in B.C. is twice that of non-Aboriginal infants, a fact which has been previously noted by the Provincial Health Officer.

Common challenges in the lives of the infants and their families include:

- 20 of the 21 families had intergenerational trauma in the parent's family of origin.
- 15 of the 21 families had a documented history of abuse or neglect in the mother's family of origin.

¹ Two of the 21 infant deaths were outside of this time frame but were referred to the Representative by the Select Standing Committee on Children and Youth.

- 14 of the 21 families had domestic violence issues in the immediate family. Eight of the families had documented domestic violence in previous generations.
- 16 of the 21 families had substance abuse in their immediate family, and 15 of the 21 had substance abuse in previous generations.
- 12 of the 21 families had documented mental health issues such as depression, suicidal behaviour and anxiety.

While acknowledging the significant challenges these families would present to those providing support from the medical, child welfare and public health systems, this review revealed a patchwork of services and limited supports to vulnerable families and their newborns in the province.

The lack of rigorous, integrated planning, sharing of information and system-wide tools for proper risk assessment and intervention resulted in many opportunities lost for these infants and their mothers.

The lack of a coordinated and responsive government approach to poverty is also a significant concern in this review. As a group, these infants lived in serious poverty as well as inadequate housing. These cases starkly show the inability of families to improve their life circumstances across generations, with devastating results. The families in this review, particularly the Aboriginal families, were often stuck in chronic, deep poverty that was the single largest risk factor in their environment.

B.C. continues to have the worst child poverty rate in the country,² and the Representative continues to advocate strongly for a comprehensive provincial poverty reduction plan. As this review shows once again, poverty is directly correlated with compromised outcomes for children. Concrete and effective prevention measures are required to make a difference in the lives of infants, children and families in this province.

All of these infants died unexpectedly and in unsafe sleep arrangements. Although the cause of sudden infant deaths remains a mystery, we do know that the risk of sleep-related infant deaths is reduced when the known risk factors are mitigated.

Although good prenatal education and information about safe sleeping is important to creating a safe environment for an infant, it is also important to note the role of the interacting factors of poverty, inadequate housing and family functioning in this circumstance. Increasing public awareness, particularly with vulnerable families, about the importance of safe sleeping is critical, but it should be done with the understanding that other significant underlying conditions of infant vulnerability also require attention.

Public health nurses identify family needs and provide support through intervention and connection to resources and services, as well as provide training and education. With their unique role, public health nurses have an opportunity to observe infants in the home environment in a non-intrusive way while assessing their health and development.

² Using LICO, B.C.'s after-tax child poverty rate was 10.4 per cent, compared to a national rate of 9.1 per cent. *2010 Child Poverty Report Card*. BC Child and Youth Advocacy Coalition, Nov. 2010.

However, there is no provincial coordinated standards-based program for postnatal public health nursing services in B.C. The province's regional health authorities offer a variety of programs that are not available everywhere in the province. In addition, inconsistent practice exists within and across health regions, and funding varies across program areas and regions. This is concerning, especially considering the vital role these nurses could play in helping assess families with vulnerabilities and collaborating as part of a support team to identify opportunities to reduce risks and improve the safety of these infants.

Targeted public health nurse home visiting programs that begin in the prenatal period and continue after birth have demonstrated effectiveness, including improving prenatal outcomes and child health. This is clearly an area where great benefit could come from a more consistent, standardized approach to the services provided.

The purpose of this review is to identify areas where the systems that support vulnerable families and infants can be improved. Whenever there is an opportunity to learn from these kinds of tragedies, self-examination and improvements in policy and practice must occur.

It is important to note that other reviews of some of these deaths have also occurred. However, it is not clear whether any of these reviews has resulted in any organizational learning or improvement. Of the 21 infant deaths, 14 were identified for a ministry case review by MCFD and in one circumstance the death underwent two reviews, for a total of 15 reviews for 14 deaths. Fourteen reviews are now complete, with one still in progress. The remaining seven deaths were not reviewed. It is not clear why these deaths were not also reviewed, despite active service delivery by the ministry to the child and/or family.

The 14 completed MCFD reviews were examined as part of this aggregate review. The following concerns arose from this examination:

- It was not clear how the decision was made to conduct a review or which type of review to conduct.
- The terms of reference were not always adequate, given the identified concerns.
- The analysis in the reviews missed key issues.
- In some cases, the issues identified in the analysis were not addressed in the recommendations.
- When recommendations are noted as complete, it was unclear if the actions taken actually fulfilled the requirement of the recommendations.
- Too few of the reviews met the ministry's quality assurance standards time frame for completion.

By not conducting reviews of all the deaths and conducting reviews that were inadequate in several areas, the ministry lost a valuable opportunity for learning and sharing information.

Some of the specific areas of potential learning from these infants deaths included:

- challenges of working in isolated communities
- effective intervention with drug-addicted parents
- impacts of domestic violence
- better integration of services and interagency communications
- appropriate discharge planning.

In addition, there does not seem to be a consistent and formalized procedure for sharing the results of reviews with other ministry staff or with other involved professionals. This is a concern that was also raised in the Representative's 2008 report *Amanda, Savannah, Rowen and Serena: From Loss to Learning*. For learning and change to occur, these results must be shared openly and consistently with all who have a role to play in these types of situations, regardless of the service they provide.

These families were known to have been facing significant life and parenting challenges, yet somehow the risks to their children associated with these challenges were ignored or not dealt with effectively. Too often in this review the documentation shows that many professionals from the public health, medical and child welfare systems saw these families and noted part of the issue, but didn't connect the dots to create a whole picture that would have clearly revealed a fragile situation where intervention and additional supports were critically necessary.

We know that intervention, support and consistent information for pre- and postnatal mothers can make a world of difference in their lives and the lives of their babies. It is not possible to say that with adequate services, all of these infants would be alive today, but as birth circumstances play a significant role in the healthy development of an infant, it is possible and reasonable to say that some of them very likely would be.

Introduction

This review examines the circumstances of 21 infants who died and the system of supports and services that were involved in their lives. These infants and their families were involved with the Ministry of Children and Family Development (MCFD).

There are many more lessons to be taken from children's lives and from their experiences with the ministry, with their families, with the medical system, their schools and communities. A public health perspective can help us to find and use the information that [may] make a difference to children's lives and, we hope, further reduce the number of children who needlessly die.

Honourable Ted Hughes, QC
BC Children and Youth Review

The death of a child is heartbreaking. When an infant dies, we are struck by their utter vulnerability and helplessness. The Representative for Children and Youth recognizes the immense sadness and emotional impact these deaths have had on the families, communities and those involved with the infants and their families.

An aggregate review such as this compounds our sorrow as a community – when we realize the numbers we are examining aren't "just numbers," they represent young lives lost, and entire families devastated. One can't help but feel the weight of those losses, when we pause to think of the grief that lies behind the statistics.

The intent of this review is not to look for blame or assign fault but rather to understand the system of services and supports that were involved in the lives of the infants and their families, to determine how the systems worked and to make recommendations intended to improve support to vulnerable families.

Many circumstances and factors can lead to a family becoming vulnerable, including poverty, substance abuse, domestic violence, physical and mental illness and a lack of adequate housing. These circumstances often lead to families coming to the attention of child welfare services and have significant impact on children's healthy development, safety and well-being.

Birth circumstances play a significant role in the healthy development of infants, and the Representative believes much can be learned from the 21 infant deaths reviewed in this report. Their deaths challenge us to strengthen our supports to the most vulnerable members of our society.

Terminology

For the purpose of this report, the term "infant" is used to describe a child under the age of 24 months. This is consistent with the definition in Webster's New World Medical Dictionary, which defines an infant as a child up to two years of age.

However, it is recognized that the usage of the term "infant" varies for different purposes and by different organizations. For example, the term "infant death" is defined by the

Provincial Health Officer in a 2003 special report, *A Review of Infant Mortality in British Columbia: Opportunities for Prevention*, as the death of a liveborn infant less than one year of age. The BC Coroners Service defines “infant mortality” as the deaths of infants during the first year of life per 1,000 live births.

The term “prenatal” refers to the period prior to birth and the term “postnatal” refers to the period after birth.

The term “Status Indian” refers to a person registered under the *Indian Act* and is recognized as legally entitled to a range of programs and services available to them.

The term “First Nations” is used to refer to individuals who have identified as having a specific First Nations ancestry, and the term “Métis” is used to describe individuals who have identified as having Métis ancestry. The term “Aboriginal” is used in the report to include individuals who identify as being First Nations, Status Indian, non-Status Indian, Inuit or Métis.

The term “Aboriginal infant” is an inclusive term for First Nations, Status Indian, non-Status Indian, Inuit or Métis infants.

In this report statistics for Status Indians are reported as there are no available comprehensive data for the more broadly defined group of Aboriginal peoples.

RCY Aggregate Reviews

Deaths and critical injuries of children in care and children who have received *reviewable services* within the year prior to their deaths or injuries are reported to the Representative. The Representative’s mandate is to review and investigate these deaths and injuries, report to the public and make recommendations for improvements to the child-serving system as required. The Representative determines if a death or critical injury will be reviewed on its own or collectively with other deaths or injuries with similar circumstances in an aggregate review.

Reviewable services

Any designated services, including services and programs under the *Child, Family and Community Service Act* and *Youth Justice Act*; mental health services for children; addiction services for children; and additional services prescribed under the *Representative for Children and Youth Act*.

In the 2006 *BC Children and Youth Review*, Hughes stated that the Representative for Children and Youth “should have the discretion to determine the kind of review that is appropriate in the circumstances. It may be a matter of collecting and reviewing information on a number of deaths with similar characteristics to identify trends or patterns that will inform or educate the child welfare system and the public.”

This is the first aggregate review completed by the Representative’s Office. Aggregate reviews involve reviewing and analyzing a group of deaths or critical injuries as well as related legislation, policies and practices to determine if there are any recurring circumstances or trends.

The purpose of an aggregate review is to explore lessons that can be learned from a group of cases that share some common factors. This review was guided by a realistic assessment of policy and practice during the review time period and an evaluation rooted in reasonable practice by a qualified person exercising professional judgment.

MCFD social workers and health service providers negotiate complex systems and delicate circumstances on a daily basis and are often responsible for making difficult decisions. Even the best practice and best analysis cannot predict the future with certainty, and it would be unfair to hold service providers to impossible standards.

The Representative acknowledges the important work of all of the service providers involved with the families in this review and did not undertake this review as a fault-finding process. Rather, the Representative examined whether the response from the systems of services was reasonable in relation to the circumstances at the time.

In this report the infants and families are not identified by name, and care has been taken to present the information in a way that does not otherwise identify them.³

Rationale for Conducting this Aggregate Review

This review focuses on the circumstances of 21 vulnerable infants and their families and the services and supports provided to the families. Thirteen of these 21 infants resided on Vancouver Island.

The review seeks to build a deeper understanding of these young lives and how we may be able to mitigate risks and improve the circumstances in which vulnerable infants and their families live.

The deaths of these infants are of particular concern to the Representative because of the possibility that they may have been preventable. Typically, they involved factors that are known to increase risk of death, and they raise a number of questions, such as:

- Were the infants and their families receiving the information and systems of support required for positive outcomes?
- How were the infants' lives impacted by broader factors like poverty, housing or limited social supports?
- How can systems such as the child- and family-serving agencies, the public health system, hospitals and health care providers work together to provide support, education, prevention and health promotion in a coordinated and consistent manner?
- How are these systems supporting and responding to vulnerable infants and families?

³ Section 16(1) of the *Representative for Children and Youth Act (RCY Act)* specifies that reports based on aggregated information not contain information in individually identifiable form.



Methodology

The Representative's mandate to review and investigate deaths and critical injuries of children receiving reviewable services came into effect on June 1, 2007, and is set out in section 11 and section 12 of the *Representative for Children and Youth Act (RCY Act)*. MCFD is responsible for reporting these deaths and critical injuries of children to the Representative.

The sample for this review was drawn from all deaths of infants age two and under reported to the Representative from June 1, 2007 to May 31, 2009. This time frame was chosen because most of the investigations by other public bodies had been concluded and the files closed when the review began.

During that time period, the deaths of 66 infants under the age of two were reported to the Representative. The Select Standing Committee on Children and Youth had referred an additional three infant deaths that occurred prior to June 1, 2007 to the Representative, for a total of 69 deaths of infants aged two years and under.

The 69 deaths were screened to determine if they met the Representative's criteria for review as set out in the *RCY Act*. The following criteria were applied:

- the infant or the infant's family received a reviewable service within the year previous to the death; and
- the policies or practices of a public body or director may have contributed to the death; and
- the infant's death or circumstances of the death were an example of a recurring circumstance observed in other deaths; or
- the death occurred in unusual or suspicious circumstances; or
- the death was or may have been due to child maltreatment.

The Select Standing Committee on Children and Youth (SSCCY) is a parliamentary committee with a mandate to increase the awareness and understanding of the B.C. child welfare system among legislators and the public.

The SSCCY's role includes the following:

- receive and review the annual service plan from the Representative for Children and Youth
- be the committee to which the Representative reports (at least annually)
- refer to the Representative for investigation the critical injury or death of a child
- receive and consider all reports and plans delivered by the Representative to the Speaker of the Legislative Assembly of British Columbia.

Thirty-two deaths met the criteria for review. The following additional selection criteria were then applied:

- The infant's death initially appeared to be unexpected and sleep-related, based on the circumstances reported.
- The infant's death was not the subject of an ongoing criminal investigation.

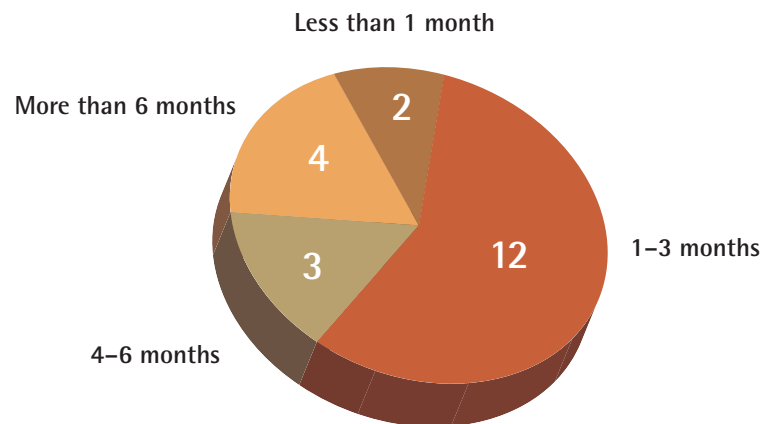
This resulted in 21 infant deaths being selected for the aggregate review.

Process for Selecting the 21 Infants and Families for this Aggregate Review



Police attended the scenes of all 21 infant deaths. The police investigations determined that the deaths did not occur in suspicious circumstances, and criminal proceedings were not initiated. At the time of their deaths, the infants ranged in age up to 21 months.

Over half of the deaths occurred between the ages of one and three months.



The map below illustrates the regions where the infants lived with their families.



Nineteen of the infants and families were primarily served by MCFD, and two of the infants and families had been solely served by a delegated Aboriginal Agency. Three of the 21 infants were children in the care of the ministry.

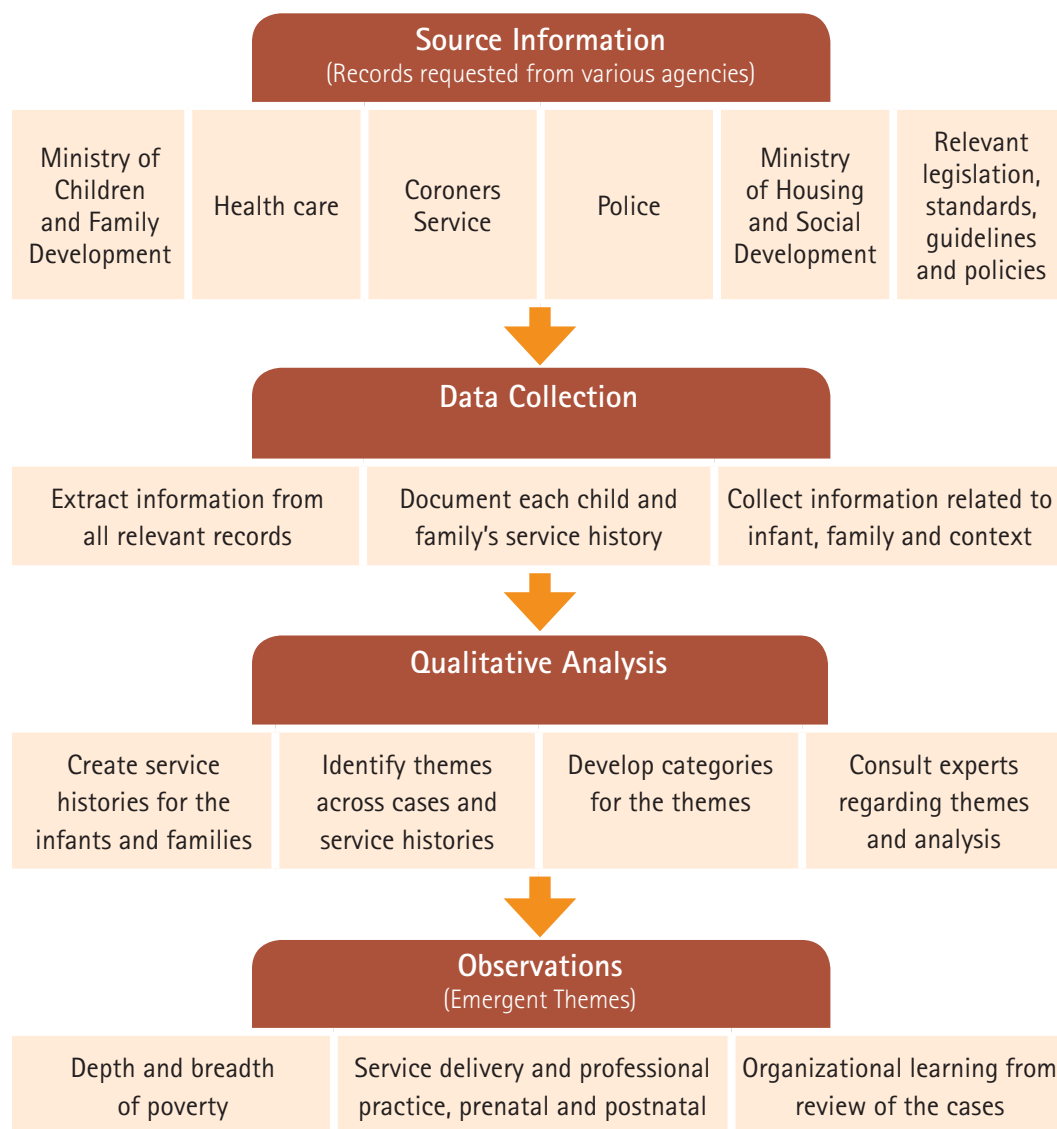
Records relating to each of the infants and their families were requested and received from MCFD (which also provided relevant records from delegated Aboriginal Agencies), the Ministry of Housing and Social Development, the regional health authorities, the Ministry of Health Services, the BC Coroners Service, the RCMP and municipal police departments (see Appendix B for a detailed list of documents reviewed).

These records were thoroughly reviewed to identify any patterns or common factors that may have presented risks to these infants, as well as the nature, level and intensity of services or supports that their families received.

The data collected from source records was examined by two reviewers. Service histories were documented for each infant and their families. The service histories were analyzed using a qualitative approach.

Themes were identified across the infant and family service histories, and categories were developed for the themes. The Multidisciplinary Team was consulted to assist with the analysis (see Appendix D, Multidisciplinary Team members). The following diagram illustrates the data collection and analysis process used in this review.

Data Collection and Analysis Process



Because this was a review under the *RCY Act* rather than an investigation, family members and service providers were not individually interviewed by the Representative's Office.

Background

Historically, sudden infant death syndrome (SIDS)⁴ was the term used to classify deaths of infants who died suddenly and unexpectedly with no conclusive physical finding. Over the years, risk factors for sudden infant death have been recognized. In B.C. there has been a shift in definition, and external risk factors are now being noted and tracked by the BC Coroners Service in collaboration with the BC Vital Statistics Agency.

The BC Coroners Service is responsible for the investigation and classification of all unnatural, sudden and unexpected, unexplained or unattended deaths. The Coroners Service has provincial responsibility for determining the facts surrounding a death as well as determining the classification of deaths. Deaths are classified as natural, accidental, suicide, homicide or undetermined.

In 2004 the Coroners Service adopted the term “sudden unexplained death in infancy” (SUDI) to reflect the sudden, unexpected and unexplained death of an infant under one year of age where there is no anatomical cause of death at autopsy, but known external risk factors are identified that could have been contributory to the death. Examples of risk factors include sleep position, sleep environment and sleep surface.

In 2007 the Representative, the Chief Coroner, the Provincial Health Officer and MCFD observed that an unusual number of sudden infant deaths were occurring on Vancouver Island. The Chief Coroner at the time directed staff to take a detailed look at the sudden infant death cases on both Vancouver Island and throughout the province. The Coroner’s preliminary information was that the majority of deaths involved unsafe sleep practices.

In 2008 the BC Coroners Service issued a public safety bulletin on infant deaths confirming that unsafe sleep practices were risk factors identified in sudden infant deaths. The bulletin encouraged parents and caregivers to follow the recommendations of the Canadian Paediatric Society on infant safe sleep environments and practices (see Appendix C).

In 2009 the Child Death Review Unit (CDRU) of the BC Coroners Service, which has a mandate to examine how and why children die, released *Safe and Sound: A Five Year Retrospective - Report on Sudden Infant Death in Sleep-related Circumstances*. The report made recommendations in a number of areas, including prenatal care, public education and public health home visiting and research (see Appendix C for report recommendations).

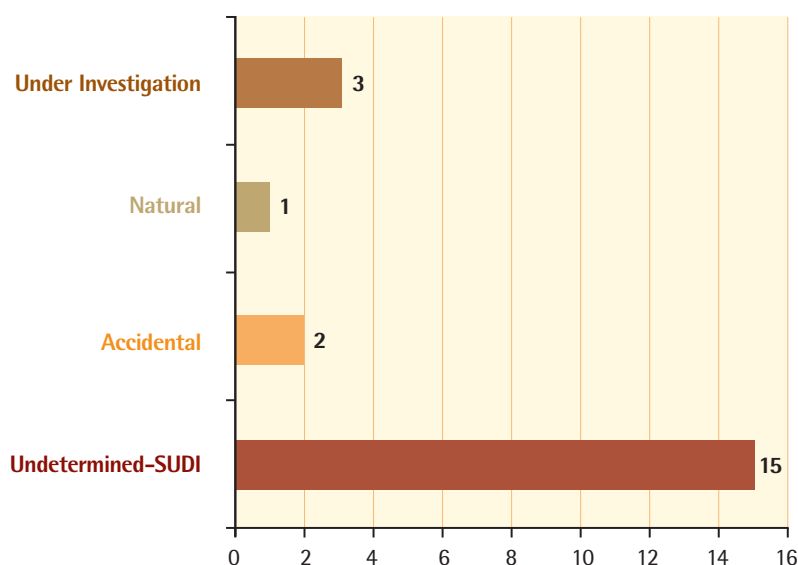
A “cluster” review was also completed by MCFD in 2008 following the deaths of five infants on Vancouver Island who had received child welfare services. These infants died within a one-month period in 2007. The purpose of the review was to analyze the five deaths to determine if immediate policy or practice changes were necessary. The overall

⁴ BC Coroners Service (2009, p. 41) *Safe and Sound: A five year retrospective - Report on Sudden Infant Death in Sleep-related Circumstances*.

conclusion of the resulting report was that known risk factors related to SIDS and safe sleeping practices were present in each death. (The recommendations arising from the MCFD cluster review are available in Appendix C.)

The Coroners Service has completed investigations into 18 of the 21 infant deaths in this review. Three remain under investigation. To date, 15 of the deaths have been classified as undetermined – sudden unexplained death in infancy. Three have been classified as natural or accidental.

The diagram below indicates the Coroners Service classifications of the deaths.



Over the 10-year period from 1999 to 2008, 1,716 infants under the age of two died in B.C.⁵ Although the numbers vary from year to year, there is no significant overall trend in the number of deaths that occurred during this time period.

This aggregate review covers the time period from June 1, 2007 to May 31, 2009. During that period, according to BC Vital Statistics, 348 infants under the age of two died in British Columbia. Nineteen of those deaths are included in this review. The other two deaths were outside of this time frame but were referred to the Representative by the Select Standing Committee on Children and Youth.

BC Vital Statistics Agency also uses the International Classification of Diseases-10 codes (ICD-10) for classifying deaths. The ICD-10 is “a system of coding diseases, signs, symptoms, social circumstances and external causes of injury or disease endorsed by the World Health Organization.”⁶ Sleep-related deaths in this system are all referred to as sudden infant death syndrome (SIDS). External risk factors are listed within the SIDS classification group as sub-groups. The term “sudden unexplained death in infancy” does not exist in the ICD-10 classification system.

⁵ BC Vital Statistics Agency, 2010.

⁶ BC Coroners Service (2009, p.40). *Safe and Sound: A five year retrospective - Report on Sudden Infant Death in Sleep-related Circumstances.*

Since the terminology used by the Coroners Service to describe and classify sudden infant death in sleep-related circumstances has changed over time, and because terminology and classification of infant deaths varies across organizational sources and jurisdictions, it was not possible for the purposes of this review to reliably determine and compare infant death rates from unexplained deaths within and between jurisdictions or over time.

Aboriginal Infant Mortality

The number of Aboriginal infant deaths cannot be accurately reported at this time because quality data for this group does not exist. However, valid statistics are available for Status Indians. A new methodology is currently being developed in partnership with First Nations communities to improve accuracy in reporting on Aboriginal population data.

Fifteen of the 21 infants who were included in the review were Aboriginal. Nine of these 15 infants lived on Vancouver Island. The high proportion of Aboriginal infant deaths and the number that occurred on Vancouver Island are of concern.

The infant mortality rate measures the number of infants who die in the first year of life, expressed as a rate per 1,000 live births. About eight of every 1,000 Status Indian⁷ infants die in their first year, compared with a rate of about four infant deaths per 1,000 non-Aboriginal British Columbians. According to 2006 data from the Ministry of Health, there is an average of 27 Status Indian infant deaths each year in British Columbia.

In 2003 the Provincial Health Officer for British Columbia issued a report highlighting the disparities in infant mortality rates between various population groups. Status Indian infants were noted to have an increased rate of mortality between the ages of 27 days and 374 days, and infants born with a low birth weight⁸ also showed an increased risk of mortality.

The Provincial Health Officer's report suggested ways to improve infant mortality rates in B.C. and highlighted disparities in infant mortality rates, particularly in First Nations communities. The state of maternal and child health and child welfare services in B.C. was not a focus of the Provincial Health Officer's report.

One tentative explanation for some Aboriginal infant deaths is a particular genetic variant that is prevalent in certain Aboriginal populations, known as CPT 1. This genetic variant is being investigated in studies in Nunavut, Alaska and B.C. to clarify its association with sudden unexpected infant death (see Appendix E for more information).

⁷ Status Indian – Recognition by the federal government of persons registered under the *Indian Act* is referred to as Registered Indian Status. Status Indians are entitled to a wide range of programs and services offered by federal agencies, provincial governments and the private sector.

⁸ Low birth weight: birth weight of less than 2,500 grams.

Lives of the Infants and Families

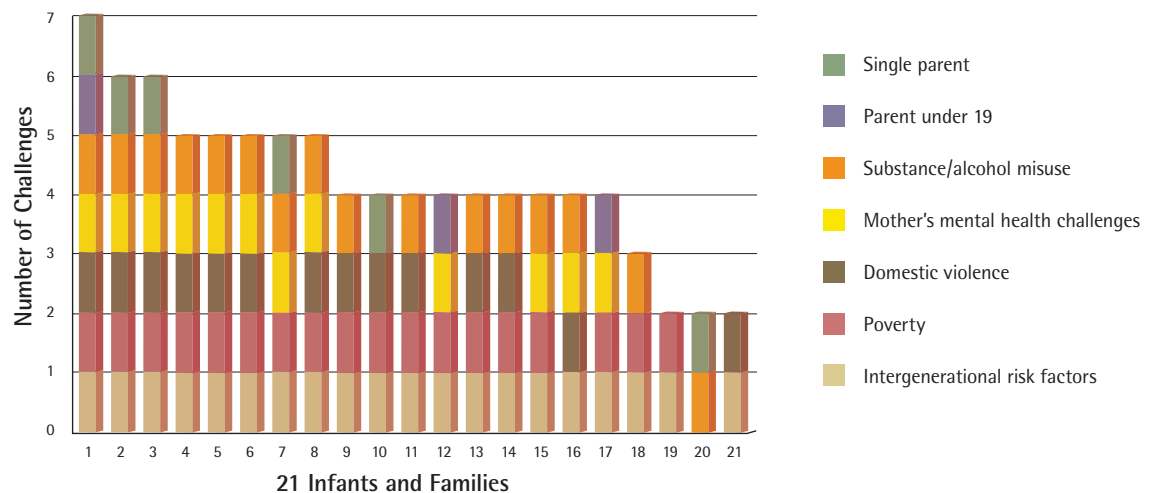
It is important to understand the life circumstances of these 21 infants and their families.

The infants and families included in this aggregate review lived in vulnerable circumstances with multiple risk factors present in their lives. The risk factors noted in the files reviewed include poverty (both deep and/or transitional), exposure to domestic violence, parental mental health challenges, parental substance and/or alcohol misuse as well as intergenerational trauma in the parents' families of origin.

The compounding effect of multiple risk factors is particularly noteworthy and may have had a large impact on infant well-being. All of the families had at least two significant risk factors, and the majority had four or more.

Displayed below are the multiple risk factors and demographic factors present in the records reviewed for each of the infants and their families.

Common Challenges in the Lives of the Infants and Families



Within the infants' families there were significant patterns of intergenerational issues associated with vulnerability spanning multiple generations. Interventions from child welfare agencies in the previous generation had not generally been effective in reducing or eliminating these risk factors, suggesting they were either persistent despite public supports or those public supports were not effective or responsive.

Intergenerational trauma, also called intergenerational transfer of psychosocial risk, is the tendency of a person when they become a parent to repeat the abuse or neglect that they themselves suffered as a child. The *World of Abnormal Rearing* identifies this as the first factor in assessing risk to a child and notes that a child raised in this environment may go on to repeat the abuse when they become a parent (Helfer, 1987). This is particularly true regarding the impact of residential schools on First Nations families which "created a veritable wave of suffering that continues to wash over generation after successive generation of Aboriginal people" (Smith, Varcoe, Edwards, 2005).

Intergenerational challenges included:

- documented history of abuse or neglect in the mother's family of origin in 15 of the 21 families
- substance abuse in previous generations of 15 families
- six of the infants' mothers had been in the care of MCFD at some point during their own childhood
- documented mental health issues in previous generations of six families
- documented domestic violence concerns in previous generations of eight of the families.

Information related to the father's family of origin was not documented in a systematic manner in the files; therefore, data related to the infant's fathers and their families of origin is not presented in this report.

Similar patterns were observed and documented within the infants' immediate families:

- domestic violence in the immediate families for 14 infants
- substance abuse in the immediate families for 16 infants
- mental health issues such as depression, anxiety and suicidal behaviour in the immediate families for 12 infants.

Neglect and maltreatment in childhood is known to be a variable that can be used to predict the likelihood of a parent mistreating their own child. It has been estimated that one-third of children who are maltreated become abusive or neglectful parents.⁹

In families where there is a history of maltreatment in either of the parent's family of origin, maltreatment is more likely to occur if other risk factors are also present.¹⁰ In the cases reviewed for this report, the most frequently cited issues in both the immediate family and the families of origin were substance abuse, mental health, domestic violence, neglect, suicide attempts and family instability.

The 2010 Canadian Incidence Study of Reported Child Abuse and Neglect found that being a victim of domestic violence (46 per cent) and having mental health issues (12 per cent) were the most frequent concerns identified by social workers in relation to primary caregivers.

Domestic Violence: The abuse and/or assault of adults or adolescents by their intimate partners.

⁹ Peirson, Laurendeau & Chamberland, 2001.

¹⁰ Mikkonen & Raphael, 2010.

Case Example

The mother of this First Nations infant was actively involved with MCFD child protection social workers during the prenatal period due to concerns regarding the care and safety of an infant sibling.

The MCFD file information indicated a lengthy history of involvement with the infant's family over a number of generations. When the infant's mother was a child, she had been removed from the care of her own parents due to domestic violence, mental health issues, neglect, sexual abuse and lack of medical attention. The infant's grandparents had suffered the impacts of attending residential schools and lived in severe poverty. The infant's mother was suspected to have been affected by prenatal exposure to alcohol.

Numerous health hazards in the family's home had been reported to MCFD. Despite the information regarding the historical abuses affecting the family and active child protection involvement, no discharge planning was done by MCFD and the hospital when the infant was born. MCFD did not make contact with the family until six weeks after the birth. Public Health had extensive and frequent contact, noting the infant's medical concerns relating to care and hospitalization for failure to thrive. MCFD was not advised of the hospitalization, nor did they appear to be monitoring the situation in order to know that the infant had been hospitalized.

MCFD received another report regarding the infant's care, and the infant was removed from parental care at approximately four months of age. At the time of placement in the foster home, the foster parent noted that the infant's body was covered with eczema and that the infant made "odd sounds." The foster parent attempted to access medical care for the infant at a walk-in clinic but did not get to the clinic before it closed for the day. The infant died that night. The death was identified as sudden unexplained death in infancy with contributing health problems.



Analysis and Recommendations

Overall Finding

Given the significant risks these infants faced, it is not possible to conclude whether their deaths were preventable. However, the lack of rigorous, integrated planning and system-wide tools for risk assessment and intervention both within and across the public health, medical and child welfare systems led to many missed opportunities for prevention and effective response.

This review illustrates a patchwork of services and limited supports to vulnerable infants and their families in British Columbia. It raises questions about why, in a number of situations, the response to significant concerns about an infant's safety did not address the severity of the presenting circumstance. One might question whether service providers had the tools they needed to intervene in a preventive manner, were unclear about their roles and responsibilities, were frustrated by a lack of resources or had, over time, become desensitized to the desperate circumstances of these families and infants. The life circumstances of the Aboriginal infants and their families in this review were particularly challenging.

An integrated, collaborative and consistent system of services may have made a significant difference in the lives of these infants. It can reasonably be presumed that had such a system been in place, some of these deaths may have been prevented. An effective system must address barriers to integration, including divided service responsibilities such as those seen between the provincial and federal governments. Until we have such a system in place, we cannot assume that vulnerable infants are safe and that unnecessary infant deaths are being prevented.

Infants are completely reliant upon adults to meet their needs, including the essentials of life. A baby born into a family struggling financially, socially and emotionally faces significant risks to its health and well-being and is highly vulnerable.

Research indicates that the risk of negative outcomes is increased by the presence of more than one vulnerability at the same time.¹¹ The vulnerability of a child is increased when other risk factors such as prenatal exposure to harmful substances, poverty and inadequate housing are co-occurring.¹²

Resilience refers to the internal and external qualities that help a person, family or community cope with difficult situations and overcome adversity. Some of the factors that contribute to resilience include social and/or community support, a sense of competence, self-esteem, temperament, social maturity, past coping ability, positive relationships, humour and morality.¹³ The importance of consistency and quality of

¹¹ Nelson, Laurendeau, Chamberland & Peirson, 2001.

¹² Mikkonen & Raphael, 2010.

¹³ Winfield, 1994; Brackenreed, 2010.

care and support to children during development as well as adequate and consistent role models continues to be discussed in the literature on family resilience.¹⁴

The families included in this report were struggling for a number of different reasons and were at risk due to a variety of social, financial, emotional and medical factors. They were all known to the child welfare system, some for generations, and had been identified as vulnerable or requiring services. The degree, intensity and consistency of support they received generally was inadequate.

Economic Well-Being

Observations: As a group, these infants lived in serious poverty and inadequate housing. They lived in conditions that would be difficult for mainstream British Columbians to imagine, and their quality of life suffered as a result.

Child poverty and inadequate housing are issues that are well known, and they are acknowledged by all levels of government. These cases starkly illustrate the inability of these families to improve their life circumstances across generations, with devastating results. Concrete and effective prevention measures are required to make a difference in the lives of infants and children. Supports to enable change may not have been adequate or effective for previous generations.

There is no “official” definition and measure of poverty in Canada or in British Columbia. Different organizations in Canada measure poverty in different ways. It can be thought of in economic terms or in terms of social impact (e.g., marginalization). Some definitions of poverty take in a broad range of factors, including:

- standards of living
- ability to meet survival needs
- whether poverty is transitional, chronic or intergenerational
- the causes of poverty, from individual to societal and systemic inequalities.

The receipt of income or social assistance is closely connected to poverty, especially among Aboriginal people. For this report, records were reviewed to determine if the families received some form of financial support, including provincial income assistance or federal social assistance for families residing on reserve.

Income assistance rates, whether provided by the B.C. government or, in the case of Status Indians living on reserve, by the federal government can be described as subsistence incomes.¹⁵

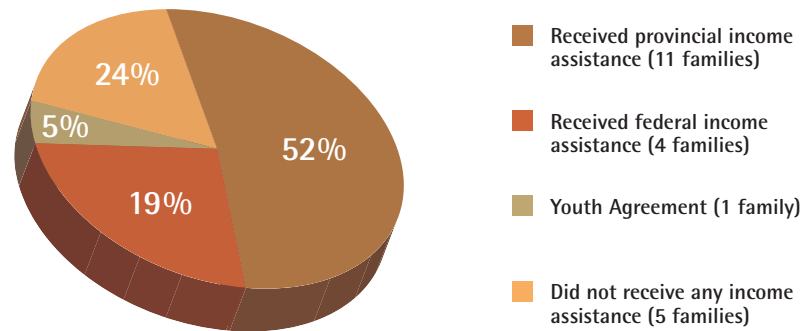
For example, an employable one-parent family with four children under the age of 18 would receive a minimum of \$375.58 support allowance per month and a shelter allowance of \$750 per month. Expecting mothers are eligible to receive a prenatal

¹⁴ West & Farrington, 1973; Brackenreed, 2010.

¹⁵ Statistics Canada (2008) *Income in Canada*. Statistics Canada Catalogue no. 75-202-XIE (as cited in First Call, 2010)

allowance of \$45 per month for up to six months following birth. Depending on family circumstances, income can be affected by other provincial and federal government supports, such as the child tax benefit, GST/HST tax credits and disability benefits.¹⁶

Families Receiving Financial Support



From the prenatal period up to and including the time of the infants' deaths:

- Of the 21 families, 16 were receiving financial support (one parent received financial assistance through a youth agreement with MCFD).
- Of the five families that were not receiving financial support, two resided with extended family. No income assistance or support was indicated for three of the families during the reviewed time period.

Youth Agreement: A provision of the *CFCS Act*. A youth agreement may provide one or more services, such as "residential, educational or other support services" and/or "financial assistance." These youth are not considered to be "in care."

According to the 2010 Child Poverty Report Card,¹⁷ Newfoundland, Nova Scotia, New Brunswick, Quebec, Ontario, Manitoba and the Northwest Territories have committed to provincial poverty reduction plans. In October 2010 Nunavut announced the beginning of a public engagement process that may lead to an anti-poverty strategy for the territory. British Columbia does not have a provincial plan to reduce poverty.

Despite a drop in B.C.'s overall child poverty rate between 2007 and 2008, B.C. continues to have the worst child poverty record in the country for the sixth year in a row based on after-tax measures, specifically low income after cut-off (LICO).¹⁸ Provincially, the rate of child poverty is 10.4 per cent, higher than the national average of 9.1 per cent. The Canadian Paediatric Society rated B.C. "poor" in addressing child poverty in their 2009 report.¹⁹

¹⁶ Ministry of Housing and Social Development, 2007 (now Ministry of Social Development).

¹⁷ First Call, BC Child and Youth Advocacy Coalition, 2010.

¹⁸ Statistics Canada. 2008. *Income in Canada*. Statistics Canada Catalogue no. 75-202-XIE.

¹⁹ A "poor" rating means a province has neither legislation nor a strategy to reduce child poverty. (Canadian Paediatric Society, 2009).

In B.C. most poverty data excludes on-reserve First Nations due to data limitations. Generalized results of poverty assessments fail to capture the depth and breadth of the deprivation and marginalization of this experience.

The percentage of children living in low income is possibly the most widely used indicator of child well-being. Low income has a negative influence on a number of dimensions of child-health and development. Socio-economic disadvantage is associated with increased risks of poor outcomes, both in the short term and the long term, in the areas of health, safety, education and family stress. Children living in low-income families are more likely to have problems with one or more basic abilities (vision, hearing, mobility and speech) and are more likely to experience developmental delay in vocabulary development, difficulty in school, injuries due to accidents or physical abuse or neglect. They are more likely to be involved with the child welfare and youth justice systems, to become teen parents, to earn less as adults and to be more frequently unemployed.

Growing Up in B.C., BC Representative for Children and Youth and Provincial Health Officer, 2010, p. 37.

Poverty experienced by children and youth is usually linked to parental poverty (e.g., poor nutrition or inadequate shelter) and childhood deprivation (e.g., being forced to leave school early or do dangerous work) and can have implications across the life-course.

The key drivers of chronic poverty include the following:

- severe and/or repeated shocks (e.g., ill health and injury, market and economic collapse, violence and conflict)
- ineffective institutional support (e.g., lack of effective social protection)
- poverty occurring at certain points in an individual's or household's life-course (e.g., in utero, childhood, old age, youth and youth households).²⁰

Different explanations for the cause of poverty have influenced social policy approaches to “curing the problem of poverty.” The approaches range from providing financial support directly to families to providing support services available outside the home.²¹ None of the approaches taken seem to have made a difference for the families included in this review. The social policy foundations for responding to poverty issues in B.C. are not clear, and there have been inadequate measures to address the need for mobility.

The families in this review, particularly the Aboriginal families, were typically mired in chronic, deep poverty that was the single largest risk factor in their environment. Changing the lives of children in these families requires strategies to deal with the immediate poverty circumstance as well as strategies to encourage more long-term solutions.

²⁰ Moore, 2004.

²¹ Mayer, 1998.

The Representative continues to advocate strongly for a comprehensive provincial poverty reduction plan, and has frequently addressed the Select Standing Committee on Children and Youth on this matter because of the correlation of poverty with compromised child development outcomes. Given that poverty was the most significant and common risk factor in the lives of these infants, the Representative once again urgently calls for the development and implementation of this plan.

The families of the infants in this review also faced significant issues in obtaining stable and adequate housing, which is critical to an infant's well-being and ability to thrive. Inadequate housing is connected to poor health outcomes.²² Inadequate housing conditions independently cause negative health outcomes, even when considered apart from other issues such as poverty.²³ Twelve of the 21 infants lived in inadequate housing, and 10 of the 12 were Aboriginal.

In this review, housing was found to be inadequate if any of the following were referenced in the file information:

- the family was living in housing described as overcrowded or inadequate
- the family lived in shelters, group homes, motels or transition housing
- the family was on a waitlist for housing.

Some families resided in the most extreme circumstances of deprivation, including:

- a home that was severely contaminated with mould
- frequent moves
- lack of a permanent residence
- regular use of transition homes and motel accommodation in lieu of permanent, stable housing.

²² Durbin, 2009.

²³ Mikkonen and Raphael, 2010.

Case Example

This First Nations child was born into a home with other young children. The family lived in poverty and often relied on relatives, transition housing and motels for accommodation. MCFD became aware that the mother was expecting early in her pregnancy.

The mother had been admitted to hospital after being assaulted by her spouse during her pregnancy. Prior to the infant's birth, 14 child protection reports had been made to the ministry, primarily about alcohol abuse and domestic violence. Four of these reports were made while the mother was pregnant with this infant; they included concerns about inadequate housing, emotional abuse of the infant's siblings and substance abuse. One of the reports was investigated and not substantiated. The other three were not investigated. The MCFD file was closed before the infant was born.

According to the MCFD file information, the newborn was assessed at birth by a program in the local hospital that worked in conjunction with the public health unit. The program reportedly assessed newborns for medical as well as social/emotional risk factors. The newborn was assessed by the program as low risk and was discharged from hospital the following day. It does not appear the hospital was aware that the family had no reasonable housing and a history of substance abuse and family violence. It appears this MCFD information was not shared with the hospital following the infant's birth.

The infant was seen three times by public health nurses from birth to three months of age. At the second visit, the mother reported that the infant had noisy breathing while asleep, which a doctor thought was possibly the result of a floppy epiglottis.

Approximately two months later the mother took the infant to see a doctor because the noisy breathing persisted and a cough had developed. The doctor thought these symptoms were possibly due to an infection and prescribed amoxicillin. At the third visit with the public health nurse, the mother informed the nurse that the infant's noisy breathing persisted, and she also informed the nurse about the previous visit to the doctor. No follow-up regarding the infant's breathing was noted on the record of the visit.

The infant died four days after the last visit with the public health nurse. On the evening of the death the infant had been left in the care of adolescent babysitters. There was no crib in the home. The babysitters placed the infant to sleep in a car seat that was on top of a soft mattress. Sometime later the car seat turned over, and the baby was asphyxiated.

At a special meeting on child poverty convened by the Select Standing Committee on Children and Youth on May 21, 2010, the BC Child and Youth Advocacy Coalition, stated: “The poorest of the poor don’t have access to supports for adequate housing... because of inadequate housing, children are being removed from their families because of concerns about neglect. Safe neighbourhoods and safe housing make a huge difference – and support parents. When we invest in that, communities support each other. But when you’re living in an impoverished community and nobody has anything extra, how do they support each other?”

Case Example

One of the infants resided with an adolescent mother and a grandmother in a motel. Over a two-month period, 10 individual service providers had some involvement with the mother and infant, including child protection social workers, hospital social workers, public health nurses, hospital workers and a family support worker.

A public health nurse had observed the infant’s living conditions and documented that the family was to be “observed” for emotional status, postpartum depression and family functioning; however, the nurse also recorded “no apparent problem” in the notes of the visit. A second nurse who visited also documented that the family should be observed for provision of a safe environment and support systems.

During at least one of the visits, the nurse noted that two adults were smoking inside the motel room with the infant present. It was also noted that the mother smoked and used marijuana. The nurse advised the mother to wait two hours after doing so before breastfeeding the infant. However, in a follow-up conversation with the child protection worker, the nurse expressed no concerns related to the infant’s care. The infant’s living conditions were not noted as a concern for the service providers.

First Nations communities consistently struggle with a shortage of adequate housing. It has been estimated that 17 per cent of on-reserve housing is in need of major repairs and that 5,000 housing units nationwide require replacing.²⁴

Waitlists for on-reserve housing can be lengthy. Waitlists for adequate housing in some B.C. First Nations communities can range from two to 10 years. In addition, housing allocation policies do not typically consider family needs in prioritizing who gets access to housing when it does become available. Nor is there a market housing solution for those who can afford to pay so that social housing can be better targeted to need.

In the following case example, services were provided to the family in an apparent effort to address their struggle with inadequate housing. However, the services provided did not match the family’s needs.

²⁴ Office of the Provincial Health Officer, 2009.

Case Example

The mother of this infant was involved with MCFD child protection social workers during her pregnancy. She had two toddlers. The family lived on reserve in a home that had extensive mould. The pregnancy was assessed as high risk, and the mother was confined to bed rest.

A service agency was contracted to provide assistance to the family to address housing-related issues. One of the stated goals of the service provider was for the family to find adequate housing. During the final weeks of her high-risk pregnancy and in the first few weeks following the infant's birth, it appears that the infant's mother was expected to locate adequate living conditions. In the months following the infant's birth, it appears that the only help the mother received from the service provider was housing lists and contact phone numbers for low-income housing agencies.

The infant was brought to the hospital three times between the ages of one month and five months for coughing, vomiting, fever and breathing difficulties. At approximately six weeks old, the infant was diagnosed with respiratory syncytial virus. At that same time a sibling was admitted to hospital and diagnosed with pneumonia. In the hospital the infant's mother advised the treating physician of her concerns with regards to the mould in the family's residence.

A few weeks after the infant was born, an MCFD social worker wrote a letter to B.C. Housing and a low-income housing provider requesting that the family be given priority on a waitlist for housing because all of the children were frequently ill with respiratory illnesses thought to be related to the mould in the house. A year later the family was still waitlisted for housing and had to move off reserve into a motel with the young children when the infant was one year old.

One day while the mother was at work, the children were being cared for by their father. The infant was placed to sleep on an adult bed in the room, propped up with a pillow and covered with a blanket. The infant began to vomit and defecate. The infant's breathing became noisy and irregular, and the infant became unresponsive. Emergency health services were called and took the infant to the hospital, where the infant was pronounced dead.

Locating adequate housing off reserve can be equally challenging for families and can mean the loss of association with other members of their families and First Nation communities.

In 2008, during the time frame covered by this review, the B.C. Office of Housing and Construction Standards released a summary report titled *Aboriginal Housing in B.C.* The authors of the report conducted community engagement sessions around the province and heard from members of both First Nations and Métis communities.

The report found a shortage of housing for Aboriginal people residing off reserve was connected in part to barriers such as income, inconsistent information about waitlists and racially based discrimination. Furthermore, the report noted that more than 28 per cent of the Aboriginal population in B.C. is deemed to be in core housing need compared to 16 per cent of the non-Aboriginal population.²⁵

In 2008 a memorandum of understanding (MOU) on housing for First Nations in B.C. was signed by the First Nations Leadership Council, Indian and Northern Affairs Canada and the government of British Columbia. The MOU stated:

“Housing and infrastructure quality are among the factors linked to the socio-economic disparities faced by some First Nations in British Columbia. Actions to support safe and affordable housing and infrastructure for First Nations communities, individuals and families will assist in addressing these disparities. The Parties agree to work together to develop a comprehensive approach to housing and explore opportunities to address issues along the full range of the housing continuum for First Nations communities, individuals and families both on and off reserve.”²⁶

This MOU is a positive step; however, action has been slow on tangible improvements. Housing issues for a First Nations family were the subject of a prior investigation by the Representative for Children and Youth in the case of a serious injury of an infant. The overall finding of the investigation was:

“The child welfare system entered into [the] child’s life in response to child protection reports from the community, but its ongoing impact on the child’s life related to his parent’s poverty and inability to afford housing that met the ministry’s standards.” The investigation also found that in the child’s First Nations community, many lived in overcrowded conditions “not by choice... [rather] as a practical way of coping with a lack of housing in the absence of any real alternative.”²⁷

The housing situation for poor families, especially Aboriginal families, can be described as a provincial crisis that has extremely negative impacts on the health and well-being of infants and children. Although the issue is acknowledged by all levels of government, a detailed action plan with performance measures to track improvement is required to give today’s children, and the generation to come, the chance to thrive.

²⁵ BC Office of Housing and Construction, 2008. Core Housing Need is the national standard measuring housing need. Canadian households are considered to be in core housing need if they do not live in and could not access housing that is in adequate condition and of suitable size without paying more than 30 per cent of gross household income to rent.

²⁶ The Union of BC Indian Chiefs, 2008.

²⁷ *Housing, Help and Hope: A Better Path for Struggling Families*, Representative for Children and Youth, 2009.

Recommendation 1

That B.C. develop a non-partisan child poverty plan, with leadership from the Premier's Office, through a special initiative that identifies strategies to address all aspects of child poverty in the province, including specific strategies to address poverty affecting Aboriginal children and families.

Detail:

The plan should have the following characteristics:

- involve Aboriginal leaders and the federal government as partners
- provide an integrated set of cross-ministry initiatives to address child poverty
- include measures to address adequate housing for families in poverty
- include measurable targets
- provide opportunities for meaningful public reporting on a semi-annual basis
- include initiatives to improve educational outcomes
- include non-partisan social and economic policy research and evaluation of strategies.

That the Representative be provided with a progress report by June 1, 2011.

Prenatal Service Provision and Professional Practice

Observations: *All of the families in this review had been involved with MCFD during or prior to the prenatal period. There is no comprehensive approach to prenatal public health care that is available to all expecting mothers in B.C.*

In a number of the 21 families, concerns were related to other children in the family. In some circumstances child protection investigations were conducted. In many circumstances MCFD's own standards for those investigations were not met. There was little evidence of follow-through or of available information about risk being used to develop an integrated plan to address vulnerability.

Health Care

The availability of prenatal services depends on the size of the community, the geographic location and the resources available. They are delivered by a variety of health professionals, including physicians, midwives, community-based services, public health nurses and pregnancy outreach programs.

Although all women in B.C. are eligible for prenatal medical care, access to and use of these services varies. In the 2009 report *Pathways to Healing* the Provincial Health Officer identified 15 or more prenatal visits with a physician as more than adequate, nine to 15 prenatal visits as adequate and fewer than nine visits as inadequate prenatal care.

The Provincial Health Officer noted the association between inadequate prenatal care and infant mortality rates and that inadequate prenatal care was twice as common among Status Indian mothers.

Information with respect to prenatal care provided by physicians of the mothers of 19 of the 21 infants was available in the form of Medical Services Plan physician billing records. In two cases no information about prenatal care was available because the mothers moved to B.C. shortly before giving birth.

The available information was reviewed with the help of a consultant pediatrician. Although the information was limited by its nature, it was apparent that all 19 of the mothers had prenatal contact with a physician. The frequency of contact varied. The nature and quality of the contact cannot be determined because the available information was contact information rather than detailed medical records.

Based on the Provincial Health Officer's criteria of nine to 15 visits, approximately two-thirds of the mothers had an adequate number of prenatal visits. There did not appear to be a difference between the Aboriginal and non-Aboriginal mothers. For the remaining five mothers, all of whom were Aboriginal, file information gave rise to concerns about clearly suboptimal prenatal care:

- One mother did not attend her first medical visit until she was at 30 weeks gestation, much later than recommended.

- Two mothers had significant breaks in prenatal medical care, although they had an adequate number of visits.
- One mother received no prenatal care.
- One mother had few contacts with her physician.

There is currently no provincial prenatal public health program with standards or performance accountabilities delivered consistently across B.C.²⁸

A 2005 report entitled *Public Health Nurse Home Visiting for Vulnerable Families*²⁹ states that the “lack of Public Health Nursing (PHN) programming in the prenatal period is a pressing issue in Canada as well as B.C.” The report also noted that public health literature demonstrates that intensive public health nurse home visiting from the prenatal period into early childhood results in the best outcomes for vulnerable families. Unfortunately, in B.C. the programming for the prenatal period has not been an area of focus despite the pivotal role that public health nurses could play in improving early childhood outcomes through involvement in the prenatal period.

Historically, public health units in B.C. provided prenatal classes. However, at present, prenatal classes are typically contracted by the health authorities and pregnancy outreach programs. Prenatal classes are not usually free. A bursary is available for those in need. Some prenatal classes can cost up to \$300. Aboriginal women living on reserve can also access programs provided on reserve.³⁰

Records of services provided by public health nurses were also reviewed. These records did not generally indicate prenatal contact. There was one circumstance observed where a public health nurse participated in an integrated case management meeting prior to the infant’s birth. In the rest of the cases it appears that public health involvement began after the infant was born.

Pregnancy outreach programs are established in B.C. for women who may not access prenatal services and for those who are at risk of poor birth outcomes. Indicators of this risk are poverty, poor nutrition, isolation/poor social support, substance use and family violence. It is not known how many of the 21 mothers accessed services through pregnancy outreach programs or attended prenatal classes, as this information was not part of the health records reviewed. However, a mother of one of the infants was unable to receive services from her local pregnancy outreach program as the program was full. In five of the 21 cases reviewed, the infant was the mother’s first child. In these circumstances access to prenatal information would be critical.

²⁸ Ministry of Healthy Living and Sport (2010).

²⁹ Interior Health Authority, 2005.

³⁰ Office of the Provincial Health Officer, 2009.

MCFD Practice

All of the families were involved with MCFD during or prior to the prenatal period. MCFD was involved for a variety of reasons, including:

- receiving a new child protection report
- participating in a youth agreement
- providing services for a child with special needs
- providing ongoing protective family support
- historical child welfare involvement.

The response of the child welfare system to requests for service or concerns about the safety and well-being of a child is mandated under the *Child, Family and Community Service Act (CFCS Act)*. MCFD's 2003 Child and Family Development Service Standards: Child and Family Service Standards (CFS) direct the assessment, investigation and response to reports of child protection concerns.

MCFD also has various guidelines and practice advisories that apply regionally for staff responding to concerns regarding an expecting mother. The policies and protocols vary in each region, and there is no provincial standard. This has resulted in the five MCFD regions developing their own policies, procedures and guidelines, resulting in inconsistent practice across the province.

MCFD provided a number of regional protocol documents dealing with their working relationship with the health authorities and hospitals. Some focused on infants who are high risk due to substance abuse by parents and provided a guideline regarding identification of risk, roles and responsibilities, discharge planning, referral, and community follow-up. Others address the reporting of and response to child protection concerns, including concerns about an expectant mother's ability to care for the expected infant. Some also include procedures for removal of infants from their mother's care at birth, and some include direction regarding prenatal integrated case planning. Some protocols include reference to delegated Aboriginal Agencies, and in one the delegated Aboriginal Agency is a signatory to the document.

There is no provincial consistency with respect to the structure and content of the protocols:

- Some provide specific and detailed direction, whereas others are very high level.
- There does not appear to be consistency with respect to interagency collaboration/ planning regarding services to high-risk parents.
- There does not appear to be a consistent expectation regarding discharge planning.
- There is an inconsistent message regarding reporting requirements and MCFD's response to reports of concerns during the prenatal period.

- There is no consistency in what constitutes high-risk circumstances where infants are prenatally exposed to harmful substances.
- Some of the protocols are out of date.

On Vancouver Island, where a guideline has been in place since 2005, it does not appear that procedures were consistently followed. It also appears that MCFD staff are confused about their role in their work with high-risk expecting parents.

When there are safety concerns regarding an expectant mother and there are no other children in the family, the *CFCS Act* does not provide the mandate to intervene on a child protection basis, but support services can be offered. When there are child safety concerns reported regarding a family that already has children and the mother is expecting, the mandate is clear. In the cases reviewed for this report, the pregnancy was not always adequately considered in risk assessment and service planning.

An expectant mother involved with child protection due to concerns about another child in the home presents a complex challenge for workers in the child protection field. They have the responsibility for assessing safety and care of the child and the capacity of the family to provide adequate care. Consideration must be given to the mother's pregnancy and the impact of an additional child in the family.

Standard 12 of CFS outlines the approach to be used when responding to a report that a child may be in need of protection. It states: "Assess every report received about a child's need for protection, and determine the most appropriate response within five calendar days of receiving the report." Appropriate responses include:

- taking no further action
- referring the family to informal and formal support services
- providing a family development response
- if the child is a youth, providing a youth service response
- conducting a child protection investigation.

In circumstances when there are active child protection concerns involving an expectant mother, the mitigation of vulnerability requires a rigorous and timely assessment and thorough planning. An incomplete assessment of the information can result in the safety and vulnerability of a child going unaddressed.

During the prenatal period 25 child protection reports were received regarding 15 of the families. The reports were made by police officers, health professionals, community professionals and community members. They generally involved concerns for the safety of the existing children in the family due to domestic violence, substance abuse, inadequate housing or inadequate supervision. Seven of the reports involved alcohol or substance abuse. Five reports involved domestic violence. In one family, four reports were received during the prenatal period, and only one of these reports was investigated. One of those not investigated involved domestic violence.

Investigations were conducted in 12 of the cases. In the other three cases there was no investigation. In one of the three cases the report was assessed and provision of support services was planned. However, the infant died before the services began. For the other two families an investigation was not conducted, although a family service file was open at the time.

Of the 12 investigations, four had not been completed by the time the mother delivered her baby. In one case three child protection reports had been made prior to the infant's birth, but the investigations were not completed until the infant was three months old.

In these cases, concerns regarding the safety of the existing children were not adequately assessed or addressed even though the mother was expecting another child, increasing the risk to all the children. Completion of these investigations would have allowed planning to occur prior to the birth of the infant to mitigate these risks. When investigations of this nature are not completed, the infant is more vulnerable at birth, especially when there has been known substance abuse or domestic violence.

Despite MCFD involvement and the expected addition of another child to the family, evidence of planning for the infant at birth and prior to discharge from the hospital was found in only three circumstances. An appropriate intervention prior to the birth of an infant would include assessing the report and developing a plan to meet the family's needs.

In 2008 MCFD released the report *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth*. The document identified a five-pillar approach to improving child welfare services over five years through prevention, early intervention, intervention and support, an Aboriginal approach and quality assurance. The document noted: "Government will place a primary focus on preventing vulnerability in children and youth by providing strong supports for individuals, families and communities...working with partner ministries...to make communities and families stronger while focusing resources where vulnerability to healthy development can be addressed."

Key actions outlined as part of the prevention pillar are indicated as development of an early years strategic plan and increasing education with regards to Fetal Alcohol Spectrum Disorders (FASD). Desired outcomes are described as an increase in the health and well-being of children and youth and a decrease in preventable vulnerabilities. The document does not describe how prevention will actually be addressed. It lacks a tangible framework for service delivery for workers who must face vulnerability every day in their front-line work with children and families. It does not describe how MCFD plans to provide workers with the tools necessary to carry out their work with families and communities and work in an integrated way with other ministries.

The Representative encourages a cross-ministry and multidisciplinary approach to lessen the vulnerability of children and families and feels strongly that every child should be cherished and that every child has a right to be safe, to have a home and a safe place to

sleep. The support of strong social work practice is critical when intervention is required with vulnerable children and families. Those working on the front lines with children and families need to be equipped with the adequate training, tools, skill sets and clinical supervision to enable them to be successful in this work.

Case Example

This infant was born to a First Nations mother who had one older child living with her. Two older children had been removed by the ministry in the past and were living with relatives. There had been 12 child protection reports over a 10-year period. The reports involved drug and alcohol abuse and domestic violence as well as exposing the children to dangerous situations and general lack of supervision and neglect. Investigations had found at one point that the family lived in very substandard housing requiring immediate attention due to the risks to the children.

The eleventh report regarding the care of the sibling was received when the mother was in the early stages of her pregnancy. It was not investigated. A second report was received subsequent to the infant's birth, which also was not investigated. Both reports were signed by a supervisor and closed. A number of months later, after another report that was not documented as a child protection report was received, the children were removed.

By not responding to the initial report, the opportunity was lost to assess the family circumstances and plan for the birth of the infant.

Hospitals

Hospitals in B.C. can set alerts on their system when requested by MCFD. Alerts may be used when an expectant mother who is considered high risk by MCFD comes to the hospital to deliver her baby. The alert notifies hospital staff to contact MCFD when the baby is born so that MCFD social workers are aware of the birth and can assess any child protection issues. The purpose of this function is to facilitate integrated service delivery between MCFD social workers and hospital staff from the time of the baby's birth.

Among the cases reviewed for this report, alerts were not commonly utilized despite knowledge of high-risk situations. Alerts with hospitals were documented in only three circumstances, despite active child protection concerns during the prenatal period. For example, in one circumstance the alert was placed six days after the infant's birth, and the hospital notified the social worker three days later.

Interagency protocols that define risk and outline the roles and responsibilities of the various agencies working with high-risk parents would minimize the likelihood of these families being missed by child welfare and the health care system and provide an opportunity for a strong, integrated approach in serving vulnerable expecting mothers and their babies.

Recommendation 2

That MCFD develop a clear policy and evidence-based strategies to support all vulnerable families in which the mother is pregnant.

Detail:

The policy and standards should require:

- collaborative assessment and case planning, including a common risk assessment tool that addresses child welfare and infant health risks
- active engagement on the part of service providers rather than passive referrals for service
- appropriate service strategies with Aboriginal communities
- clear identification of a case manager and of roles and responsibilities of all individuals on the care team
- documentation of the plan in the files of all service providers
- an implementation plan for the protocol and for any training required within each of the service sectors
- follow-up monitoring.

A progress report should be provided to the Representative by June 30, 2011.

Full implementation should be achieved by January 31, 2012.

Postnatal Service Provision and Professional Practice

Observations: *A number of agencies and professionals in B.C., including health authorities, public health programs, physicians and child welfare authorities, are involved in assessing, planning and providing support services to vulnerable infants and their families.*

This group of infants and their families were involved with a patchwork of service providers from across the health and child welfare systems. Opportunities to reduce risks and threats to the safety of the infants were lost as effective collaboration and clarity about roles and responsibilities were lacking. As a result, the responsibility for the duty of care for these infants was unclear and service responses were limited.

Health Care

Information from the B.C. Medical Services Plan's physician billing records was reviewed with the help of a consultant pediatrician. From the available information it appeared that the mothers and the infants had reasonable and expected contact with physicians in the postnatal period. A number of the infants required medical follow-up after birth for medical conditions ranging from cradle cap and thrush to respiratory issues and seizures. Although there were no instances of inattention to medical care needs, the nature and quality of the medical care received cannot be determined from the available records.

Public health services are voluntary. It is generally accepted that follow-up after a birth is a critical component of early infant care. Public health nurses generally contact mothers shortly after they go home from the hospital. Contact by a public health nurse can be in the form of a phone call or an in-person visit. Those who are not first-time mothers may receive a phone call instead of an in-person visit depending on the circumstances.

Through home visits, public health nurses have a unique opportunity to observe infants in their home environment in a non-intrusive way while assessing an infant's health and development. The nurse's role is to identify family needs and to support families through interventions and connection to resources and services, as well as to provide training and education.

In 17 of the 21 files examined, there was public health documentation titled "newborn assessment." The assessment documents identified the number of contacts with a public health nurse and the issues discussed; however, they did not include any recognizable assessment information. In some circumstances it was unclear if the contact was by phone or by a visit. In three circumstances the MCFD file noted contact with public health; however, there was no reference to that contact on the public health file.

Thirteen of the files clearly documented home visiting, which ranged from one to four visits. In one case, there was extensive and frequent public health contact. In addition, the public health records for three families noted postnatal support from a midwife.

There is no province-wide coordinated standards-based program of postnatal public health nursing services in B.C. Regional health authorities offer a variety of nurse home

In Canada the most commonly used postpartum screening tool is the Parkyn tool, developed in British Columbia in 1985. This screening tool is designed to assist health professionals in the assessment of risk factors such as congenital or acquired health challenges, developmental factors and family interaction factors that should be taken into account when determining priority and/or vulnerable families. Only one of the infants' families was assessed using this screening tool.

visiting programs, including a combination of targeted and universal prenatal, postpartum and early parenting services.

Although there are maternity discharge programs in the postpartum period, they are not available everywhere in the province. With the creation of the current regional health authorities in B.C., several public health nursing units were collapsed into larger organizational units. According to the 2005 report *Public Health Nurse Home Visiting for Vulnerable Families*, inconsistent practice exists within and across health regions, and funding varies across program areas and regions.

The report states that a “common theme across [Canada] of limited resources or declining resources dedicated to longer-term public health nurse follow-up for families is of great concern.... A provincially mandated and funded program

has the benefits of identifying standards, frameworks and outcomes and supporting evaluation efforts.”³¹

Approximately 15 per cent of women and children in B.C. are considered vulnerable or at risk for poor perinatal and child health outcomes due to socioeconomic disparities or other health-related issues.³² A standardized provincial universal and targeted program of home visits for vulnerable families could potentially fill a gap in B.C. public health programming. New approaches are required, including an effective standardized approach to assessment.

Government has committed to launch a nurse-led, in-home individual parent training program for first-time, at-risk parents and their infants, provided during pregnancy and up to two years after delivery.³³ The development of a comprehensive plan and evaluation framework to guide the implementation and evaluation of this standardized, intensive home visiting program in British Columbia are also to be undertaken as part of this program.

Targeted public health nurse visitation programs, beginning in the prenatal period and continued for an extended period after birth, have demonstrated effectiveness, including:

- improved prenatal and child health outcomes
- improved economic self-sufficiency and maternal employment
- fewer emergency department visits
- fewer unintended injuries
- decrease in number of child abuse and neglect reports
- improved mother-child interaction and improved mental health.³⁴

³¹ Reiter, 2005.

³² Ministry of Health Services, Ministry of Children and Family Development, Province of British Columbia, Nov. 2010.

³³ *Ibid.*

³⁴ Ministry of Healthy Living and Sport, 2009.

Processes and expected outcomes of targeted home visiting programs have been identified in one evidence-based program, the Nurse Family Partnership Program,³⁵ developed by Dr. David Olds, from the United States. Women enrolled in this program are visited one-on-one by a public health nurse in their own home throughout the pregnancy and for the first two years of the child's life.

The program is based on voluntary participation and is offered to women who meet eligibility criteria, including having a low income and being a young first-time mother. Women are enrolled in the program early in their pregnancy and receive their first home visit by no later than the end of the 28th week of gestation.

Key components for success include:

- fidelity to the program
- established prenatal intake and vulnerability criteria
- program delivery by public health nurses
- evidence-based curriculum
- defined visiting schedule and program duration
- evaluation.

The Representative is encouraged by these efforts to develop a targeted approach to public health for vulnerable families and supports government's efforts to move forward in the establishment of a nurse-led, intensive home visiting program for vulnerable women and families.

Another example of a program that takes an integrated, multidisciplinary and multi-agency approach is the Sheway program.

Sheway, a Coast Salish word meaning "growth," is a program located in the Downtown Eastside of Vancouver that provides health and social service supports to pregnant women or women with children under 18 months of age who are dealing with substance abuse issues. Established in 1993, the program has shown success in meeting the health and social needs of a population with highly complex needs. Services are provided through both outreach and drop-in.

Key program areas include food and nutrition services, primary health care services, counselling services, healthy children development, advocacy, community education and fundraising. Sheway is a partnership initiative among the Vancouver Coastal Health Authority, Ministry of Children and Family Development, Vancouver Native Health Society and the YWCA of Vancouver.³⁶

³⁵ Olds, 2008.

³⁶ Office of the Provincial Health Officer, 2009.

MCFD Practice

In 16 of the 21 cases, MCFD received a new child protection report, completed a previous investigation or was involved in ongoing child protection actions after the birth of the infant.

In the postnatal period, at the request of mothers, professionals or health care providers, MCFD may provide a variety of support services and referrals to professionals such as infant development workers, speech and language pathologists, occupational therapists, audiologists, counsellors, psychologists and psychiatrists. The support services may include:

- parenting classes
- alcohol and drug treatment
- mental health counselling
- financial support for transportation.

These services are provided in response to specific needs. How or if they are provided depends on a number of factors, including resources and availability.

MCFD also has a mandate to respond to reports regarding the safety and well-being of infants. When a report is received, it is assessed to determine the most appropriate response. This can include referring the family to community agencies, providing support services and in some circumstances investigating the infant or child's need for protection.

When a decision is made to investigate a child protection report involving a vulnerable infant, the timeliness of the response is critical. The ministry CFS standard, Conducting a Child Protection Investigation, directs social workers to commence an investigation immediately if a thorough assessment determines that:

- the child's safety or health may be in immediate danger, or
- the child is vulnerable to serious harm because of age or developmental level.

The practice standard also sets out the minimum requirements for conducting an investigation:

- seeing the child and all other vulnerable children in the home
- interviewing the child and all other vulnerable children in the home, where developmentally appropriate and with supports if necessary
- directly observing the child's living situation
- seeing and interviewing the parent
- reviewing all relevant and necessary information related to the report, including existing case records and files
- obtaining information from people who may have relevant knowledge of the family and/or child
- throughout the investigation considering and providing services that ensure the child's safety, including out-of-home care options, and if the child is Aboriginal, working in partnership with the appropriate Aboriginal community or agency.

In seven of the 21 families, child protection reports were received and investigated after the birth of the infant. In another four families, reports received during the prenatal period were not responded to until after the infant's birth.

Responsiveness in commencing and conducting investigations was lacking in some cases. In one case, the social worker did not make contact with the infant's mother until 34 days after the decision was made to investigate. In another case, the investigation began 15 days after the child protection report was received by MCFD. Efforts to obtain information from people who may have had relevant knowledge of the family and/or the infant were not completed during child protection investigations in six of the cases.

MCFD audits specific standards of practice internally to assess rates of compliance. During the period of time covered by this review,³⁷ MCFD audits found that the overall provincial average of compliance with the standard for fulfilling the requirements of a child protection investigation was 65.8 per cent. The elements of a child protection investigation measured in this standard include:

- reviewing all necessary information related to the report, including case records and files
- obtaining information from people who have relevant knowledge of the child and/or family
- receiving documentation that a medical examination of the child has taken place
- directly observing the child's living situation.

Of note, the Vancouver Island region, where 13 of the 21 infants included in this review died, was assessed as having a 47 per cent rate of compliance in conducting child protection investigations.

MCFD audit information regarding the timeliness of completed child protection investigations was also examined for the two-year period covered by this review. The overall provincial average of compliance for completing investigations within the required 30 calendar day time frame was 35 per cent.

Less monitoring of the compliance with ministry standards is also a significant concern. MCFD internal audits for three periods were examined: the 29 months prior to the review, the two-year period covered by this review and the 18-month period since the review.

MCFD revised its internal audit program in 2004. It appears that since the new audit program came into effect, there has been a steady reduction in the number of files audited – a 23 per cent drop between the first and second periods examined and a further 53 per cent reduction in the third period examined.

³⁷ June 1, 2007 to May 31, 2009

Respite Care

Nine of the 21 infants were being cared for by a caregiver other than their parent at the time of their death. Four of the nine infants were being cared for by relatives. Five of the nine infants were being cared for in respite care or a foster home, and three of these infants were legally in care under the *CFCS Act*.

CFCS Act Section 5

Support service for families

- 5 (1) A director may make a written agreement with a parent to provide, or to assist the parent to purchase services to support and assist a family to care for a child.
- (2) The services may include, but are not limited to, the following:
- (a) services for children and youth;
 - (b) counselling;
 - (c) in-home support;
 - (d) respite care;
 - (e) parenting programs;
 - (f) services to support children who witness family violence.

Respite care is provided on a temporary basis for the purpose of providing a break to a parent by placing the child with a ministry-approved alternate caregiver for a short period of time. Section 5 of the *CFCS Act* provides the legal authority for support service agreements with parents to receive respite care. Standard 7 of the CFS standards directs social workers to provide services to families that build on strengths and promote resiliency within children, families and communities. However, the CFS standards are silent on respite care.

MCFD does not have policy regarding providing respite care to children whose families are involved with MCFD on a child protection basis. Furthermore, the ministry does not appear to track information regarding the number of children who are in respite care at any given time.

MCFD's 2006 Caregiver Support Service (CSS) standards are the standards of practice that apply to MCFD staff responsible for residential resources for children and youth. CSS standard 16 states that "all levels of caregivers may provide respite services (out-of-home care provided by a director for a child's parent with whom there is a support agreement) for families whose children are not in care." There is no further policy regarding respite care in the CSS standards.

There is a policy regarding the use of funding for respite care in programming for children and youth with special needs. However, the policy appears to apply only to children who have been designated by MCFD as having special needs, and the policy is not referenced in the CFS standards.

Following the case review of the death of one infant, an MCFD regional office developed a practice advisory to address the gap in policy with regard to respite care for children not in the legal custody of the ministry.

However, because it was developed in one regional office, this practice advisory did not automatically apply elsewhere in the province, and MCFD did not make it a standard practice for all regions. There are no provincial guidelines in place to assist front-line social workers in decision-making and information-sharing when a child is not in the legal care of the ministry but is receiving respite care.

Case Example

The mother of the infant had been diagnosed with FASD at a young age. Her capacity to parent was limited. Prior to the infant's birth she had transferred the care of her first child to her former spouse as she was unable to handle the child's behaviour. She used harmful substances while pregnant with her second child. Her prenatal substance use, limited capacity and lack of financial resources were factors that the staff in the hospital felt placed her at risk.

The infant was born prematurely and was transferred to the neonatal intensive care unit due to high medical needs. Prior to discharging the infant, health professionals noted concerns about the home the infant would be living in, the mother's capacity and her social situation. The infant was discharged at six weeks of age.

When the infant was two months old, the social worker contacted the public health nurse to request that she provide information to the infant's mother regarding safe sleep as the mother had informed the social worker that the infant currently slept in a car seat and also in the mother's bed. The public health nurse contacted the mother, who said that she did not have a crib for the infant and could not afford one. The mother said that the infant was currently sleeping in a playpen. The nurse discouraged the mother from using a playpen and encouraged her to purchase a crib. On the same day, the nurse contacted the social worker regarding financial assistance for a crib. The public health notes indicate that the nurse planned to follow up with the MCFD social worker in two weeks. However, there is no indication of any further follow-up regarding the infant's sleeping arrangements.

Over a number of weeks the mother's capacity to take care of the infant began to deteriorate, and beginning at three months old, the infant was provided temporary respite care with increasing frequency in three different homes. The ministry social worker requested and received approval for the purchase of a playpen for the infant to sleep in while in respite care in one of the three homes because the caregivers did not have an appropriate place for the infant to sleep.

The third home offering respite care was an MCFD-approved foster home. The foster home file information did not indicate that the foster parents had received any specialized training with respect to caring for infants or caring for infants with high medical needs. In this home the infant also slept in a playpen. On the night of the death the infant was put to sleep on its side in the playpen, with a blanket placed against its back. A couple of hours later the caregiver found the infant unresponsive.

A post-mortem examination following the infant's death indicated that an untreated kidney infection caused the death, and an inter-current viral infection and aspiration pneumonia were contributory. A pediatric review of the infant's medical and post-mortem information indicated that the kidney infection was treatable, had it been recognized earlier. However, the infant's symptoms may have been misinterpreted as a cold or flu.

Recommendation 3

That MCFD develop clear standards of practice for situations in which children and infants are placed in respite care under s. 5 of the *Child, Family and Community Service Act*.

Detail:

Standards of practice should afford the same protection as those provided to children in legal care, and include:

- taking into account the unique needs of infants and children who may be more vulnerable due to medical concerns, developmental levels and other such factors
- requirements for information-sharing, including medical information specific to a child's unique needs, among social workers, caregivers and other service providers
- requirements for safe sleep environments and how they are to be addressed when problems arise (e.g., when a caregiver does not have a crib)
- tracking and reporting on the number of children placed in respite agreements under section 5 of the *CFCS Act*
- province-wide application, including delegated Aboriginal Agencies.

**A progress report should be provided to the Representative by June 30, 2011.
The standards should be fully implemented by January 31, 2012.**

Foster Care

Three infants living in foster homes when they died were in the legal care of MCFD. The ministry's Caregiver Support Standards set out standards of practice with respect to the placement, documentation and selection of a caregiving home when a child is placed in foster care.

In reviewing the deaths of these infants, the following issues were identified:

- An assessment of the appropriateness of the home and documentation supporting the assessment and decision to place the infant in the home did not appear to be completed.
- Information regarding the infant's health and medical issues did not appear to be shared with the foster parent at the time the child was placed in the home.
- Prior concerns regarding the care of other children in the foster home did not appear to be adequately considered, assessed or investigated.

Despite the legal arrangement that results in the placing of an infant in care, whether in foster care or temporary respite care, the quality of care provided to the infant by the alternative caregiver should be the same.

The Representative is not questioning the level of care provided by the individual caregivers. However, it appears that there is a lack of policy and guidelines regarding the placement of infants, particularly those with identified risks. This leads to inconsistent information-sharing between the front-line social workers and caregivers who provide respite and foster care.

Case Example

This First Nations infant was 11 months old when removed from the parents along with two siblings for a second time. MCFD's Child and Family Service Standards and Caregiver Support Standards direct social workers when removing Aboriginal children from their parents to place the children with extended family or within their Aboriginal community whenever possible. The baby and siblings had been cared for by a relative in the past, and in fact the relative had custody of another sibling. The relative's home was not an MCFD-approved foster home.

When MCFD placed the baby and two siblings with the relative, there were 11 other people residing in the home. Several people shared each room. There was no adequate sleeping arrangement for the baby, who slept on a bed with one sibling. Another sibling slept on the floor in the same room. There is no indication that the relatives had been advised regarding safe sleeping practices or that MCFD staff observed the sleeping arrangements for the children. A notation on the MCFD file indicates concern about the children's safety due to the presence of another relative in the home.

Four days later, the infant died while sharing a bed with a sibling. While MCFD followed standards regarding placing Aboriginal children with extended family, it appears that other standards for safe infant care were not met.

Recognizing Aboriginal Status

Fifteen of the 21 infants in this review were Aboriginal. MCFD identified 13 of the infants as Aboriginal and incorrectly identified two infants as non-Aboriginal. Of the 15 Aboriginal infants and families, 13 were involved with MCFD and two were involved with Aboriginal Agencies that were fully delegated to provide child protection services.

In British Columbia the *Child, Family and Community Service Act (CFCS Act)* provides the legal authority for child welfare services. Under the *CFCS Act*, the "Director" is designated as the responsible authority. Under the current organizational structure, MCFD has designated a Director in each of its regions throughout the province. In turn, each Director delegates authority to staff to administer the child welfare provisions of the *CFCS Act*.

In addition, a First Nations Director is designated to provide authority to delegated Aboriginal Agencies and their staff to administer the *CFCS Act*. The level of responsibility undertaken by each delegated Aboriginal Agency varies depending upon the level of delegation provided by the First Nations Director. Currently, there are 24 delegated Aboriginal Agencies with various levels of delegation responsibilities.

Of the 13 families involved with MCFD, four were also receiving support services through either partially delegated Aboriginal Agencies or social development programs through their First Nation or Métis community.

MCFD service providers are legally required to consider the best interest of the child. If the child is Aboriginal, the importance of preserving the child's cultural identity must be considered in determining the child's best interests.³⁸ Given this legal requirement, the discrepancy in numbers raises questions about MCFD's process for identifying, documenting and following through with Aboriginal children in the welfare system and ensuring that their cultural connections are maintained.

Being identified as Aboriginal is important because it can impact the types of services offered and the funding available for the infant and family. In the event that a child is removed from the care of their parents, it is important that Aboriginal identity be recognized in order for planning to occur that ensures that the child remains connected to their culture and community. A secure sense of connection with caring people is critical to a child's personality development.

First Nations also provide support services to families that reside on reserve through the First Nations and Inuit Health Branch of Health Canada. Support is provided in areas such

as prenatal nutrition, Fetal Alcohol Spectrum Disorders (FASD) and maternal and child health programs. Individual First Nations provide these services through their health, education and social development departments. Financial assistance is also provided by First Nations to families on reserve who qualify.

³⁸ *CFCS Act*, 2006, Part 1 (4).

The system of supports and services to Aboriginal families can be multi-faceted and complex. For example, a child welfare case can be managed by the ministry, by a delegated Aboriginal Agency or sometimes by both. At the same time, the family can be receiving support services from other agencies, and if they are living on reserve, from their First Nation.

This review found that when the delegated Aboriginal Agency had full delegation, the roles and responsibilities appeared to be clear. This may be because the agency had responsibility for all aspects of child welfare service and had significant capacity to address a range of concerns.

In circumstances where both MCFD and a delegated Aboriginal Agency or a band were jointly providing services, things were less clear, and there were gaps in service. For example, in two cases reviewed it appeared that MCFD was depending on the band for delivery of services without clarity on who was responsible for what.

When there are multiple agencies involved, it is essential that there be effective communication and coordination to reduce the likelihood of gaps in service. The MCFD reviews conducted in two infant deaths where some services were provided by MCFD and some by a delegated Aboriginal Agency or band recommended that protocols be developed to more clearly outline roles and responsibilities. MCFD has indicated that these recommendations have been completed.

In the 2009 report *Housing, Help and Hope: A Better Path for Struggling Families*, the Representative recommended that MCFD work in consultation with the delegated Aboriginal Agency, the child's First Nation and Indian and Northern Affairs Canada to ensure that sections 3(b) and 71 of the *CFCS Act* are fully realized and that the purpose and intent of the Delegation Confirmation Agreement are fulfilled.

The Representative indicated that this would require clarifying the nature and extent of the consultation and participation expected from each party in child welfare matters, and amending the delegation confirmation agreements to reflect this understanding. The report further recommended that the outcome of this work should be formally shared with MCFD staff, other delegated Aboriginal Agencies and First Nations across B.C.

The most recent update from MCFD is that training was undertaken in local areas regarding the protocol between MCFD and delegated Aboriginal Agencies. This protocol is under review by INAC, MCFD and delegated Aboriginal Agencies. There has been no progress on province-wide sharing of a specific outcome with MCFD staff and delegated Aboriginal Agencies.

Hospitals

In Canada there has been a reduction in the length of hospital stay following birth.³⁹ Between 1995 and 2005 the mean maternal length of hospital stay for childbirth declined considerably, from 2.6 to 2.2 days for vaginal delivery and from 5.0 to 3.9 days for caesarean delivery.⁴⁰

In British Columbia between 2006 and 2007, 72.5 per cent of women stayed in hospital less than 48 hours following a vaginal delivery, and 86.3 per cent stayed less than or equal to 96 hours following a caesarean delivery.⁴¹

This has resulted in the delivery of postpartum care on an outpatient basis by a variety of care providers, including hospitals, health centres, public health nurses and primary care providers. Because the regional health authorities in B.C. are not required to comply with detailed province-wide standards that outline how care is to be delivered, there are many different models of postnatal care delivery across the province.

It is unclear what is expected or what is considered standard practice. The result is a fragmented system of unpredictable care, where the initiative for accessing services is often left with the mother. This is not a good method of reducing risks to vulnerable infants.

Newborn records were available for 20 of the 21 infants. Half of these infants were discharged within one day of being born, including two infants who were discharged from hospital on the same day of their birth. The remaining 10 infants stayed in hospital from three days to two months, depending upon the medical issues identified at the time of their birth.

³⁹ D'Amour, Goulet, Labadie, Bernier and Pineault, 2003.

⁴⁰ Public Health Agency of Canada, 2008.

⁴¹ BC Perinatal Health Program, 2007.

Recommendation 4

That the Ministry of Health Services lead the development of a clear practice protocol to support effective and responsive public health nursing practice when nurses are working with high-risk infants in vulnerable families.

Detail:

The protocol should have the following characteristics:

- a clear definition of "high risk"
- a standardized risk assessment tool and identification of when it is to be used
- standards for home visiting, including frequency and length of service
- if possible, it should be informed by evaluations of the proposed B.C.-specific Nurse Family Partnership Program
- delivery of information on safe sleeping practice.

The protocol should also build on the MCFD protocol referred to in Recommendation 2 and provide for:

- collaborative case planning with MCFD and hospitals with respect to discharge planning and other services that are required prenatally
- active engagement on the part of service providers
- clear identification of a case manager and of roles and responsibilities of all individuals on the care team
- documentation of the plan in the files of all service providers
- a plan for implementation of the protocol and for any training required within each of the service sectors.

An update should be provided to the Representative by June 30, 2011.

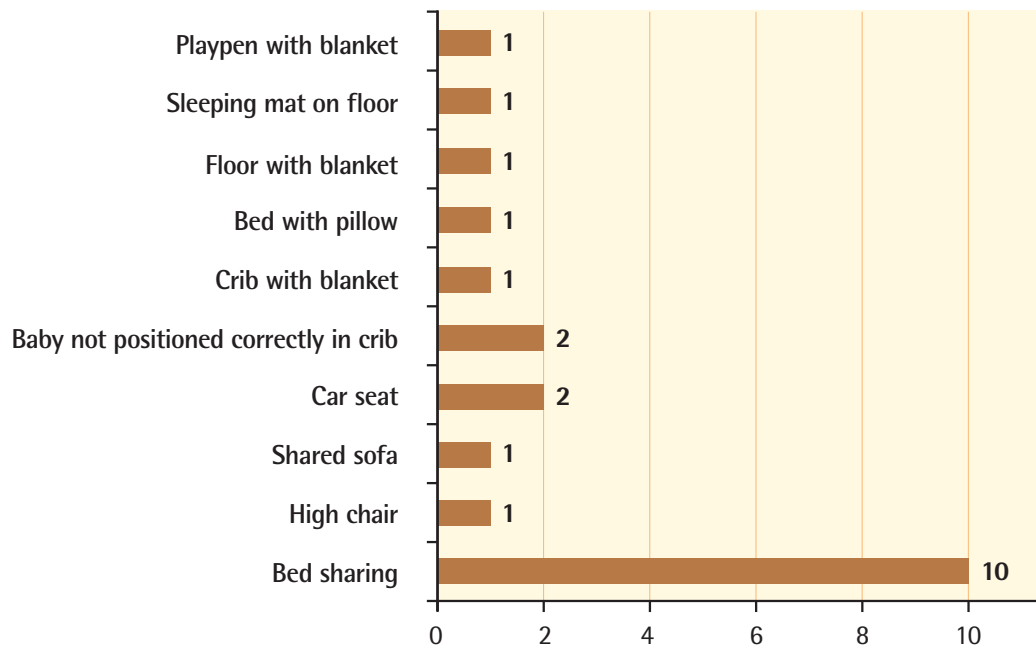
The protocol should be fully implemented by January 31, 2012.

Safe Sleeping

Observations: *All 21 infants died unexpectedly. Initial information at the time of their deaths noted that sleeping circumstances may have been an issue. Despite a number of initiatives that have provided information about safe sleeping, there is some variation in what is promoted as safe sleeping practice. This could confuse parents, caregivers and service providers.*

A coordinated social marketing campaign about safe sleeping for infants is needed, with a targeted strategy for more vulnerable infants and families. The campaign should address interacting factors underlying vulnerability and specifically reach out to those most vulnerable in B.C.

The figure below illustrates the sleeping environment at the time of the infants' deaths.



Infants typically spend a significant part of their lives sleeping. On average, newborn infants sleep up to 16 hours per day. By six months, infants typically sleep between 11 and 12 hours per day. Therefore, their sleeping arrangements and conditions are an important aspect of their life circumstances.

Information about safe sleep practices for infants can be provided to parents and caregivers by physicians, midwives, public health nurses, prenatal classes, doulas, counsellors and social workers through home, hospital and clinic or office visits. Information comes in many different forms, such as brochures, website information, manuals, pamphlets, books, cards and information sheets.

The information provided needs to be clear and consistent. There is currently a range of information provided by different provincial organizations, which can be confusing. The provincial government's Best Chance website (www.bestchance.gov.bc.ca) informs families that "bed sharing is when your [infant] shares the same sleeping surface with you or another adult. Bed sharing is not recommended for infants because it increases the chance of suffocation."

By comparison, room sharing (also called co-sleeping) is when the baby sleeps in the same room as the caregiver, but not on the same surface (e.g., baby is in a crib beside the caregiver's bed). A review of the literature on room sharing/co-sleeping found that sharing a room with an infant may actually be a protective factor against SIDS deaths because room sharing tends to be associated with a mother who is actively breastfeeding.⁴²

The Canadian Paediatric Society (CPS) recommends that infants under the age of 12 months sleep in their own crib (specifically one that meets the federal government's safety standards) and that the infant should be placed on his or her back to sleep. However, in circumstances when an infant does not sleep in a crib, the information regarding what constitutes a safe sleep surface appears to be unclear.

The 2010 edition of the *Baby's Best Chance Handbook*,⁴³ published by the B.C. Ministry of Health Services, states: "Your baby should sleep on a firm, flat mattress. Do not put your baby to sleep on a waterbed, sagging mattress, feather bed, air mattress, pillow-top mattress, sofa, couch, daybed or any other surface that is very soft." The use of a playpen as a sleep surface is not mentioned.

The Coroners Service Child Death Review Unit report *Safe and Sound: A Five Year Retrospective Review on Sudden Infant Death in Sleep-related Circumstances* notes that "surfaces such as car seats, strollers, sitting devices, adult beds, infant swings, playpens, couches, futons, waterbeds or air mattresses are not recommended." The report references the CPS recommendations dated 2009 for safe sleeping environments for infants and children.

The CPS information discusses the use of waterbeds, air mattresses, pillows, soft materials, loose bedding and car seats but does not reference playpens specifically.

MCFD's *Safe Sleeping for Babies* brochure states that infants "should sleep on a firm, flat, well-fitting mattress on a surface designed for infant sleep such as a crib, playpen or bassinet." In June 2009 the brochure was amended by removing "playpen."

Service providers require clear and consistent messaging regarding safe sleep in order to work effectively with families and infants. Recognizing this need, the Provincial Health Officer issued a directive in 2009 to each of the health authorities and advised of the risk of bed sharing. The directive required hospitals to ensure bed sharing did not occur in hospital after birth.

⁴² Mckenna & McDade, 2005.

⁴³ Ministry of Health Services, 2010.

An important aspect of determining an infant's safety in his or her environment must include an assessment of the baby's sleep environment. Social workers on the front lines require the appropriate tools and skill sets to complete assessments adequately and appropriately. This includes having clear, consistent standards and policy and the tools to work collaboratively to ensure that support, education and help is provided to vulnerable families about safe sleeping for their children.

The Child and Family Service Standards do not set out specific criteria for a social worker to use when conducting a home visit as part of a child protection investigation. Standard 16 states that the worker must, at minimum "[see] the child in the home" and "observe the child's living situation." However, the standard does not speak to how the worker should assess these factors, especially when the child is an infant.

Currently, safe sleep is discussed in two of MCFD's 2006 Caregiver Support Standards, which refer to safe sleep on the foster home monitoring form. Both of the standards are vague, unclear and offer little description of what constitutes safe sleep practice and, perhaps more importantly, what is not considered a safe sleep environment. The standards are of little practical help to front-line social workers who work with families on a daily basis.

It is evident from this review that an organized, coordinated system to ensure that parents and caregivers receive the appropriate information about safe sleep practices and environments is lacking. This is especially important for Aboriginal families. However, although much more work is required to protect vulnerable infants, the Representative is encouraged by the efforts underway in some agencies to help address this issue.

One example is the work being done by the Child Death Review Unit of the BC Coroners Service in partnership with BC Vital Statistics to capture data with improved consistency. Sudden infant death cases are being recoded to include risk factors such as sleep surface, sleep position and prenatal exposure to substances. It is hoped that this recoding will result in improved identification, reporting and monitoring of risks.

Although public health educational programs and campaigns do exist, not much is known about their impact on mothers or the degree to which the information gets to them. We do know that the risk of sleep-related infant deaths is reduced when the known risk factors are avoided.

Although good education and information about safe sleeping is important in creating a safe environment for an infant, the Representative acknowledges the importance of the interacting factors of poverty, inadequate housing and family circumstances. Ensuring that a family has a safe crib is important, but it doesn't solve the problem if the infant is crowded into a smoke-filled motel room or the crib is placed in a mould-infested house. Therefore, the following recommendation is made with the understanding that all underlying conditions of infant vulnerability require attention.

Recommendation 5

That the Ministry of Health Services lead an initiative with MCFD and other partners to develop and implement a creative social marketing campaign on safe sleeping.

Detail:

The initiative should have the following features:

- be targeted to the needs and circumstances of vulnerable families, both in terms of the information and in the mechanisms through which it is delivered
- have a clear and consistent message that can be used by all agencies that serve vulnerable families
- provide information about how to create a safe sleeping environment for infants, including practical help such as how a family can receive a Health Canada–approved crib if adequate financial resources are not available.

The campaign should be fully implemented as soon as possible and no later than September 1, 2011.

Learning and Improving Practice

Observations: Of the 21 infant deaths, 14 deaths were identified for a ministry review and one death was reviewed twice. Fourteen of the reviews have been completed, and one review is still in progress. The remaining seven deaths were not reviewed.

Rigorous self-examination is crucial to ongoing learning and the improvement of practice. Case review is a critical component of MCFD's quality assurance activities. It can make an important contribution to the development of standards and policies and should also inform training requirements. The review of a death provides the opportunity to examine circumstances with a tragic outcome, reflect and implement change to prevent those circumstances from recurring.

The purpose of examining these reviews was to determine if MCFD reviewed the deaths of the infants in accordance with the legislation and standards and if learning occurred to improve service delivery to children and families. The Representative found that there were opportunities for learning that were not appropriately pursued. MCFD reviews were not conducted on the deaths of all the infants who died, and it is unclear how decisions were made with respect to the type of review conducted.

The reviews generally were not completed within the time frames set out in the standards. In some instances the findings did not encompass the presenting issues, and in some instances the recommendations developed did not address identified practice concerns.

Case reviews, both individually or as part of an aggregate review, can provide opportunities for improving practice. As a recent British report⁴⁴ states:

“One local authority had experienced a number of child deaths and recognised the importance of learning lessons from each event and of noticing trends over a number of SCRs (Serious Case Reviews). The local authority has introduced a number of innovative methods to help practitioners and managers learn from previous cases. These have included the facilitation of workshops which have captured local and national issues and themes arising from SCRs....

“Through these and other learning events, the local authority is able to evidence change and improvement through learning lessons and recognising recurring themes in their own SCRs. The learning is shared across agencies and is proving beneficial to social workers and health visitors especially.”

MCFD's 2004 Quality Assurance Standards provide direction in determining if a review is to be completed, the type of review to be conducted and the time frame. The Regional Executive Director of Practice examines the information and makes a decision whether or not to conduct a review of practice and which type of review to conduct.

⁴⁴ Lord Laming, *The Protection of Children in England: A Progress Report*, 2009.

The duty of a director to consider conducting a case review is stated in the *Child, Family and Community Service Act (CFCS Act) Regulations Part 5.1*:

- 19.1 (1) In this section, "critical injury" means an injury to a child that may
- (a) result in the child's death, or
 - (b) cause serious or long-term impairment of the child's health.
- (2) After a director becomes aware of the critical injury or death of a child, the director must consider conducting a review of that critical injury or death if
- (a) the child or the child's family was receiving a service under the Act at the time of, or in the year previous to, the critical injury or death of the child, and
 - (b) in the opinion of the director, the service received, or a policy or practice relating to the service received, may have significantly contributed to the critical injury or death of the child.

There are two types of case reviews: file reviews (formerly known as Deputy Director Reviews) and comprehensive reviews (formerly known as Director's Case Reviews).

File reviews examine only the information documented on the file. The fact base is outlined and analyzed using file records. Practice is analyzed against a set of standards. Recommendations are developed and tracked for implementation.

Comprehensive reviews include both a review of file information as well as interviews with relevant individuals. Terms of reference are established to define the scope of the review. Facts are established and verified. The information is analyzed, and findings are made. Recommendations are developed and tracked for implementation.

MCFD is in the process of revising its case review methodology to establish a more integrated approach to reviews. This development process appears to be ongoing.

Of the 14 infant deaths which were identified for review by MCFD, 13 have been reviewed and one

is in progress. Six deaths had a comprehensive review, seven had a file review, and one death had a file and then a comprehensive review.

The following observations were made regarding the MCFD reviews:

- It was not clear how the decision was made to conduct a review or which type of review to conduct.
- The terms of reference were not always adequate given the identified concerns.
- The analysis in the reviews missed key issues.
- In some cases the issues identified in the analysis were not addressed in the recommendations.
- When recommendations are noted as complete, it was unclear if the actions taken actually fulfilled the requirement of the recommendations.

It is not known why seven of the infant deaths were not reviewed by MCFD despite active service delivery to the child and/or the family. The *CFCS Act* Regulations require a review only in circumstances where in the opinion of the director the service received or a policy or practice relating to the service received may have significantly contributed to the critical injury or death of the child. However, reviews can also be conducted at the Director's discretion. Few records from the Regional Director offices were provided. It is not known what standards are expected for documentation in the Regional Director offices.

From the file information examined it appears that a ministry review would have been prudent for all of the deaths. For example, in one case the lack of prenatal child welfare planning, lack of high risk discharge planning and an incomplete child protection investigation prior to the child's death were of concern. A review of practice would be an opportunity to understand how the child welfare system may have better served this infant and family.

In another case a decision was made to include the case in a regional review of five deaths of infants in 2007 rather than conduct an individual review. The cluster review did not examine practice in each of the five included deaths.

While many of these deaths were classified by the coroner as sudden unexplained death in infancy, in each there was reason to consider that the infant may be at risk, and in each there was recent or current service involvement by the ministry.

The above-noted circumstances demonstrate that the decision to not conduct a review in the death of a child can result in the loss of valuable information and learning. Specifically, these potential areas of learning were:

- challenges of working in isolated communities
- effective intervention with drug-addicted parents
- impacts of domestic violence
- better integration of services and interagency communication
- appropriate discharge planning.

Of the 14 reviews examined by the Representative, eight were file reviews. A file review can provide substantial information and can be adequate in some circumstances. However, in some of the circumstances it may have been more valuable to have conducted a comprehensive review.

For example, in one circumstance where a file review was conducted, a comprehensive review could have provided more insight into a complex case in which the child was in care at the time of death. The foster home where the infant died had been the subject of a number of complaints and investigations, there were concerns regarding the delay in following up on previous child protection concerns, and there was significant public attention.

The Quality Assurance Standards provide time frames for decision and completion of reviews:

- A decision to conduct a review is to be made within 20 working days of the serious occurrence.
- A Deputy Director's Review (File Review) is to be completed as soon as possible and within 90 days of the decision to begin a review.
- A Director's Case Review (Comprehensive Review) is to be completed as soon as possible and within eight months of the decision to conduct a review.

Meeting time frames with respect to reaching the decision to conduct a review was difficult to assess, as the necessary information was not in the files reviewed.

Fourteen completed reviews have been examined in terms of meeting time frames. Of the eight file reviews, only one met the time frame of completion within 90 days after the decision. One file review was completed more than two years after the death.

Of the six completed comprehensive reviews, two met the time frames for completion and four did not. One review took 19 months to complete, and the one outstanding is significantly overdue, as it has been 2 1/2 years since the infant's death.

The development of appropriate terms of reference is critical in ensuring that a full picture emerges. The right questions need to be asked to reach conclusions and to ensure that appropriate action can be taken that leads to learning and improves practice.

The terms of reference developed in six comprehensive reviews were examined. In one case the terms of reference were not examined as the review has not been completed. Of the six, five were found to be appropriate to the circumstances under review.

In one review the terms of reference did not provide for a full examination of the circumstances. The children in this family had been in care for eight months when the infant died, while family services had been provided for a number of years. There had been very active child protection activity for over a year prior to the children being removed. The Representative's review of this activity raises concern about the quality of the practice. The terms of reference when established were limited to the practice while the children were in care, although the review itself did consider the child protection practice prior to the children coming into care.

Evidence is the basis of making findings and developing recommendations. Practice standards, policies and relevant protocols provide a framework for careful analysis of practice. It is critical that the reviewer remain objective and unbiased.

The following is an example of a ministry review where the findings were not consistent with the fact base. The single term of reference for the review was as follows:

Was the Ministry's response to and documentation of information received from [date] to the time of [the infant's] death consistent with legislation, policy, service standards and relevant protocols?

The finding of the ministry review was:

The Ministry's response to and documentation of information received from [date] to the time of [the infant's] death was consistent with legislation and relevant protocols, and on occasion inconsistent with policy and service standards.

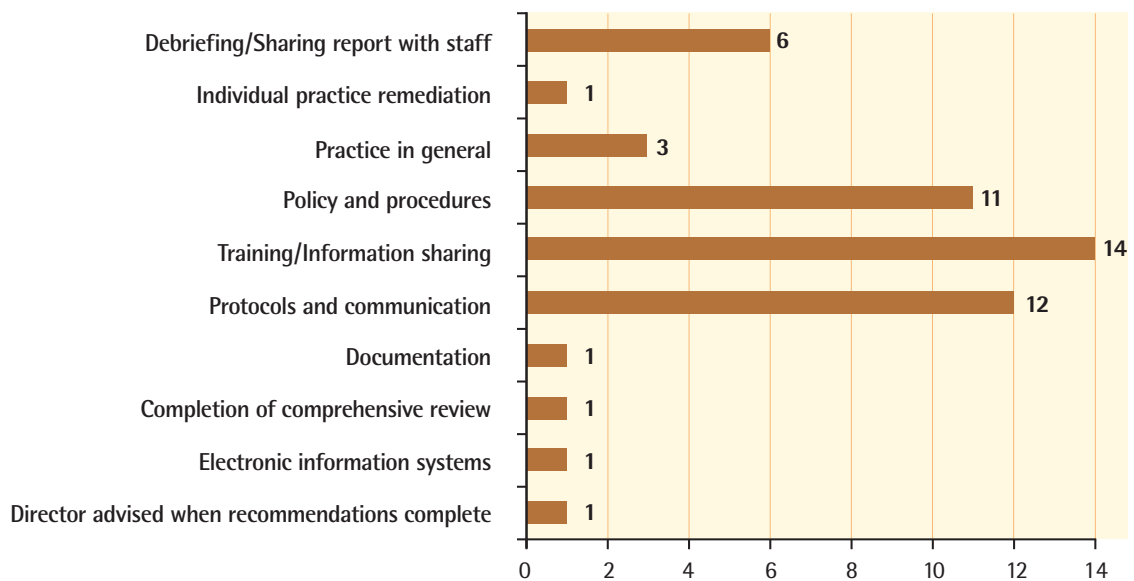
However, the ministry review identified a number of practice issues but failed to identify the lack of coordination between MCFD and the First Nations band in delivering services to the family and the reliance on After Hours service providers to contact the family.

Given the significant number of practice issues that were identified in the ministry review, it is unclear how it was determined that practice met standards except on occasion. The failure of the review to identify these practice issues or to develop recommendations from the findings was a missed opportunity to learn, identify remedial steps and make necessary changes. Instead, the review made only one recommendation: to distribute a pamphlet on safe sleeping for babies to staff in the region. While this is important, training social workers in assessing families where there are child protection concerns and the mother is expecting another child should also have been mentioned.

A total of 51 recommendations were developed as a result of MCFD reviews. One review didn't contain recommendations but included a number of activities with completion dates under the heading of Organizational Development. One review had no recommendations.

The following chart characterizes the focus of the 51 recommendations arising from the 13 reviews that contained recommendations.

MCFD Review Recommendations (n=51)



Of the 51 recommendations, 40 were identified as complete and closed at the time of writing. Eleven remain outstanding.

The development of and response to recommendations is a key component of a strong quality assurance framework and an opportunity for learning. This is particularly true when recurring findings and recommendations are shared and analyzed. Frequently the reviews include the recommendation that the findings be shared with involved staff. Occasionally this includes the recommendation that the finding be shared with the team leaders. As the reviews are completed within the regions, it is important that there be a process through which this information can be shared with MCFD staff and other professionals.

Unfortunately, there is a wealth of information in the reviews which is not collated in any meaningful way in order to inform practice. As a result, there does not appear to be a consistent and formalized procedure for sharing the results of reviews with other ministry staff or with other involved professionals.

The Representative has previously examined and made recommendations with respect to the case review process in the 2008 report *Amanda, Savannah, Rowen and Serena: From Loss to Learning*. It was noted that the ministry's case reviews of deaths did not serve as a stimulus for organizational learning. The report noted that it did not appear that there was a consistent and formalized mechanism for sharing the results of the reviews. The Representative's recommendations included:

- that the lead responsibility for Director's Case Reviews be situated in the provincial office of the Ministry of Children and Family Development
- that Director's Case Reviews be conducted in every case in which a child receiving services from the Ministry of Children and Family Development or in its care dies or is critically injured in unusual or suspicious circumstances
- that the Ministry of Children and Family Development share all case reviews with involved ministry staff, families and caregivers of the child fully and promptly.

To date, MCFD has indicated that responsibility for case review will remain with the regions and that issues relating to case reviews are part of an ongoing review of quality assurance that is not yet complete. However, it is of concern that the designated responsibility for the case review function under the *CFCS Act* was moved from the Provincial Director (a position which no longer exists) to Regional Executive Directors of Practice. In 2010, it was moved to Regional Directors of Quality Assurance Practice, which means there is no consistent provincial oversight or accountability for this function.

Recommendation 6

That MCFD take immediate action to implement improvements to the case review function to enable management and staff in the ministry and other agencies that serve vulnerable children to learn from the results of the reviews.

Detail:

Improvements required include:

- providing clear criteria for when and how to conduct a review
- at minimum conducting a file review on all sudden unexplained infant deaths
- fully documenting decisions to undertake a review, type of review, development of terms of reference and development of recommendations
- meeting standards for timeliness
- using a multidisciplinary, multi-agency approach to inform the analysis and recommendations of comprehensive reviews
- aggregating and reporting out on results to further add value to learning
- engaging other ministries and service providers in learning from the results of the case reviews.

An update should be provided to the Representative by June 30, 2011.

The protocol should be fully implemented by January 31, 2012.

Recommendation 7

That MCFD implement previous recommendations made by the Representative with respect to re-establishing the role of Provincial Director in order to support a more effective process for case reviews, to avoid conflicts of interest and accountability and to drive more effective organizational learning.

The role of Provincial Director should be re-established by April 1, 2011.

Conclusion

The life circumstances observed among the group of infants described in this aggregate review must command the attention of all British Columbians and move us to redouble our efforts to improve preventive practice so that deep-seated intergenerational patterns do not continue to burden the children of generations yet to come.

This is difficult and complex work, both for policy-makers and for front-line workers who are confronted with circumstances that can easily seem overwhelming. The policy foundation for work with families struggling with poverty and other significant challenges is weak, and as a result, the current practice is inconsistent and often not effective.

Vulnerable infants and their struggling families in B.C. today deserve better systems of support, and our duty of care requires much stronger efforts on their behalf as well as the rigorous monitoring of the results of our efforts.

We must do a better job of equipping the hard-working professionals in our child-serving and health care systems with the necessary tools, training and support to do a more effective job in these kinds of challenging situations. We must not become numb to these desperate situations. As a society, we must not accept that a crowded hotel room or a mouldy apartment is an adequate substitute for a real family home just because it provides a roof over their heads and is one step above sleeping on the streets.

The Representative cannot definitively determine whether or not the deaths of these 21 infants were preventable. However, we do know that reducing the kinds of risks and vulnerabilities described in this review can lead to fewer sudden infant deaths, particularly given the multiple common risks these infants faced.

British Columbians want the best possible chances for all of our children to be healthy and strong. However, this review clearly shows that the level of support in our systems to counter the barriers and the risk factors these families faced was insufficient.

Although there are no simple answers to these difficult situations, that must not deter us from action. There is ample evidence of measures that make a difference when strong systems build on the resilience and strengths of families.

We can do a better job for these families, and we can begin by better integrating the services we provide as well as the sharing of important information. And above all we must demand that our government work at all levels, in bold and responsive ways, to address the deep, persistent poverty and life circumstances that inevitably play a constant role in so many of these tragedies.

It is everyone's responsibility to support vulnerable children and families. When we undertake the difficult and sometimes painful process of going back to examine in detail the lives and deaths of infants lost, we as a community have an even greater obligation. It is a duty owed to the memory of the children we've lost, to their still-grieving families, and to all B.C. children beginning their life path. We have a responsibility to act decisively on what is learned.

Glossary

Child in care: Any child under 19 years of age living under the custody, care or guardianship of a Director under the *Child, Family and Community Service Act*.

Child protection report: A report received about a child's need for protection due to abuse or neglect. Every report received is assessed to determine the most appropriate response. Responses include taking no further action, referring the family to support services, providing a family development response, providing a youth response if the child is a youth or conducting a child protection investigation.

Child protection investigation: A process of inquiring into or tracing through inquiry, collection of information, interviews with parents, teachers, daycare providers, public health nurses, physicians and extended family members to evaluate whether a child is in need of protection.

Delegated Aboriginal Agency: Through delegation agreements the First Nations Director (the Director) gives authority to Aboriginal Agencies and their employees to undertake administration of all or parts of the *Child, Family and Community Service Act (CFCS Act)*. The amount of responsibility undertaken by each agency is the result of negotiations between the ministry and the Aboriginal community served by the agency and the level of delegation provided by the Director.

Hughes Review (BC Children and Youth Review): The 2006 independent review of British Columbia's child protection system by the Hon. Ted Hughes, QC. It was a review that recommended the appointment of an independent Representative for Children and Youth.

Intake: The process by which child protection reports and requests for service are introduced into an office. These reports and requests for service are assessed and assigned to social workers for follow-up.

Intergenerational trauma: The tendency of a person when they become a parent to repeat the abuse or neglect that they themselves suffered as children.

Reviewable service: Any of the following designated services:

- services or programs under the *Child, Family and Community Service Act* and the *Youth Justice Act*
- mental health services for children
- addiction services for children
- additional designated services that are prescribed under section 29(2)(b) (e.g., health care)

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Appendix A: Representative for Children and Youth Act

Part 4 – Reviews and Investigations of Critical Injuries and Deaths

Section 11 - Reviews of critical injuries and deaths

- (1) After a public body responsible for the provision of a reviewable service becomes aware of a critical injury or death of a child who was receiving, or whose family was receiving, the reviewable service at the time of, or in the year previous to, the critical injury or death, the public body must provide information respecting the critical injury or death to the representative for a review under subsection (3).
- (2) For the purposes of subsection (1), the public body may compile the information relating to one or more critical injuries or deaths and provide that information to the representative in time intervals agreed to between the public body and the representative.
- (3) The representative may conduct a review for the purpose of identifying and analyzing recurring circumstances or trends to improve the effectiveness and responsiveness of a reviewable service or to inform improvements to broader public policy initiatives.

Appendix B: Documents Reviewed

Ministry of Children and Family Development

- Family service records, including electronic records
- Child service records, including electronic records
- Resource records, including electronic records
- File reviews, comprehensive reviews and Vancouver Island Cluster Review
- Provincial office and Regional Director office records received
- Reportable Circumstances reports
- Integrated Practice Analysis Tracking System (IPAT)
- Integrated Case Practice Audit Tool (ICPAT)

Health Care

- Hospital records
- Community and public health records
- MSP records
- Medical clinic records (if applicable)
- Pharmanet records (if applicable)

Coroners Service

- Kimble reports
- Pathology and toxicology reports
- Coroners reports

Police

- Sudden death reports and Occurrence reports
- Interview transcripts
- Scene photographs
- Witness statements

Ministry of Housing and Social Development (MHSD)

- Income assistance records

MCFD Legislation, Policies, Standards and Other Related Documents

- Aboriginal Operational and Practice Standards and Indicators (AOPSI)
- Child, Family and Community Service Act and Regulations (1996)
- Child and Family Development Service Standards: Child and Family Service Standards (Nov. 2003)
- Child and Family Development Service Standards: Child in Care Service Standards (Nov. 2003)
- Quality Assurance Standards (2004)
- Caregiver Support Service Standards (2006)
- Standards for Youth Support Services and Agreements (2004)
- Standards for Foster Homes (1998)
- The Vancouver Island Region *High Risk Expecting Parents Guidelines* (2005)
- The Fraser Region *Operating Policies and Procedures: Reports of Pregnant Women Whose Behaviour or Health are High Risk* (2006)
- The North Region *Protocol for Child Protection Risks in Pregnant Mothers*
- The Vancouver Coastal Region *Director's Office Practice Bulletin*
- The Interior Region *Practice Advisory Guidelines for Assessing Capacity of Youth to Care for their Own Children* (2009)
- Care of Substance Exposed Infants: Discharge from Hospital to Community, An Interagency Guideline Capital Health Region & MCFD (1999)
- Care of Substance Exposed Infants: Discharge from Hospital to Community, An Interagency Guideline Vancouver Island Health Authority & MCFD (Mid Island) (June 2008)
- Interagency Protocol & Procedures for Removing At-Risk Infants from the West Coast General Hospital (Feb. 2009)
- Cowichan District Hospital Protocol (2001)
- Vancouver-Richmond ICM Discharge Planning (undated)
- Protocol Agreement Between Interior Health-East Kootenay Regional Hospital and MCFD (2008)
- Fraser Health & Fraser Region Ministry of Child and Family Development: Child Welfare Alerts Protocol & Guidelines (Sept. 2009)
- Children & Women's Health Centre Protocol with MCFD (2008)

Appendix C: Summary of Recommendations from Other Reports

The 2009 BC Coroners Service, Child Death Review Unit report recommendations were addressed to the government, health systems, industries, research bodies and community organizations and touch on the following areas:

- Prenatal care (e.g., safe sleep education in service delivery, early prenatal registration programs to increase early initiation of prenatal care, expand Pregnancy Outreach Programs for high-risk parents and families)
- Public education (e.g., establish best practices for safe sleep and disseminate safe infant sleep information in a consistent fashion)
- Education and training of health professionals (e.g., increase awareness, provide resource materials)
- Infant death classification (adopt standard criteria for defining and classifying sleep-related deaths and provide training to death investigators)
- Social determinants of health (e.g., pursue strategies that address social determinants of health, increase housing options, community-based crib lending program)
- Consumer product safety (e.g., include safe sleep information on labels of relevant infant products)
- Home visiting (e.g., provide intensive home visiting services for higher risk mothers and families that include education on preventive child health and safety and provision of increased monitoring and support when required)
- Research (e.g., pursue research that seeks to gain a better understanding of the relationship between sudden infant death and socioeconomic factors)
- Working with and supporting Aboriginal communities (e.g., work with Aboriginal communities to develop culturally appropriate, community-based, practical programs to promote safe sleep and reduce the risk of sudden infant deaths)

The 2008 MCFD cluster review report recommendations were addressed to internal MCFD teams:

- The Child Welfare Policy team will consult with the Provincial Health Officer and the BC Coroners Service Child Death Review Unit before finalizing the Safe Sleeping for Babies information bulletin.
- The Directors of Integrated Practice will disseminate the Safe Sleeping for Babies information to ministry staff and caregivers, the Aboriginal Policy and Service Support team will disseminate the information to delegated Aboriginal Agencies staff and caregivers, and the Integrated Quality Assurance team will disseminate the information to those who are involved with the ministry via the ministry's internet site.

- The Directors of Integrated Practice will demonstrate to the Regional Executive Directors how the Safe Sleeping for Babies information has been disseminated to the regions.
- The Learning Education and Development Team in Strategic Human Resources will incorporate the Safe Sleeping for Babies information in any update or revision to caregiver support training. In the interim, the Regional Council Support Team will advise the regions to include this information in any deliveries of training to caregivers.
- The provincial Integrated Quality Assurance team will disseminate the literature review portion of this report to ministry staff.

**Canadian Paediatric Society's Recommendations for a Safe Sleeping Environment
Journal of Paediatric Child Health, November 2004, reaffirmed February 2010.**

Understanding the family dynamics and the reasons for choosing a particular sleeping environment, in conjunction with the awareness of dangerous bedsharing practices, are all important considerations in offering guidance to parents in their choices for sleeping arrangements. No sleep environment is completely risk-free, but much can be done to educate parents on the provision of safer sleeping environments for their infants. The advice given must be guided by the available evidence-based data, which indicate that when infants sleep in their own crib, they are significantly safer than when they bedshare.

Based on the available scientific evidence, the Canadian Paediatric Society recommends that for the first year of life, the safest place for babies to sleep is in their own crib, and in the parent's room for the first six months. However, the Canadian Paediatric Society also acknowledges that some parents will, nonetheless, choose to share a bed with their child. With these caveats in mind, the following recommendations are proposed with the understanding that no randomized studies can be performed to measure the potential impact of these recommendations for a reduction in the incidence of any sudden unexpected infant death.

- Infants should sleep on their back, in cribs meeting the Canadian Government's safety standards (46). This is the recommended sleeping arrangement for the first year of life, under all circumstances.
- The infant sleep environment must be free of quilts, comforters, bumper pads, pillows and pillow-like items. Dressing infants in sleepers should be considered to eliminate the need for any covers over the baby, other than a thin blanket.
- Parents should also be aware that room-sharing is protective against SIDS and that this type of sleeping arrangement is a safer alternative to bedsharing. This may be particularly appealing to mothers who breastfeed and want their baby to be near them without sharing the same bed surface.

- Effective counselling to prevent maternal smoking should begin at the onset of pregnancy, and ideally, well before that.
 - Mothers who smoke during their pregnancy should be informed that their infant has a greater risk of SIDS. Passive exposure to environmental tobacco smoke is also associated with an increased risk of SIDS.
 - When there is exposure to cigarette smoking, pre- or postnatally, the risk of SIDS is further increased with bedsharing.
- Hospitals should not allow mothers to sleep in the same bed with their newborns in view of the effects of postpartum maternal weakness or fatigue, analgesia or post anesthesia. This policy will also serve to educate parents on safe sleeping practices. However, it must not compromise in any way the maternal-infant interaction necessary for the initiation of successful breastfeeding.
- Parents should not place infants on waterbeds, air mattresses, pillows, soft materials or loose bedding, even for temporary sleeping arrangements (e.g., during travel). Car seats and infant seat carriers must not replace the crib as a sleep surface due to the risk of the harness straps causing upper airway obstruction.
- Sleeping with an infant, or letting the infant sleep alone on any type of couch, recliner or cushioned chair is dangerous, placing infants at substantial risk for asphyxia or suffocation. Any makeshift bed is dangerous as well.

Appendix D: Multidisciplinary Team

Under part four of the *Representative for Children and Youth Act* (see Appendix A: *Representative for Children and Youth Act*) the Representative is responsible for investigating critical injuries and deaths of children who have received reviewable services from the Ministry of Children and Family Development (MCFD) within the 12 months before the injury or death.

The Act provides for the appointment of a multidisciplinary team to assist in this function, and a regulation outlines the terms of appointment of members of the team.

The purpose of the multidisciplinary team is to support the Representative's investigations and review program, providing guidance, expertise and consultation in analyzing data resulting from investigation and reviews of injuries and deaths of children who fall within the mandate of the Office, and formulating recommendations for improvements to child-serving systems for the Representative to consider.

The overall goal is prevention of injuries and deaths through the study of how and why children are injured or die and the impact of service delivery on the events leading up to the critical incident. Members meet at least quarterly.

The multidisciplinary team brings together expertise from the following areas and organizations:

- Ministry of Children and Family Development, Child Protection
- Policing
- BC Coroners Service
- BC Injury Research Prevention Unit
- Aboriginal community
- Pediatric medicine and child maltreatment/child protection specialization
- Nursing
- Education
- Pathology
- Special needs and development disabilities
- Public health

Multidisciplinary Team Members

Dr. Evan Adams – Dr. Adams is the Aboriginal Health Physician Advisor for the Office of the Provincial Health Officer, as well as a family physician. He is a Masters candidate at the Johns Hopkins Bloomberg School of Public Health, a past-president of the Rediscovery International Foundation and a Youth Advisory Committee member at the Vancouver Foundation. He is a member of the Coast Salish Sliammon First Nation.

Lucy Barney – Ms. Barney is a registered nurse from Lillooet Nation. She completed her Masters of Science in Nursing from the University of British Columbia and is currently employed as a perinatal nurse consultant with the BC Perinatal Health Program. She is the vice president of the Native and Inuit Nurses Association of BC and is a member of other advisory committees. Ms. Barney has assisted in investigations with other provincial and national agencies. Ms. Barney's expertise is Aboriginal Health, and she developed the braid theory which looks at the mind, body and spirit and demonstrates a holistic view on health.

Karen Blackman – Ms. Blackman is currently the Senior Director of Practice Support and Quality Assurance with the Ministry of Children and Family Development. She has 21 years of experience, including work as a social worker, team leader, practice analyst and community services manager in the ministry. Ms. Blackman holds a Bachelor of Social Work degree and a Master of Arts in Leadership and Training.

Beverley Clifton Percival – Ms. Percival is from the Gitksan Nation and is a negotiator with the Gitksan Hereditary Chief's Office in Hazelton. She holds a degree in anthropology and sociology and is currently completing a Master of Arts degree at UNBC in First Nations Language and Territory. Ms. Percival has worked as a researcher, museum curator and instructor at the college and university level.

Ruby Fraser – Ms. Fraser is Regional Director, Quality and Risk Management for the Northern Health Authority, monitoring health care incidents across the continuum from community to acute care.

Dr. Jean Hlady – Dr. Hlady is a clinical professor in the Department of Pediatrics at the University of British Columbia's Faculty of Medicine. She is also a practising pediatrician at BC Children's Hospital and has been the Director of the Child Protection Service Unit for 21 years, providing comprehensive assessments of children in cases of suspected abuse or neglect. Dr. Hlady also served on the Multidisciplinary Team for the Children's Commission.

Norm Leibel – Mr. Leibel is the Deputy Chief Coroner for the BC Coroners Service. He has 25 years of policing experience and 17 years as a coroner. Mr. Leibel has examined the circumstances around child deaths in criminal and non-criminal settings, with the goal of preventing similar deaths in similar circumstances in the future. Mr. Leibel was a member of the Multidisciplinary Team for the Children's Commission.

Sharron Lyons – With 32 years in the field of pediatric nursing, Ms. Lyons currently works as a registered nurse at the BC Children’s Hospital, is past-president and current treasurer of the Emergency Nurses Group of BC and is an instructor in the provincial Pediatric Emergency Nursing program. Her professional focus has been the assessment and treatment of ill or injured children. She has also contributed to the development of effective child safety programs for organizations like the BC Crime Prevention Association, the Youth Against Violence Line, the Block Parent Program of Canada and the BC Block Parent Society.

Russ Nash – Mr. Nash is currently the Officer-in-Charge of a Major Crime Section with the RCMP. He has expertise in extensive criminal investigations and, in particular, in homicide investigations. He has been involved in a variety of RCMP programs focused on youth, including the D.A.R.E. program, and has also volunteered as a coach and manager of youth sports teams.

Dr. Ian Pike – Dr. Pike is the Director of the BC Injury Research and Prevention Unit and an assistant professor in the Department of Pediatrics in the Faculty of Medicine at the University of British Columbia. His work has been focused on the trends and prevention of unintentional and intentional injury among children and youth.

Dr. Dan Straathof – Dr. Straathof is a forensic pathologist and an expert in the identification, documentation and interpretation of disease and injury to the human body. He is a member of the medical staff at the Royal Columbian Hospital, consults for the BC Children’s Hospital and assists the BC Coroners Service on an ongoing basis.

Appendix E: CPT 1

CPT 1 is an enzyme in the body that helps change fat to energy. Fats are an important fuel source for the body between meals.

A complete lack of the CPT 1 enzyme is extremely rare; however, the consequences are serious because it places greater demand on sugar stores in the body, which can result in extremely low blood sugar, and sudden death can occur. Simple steps like frequent feeds and ensuring that fasting does not occur during illness can reduce the risk of sudden death.

A mild form, called the CPT 1 variant, occurs at a very high frequency in Canadian Inuit infants in Nunavut. Among 422 live births, the CPT 1 variant was observed in two out of three infants. Whether this variant contributes to the higher mortality rate seen in Canadian Inuit infants is the focus of ongoing studies. In Alaska 129 infants with the CPT 1 variant have been identified, and all of these infants' mothers are Alaskan Native Americans. When researchers at BC Children's Hospital were investigating the sudden unexpected death of young children, the same CPT 1 variant found in the Inuit and Alaskan Native Americans was seen also in B.C. infants of First Nations descent.

A blood test for treatable metabolic disorders is done on all B.C. newborn infants. Currently, CPT 1 is not part of that testing. However, the blood samples are stored after screening is completed and can be used for public health research. The UBC Clinical Research Ethics Board and the First Nations Health Council approved a study to determine the prevalence of the CPT 1 variant in B.C. and to determine if there was an association between the CPT 1 variant and sudden death.

The research has led to the conclusion that about 200 First Nations infants are born in B.C. each year with the CPT 1 variant. It is more common on Vancouver Island and along the B.C. coast. It is estimated that 19–24 per cent of First Nations infants born on Vancouver Island have the CPT 1 variant, compared to 4 per cent in the Interior of B.C. Historically, this may have been a genetic advantage for adult survival, but extensive research is needed to fully understand this issue.

A First Nations infant who has the CPT 1 variant is approximately three times more likely to die suddenly than an infant who does not have the variant. To put this into perspective, the mortality rate associated with the CPT 1 variant is approximately 1–2 per cent. On Vancouver Island the increased frequency of the CPT 1 variant mirrors the increased rate of infant mortality among First Nations. In B.C. a study is in the planning stages to get a better understanding of the natural history of the CPT 1 variant. Further research will continue to shed light on the role of this variant in the health of Aboriginal populations.

From Sinclair, Collins, Arbour, Popescu, and Vallance, to be published in the *Journal of Inherited Metabolic Diseases*, 2011.



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