

Child Protection Issues and Pediatric Forensic Pathology

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INTRODUCTION

The primary responsibility for the investigation and prosecution of cases involving child abuse deaths rests with the police, Crown prosecutors, and the criminal justice system, and these are the agencies with the greatest role in the legal control and use of information from forensic pediatric pathology reports. However, if the parents involved have other children at the time of the death, or subsequently have more children, there are also very serious implications for the parents and these children in the child protection system. If forensic pediatric pathology reports are unreliable, there are likely to be profound implications in the child protection system, even though the actors in that system have less direct involvement in the preparation of these reports than those in the criminal justice and coroner's systems.

Although many of the issues related to the use of forensic pediatric pathology reports in the child protection system overlap with those in the criminal justice system, there are also some important differences between the criminal justice and child protection systems. In some respects there are even greater challenges in the child protection context in dealing with uncertainties or inadequacies in forensic pediatric pathology reports. For forensic pathologists, police, and the criminal justice system, a lengthy investigation that ultimately results in a just outcome is not a problem. Child protection agencies and the Family Courts, however, must make decisions about children whose lives are still going on; decisions must be made, and delay in making a permanent decision works against the interest of children. Further, in the criminal justice system, the focus of

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inquiry is retrospective and narrow: what was the cause of a child's death? In the criminal justice system, genuine uncertainty about the cause of a child's death is resolved by the presumption of innocence: without a reasonable prospect of conviction based on proof of guilt beyond a reasonable doubt, no charges should be laid.

In deciding whether a child will be removed from parental care, child protection workers and Family Court judges have a much broader scope of inquiry, one that is both retrospective and prospective. They must consider all of a parent's conduct toward any children, including whether they were responsible for the death of other children, as this clearly reflects on their ability to care for other children in the future. While the child protection system may take account of parental misconduct or neglect that does not result in a criminal conviction or even charges, genuine uncertainty about responsibility for the death of siblings is much more difficult to deal with in the child protection system than in the criminal justice system, as decisions are being made about the future care of children, and the presumptions of the criminal law do not apply.

This paper is intended to orient Commissioner Goudge and his staff, the parties to the Commission hearings, and interested readers to issues related to forensic pediatric pathology in the Ontario child protection system, and to the problems that arise if it is discovered that there have been errors in previously undertaken forensic pediatric pathology reports. This paper also discusses the changes in legislation and policy in Ontario's child protection system during the period from 1981 to 2001.

We have some important introductory, cautionary comments for readers, some methodological and others substantive.

As a methodological note, we relied primarily on the existing legal and child welfare literature, including a review of reported case law, mainly from Canada, but also some cases from

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England. There is only a limited literature on the problems that arise in the child protection system after a child has died in circumstances where the parents are considered responsible for that death or there is uncertainty about the cause of death, and there are only 21 reported Canadian child protection cases from the Family Courts that raised these issues. We did not contact any of the agencies, parents, children, or professionals involved in any of the Ontario child protection cases in which Dr. Smith was involved, nor did we interview any professionals about their experiences in other cases involving parental responsibility for, or uncertainty about responsibility for, the death of a sibling.¹ A complete review of the issues raised in this paper would require interviews with such individuals and analysis of their experiences and perspectives.

Two important substantive observations about the discussion in this paper may affect how the Commissioner and others view the issues that are discussed.

One is that, while responding to the death of a child in a situation in which there is uncertainty about the cause of death or there are clear allegations of parental responsibility is a “core business” for coroners, forensic pathologists, and homicide detectives, for child protection agencies and staff this is a tragic but rare event. Local agencies and staff inevitably have little or no experience in dealing with these most challenging cases, and must rely on professionals with more investigative knowledge in this area, such as pathologists. Because of the relative infrequency of child death cases in a child protection system that deals with thousands of cases each year, it is understandable that there is only limited local experience in dealing with these cases. Further, because of the infrequency of these events, the literature on child abuse can provide only limited guidance for practitioners and researchers. While research may allow child protection professionals and the courts to make some assessment of the risk that a particular parent will abuse or neglect a child, it is impossible to predict the likelihood of the very rare event that a particular parent will kill

¹ In preparing this report, the authors had a discussion with Ms. Jeanette Lewis, Executive Director of the Ontario Association of Children’s Aid Societies, about some of the policy issues raised.

his or her child. In a concluding section of this paper, we address the question of how to increase knowledge and expertise in the Ontario child protection system for dealing with these most challenging cases. Local Children's Aid Societies must be prepared to respond appropriately to these most challenging cases, even though they occur rarely in any locality.

As a final introductory comment, it is important to understand the problems related to unfounded allegations of parental responsibility for child abuse and neglect deaths in context. There have been very significant changes in social attitudes, knowledge, legislation, and policies regarding child abuse and neglect. Historically, there was often a failure to recognize or adequately respond to cases of parental abuse or neglect of children. More recently, health-care professionals, police, the courts, and child welfare professionals have done a much better job of understanding and responding to child abuse and neglect. It is also now clear that there have in recent years been some cases in which there was a misdiagnosis of parental abuse or neglect. Although these cases are small in number, even a single case of an unfounded allegation of parental abuse or neglect resulting in death has devastating effects on the wrongly accused parent and any surviving children.

Understandably, the public, professionals, and the Ontario government want an inquiry into allegations of professional incompetence related to forensic pediatric pathology in order to ensure that they do not reoccur. It must, however, also be appreciated that, in the context of the child protection system, it is very difficult to achieve the perfect balance between not making unfounded accusations and not protecting children from parents who actually have a history of abuse or neglect of a child's siblings.

THE CHILD PROTECTION CONTEXT

Before examining the specific challenges posed by child protection cases involving sibling deaths and forensic pathologists, we provide a general description of the child protection system in Ontario

and a brief history of the evolution of that system, with a particular focus on the period from 1981 to 2001.

The Nature and Dilemmas of the Child Protection System

Parents have significant rights and responsibilities for the care of their children. The government, however, also has the responsibility to ensure that the needs of children are met. While parents have a significant degree of autonomy in making decisions about matters such as recreational and cultural activities, religious upbringing, and discipline of their children, if there are concerns about physical, emotional, or sexual abuse or neglect, a government-mandated child protection agency may become involved with the family. In many cases, a child protection agency is involved with a family on a voluntary basis, perhaps because the agency was contacted by the parents, providing counselling and support for parents who may be having difficulty in adequately caring for their children. However, the agency also has a legal mandate to provide services on an involuntary basis, and has very significant coercive powers. It is clear that the agency should only be involved with a family on an involuntary basis if there are significant parenting concerns. As articulated by Stortini J. in *Re Brown*:²

[T]he community ought not to interfere merely because our institutions may be able to offer a greater opportunity to the children to achieve their potential. Society's interference in the natural family is only justified *when the level of care of the children falls below that which no child in this country should be subjected to.*

Child protection agencies are responsible for protecting children from parents whose conduct constitutes physical abuse or neglect, sexual abuse, emotional abuse or neglect, or failure to provide adequate care. One of the challenges in this area is that, like the more general definition in *Re Brown*, there is a degree of vagueness to the definitions of child abuse and neglect. While some

² (1975), 9 O.R. (2d) 185, at 189 (Ont. Co. Ct.).

cases clearly involve abuse or neglect, in others the subjective assessments of the particular worker and judge involved will determine whether the level of care has fallen below “that which no child in this country should be subjected to.”

Agency staff may enter premises without warrant to investigate suspected abuse or neglect, and may apprehend children believed to be in need of protection. If there are abuse or neglect concerns, the parents may be required to submit to ongoing court-ordered supervision by agency staff (a supervision order), or, if the risk is more serious, the children may be placed in agency care on a temporary basis (called Society wardship in Ontario). The agency may also seek to permanently remove children from parental care (called Crown wardship in Ontario), either with a view to having the child remain in long-term care, perhaps with regular continuing contact with the parents, or with the intent of having the child adopted.

The process of removal from care and suspension or termination of parental rights is subject to legislative regulation and judicial control. If parents (or older children) disagree with the decisions of the agency, there will be a contested hearing in Family Court. In practice, many cases, even those involving permanent severance of a parent–child relationship, are resolved on a consent basis or without a contested hearing, but some cases are resolved only after extensive litigation. In some cases parents will not contest the agency’s application because they genuinely believe that the agency is acting in their child’s best interests, but in other cases they consent to the agency’s application because they lack the emotional strength or resources to litigate, or because they feel that the outcome of the litigation is inevitable. Although Legal Aid is provided to parents with very low incomes who are contesting a Children’s Aid Society (CAS) application, parents of modest means are expected to pay for a lawyer themselves and might find the cost of litigation financially ruinous.

While parents may view the process of agency involvement as coercive, and even punitive, the focus of the process is the protection of children and the promotion of their welfare. It is,

however, now clearly accepted that the child protection process involves a threat to the “security of the person” of parents and must be carried out in accordance with the *Charter*-guaranteed “principles of fundamental justice.”³ For example, parents who are indigent generally have a constitutional right in a child protection case to counsel paid for by the state, and, with narrow exceptions, parents have a constitutional right to disclosure of information that the agency has obtained in its investigation.⁴ The child protection process, however, is not a criminal proceeding, and standard of proof for the agency is the civil standard of proof, that is, proof on the balance of probabilities, rather than the criminal burden of proof beyond a reasonable doubt. The rules of evidence are much broader in the child protection process than in the criminal context, allowing the child protection court to consider evidence that would clearly be inadmissible in a criminal trial.

While the standard of proof in a child protection case is civil, there is a clear onus on the agency to establish its cases and to justify involuntary state intervention in family life. The dilemma that this poses was discussed by Judge Karswick in *Re Chrysler*:⁵

While I have not been able to find any clear evidence of abuse, I suspect that the C.A.S. is attempting to take preventative steps. It seems to me that in such a situation the potential for real and immediate abuse must be clear before the state should be permitted to intervene by removing the child from her parents. If it were otherwise, it would allow a C.A.S. to be the final arbitrator in a so-called child abuse case and would leave the parents and the child with no real recourse to a really independent and impartial court. In adopting this principle, *I realize that there is always the danger that some real and even irreparable harm may be inflicted upon the child if the parents are really potential child abusers, but the C.A.S. has not been able to prove that fact* because of the unavailability of witnesses who can testify to the alleged abuse and therefore has not been able to meet the standard of proof required by the court.

I think that this risk must still give way to the greater risk of the irreparable harm that can be inflicted upon a child and the danger to society of the serious undermining of the parents and the family if a C.A.S. is permitted to act in an arbitrary way, even though its intentions are motivated by the highest ideals and concerns.

³ See, e.g., *New Brunswick (Minister of Health v. G.(J.)*, [1999] 3 S.C.R. 46. For a fuller discussion, see N. Bala, “The Charter of Rights and Family Law in Canada: A New Era” (2001) 18 *Canadian Family Law Quarterly* 373–428.

⁴ The exceptions to the agency duty of disclosure in a child welfare case are similar to those that apply in a criminal case; an agency does not, for example, have to disclose the identity of an informant, like a neighbour, who may have reported suspected abuse or neglect, and in some circumstances might not disclose the identity of a foster parent with whom a child is placed. Some of the contents of the agency file may also be subject to solicitor–client privilege.

⁵ [1978] O.J. 2642, at para. 42–43, 5 R.F.L. (2d) 50, at 58 (Ont. Prov. Ct.). Emphasis added.

The dilemma faced by child protection agencies and Family Court judges is especially clear in cases where an application is being made to have a child made an agency ward and there is a prior sibling death. If the agency can convince the court, on the civil standard of proof, that one or both parents are responsible for the death due to their neglect or abuse, there are clearly concerns about the safety and well-being of any other children who may be in their care. However, if the agency, inevitably relying at least in part on the investigation of police and pathologists, does not have sufficient proof, but can merely raise suspicions of parental responsibility, the case should be dismissed, leaving the surviving siblings at risk if the suspicions are actually well founded. It must also be appreciated that parents should not lose custody of surviving children merely because a child in their care has died in circumstances in which doctors may be unable to determine the cause of death. It should, however, be appreciated that if there is evidence that a deceased sibling was abused (for example, bruising or fractures not consistent with the parental explanation) this type of past parenting conduct may be admissible to establish that a child is in need of protection, even if the cause of death is uncertain.

In cases involving serious allegations of abuse or neglect, or possible homicide, there may be parallel child protection and criminal investigations and proceedings. In practice, if the police are involved in a case, they will generally take the lead in the investigation of any alleged criminal acts, sharing information with the child protection agency, but ultimately each agency is responsible for carrying out its own investigation for its own purposes. CAS workers will usually have a continuing relationship with the parents while the investigations proceed, supervising the parents' care of surviving children, or, if the children are in CAS care, supervising their visits with the children and discussing the children's care. If matters proceed to court, the child protection process will inevitably consider a broader range of parental conduct. While past conduct may be very important,

the ultimate question in the child protection process is prospective: will these parents care adequately for the child, or do they pose sufficient risk that they should lose custody? If they lose custody, is the situation such that there should be a permanent termination of parental rights? In short, child protection proceedings are primarily concerned with the future, whereas criminal proceedings are primarily concerned with the past.

In the child protection process, there is no “right to silence.” Child protection workers have no duty to caution parents about the use of their statements, and anything that parents say can be used in court.⁶ If parents fail to answer questions of child protection workers, agency workers and the Family Courts may use this as the basis of an inference that they have something to hide, and their “lack of co-operation” may be a factor in deciding that they will not work well with agency staff and that a supervision order will not be adequate to protect the children, requiring their removal from the home. Further, admissions that a parent makes to a child protection worker, if relevant, may be admissible in a criminal trial, even if the parent was not cautioned about the potential use of the statements in those proceedings.

In Ontario, child protection services are provided by a local Children’s Aid Society (CAS). Most CASs service all child protection cases in a particular region, though a few agencies service only those of a specified religious background (Catholic or Jewish) in a particular area, and in some areas, agencies have been established to service Aboriginal families and children. CASs operate pursuant to the *Child and Family Services Act* (CFSA), and presently receive all of their core funding from the provincial government. These agencies are non-profit corporations with local boards. While there is a degree of local control and policy setting, and staff are employees of the local agency, the provincial government has significant control over the local CASs through legislation, regulations, and control of funding; at present, responsibility for CASs rests with the

⁶ *Family and Child Services of St. Thomas v. W.F.*, [2003] O.J. 717 (Ont. Ct. J.), per Schnell J.

Ministry of Children and Youth Services (MCYS), and during the 1981–2001 period, it rested with the Ministry of Community and Social Services (MCSS). During the 1981–2001 period, the provincial government gradually increased its control over CAS operations, with an evolving set of policies and regulations governing such issues as investigations in child abuse and neglect cases, and staff qualifications.

Although technically CAS workers are not civil servants, they exercise very significant statutory powers, and they collaborate with other government-mandated agencies, including police, hospitals, and coroners, as well as with professionals in private practice, including physicians and psychologists. Child protection work is a very demanding type of social work; because CAS workers have these investigative and coercive powers, they are often resented by the parents and children whom they are trying to help, making this a particularly challenging type of work. Compared to other social work and therapeutic settings, where the client’s trust is an important aspect of the professional relationship, there can be high levels of distrust between CAS workers and the parents with whom they are working. Although CAS workers may want to help parents to provide better care for their children, there is often an implicit threat that if the parents do not meet worker expectations, the worker may apprehend the children. Parents usually are aware that whatever they tell CAS workers may later be used against them, and CAS workers are expected to have a degree of skepticism about what parents tell them. Parents in these cases, many of whom are already suffering from mental illnesses, emotional disturbances, substance abuse problems, or social marginalization, can be very resistant to intervention in their lives by social workers employed by the CAS. The investigative and court-related aspects of the work are much more adversarial than most types of social work and may result in “clients” expressing great hostility and anger toward social workers employed by the CAS.

Further, if a case “goes bad,” it can have very serious implications for a CAS worker, making this stressful work. If a child who is under the supervision of the agency dies, there may be an inquest or even criminal negligence charges against the workers responsible for the case. Child protection workers who were responsible for supervising a family where a child dies as a result of parental abuse or neglect may find it difficult or impossible to remain in the field. There are educational and training qualifications for child protection workers, which include training about identification, investigation, and responding to cases of child abuse and neglect, but the training does not deal with the investigation of child deaths, and few workers or supervisors would have experience with this type of case.

The demands, challenges, and frustrations of child protection work result in this being a field where there is a relatively high staff turnover. It is not uncommon for a number of child protection workers to be responsible for working on a single case over the space of a few years, and for some of them to be working at their first job as a social worker. Compared to police, prosecutors, physicians, and pathologists who may be working on a case, child protection workers are often relatively inexperienced and poorly paid, and have low professional status. Understandably, CAS workers often defer to these higher status professionals. It is, however, child protection workers who are responsible for making the most important initial decision after an unexplained child death—that of what should happen to any surviving siblings.

One of the realities of child protection work is that, while issues of abuse and neglect affect children from all social and economic strata in society, the majority of families involved with the CAS are members of socially marginalized and economically disadvantaged groups. Aboriginal peoples, certain immigrant groups, those on social assistance or the unemployed, persons with intellectual disabilities, those with criminal records, and single parents are disproportionately represented in the caseloads of child protection agencies. In some measure, the disproportionate

representation of marginalized groups in child protection caseloads reflects social realities; the social, emotional, cultural, and intellectual factors that result in poverty and disenfranchisement also affect parenting capacity. But those who are socially marginalized may also be subject to a degree of scrutiny by state agents, such as social assistance workers and probation officers, which may result in greater reporting of child abuse and neglect than among those who are members of higher socio-economic groups. Further, child protection agency staff tend to be relatively well-educated members of dominant social, linguistic, and racial groups, and there is the potential for the misunderstandings and differences in values, experiences, and opportunities to affect how cases are handled. This was recognized in a 1973 Ontario case, where the judge wrote:⁷

In a hearing such as this there is danger in over-reliance upon any group of witnesses self-conscious respecting their professionalization. I resolved not to fall victim to this specific bias of the profession, the group psychology of the social workers....

It was manifest from the opening that this was a contest between the right of a subsocio-economic family to subsist together and the right of the public, represented by the Children's Aid Society, to insist upon higher standards of parental care than the couple in question were capable of offering. Many witnesses called for the Society were persons of superior education with post-graduate degrees in social work or some other related specialty. One could not listen to their testimony with all the sombre implications of this application without resolving that this Court must not be persuaded to impose unrealistic or unfair middle class standards of child care upon a poor family of extremely limited potential.

Concerns about how the values, biases, and personal experiences of professionals affect the handling of child protection cases may arise in cases where there is an unexplained child death. Professionals may, for example, misinterpret parental reactions to the death as indicative of guilt.

One particularly marginalized group in Canadian society are Aboriginal Canadians, and Aboriginal children have been dramatically overrepresented among children in the care of child welfare agencies.⁸ In part the high rates of apprehension and placement in care of Aboriginal

⁷ *Re Warren* (1973), 13 R.F.L. 51, at 52 (Ont. Co. Ct.) per Matheson J.

⁸ For a fuller discussion of issues related to Aboriginal children and the child welfare system, see, e.g., M. Sinclair, N. Bala, H. Lilles & C. Blackstock, "Aboriginal Child Welfare," chap. 7 in *Canadian Child Welfare Law*, ed. Bala et al.

children are a reflection of the social disorganization of many Aboriginal families as a result of a parental history of abuse in residential schools, high levels of poverty and substance abuse, and social marginalization, which have resulted in relatively high levels of neglect and abuse in some Aboriginal communities. It is also clear that historically many child welfare agencies and their staffs were at best insensitive and at worst racist in their dealings with Aboriginal families and children, and inappropriately regarded some traditional Aboriginal child-care practices as neglectful. Aboriginal children were often placed for adoption with non-Aboriginal families, resulting in a form of “cultural genocide,” as well as high rates of placement breakdown.

In 1984, the *Child and Family Services Act* was enacted by the Ontario legislature, with provisions to specifically recognize the special status and issues of Aboriginal children. If an Aboriginal child is apprehended, the child’s community must be notified of court proceedings, and may participate along with the parents. There is a statutory preference for placement of Aboriginal children with members of their community or in another Aboriginal community. In some parts of Ontario there are now Aboriginal controlled CASs, with staff and programs more sensitive to the cultural and social needs of Aboriginal children and families. While there has been progress in recognizing and addressing the needs of Aboriginal children and families involved in the child welfare system, there continue to be concerns about high rates of apprehension of Aboriginal children and the vulnerability of Aboriginal families in their dealings with child welfare agencies.

Brief History of Child Protection in Ontario

The first CASs and child protection legislation came into existence in Ontario in the late nineteenth century. In the first part of the twentieth century, when there was no government financial support

(Toronto: Thompson Education Press, 2004); and Aboriginal Child Welfare Information Sheets of Centre of Excellence for Child Welfare, at www.cecw-cepb.ca/pubs/infosheets_aboriginal_e.html, accessed September 12, 2007.

for families, CASs dealt mainly with cases involving parents who were destitute and unable to care for their children, unwed mothers placing children for adoption, orphans, and delinquent youth. CASs and police were only rarely involved in investigations of abuse or neglect that resulted in criminal prosecutions, and then only in the most egregious cases.

Although parental ill-treatment and infanticide were endemic throughout history, it was only in the early 1960s that researchers and child protection professionals began to fully appreciate the problems in detecting child abuse. In 1962 a seminal article by American pediatrician Henry Kempe identified the “battered child syndrome,” describing how abusive parents might repeatedly bring children into hospital emergency rooms claiming that they had been “accidentally” injured, and advocating for doctors and child protection professionals to investigate for possible child abuse or neglect cases where the injuries of children seemed inconsistent with parental explanation.⁹ As a result of growing awareness of the issues, in many jurisdictions laws were enacted to require reporting of suspected child abuse and neglect, with Ontario enacting its first such law in 1965.

In the mid-1970s, there were two highly publicized tragic cases of child abuse and neglect that demonstrated some of the inadequacies in Ontario’s child protection system, and ultimately resulted in changes in laws and policies that were intended to increase protections for children.

In the *Ellis* case,¹⁰ a woman who herself had a history of having been abused as a child had five children, all of whom suffered abuse or neglect. The first child was neglected in her care, and was eventually apprehended and made a Crown ward; the neglect of that child resulted in criminal charges against the mother and a probation sentence. The second child, born just before the apprehension of the first, died at age eleven months, with both a pathologist and a Coroner’s jury expressing concerns about neglect, but no criminal charges were laid. A year and a half after the

⁹C.H. Kempe, F.N. Silverman, B.F. Steele, W. Droegemuller & H.K. Silver, “The Battered Child Syndrome” (1962) 181 *Journal of the American Medical Association* 17–24.

¹⁰ Discussed in Peter Silverman, *Who Speaks for the Child? The Plight of the Battered Child* (Don Mills, Ont.: General Publishing, 1978) at chapter 1.

death of the second child, the woman had a third child. Despite supervision by the CAS, the third child drowned in the bathtub while unattended, at the age of one and a half years. Just before the third child died, the woman had a fourth child; that child was apprehended at the age of about two months, suffering from “gross malnutrition,” and was eventually made a Crown ward. Less than two years after the death of the third child, the woman had a fifth child, who was apprehended by the CAS at birth. The CAS was seeking Crown wardship, but before a decision was made, the mother was sent for a court-ordered assessment by an experienced social worker from the Family Court Clinic. That social worker concluded that the mother “should have another chance,” and that with appropriate support she would not pose a risk to the safety of her child. The judge decided to return the fifth child to the mother, relying in significant measure on the opinion of the social worker and largely ignoring the prior deaths. Perhaps influenced by the criminal evidentiary rules that normally preclude consideration of past conduct not related to the matters before the court (the “similar fact rule”), the judge commented: “I specifically did not base my judgement on past history, or some of the unfortunate things which had occurred to prior children with which [the mother] ... has been associated.” The infant was returned to the mother’s care under the supervision of the social worker who had supported the mother, but was dead within a month due to neglect. The *Ellis* case resulted in a highly publicized Coroner’s inquest, and the enactment of the following provision in the *Child Welfare Act* in 1978:¹¹

Notwithstanding any privilege or protection afforded under the *Evidence Act*, before making a decision that has the effect of placing a child in or returning a child to the care or custody of any person ... the court may consider the past conduct of a person toward any child who is or has been at any time in that person’s care, and any statement or report, whether or oral or written, including a transcript, exhibit or finding in a prior proceeding, whether civil or criminal proceeding that the court considers relevant to such consideration ... is admissible into evidence.

¹¹ *Child Welfare Act, 1978*, S.O. 1978, c. 85, s. 28(4).

Although discretionary, this provision clearly indicates that the criminal evidence rules are not to apply to child protection cases. This provision was intended to ensure that the situation in *Ellis* did not recur, and that in future cases the courts would consider a person's parenting history, including the abuse or neglect of children other than the child who is subject of the immediate proceedings, and in particular to take account of a situation in which a person was responsible for the care of a child who died, whether or not there was a criminal prosecution and conviction. This relatively rapid legislative response illustrates that policy-makers and politicians can be very responsive to even a single, highly publicized child abuse case. Although the legislative response to the *Ellis* case was appropriate, there is a danger of overreaction to tragic cases, with responses that may in the long run do more harm than good.

While *Ellis* involved poor judgment by the courts and a problem that could be addressed by legislative change, the other highly publicized Ontario child abuse death of the late 1970s, the *Popen* case, resulted from problems in the management of high-risk cases by a local CAS, and raised issues that could really only be addressed by institutional change. The *Popen* case involved the death of a 19-month-old child due to parental abuse and neglect, despite the involvement of the CAS and a number of professionals from different agencies in the life of the young child. The *Popen* case was the subject of a public inquiry chaired by Judge Ward Allen, who reported in 1982.¹² The *Allen Report* detailed mismanagement by the local CAS, and a lack of coordination and communication between agencies and professionals who were servicing the family. The four-volume *Report* made 87 recommendations for an improved response to child abuse and neglect cases. It resulted in the provincial government taking a greater degree of responsibility over local

¹² H.W. Allen, *Judicial Inquiry into the Care of Kim Anne Popen by the Children's Aid Society of the City of Sarnia and The County of Lambton*, 4 vols. (Toronto: Queen's Printer for Ontario, 1982) [the *Allen Report*]. The *Popen* case is described in Cyril Greenland, *Preventing Child Abuse and Neglect Cases* (London: Tavistock Publications, 1987) at 98–121.

child protection agencies and beginning to set province-wide standards for the investigation of and response to child abuse and neglect.

The Reforms of the Early 1980s

In the early 1980s the child protection system in Ontario went through a major systemic and legislative change, culminating in the enactment of the *Child and Family Services Act (CFSA)* in 1984. In part, these changes may be viewed as a response to the *Allen Report*, and in particular its expectations for greater provincial government responsibility for the provision of child welfare services by local CASs. In significant measure, however, the CFSA was also a reflection of broader trends in the child welfare field in North America.¹³ One of the trends of this period was the articulation of the “least disruptive alternative” principle and support for “family autonomy.” While recognizing the dangers of abuse and neglect, and allowing for the removal of children from parental care in cases of substantial risk, there was also recognition of the emotionally disruptive effects of removing children from their families. Accordingly, where possible, parents were to be supported in the care of their children, and services were to be provided to children in their homes. One example of the support for “family autonomy” was a narrowing of the definition of “child in need of protection.” For example there was an elimination of vague grounds for agency intervention such as “parental unfitness,” and the enactment of a new requirement that agencies establish a substantial risk to a child’s health or safety to justify removal from parental care.

The CFSA also explicitly recognized the importance of a child’s culture and heritage, and in particular the importance of Aboriginal heritage, with provisions for the involvement of First Nations communities in child protection proceedings, and allowing for the establishment of Aboriginal child welfare agencies. Another theme of the CFSA was greater recognition of legal

rights for both parents and children, reflecting the fact that the *Charter of Rights* came into force in 1982.

There is some tension between the desire to both deal more effectively with child abuse and neglect and respect “family autonomy.” In some measure, this tension was addressed by placing an increased emphasis on the provision of “preventative services,” which are intended to prevent a child from coming into care; these services, including counselling and parenting education programs, can be provided to high-risk families (often but not always headed by a single mother) on a voluntary basis, or may be provided pursuant to a supervision order made by a court with the intent of allowing a child to remain safely at home. Another important innovation that was intended to resolve the tensions between recognition of the importance of family autonomy and protection from abuse is “permanency planning.” Permanency planning, reflected in the CFSA, places an emphasis on making earlier decisions to promote the interests of a child in having a permanent, stable home. As soon as is consistent with the interests of a child, a “permanent” decision should be made, either to have the child at home with appropriate supports, or removed and placed in a long-term foster home or, if possible, an adoptive home. In some measure, the reforms of the early 1980s were premised on an increase in resources for the child welfare system, and an expectation that there would be better decision making by child protection staff and the courts. To promote better decision making, province-wide standards were introduced for the handling of cases, and there was a gradual increase in the educational requirements for CAS staff.

In comparison to the child protection legislation of an earlier era, by the mid-1980s Ontario’s CFSA had established a more complex, legally regulated child protection system. While child abuse and neglect were heightened concerns, there was also an expectation of “better” decision making,

¹³ See discussion in, e.g., N. Bala, “The Children’s Act: A Consultation Paper—Child Welfare Reform in Ontario” (1983) 4 *Canadian Journal of Family Law* 233–243.

and, as set out in Table 1 below, the overall trend in the mid-1980s and early 1990s was toward having fewer children in agency care, and many more under supervision at home.

Out-of-Home Placement Trends: 1971–2002

Table 1 depicts placement trends for Ontario child welfare services from 1971 to 2002. During this period, the number of children in out-of-home care at year end (Row A) dropped from a high of 17,800 in 1971 to a low of 10,000 in 1991, increasing to 17,400 in 2002. As shown in Row D, controlling for the change in the child population during this period, the rate of children placed per 1,000 children in the province shows a similar pattern, with the rate dropping from 6.09 per 1,000 in 1971 to a low of 3.68 per 1,000 in 1996 and increasing rapidly to 5.83 per 1,000 in 2002.

Table 1: Child Welfare Service Trends in Ontario, 1971–2002									
	1971	1976	1981	1986	1991	1996	1998	2000	2002
A: Children in care at year end	17,800	13,900	13,000	9,900	10,000	10,400	12,500	15,000	17,400
B: Families served during year	28,300	34,200	48,500	67,700	86,000	114,100	121,700	130,200	136,700
C: Ontario population under 19 years (1,000s)	2,922	2,882	2,696	2,564	2,678	2,833	2,885	2,936	2,988
D (A/C): Children in care/1,000 children	6.09	4.82	4.83	3.85	3.75	3.68	4.34	5.12	5.83
Source: Data compiled by Nico Trocmé from reports generated by the Ministry of Child and Youth Services and the Ontario Association of Children’s Aid Societies. Figures rounded to the nearest 100.									

Row B provides the total number of families served during each year, which includes families receiving services at year end as well as all families coming into contact with CASs during the year but not receiving services at year’s end. This rough figure is the only available statistic that measures service activity beyond out-of-home placement. It includes families who received ongoing services, families who were investigated but were not receiving ongoing services, and families who were receiving services without being investigated for child abuse or neglect.

Two important things stand out when one compares the data on children in care to that on families served (Rows A and B). First, the decrease in the number of children in care from 1971 to the mid-1990s occurred despite a dramatic increase in reports and investigations for alleged child abuse and neglect. This trend reflected a shift in child welfare service approaches that occurred across North America during this period: at the point of initial involvement, family preservation programs were developed to serve children in their home whenever possible while, at the same time, permanency planning programs were developed to have children temporarily placed in care moved back into their homes or into permanent, stable placements such as adoptions. Second, as discussed below, the increase in the number of children in care from the mid-1990s reflected both a change in approaches within the child welfare system in Ontario and a response to the continued increase in reports of abuse and neglect to the child welfare system.

Responding to Child Abuse and Neglect in the late 1990s

As Table 1 shows, as a result of changes in legislation and policy in the early 1980s, by the mid-1990s the rate of children in care had declined significantly, although the total number of families receiving services from CASs was increasing. Many families were receiving services on a voluntary basis, though a significant number had children living with their parents under court-ordered agency supervision, some of them in situations that under the pre-CFSA legislative standard would have led to the children being placed by the court in agency care. In the later part of the 1990s there were a number of related developments that led to very significant changes in child protection in Ontario, and a dramatic increase in the number of children apprehended from parental custody and placed in CAS care.

In the mid-1990s there were a number of highly publicized cases in Ontario in which children who were receiving services from the CAS while in their parents' homes died as a result of

parental abuse or neglect. Coroner's inquests into these cases revealed that some of the workers involved had been too trusting of the parents, relying on parental assurances that they were providing good care for their children. During this period, the Office of the Chief Coroner assumed a greater role in developing understanding of and responses to child abuse and neglect in the province. In 1995, the Pediatric Death Review Committee, chaired by Dr. James Cairns, Deputy Chief Coroner, developed a new protocol for the investigation of unexpected deaths of children under two years of age. This protocol was sent to all sent to all coroners, pathologists, and police chiefs in Ontario, and included the following statement:

Unfortunately, in this day and age CHILD ABUSE IS A REAL ISSUE and it is extremely important that all members of the investigative team "THINK DIRTY". They must actively investigate each case as potential child abuse and not come to a premature conclusion regarding the cause and manner of death until the complete investigation is finished and all members are satisfied with the conclusion.¹⁴

This protocol both reflected and reinforced growing professional awareness and concerns about child abuse and neglect in the mid-1990s.

In 1996 the Office of the Chief Coroner and the Ontario Association of Children's Aid Societies, with the support of the Ministry of Community and Social Services, established the Ontario Child Mortality Task Force to review cases in which children had died during 1994 and 1995 while receiving services from a CAS. The *Final Report*¹⁵ of the Task Force made a number of recommendations and led to the adoption of the Ontario Risk Assessment Model (ORAM), which has led to a more standardized assessment of child abuse and neglect cases.¹⁶ In 1997 a decision was made that the Pediatric Death Review Committee of the Office of the Chief Coroner would review

¹⁴ Office of the Chief Coroner, Pediatric Review Committee (Chair James Cairns), *Protocol for the Investigation of Sudden and Unexpected Deaths in Children under Two Years of Age* (1995). CAPITAL LETTERS for emphasis in original.

¹⁵ Ontario Child Mortality Task Force Final Report, *OACAS Journal*, Special Edition (July 1997).

¹⁶ Some of the background to the inquests and a summary of the recommendations is discussed in Kirsten Johnson Kramar, *Unwilling Mothers, Unwanted Babies: Infanticide in Canada* (UBC Press, 2005), 151–155.

all deaths of children who died with an open CAS file in order to provide better systemic information about child mortality.

In 1997, a young infant, Jordan Heikamp, died of malnutrition while in his mother's care, resulting in criminal charges against both his mother and the CAS worker responsible for supervising the case.¹⁷ Although the charges against both the mother and worker were dismissed after a preliminary inquiry, the effect of these highly publicized cases and inquests was to make CASs and child protection workers more cautious about leaving children in the care of parents in situations of potential risk.

There were other systemic developments during this period. One was that, with the election of the Conservative government led by Premier Harris in 1995, there were significant cuts to social assistance payments and to funding for various social agencies that provided support services to parents. The funding formula for CASs was also changed, resulting in cuts to preventative and support services for families that were not involved in the court system. These changes increased the difficulties faced by parents, especially in low-income families, and hence increased the risks in some cases, and also made apprehension of children by the CAS more likely.

In 1997 *The Toronto Star* ran a series of stories on child abuse deaths,¹⁸ increasing public and professional awareness issues of child abuse and neglect, as well as adding to pressure on the government to take clear action to deal more effectively with the issue. With increased public and professional awareness of abuse and neglect came dramatic increases in the late 1990s in the number of suspected cases reported to the CAS in Ontario (see Table 2). Some, but clearly not all, of the increase in the number of reports reflected growing professional awareness, especially amongst the police, of the harmful effects on children of living in families where domestic violence

¹⁷ See, e.g., "Charges Dismissed against CCAS Worker" (August 2000) 44 *OACAS Journal*, 2, 8–10.

¹⁸ For critical discussions of *The Toronto Star* series, including concerns about its potential distorting effects, see N. Crane, "Blanket Statements" (March 1998) *Ryerson Review of Journalism*, at www.rrj.ca/print/254, accessed July 8,

was occurring, with a dramatic increase in the number of cases reported based on exposure to spousal violence. While, upon investigation, some of these cases were unsubstantiated or did not meet agency definitions of maltreatment, there was actually an increase in both the number of cases reported and the proportion substantiated; the increased rate of substantiation likely, at least in part, reflected changing CAS standards and attitudes toward substantiation. (See Table 2 below.)

In 1997, the government appointed a Panel of Experts, chaired by Family Court Judge Mary Jane Hatton, to report on child protection issues. That committee reported in June 1998. Although not all of the Panel's recommendations were accepted, many of them were reflected in Bill 6, amendments to the *Child and Family Services Act*, that came into force in 2000.¹⁹ These amendments were intended to increase the protections that CASs afford to children. The definition of "child in need of protection" was extended, in particular in situations of neglect and emotional abuse. In situations where abuse or neglect of a child had not yet occurred, but there was a concern about future risk, it was no longer necessary for the agency to establish that there was a "substantial risk of future harm," it was only necessary to establish a "risk of likely harm." The provision for the admission of "past conduct" evidence was somewhat extended, and now reads:

50(1) Despite anything in the *Evidence Act*, in any proceeding under this Part,

- (a) the court may consider the past conduct of a person *toward any child* if that person is caring for or has access to or may care for or have access to a child who is the subject of the proceeding; and
- (b) any oral or written statement or report that the court considers relevant to the proceeding, including a transcript, exhibit or finding or the reasons for a decision in an earlier civil or criminal proceeding, is admissible into evidence.

2007; and Kirsten Johnson Kramar *Unwilling Mothers, Unwanted Babies: Infanticide in Canada* (UBC Press, 2005), 135–157.

¹⁹ For a discussion of Bill 6 and the process leading to the amendments, see N. Bala, "Reforming Ontario's Child and Family Services Act: Is the Pendulum Swinging Back Too Far?" (1999) 17 *Canadian Family Law Quarterly* 121–172.

Although similar to the original “past parenting provision,” enacted in 1978 in response to the *Ellis* case, the 2000 amendment made clear that the court could consider the conduct of a parent or other custodian toward any child, whether or not the person was acting in a parental role toward that child. A number of provisions in the 2000 amendments make it more difficult for a parent to regain custody of their children once they are placed in the care of the CAS. There were also provisions in the 2000 amendments to strengthen the obligations on professionals to report suspected child abuse and neglect.

While the 2000 amendments were legally important, it is significant that, as illustrated in Table 1, the major increase in the number of children in care began well before the new law came into effect. This makes clear that the shift in the attitudes of child protection workers and other professionals, the changes in the policies of child protection agencies and other social service agencies, and new provincial government funding policies had more impact on the number of children in care than did the legislative reforms.

There was a very large increase in the number of children in CAS care in 1996 to 2002. It is, however, an open question whether the children of Ontario were better off as a result of this increase, or whether they might have been better served if more resources were devoted to providing preventative and support services for families, with fewer children taken into care. There are unquestionably children who face a serious risk in the care of their parents and who must be removed from parental care to ensure their protection. Some of the children who are taken into care, especially those apprehended at a young age, are placed in stable, loving environments, perhaps involving adoption or long-term foster care. Some children who are taken into care, however, end up moving through a series of foster and group home placements, and never find a secure, nurturing home environment. There is no clear evidence that the actual incidence of child abuse and neglect in the province declined during this period as a result of the dramatic increase in the number of

children in care. Of course, the measurement of the actual rate of child abuse and neglect is very difficult, and is not captured by data on reported cases, nor is it necessarily reflected in child homicide rates. It is notable, however, that the *First Report of the Pediatric Death Review Committee* of the Office of the Chief Coroner in June 2004 reported a fairly stable rate of child homicides in Ontario during the 1995 to 2000 period, despite the increase in apprehensions. Further, as described below, the reported number of child abuse and neglect cases increased dramatically during this period, though that may well have reflected increased awareness of issues of abuse and neglect, and changes in operating definitions of CASs. In sum, there should be further research and reflection on whether the major changes in child protection policy and practice in the late 1990s and early years of this decade improved the welfare of children, and whether this more intrusive policy was worth its human and financial costs.

In the past few years there has been growing concern about the human and financial costs of the increase in the number of children being taken into care. It is interesting to note that in 2006 another set of amendments were made to the CFSA²⁰ that were intended to reduce the number of children in care, though emphasizing placement of children with relatives and open adoption rather than return to parental care.

Child Abuse and Neglect Investigations: 1993–2003

The Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) is a periodic survey conducted by a team of researchers led by Dr. Trocmé and funded by the Public Health Agency of Canada and the Ontario Ministry of Children and Youth Services. The OIS allows for detailed estimates of the reported cases of children abused, *categorized by forms* of maltreatment and key child and family characteristics. Table 2 presents estimated rates of investigations and of substantiated maltreatment in Ontario in three periods studied: 1993, 1998, and 2003. During the 10-

²⁰ S.O. 2006, c. 5.

year period from 1993 to 2003, the number of children investigated because of reported maltreatment nearly tripled, and the number of cases regarded as substantiated by CAS workers increased almost fivefold from 12,300 in 1993 to 58,500 in 2003.

	1993	1998	2003
A: Investigated children	45,000	64,600	128,100
B: Substantiation rate	27%	36%	46%
C: Substantiated maltreatment (A x B)	12,300	23,100	58,500
D: Maltreated children per 1,000 children (C/Child Pop)	5.47	9.82	24.44
Source: OIS 1993, ²¹ OIS 1998, ²² OIS 2003. ²³			

The overall increase in the number of victims reported to and substantiated by child protection authorities varied considerably by form of maltreatment (Table 3). The number of sexual abuse victims substantiated by child welfare authorities has been consistently declining. In contrast, the reported number of child victims of physical abuse and neglect increased threefold and fourfold respectively from 1993 to 2003. During this period, the number of victims of emotional maltreatment and exposure to domestic violence reported to and substantiated by child protection authorities has exploded, rising from 1,000 confirmed victims in 1993 for both categories combined to 8,700 victims of emotional maltreatment and another 18,500 victims of exposure to domestic violence in 2003.

	1993	1998	2003
Physical abuse	4,200	7,500	14,100
Sexual abuse	3,400	1,800	1,500
Neglect	4,400	7,300	15,700
Emotional maltreatment	1,000	5,900	8,700

²¹ N. Trocmé, D. McPhee et al., *Ontario Incidence Study of Reported Child Abuse and Neglect* (Toronto: Institute for the Prevention of Child Abuse, 1994).

²² N. Trocmé, B. Fallon et al., *1998 Ontario Incidence Study of Reported Child Abuse and Neglect* (OIS 1998) (Toronto: Centre of Excellence for Child Welfare, Faculty of Social Work, University of Toronto, 2002), p. 230.

²³ B. Fallon, N. Trocmé, et al., *Ontario Incidence Study of Reported Child Abuse and Neglect—2003: Major Findings* (Toronto: Centre of Excellence for Child Welfare, 2005), p. 160.

Exposure to domestic violence			18,500
Source: See Table 2.			

The increase in rates of physical abuse, neglect, emotional maltreatment, and exposure to domestic violence reported in Ontario reflected a dramatic expansion in the child welfare mandate in Ontario as well as increased awareness of the problem of child maltreatment. Increased awareness was especially marked among professionals whose work brought them into contact with children and families. While, in 1993, professionals accounted for just over half of all of substantiated referrals, by 2003, 78% of substantiated cases were referred by a professional. The most dramatic expansion was among the police, who referred 11% of substantiated cases in 1993, compared to 37% of all substantiated cases in 2003.

The increase in the number of child abuse and neglect cases being identified, reported, and substantiated was also partially due to increased attention given to siblings once a report was received. From 1993 to 2003 the average number of investigated children per family has increased from 1.27 to 1.71. Two factors in particular would appear to explain this shift: firstly, siblings are more likely to be investigated in exposure to domestic violence cases, which have come to account for a substantial proportion of all investigations; secondly, under the Ontario Risk Assessment Model introduced in 1997, protocols for all forms of maltreatment investigation put greater emphasis on investigating all children in a household if one was reported as being abused or neglected.

A third factor of note in interpreting the increase in caseloads in Ontario is that the proportion of children being investigated multiple times increased. In 1993, 50% of victims had had no previous contact with child welfare authorities. By 1998, the number of substantiated cases with no previous contact had dropped to 40% and remained at that level in 2003.

While there was a dramatic increase in the number of reported cases of abuse and neglect in Ontario during this period, there is no evidence of an actual increase in the incidence of child abuse

and neglect. It would seem that changes in policies, legislation, and professional attitudes were primarily, if not totally, responsible for these dramatic changes.

Child Homicides

Table 4 sets out the total number of children in Canada under the age of 12 reported by the police as being killed by their parents, a rate that has remained relatively stable from 1981 to 2001. Although there is no reported Ontario-specific data for this period, the Statistics Canada *Homicide Survey* reports that, during the same time period, 29% of homicides against victims of all ages across Canada occurred in Ontario. One can therefore estimate that an average of under 10 homicides per year of children under 12 were committed by parents in Ontario from 1981 to 2001, with no evidence of a changing trend over time. Several incidents involved multiple children: the average number of child victims per incident was 1.15.

Table 4: Homicides of Children under 12 by Parents²⁴

Year	Number of Incidents	Number of Victims	Perpetrator			
			Father	Step-Father	Mother	Step-Mother
1981	24	27	8	2	14	-
1982	28	31	13	1	14	-
1983	31	32	16	1	14	-
1984	40	50	26	1	13	-
1985	29	31	14	1	14	-
1986	41	50	23	-	18	-
1987	27	30	17	-	10	-
1988	23	28	11	-	12	-
1989	28	37	11	2	15	-
1990	26	31	16	-	10	-
1991	24	28	8	1	13	2
1992	28	32	10	1	17	-
1993	32	32	13	4	15	-
1994	40	43	20	4	16	-
1995	32	36	18	2	11	1
1996	37	41	19	6	12	-
1997	45	54	18	3	23	1
1998	41	47	22	3	15	1

²⁴ Canadian Centre for Justice Statistics, *Homicide Survey, 1999 & 2002*. The *Homicide Survey* documents police-reported data on homicide incidents, victims, and accused persons. Whenever a homicide becomes known to police, the investigating police department completes a survey questionnaire, which is then forwarded to the Canadian Centre for Justice Statistics.

1999	23	26	13	3	7	-
2000	24	27	11	4	9	0
2001	25	30	12	2	11	1

Results from the *Homicide Survey* must be interpreted with caution.²⁵ Under-reporting and under-detection of child abuse and neglect fatalities have been documented in many jurisdictions. In Ontario, in 1987, Greenland²⁶ reviewed all child deaths due to injuries in the home over a 10-year period and concluded that several child abuse and neglect fatalities had been improperly classified as accidents, and, due to his meticulous search of the Coroner files, three additional cases were later identified as being due to parental maltreatment after parental confessions. In an Illinois study of child deaths classified as “undetermined,” Christoffel, Anzinger, and Merrill²⁷ found that 89% of these deaths could be attributed to maltreatment. In a second study examining child deaths attributed to natural causes, Christoffel, Zieserl, and Chiarmonte²⁸ found evidence of suspected abuse in 12% of the cases reviewed. A review of 384 infant and preschooler deaths in Missouri found that 52% of the definite maltreatment fatalities identified had not been classified as homicides.²⁹ A review of computer records on intentional injury fatalities in New Zealand found that less than a third of child abuse deaths had been properly labelled under the International Classification of Diseases (ICD) code for “child battering and other maltreatment,” the rest falling in a range of other ICD assault classifications not specific to maltreatment.³⁰ Synthesizing findings from studies of misdiagnosed

²⁵ N. Trocmé & R. Brison, “Homicides and Injuries Due to Assault and to Abuse and Neglect,” in *For the Safety of Canadian Children and Youth: From Data to Prevention Measures*, ed. G. Beaulé (Ottawa: Health Canada, 1998).

²⁶ C. Greenland, *Preventing CAN deaths: An International Study of Deaths Due to Child Abuse and Neglect* (London: Tavistock Press, 1987).

²⁷ K. Christoffel, N. Anzinger et al., “Age-Related Patterns of Violent Death, Cook County, Illinois, 1977 through 1982” (1989) 143 *American Journal of Diseases of Children* 12, 1403–09.

²⁸ K. Christoffel, E. Zieserl et al., “Should Child Abuse and Neglect be Considered When a Child Dies Unexpectedly?” (1985) *American Journal of Diseases of Children* 139, 876–880.

²⁹ B. Ewigman, C. Kivlahan et al., “The Missouri Child Fatality Study: Underreporting of Child Maltreatment Fatalities” (1993) 91 *Pediatrics* 2, 330–337.

³⁰ Kotch, Chalmers, Fanslow, Marshall & Langley, [AQ: Author’s initials?] “Morbidity and Death Due to Child Abuse in New Zealand” (1993) 17 *Child Abuse and Neglect* 2, 233–247.

deaths, McClain, Sacks, Froehlke, and Ewigman³¹ concluded that, in the United States, as many as 85% of child maltreatment deaths are misdiagnosed as either injuries of undetermined intentionality, accidents, Sudden Infant Death Syndrome (SIDS), or deaths from natural causes.

The Evolution in Responses to Child Sexual Abuse

Before concluding the historical review of changes in the child protection field, it is worth surveying the evolution in responses to child sexual abuse. Consideration of the responses during this period of health professionals, police, and child protection workers to child sexual abuse is instructive, as many professionals were dealing with both child sexual abuse and child death cases, and attitudes and understandings of the two different types of cases influenced each other. For both types of cases, there is a similar pattern of historical under-reporting and failure to protect children, followed by growing awareness, understanding, and reporting that resulted in greater protection for children but also some prominent incidents of misdiagnosis and perpetration of injustice against wrongly accused adults. The history of both types of cases reveal that there is a need to be aware of issues of abuse, but that investigators and physicians need to be maintain balance and objectivity, and be aware of the dangers in “thinking too dirty.”

Historically, child sexual abuse was widespread but largely ignored. Children rarely disclosed their victimization, and if they did, police, doctors, and child welfare workers often dismissed their reports as unreliable, malicious, or fantasies. Understanding of child sexual abuse in Canada was substantially increased by the 1984 release of the *Badgley Committee Report*.³² This

³¹ McClain, Sacks, Froehlke & Ewigman, “Estimates of Fatal Child Abuse and Neglect, United States, 1979 Through 1988” (1993) 91 *Pediatrics* 338–343.

³² *Sexual Offences Against Children* (Ottawa: Minister of Supply and Services Canada, 1984), 2 vols. [the Badgley Committee Report]. The 1990 *Report of the Special Adviser to the Minister of National Health and Welfare on Child Sexual Abuse in Canada: Reaching for Solutions* (Ottawa: Health & Welfare Canada, 1990) [the Rix Rogers Report] further documented legal institutional and societal deficiencies in Canada’s responses to child sexual abuse.

government-commissioned report documented the extent of child sexual abuse, revealed major problems in how the legal and social services systems dealt with victims of abuse, and made many recommendations to improve how the legal system and society respond to child abuse.

In the 1980s a process of reform of laws governing child sexual abuse and child witnesses began in many jurisdictions, which resulted in the criminal justice system slowly becoming more responsive to the needs of children who were victims of familial abuse.³³ Changes to the criminal law were intended to make it less traumatic for children to testify about their victimization, for example, to allow children to testify via closed circuit television so that they would not be intimidated into silence by the presence of their abuser. Clinicians and researchers were learning much about child sexual abuse, including that children were often reluctant to disclose and, in intrafamilial cases, would often falsely recant a true allegation due to feelings of guilt or pressure from family. Unfortunately, some of the leading writers on child sexual abuse in the early 1980s also asserted that children “never fabricate” allegations of child sexual abuse, and that a child’s report of abuse will only be untrue if the child has been “coached” by a adult who wants the child to make an unfounded allegation.³⁴ It is now clear that, while most disclosures of abuse by children are true, children do not always accurately report what has happened to them.

In the 1980s and 1990s, there were a number of highly publicized cases in Canada, Great Britain, and the United States in which innocent persons were being charged, and in some cases convicted, of sexual abuse of children.³⁵ A number of these cases, such as the Martensville, Saskatchewan, daycare case, were the result of overzealous, inadequately trained police investigators engaging in inappropriate questioning to “encourage” young children to “disclose”

³³ N. Bala, “Double Victims: Child Sexual Abuse and the Canadian Criminal Justice System” 15 *Queen’s Law Journal* 3–30.

³⁴ R. Summit, “The Child Sexual Abuse Accommodation Syndrome” (1983) 7 *Child Abuse and Neglect* 177–193.

³⁵ A. Bissett-Johnson, “Family Violence—Investigating Child Abuse and Learning From Mistakes” (1993) 16 *Dalhousie Law Journal* 5–61; and S. Garven, J.M. Wood, R.S. Malpass & J.S. Shaw, “More than Suggestion: The Effect of Interviewing Techniques from the McMartin Preschool Case” (1998) 33 *Journal of Applied Psychology* 347–

suspected abuse.³⁶ Under-trained but well-intentioned police, child welfare workers, and therapists engaged in inappropriate questioning of children, based on the maxim that “children don’t lie” about abuse, and some children came to believe that they were abused, even though it is now clear that this did not occur. Poor professional interview practices continued even after experimental researchers began to publish work establishing that children, especially young children, can be quite suggestible, especially if they are subjected to persistent, leading questioning by authority figures.

In one infamous set of cases in 1987 in Cleveland, England, two hospital-based pediatricians played a central role in making unfounded child sexual abuse allegations against a large number of parents. Using a number of diagnostic techniques, including one known as “anal reflex anal dilatation,” they reported that over one hundred and twenty children were victims of sexual abuse. Unfortunately, while described in the medical literature of this period, these diagnostic techniques were never scientifically validated and were later discredited. Once the reports were made by the doctors to the local child protection agency, the workers felt compelled to remove the children from their families and place them in foster care. Initially, public opinion favoured the doctor and the social workers, but as the number of cases increased and the parents began to seek public support, opinion shifted and a public inquiry, conducted by Elizabeth Butler-Sloss, was established to investigate the handling of these cases.³⁷ In the end, over 80% of the allegations were found by the child welfare courts to be unfounded. One of the major findings of the Butler-Sloss Inquiry was that the children had been removed precipitately by child protection workers who had failed to seek corroborative evidence to support the allegations of the pediatricians and had failed to carry out comprehensive assessments of the children and their families. Concerns were also expressed about

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³⁶F. Harris, *Martensville: Truth or Justice: The Story of the Martensville Daycare Trials* (Toronto: Dundurn Press, 1998).

³⁷E. Butler-Sloss, *Report of the Inquiry into Child Abuse in Cleveland, 1987* (London, England: Her Majesty’s Stationer, 1988).

the interview techniques used by the doctors and child protection investigators when questioning the children.

There has been a significant amount of research into child abuse over the past four decades. Much more is known about the nature, incidence, and costs of familial child sexual abuse, and the justice and social service systems have greatly improved how they support victims and respond to abusers. Victims of child abuse are more willing to disclose, and there is evidence that the changes in legislation, policies, and attitudes have contributed to a gradual decline in the incidence of child sexual abuse. It must, however, also be recognized that there continue to be professionals and writers in the child sexual abuse field who have simplistic views that do not reflect the complexity and challenges of these cases.

SOCIAL SCIENCE RESEARCH ON RISK TO SIBLINGS

The Risk to Siblings of Children Who Have Been Killed by Parents

There is only a small amount of research available to guide child welfare agencies and the courts in assessing the risk to siblings of children who have died due to parental abuse or neglect. Greenland³⁸ reported on a review of suspected child abuse and neglect deaths conducted in 1980 in New York City where 14% of children who died due to parental abuse or neglect also had a sibling who had died as a result of suspected abuse or neglect, and 44% had a sibling who had sustained a serious injury due to abuse or neglect. In his own review of 100 child abuse and neglect deaths from the Ontario's Coroner's office (1973–82), Greenland found that in 9 of the 60 battered child syndrome death cases, victims had a sibling who had either sustained a serious injury or had died as a result of an injury. In 22 of these cases, the family had been involved with child welfare authorities at the time of the death.

³⁸ C. Greenland, *Preventing CAN Deaths: An International Study of Deaths Due to Child Abuse and Neglect*. (London: Tavistock Press, 1987).

While Greenland's findings are consistent with those reported in other reviews of child abuse and neglect deaths,³⁹ it is important to distinguish between a history of previous deaths or severe injuries known to be caused by maltreatment and a tragic series of deaths that may be related to genetic or environmental factors. In his analysis of the statistical confusion that emerges from analyzing patterns related to multiple sudden infant deaths, Hill⁴⁰ shows that the odds that two siblings deaths are related to SIDS are 5 to 10 times higher than the odds that the deaths are due to homicide, and that the odds of three deaths being related to SIDS versus to homicide are approximately even. Hill's analysis was written as a rebuttal to the confusion created by Roy Meadow, the prominent British pediatrician who maintained that "one cot death is a tragedy, two cot deaths is suspicious and, until the contrary is proved, three cot deaths is murder."⁴¹

The Risk to Children Whose Siblings Have Been Abused or Neglected

It is well established that a history of a parent having previously abused and neglected a child is a good (but not perfect) predictor of future abuse and neglect.⁴² For instance, a study of 137 physically abusive fathers⁴³ found that fathers who were known to have abused a child in the past were nearly three times more likely to re-abuse compared to those who had no previous record of abuse. Examining the factors considered by child protection workers in assessing risk of future maltreatment, Cooney also found that past physical abuse was one of the most important determinants of their risk ratings. In an earlier study, Cooney found that, in cases of neglect, another factor that predicted ratings of severity was if there had been prior involvement with child protection

³⁹ See, e.g., P. Reeder & S. Duncan, *Beyond Blame: Child Abuse Tragedies Revisited*. (London: Routledge, 1993).

⁴⁰ R. Hill, "Multiple Sudden Infant Deaths—Coincidence or Beyond Coincidence?" (2004) *Paediatric and Perinatal Epidemiology* 18, 320–326.

⁴¹ As cited in R. Hill, "Multiple Sudden Infant Deaths—Coincidence or Beyond Coincidence?" (2004) *Paediatric and Perinatal Epidemiology* 18, 320–326.

⁴² T. Fuller, S. Wells et al., "Predictors of Maltreatment Recurrence at Two Milestones in the Life of a Case" (2001) 23 *Children and Youth Services Review* 1, 49–78.

⁴³ C. Cooney, "Physically Abusive Fathers and Risk Assessment" (2006) *Child Abuse and Neglect* 30, 467–480.

authorities.⁴⁴ Greenland's previously cited review of child abuse and neglect deaths⁴⁵ found that previous injuries to the child killed were noted by the Coroner's office in 63% of cases.

While a history of previous maltreatment is strongly associated with future maltreatment, the extent to which this relationship can be used to predict risk of maltreatment to specific siblings has not been studied as closely. Parenting research shows that while there are generally more similarities than differences in the way parents treat their children,⁴⁶ the differences in treatment of different children are nevertheless noteworthy, especially in situations involving stepchildren or children with very different temperaments.⁴⁷

There is ample evidence that in cases of sexual abuse of an older sibling, younger siblings are at very high risk of being victimized as well.⁴⁸ Two studies that have examined risk to siblings in cases of physical abuse and neglect point to increased risk for siblings. In an American study of cases of investigated abuse and neglect, Jean-Gilles and Crittenden⁴⁹ found that 58% of the siblings of maltreated children were also victimized. In another American study using children's self-reports, Hines, Kaufman-Kantor, and Holt⁵⁰ found a high correlation (.51-.71) between siblings' reports of parental neglectful behaviours. In her international review of published cases of Munchausen

⁴⁴ C. Coohy, "Making Judgments about Risk in Substantiated Cases of Supervisory Neglect" (2003) *Child Abuse and Neglect* 27, 821-840.

⁴⁵ C. Greenland, *Preventing CAN deaths: An International Study of Deaths Due to Child Abuse and Neglect* (London: Tavistock Press, 1987).

⁴⁶ J. Neiderhiser, E. Hetherington, A. Pike & D. Reiss, "Adolescent Perceptions as Mediators of Parenting: Genetic and Environmental Contributions" (1998) 34 *Developmental Psychology* 6, 1459; and T. O'Connor, J. Neiderhiser, D. Reiss, E. Hetherington & R. Plomin, "Genetic Contributions to Continuity, Change, and Co-occurrence of Antisocial and Depressive Symptoms in Adolescence" (1998) 39 *Journal of Child Psychology and Psychiatry* 3, 323.

⁴⁷ J. Belsky & J. Vondra, "Lessons from Child Abuse: The Determinants of Parenting," in *Child Maltreatment: Theory & Research on the Causes & Consequences of Child Abuse and Neglect*, ed. C. Cicchetti & V. Carlson (Cambridge: Cambridge University Press, 1989); J. Neiderhiser, E. Hetherington, A. Pike & D. Reiss, "Adolescent Perceptions as Mediators of Parenting: Genetic and Environmental Contributions" (1998) 34 *Developmental Psychology* 6, 1459; R. Plomin, D. Reiss, E.M. Hetherington & G.W. Howe, (1994). "Nature and Nurture: Contributions to Measures of the Family Environment" (1994) *Developmental Psychology*, 30, 32-43.

⁴⁸ R. Bolen, *Child Sexual Abuse: Its Scope and Our Failure* (New York: Kluwer Academic, 2001); and R. Wilson, "Recognizing the Threat Posed by an Incestuous Parent to the Victim's Siblings: Part I: Appraising the Risk" (2004) 13 *Journal of Child & Family Services* 2, 143-162.

⁴⁹ M. Jean-Gilles & P. Crittenden, "Maltreating Families: A Look at Siblings" (1990) 39 *Family Relations* 3, 323-329.

⁵⁰ D. Hines, G. Kantor et al., "Similarities in Siblings' Experiences of Neglectful Parenting Behaviors" (2006) *Child Abuse and Neglect* 30, 619-637.

Syndrome by Proxy—where a child’s symptoms or illnesses are deliberately produced by a parent—Sheridan⁵¹ found that 61% of the known siblings had similar symptoms and 25% had died.

The results are further supported by the 2003 Ontario Incidence Study (OIS–2003) finding that 70% of victims of maltreatment had at least one sibling who was investigated because of suspected maltreatment.⁵² The OIS–2003 tracked 7,172 child maltreatment investigations conducted in a representative sample of 16 child welfare service areas across Ontario in the fall of 2003. The OIS is the only province-wide source of data with details about investigated siblings.

The only study we found that specifically considered the risk factors for the abuse of only one child in a family was a case file review of 795 siblings of a cohort of abused and neglected children in England.⁵³ As in previous research, the study found that siblings were at high risk of abuse or neglect: in 37% of cases all children had been victimized, and in a further 20%, more than one had been abused or neglected. In 40% of cases, however, only one child appeared to have been abused or neglected. In comparing the maltreated children to their non-maltreated siblings, the authors failed to find consistent child-specific differences to explain the apparent singling out of just one child for mistreatment; in particular, they did not find that stepsiblings or children with difficulties were at increased risk of maltreatment.

In their review of 20 child abuse and neglect deaths in Wales, Brandon, Dodsworth, and Rumball⁵⁴ found that in several cases the victim’s siblings’ experiences of abuse had been discounted or ignored. Referring to Reder and Duncan’s⁵⁵ review of child abuse deaths in England, Brandon and colleagues note that “although there is a popular belief that one child in a family is

⁵¹ M. Sheridan, “The Deceit Continues: An Updated Literature Review of Munchausen Syndrome by Proxy” (2003) *Child Abuse and Neglect* 27, 431–451.

⁵² B. Fallon, N. Trocmé et al., *Ontario Incidence Study of Reported Child Abuse and Neglect— 2003: Major Findings* (Toronto: Centre of Excellence for Child Welfare, 2005).

⁵³ C. Hamilton-Giachritsis & K. Browne, “A Retrospective Study of Risk to Siblings in Abusing Families” (2005) 19 *Journal of Family Psychology* 4, 619–624.

⁵⁴ Brandon, Dodsworth, and Rumball, “Serious Case Reviews: Learning to Use Expertise” (2005) *Child Abuse Review* 14, 160–176.

⁵⁵ P. Reder & S. Duncan, *Beyond Blame: Child Abuse Tragedies Revisited*. (London: Routledge, 1993).

singled out and maltreated, violence and neglect are often a caregiving pattern common to all siblings.”⁵⁶

In summary, there is very consistent evidence that maltreating parents are at risk of repeating the maltreatment, and that siblings of maltreated children are at increased risk of maltreatment. There are, however, also cases in which only one child in a family is maltreated, though there is at present insufficient research to establish clear markers to help distinguish the two types of cases.

ONTARIO CHILD PROTECTION CASES WHERE A SIBLING HAS DIED

In this section of the paper, we review the issues that arise when a child protection agency and the courts make a decision about the care of a child whose sibling has died in circumstances where there is suspicion of parental responsibility, with a particular focus on Ontario in the 1981–2001 period.

Parallel Proceedings and Delay

If a child who dies in circumstances that raise suspicions of parental abuse or neglect has a surviving sibling, there is a significant likelihood that there will be simultaneous criminal and child protection investigations, and quite possibly parallel court proceedings. There will be some overlap in the issues that arise in the two processes, though there are also some significant differences in the issues, as well as in the procedural and evidentiary rules. If the two processes are proceeding simultaneously, this can complicate the work of the courts and various professionals, as well as create significant difficulties for parents and place added emotional stress on a surviving child.

The criminal process is fully retrospective, with a focus on the causes and legal responsibility for the death of the child. The burden of proof is high—proof beyond a reasonable doubt—and the rules of evidence strict. The scope of the child protection process is much broader,

⁵⁶ Brandon, Dodsworth & Rumball, “Serious Case Reviews: Learning to Use Expertise” (2005) *Child Abuse Review* 14, 160–176 at 167.

both retrospective and prospective, considering virtually all aspects of the parents' prior parenting history, and trying to assess future parenting capacity as well. The standard of proof in the child protection process is the lower civil standard—proof on the balance of probabilities—and the rules of evidence are more expansive. Judges dealing with child protection cases—making decisions about a child's future—are likely to consider evidence that would clearly be inadmissible in a criminal proceeding. For example, in some child protection cases where one of the issues is the alleged abuse or neglect of a sibling, the courts have admitted and considered the results of a polygraph test that the police conducted on one of the parents during their investigation of the circumstances of the death,⁵⁷ even though this type of evidence is inadmissible in criminal proceedings. The child protection process may continue and result in a termination of parental rights, despite the fact that the parent is not charged, or is acquitted in criminal court.⁵⁸

If there is a conviction or guilty plea in the criminal process before the child protection process is resolved, this will be admissible in the child protection proceeding as proof of parental responsibility for the death. In this situation, there may well be a motion by the agency for summary judgment in the child protection process, seeking to terminate parental rights without a trial.⁵⁹

There are, however, significant potential problems if the criminal process is not resolved in an expeditious fashion. It will usually be in the interests of the child to have a decision made about a permanent placement as soon as possible. This is reflected in provisions in the CFSA, including the present s. 1(1)3(iii), which establishes the principle of “early ... decision-making to achieve permanent plans for children in accordance with their best interests.” There are also statutory time limits for decision making in the Act; the specific time limits were changed a number of times in the 1978–2000 period, each time being made shorter, so that the present provision (s. 70 of the CFSA,

⁵⁷See, e.g., *Children's Aid Society of Peel v. P.(L.)*, [2003] O.J. 2548 (Ont. Ct. J.), per Dunn J.; and *Dans la situation X.B.*, [2002] J.Q. 6838 (Cr Que.—Ch jeunesse).

⁵⁸See *Re L.U. (a child) and L.B. (a child)*, [2004] E.W.C.A. Civ 567 (Eng. C.A.).

⁵⁹*Catholic Children's Aid Society of Metropolitan Toronto v. L.O.*, [1996] O.J. 3018 (Ont. Ct. J.), per Chapnik J.

in force since 2000) generally requires a permanent order to be made within 12 months of a child of less than six years of age coming into care, and within 24 months of a child six years of age or older coming into care. It must also be appreciated that children beyond the age of infancy whose parents are subject to criminal prosecution for the death of a sibling experience enormous emotional stress while the proceedings are unresolved;⁶⁰ the uncertainty is very difficult for them, and they may experience guilt or anger, or feel rejected if they cannot see their parent. They may also be subject to taunting from other children.⁶¹

A parent facing criminal charges about the prior child death will be expected (or may be required) to testify about the circumstances of that death if a child protection trial is held concerning a surviving child before the criminal trial, though the parent can invoke *Canada Evidence Act*⁶² s. 5 and the *Charter of Rights* s. 13 to ensure that the testimony is not used in the later criminal proceeding.

These cases can be very complex, and the investigation of police and pathologists may proceed slowly. In a British Columbia case, it was held that the child protection agency was entitled to access to police and medical records concerning an ongoing investigation into the death of a child so that the agency could determine how to deal with surviving children, even though if the surviving child were to be apprehended and protection proceedings commenced, the agency would be required to disclose any information obtained to the parents. The Crown and police objected that since charges had not yet been laid, disclosure of the documents might jeopardize the criminal investigation, alerting the suspect parents to sensitive areas. In ordering disclosure, Dollis Prov. Ct. J. observed that the agency was obliged to find out whether the parents posed a risk to the surviving children, and concerns about undermining the integrity of the criminal investigation were a lower

⁶⁰ See, e.g., *S.G.M. v. M.R.M.*, [1996] B.C.J. 960 (B.C.S.C.).

⁶¹ *T.M. v. Alberta (Public Inquiry Into the Death of J.C.)*, [1999] A.J. 1371 (Q.B.).

⁶² For an example of a case where a parent testified in a child protection case under the protection of the *Canada Evidence Act*, see *Children's Aid Society of Kingston v. M.T.*, [1996] O.J. 2444 (Ont. Ct. J.—Prov. Div.).

priority, giving “greater priority to the interests of the living children.”⁶³ Similarly, in a 1995 Ontario case, Steinberg J. held that even if the police have investigated a child’s death and concluded that charges should not be laid, the agency can have access to police investigative files, notwithstanding protection of privacy legislation.⁶⁴ The judge noted that the Ontario *Freedom of Information and Protection of Privacy Act* s. 74(2) allowed a court to order disclosure of a record that “may be relevant to consideration of whether a child is suffering abuse or is likely to suffer abuse,” and concluded: “The protection of the children under these sections has been given priority over the privilege accorded to the police.”

Further, if the child protection matter proceeds to a hearing before the completion of the criminal process or investigation, either the agency or parents could subpoena the police or a pathologist to testify about their ongoing work investigations. Although there is no reported case law on the issue, it seems likely that a judge would require the witness to testify based on an assessment of the case to the time of the child protection hearing. Any possible claim to privilege would be likely to be subordinated to a concern about protection of the children and promotion of their best interests.

Apprehensions and Investigations

If there is a sibling of a child who dies due to parental abuse or neglect, or there is a reasonable suspicion that the parents were responsible for the death, child abuse reporting laws require that any doctor, police officer, or other professional aware of the case report to the CAS so that an investigation can be carried out to learn whether any siblings are at risk. In many cases of deaths due to parental abuse or neglect, the CAS is already involved in the case before the death.

⁶³ *Re A.J.S.*, [2000] B.C.J. 2765 (Prov. Ct.), per Dollis Prov. Ct. J., para.26.

⁶⁴ *Children’s Aid Society of Hamilton Wentworth v. M. (T.)* (1995), 30 R.F.L. (4th) 213 (Steinberg J.). The court that orders disclosure of the police file to the C.A.S. may, however, allow the police or Crown to redact certain parts of the

Although practices vary by agency and over time, it is now very likely that if a child dies due to parental abuse or neglect, the CAS will apprehend any siblings, and may well apprehend any later born siblings or half-siblings at birth, while carrying out an investigation. From 1981 to 2001, and especially earlier in that period, some agencies were less likely to apprehend during an investigation, especially if the evidence of parental abuse or neglect was not strong. Even now, if there is genuine uncertainty as to the cause of death, there is a reluctance to apprehend a sibling and perhaps no legal basis to apprehend the child in the absence of other evidence of abuse. Further, as regards later born siblings, the CAS may not even be notified of the later birth of a sibling as health-care providers may not be aware of the concerns related to the earlier death.

A child protection investigation concerning surviving siblings that commences after the death of a child is especially delicate, as the parents will very likely be in shock and grief at the death of their child, even if they have some degree of responsibility for the death, and may also have feelings of guilt at the death, even if they did not have responsibility. Surviving siblings, unless infants, are also likely to be experiencing shock and grief at the death. While agency staff must be sensitive to the emotional state of parents and surviving siblings, they also have a paramount duty to protect the safety of any surviving children.

The statutory test for a CAS apprehension and a court decision to have a child in temporary care during an investigation and pending trial evolved in the 1981–2001 period. From 1978 to 1984 the *Child Welfare Act, 1978*⁶⁵ provided that a CAS worker could apprehend a child “apparently in need of protection,” and required the agency to “show cause why the child should remain” in agency care pending completion of the trial. The *Child and Family Services Act* of 1984 was intended to provide a clearer and narrower ground for intervention, and as discussed above, the number of children in care did decline after that Act came into force. The 1984 Act provided that a CAS

file and to restrict further disclosure by parties to the protection process, to the extent that this is necessary to protect the privacy of third parties; see *Children’s Aid Society of Algoma v. P.(D.)*, [2007] O.J. 3601 (Ont. Sup. Ct.).

worker should only apprehend a child if the worker believed “on reasonable and probable grounds” that a child was in need of protection and that there was a “substantial risk to the child’s health or safety” if the child remained in parental care; a court was only to allow the child to remain in agency care on a temporary basis if also satisfied that there was a “substantial risk to the child’s health or safety” and that the child could “not be adequately protected by a supervision order.”⁶⁶

Under a supervision order, terms could be put in place, for example, to have supportive counselling or parenting education for the parents, and perhaps requiring the children to attend a daycare where professional care will be provided. Supervision orders also include terms allowing for regular and surprise home visits by a child protection worker, so that the well-being of children can be monitored. While supervision orders can be appropriate in some cases, there are human and resource limitations to the amount of supervision and protection that can be provided. If the case involves potential high risk, there may be real concerns about whether such an order can ensure the safety of a child, especially if there is an ongoing investigation at the interim and there is uncertainty about the nature of the risk posed to a child by his or her parents. Given the complexity of intervening in such cases, it is important to conduct thorough multidisciplinary assessments as quickly as possible.

In 2000 the CFSA was amended to increase protection to children, and it became somewhat easier for the CAS to apprehend a child. Since 2000 the CFSA has provided that a child is to remain in agency care pending trial if a judge is “satisfied that there are reasonable grounds to believe that the child is likely to suffer harm and that the child cannot be protected” by a supervisory order.⁶⁷ As discussed above, there was a significant increase in the number of children in care during the late 1990s, though this may have reflected changing professional attitudes as much as legislative change.

⁶⁵ S.O. 1978, c. 85, s. 21(1) & 28(13).

⁶⁶ S.O. 1984, c. 55, s. 47(3); in R.S.O. 1990, chap. C11 this provision was renumbered s. 51(3).

⁶⁷ C.F.S.A. s. 51930, enacted by S.O. 1999, c.2, s. 13.

The 2000 reform was discussed in *Children's Aid Society of the County of Simcoe v. D.M.*⁶⁸ by Timms J.:⁶⁹

[T]he new subsection “lowered the bar” for the Society (and consequently the court) with respect to the degree of risk that had to be established before the children would not be returned to their parents. Whereas previously, the court had to find both “reasonable” and “probable” grounds, now those grounds only need be “reasonable.” Whereas previously, the degree of risk had to be “substantial,” now there is no modifier at all to the degree of risk.... The risk is no longer “to the child’s health or safety,” it is now “that the child is likely to suffer harm.” ... The removal of the word “substantial” can only have one result. If the Society formerly had to meet a test similar to “beyond a reasonable doubt” now it is closer to the “balance of probabilities.”

While the change in the wording of the statute was significant for some types of cases, in most cases involving siblings of a child who died in suspicious circumstances, the outcome, especially at the interim stage, is usually more likely to be determined by a factual assessment than a subtle interpretation of legislation.

If the child protection agency believes one or both parents were responsible for the death of a child, the usual practice is the immediate removal of any surviving siblings from their care. This is illustrated in the 1997 case of *New Brunswick (Minister of Health and Community Services) v. H.B.*⁷⁰ In this case, a child died of suspected parental neglect after years of agency involvement with the family, leaving two siblings who were apprehended immediately by the child protection agency. At trial, a child protection agency supervisor was asked if the home conditions for the children prior to their sibling’s death warranted apprehension; the supervisor “replied that without J.’s death, the conditions did not warrant taking protective care.”⁷¹ This case illustrates that the death of the child, rather than the conditions that contributed to it, was the critical factor in the decision to apprehend the siblings.

⁶⁸ [2000] O.J. No. 2159.

⁶⁹ *Children's Aid Society of the County of Simcoe v. D.M.* [2000] O.J. No. 2159 at para. 3.

⁷⁰ [1997] N.B.J. No. 485 (Q.B.).

Past Parenting Evidence

Section 50(1)(a) of the *Child and Family Services Act* allows the court, when making a disposition order regarding specific children, to also consider a parent's conduct toward other children in the past. If a parent has been found responsible for the death of another child in their care, or even found to have failed to protect a child who died as a result, this can be used to help assess the parent's potential treatment of the child or children in question; however, the court will not only consider a parent's previous actions toward another child, but also the parent's current attitude toward those actions.

If a parent has already been convicted in criminal court of causing the child's death by the time a protection application for the surviving siblings is heard, this conviction serves as conclusive evidence that the parent is responsible for the child's death. However, under the CFSA, a criminal conviction is not required in order to conclude, for the purposes of the protection hearing, that the parent is responsible for the death of the child; the court may consider other circumstances, and evidence that would perhaps not be admissible in criminal court, as well.

The conclusive nature of a previous conviction in ascertaining the parent's responsibility for a child death is not limited to criminal convictions alone. Even a prior proceeding under the CFSA in which a parent was found responsible for a previous death is considered, in the words of Aston J. in *Children's Aid Society of London and Middlesex v. D.W.*, "unassailable and cannot be the subject of collateral attack."⁷² The case in question before Aston J. was one in which, following the death of a couple's first child, two children born subsequently were apprehended at birth. In a child protection proceeding concerning those children, Judge Sheffield found that the first child was abused and likely died of Shaken Baby Syndrome. When a fourth child was born, CAS again applied to have that child made a Crown ward and placed for adoption. Aston J. noted that, while he

⁷¹ *New Brunswick (Minister of Health and Community Services) v. H.B.*, [1997] N.B.J. (Q.B.) at para. 47.

⁷² [1997] O.J. No. 6340 at para. 7.

did not have the discretion to question the first judge's assessment of past events, "what can be examined, I think, is what Judge Sheffield had to say about the future, the prediction that he made about the possibility or probability of risk to [the subsequent child]."73 In light of changes in the parent's attitudes and behaviours, the fourth child was to be gradually returned to his parents' care, a recognition that new circumstances, increased maturity, and positive efforts by parents may allow them to parent subsequent children even if they have previously been found unfit to parent other children in the past. Justice Aston was pointing out that he was in no position to question past findings about the cause of death of another child, but the ultimate focus of the proceedings is on whether the child before the court is in need of protection in the future.

Although there do not appear to be any reported cases that raised the issue, if a parent could bring forward cogent new evidence about the cause of death that was not reasonably available at the time of the prior hearing, this might be admissible to call into question the prior finding to the extent that the agency wished to rely upon it as part of its case. While ordinarily courts are loath to allow such "collateral attacks" on the findings of another court, since there is an overriding concern about making a determination that promotes the welfare of the child before the court, there should be flexibility in how evidentiary rules are applied. There would, however, have to be cogent evidence, such as an opinion from a pathologist, raising serious doubts about the prior finding.

Child Protection Decisions: The Significance of a Sibling's Death

When assessing future risk to surviving children, a parent's responsibility for the death of another child is of course very important, but not necessarily determinative. A parent can retain custody of children despite being found criminally liable for the death of their sibling. It is possible, for example, that the deceased child may have had special vulnerability, and that a parent can

⁷³ *Children's Aid Society of London and Middlesex v. D.W.*, [1997] O.J. No. 6340 at para. 7.

demonstrate a change in capacity or circumstances that would reduce the risk to other children to an acceptable level. The opposite situation may also occur, where a parent is found not to be responsible for the death of the child, but at a protection hearing concerning the surviving siblings, the parent is still found to be providing those children with inadequate care. Child protection proceedings will determine whether a child is in need of protection on the basis of information about all the circumstances of the case, and not only on the circumstances of another child's death.

Failure to Protect a Previous Child from Death

A child protection agency may also decide to apprehend a child at birth if a parent failed to protect a previous sibling who died due to abuse by the parent's partner or former partner. In *Children's Aid Society of Halifax v. L.F.*⁷⁴ the CAS applied for permanent custody of a child whose mother had, several years earlier, witnessed the murder of her first child by a previous partner, and had stayed in a relationship with that partner after the murder. When the mother became pregnant by a new partner, the couple moved to Nova Scotia from Alberta, where her first child had been killed, to avoid having the child protection authorities there involved. While the death of the first child was clearly influential in the decision of the Nova Scotia agency to apprehend the second child, the court's decision to make the child a permanent agency ward was made based on an assessment of a range of parenting concerns and did not seem to place great weight on this fact, although the judge mentioned that the couple "ran from Alberta authorities to avoid what has happened in Nova Scotia."⁷⁵

In *New Brunswick (Minister of Health and Community Services) v. B.G.T.*⁷⁶ a father had been convicted of criminal negligence in the death of the couple's previous child and sentenced to six years in prison. The couple later had another child who was apprehended at birth and placed with

⁷⁴ [1983] N.S.J. No. 134.

⁷⁵ *Children's Aid Society of Halifax v. L.F.* [1983] N.S.J. No. 134 at para. 132.

foster parents, but then returned, under supervision, to his mother, on the condition that she not allow the child to have any contact with his father. However, when it became apparent that the mother was indeed permitting contact between father and son, the boy was again apprehended. In his judgment, Athey J. found it noteworthy that, during the father's trial for the first child's death, the mother continued a relationship with him: "She says that they had fun, rented movies, laughed, joked, ate out, fought and argued."⁷⁷ The child was made a permanent ward of the child protection agency, with no access granted to the parents.

In many cases, the death of a child is the tragic culmination of a case where there has been a history of abuse or neglect, and it is clear that the parents in question should not be allowed to parent other children. One situation in which this can occur is when a parent admits to having abused surviving siblings, as was the case in *Dans la situation de X.B.*⁷⁸ The father was convicted of involuntary homicide of one of his twin sons, and admitted to abusing the surviving twin. The two-year-old twin was accordingly removed from his parents' care.

Previous Suspicious Death

In cases where a child's death is suspicious but the cause is uncertain, children born subsequently may not be apprehended at birth, but the prior suspicious death may be a factor in decisions made later about these younger siblings. In *Children's Aid Society of the City of Ottawa v. J.L.*,⁷⁹ the CAS began a protection application for a child of two deaf mute parents after their second child was hospitalized with injuries that suggested possible child abuse. Two years earlier, the parents' first child had died at five months of age, which the family physician characterized as a "crib death." The pathologist who performed the autopsy on the first child testified that he found evidence of

⁷⁶ [1999] N.B.J. No. 587 (N.B. Q.B.).

⁷⁷ *New Brunswick (Minister of Health and Community Services) v. B.G.T.* [1999] N.B.J. No. 587 (N.B. Q.B.) at para. 27.

⁷⁸ [2002] J.Q. no 6838; [2004] R.D.Q. no 27.

⁷⁹ [1977] O.J. No. 36.

hemorrhage and stated: “I could not rule out the possibility that this is traumatic.”⁸⁰ At the child protection hearing for the second child, a second pathologist also testified about the death of the first child, stating that “the evidence is clearer of neglect than it is of battering,” though she “could not rule out child abuse.”⁸¹ The decision of the trial judge, first overturned but then restored on further appeal, made the child a permanent ward. This case illustrates that, while the suspicious death of one child may not be sufficient to warrant the second child’s apprehension at birth, it was considered relevant in deciding to remove the child from parental care once the child in question exhibited symptoms of abuse. Further, it illustrates how both the trial judge and the appeal court placed considerable weight on the evidence about the death of the first child, even though no criminal charges were laid, as well as taking account of the treatment of the second child, who was the subject of the proceedings.

A similar situation arose in *Children’s Aid Society of Shelburne County v. S.L.S.*,⁸² where the CAS was granted permanent custody of a child based on the mother’s inadequacy as a parent. In addition to a description of domestic violence, drug use, prostitution, and other criminal activity, the judgment notes that the mother had already had a son who “died in his stroller (S.I.D.S.). He was a grumpy and moody child and [the mother] ‘wished he would die, and he did.’”⁸³ While there was apparently no expert testimony from a physician involved in treating or examining that child, a psychiatrist who prepared a report for the child protection hearing specifically highlighted the mother’s “comment about her first child, who died of Sudden Infant Death Syndrome while in a stroller,” and observed that was “a phenomenon quite unknown to me and in my opinion very suspicious.”⁸⁴

⁸⁰ *Children’s Aid Society of the City of Ottawa v. J.L.*, [1977] O.J. No. 36 at para. 4.

⁸¹ *Children’s Aid Society of the City of Ottawa v. J.L.*, [1977] O.J. No. 36 at para. 6.

⁸² [2000] N.S.J. No. 356 (Fam Ct.), affirmed [2001] N.S.J. No. 138 (C.A.).

⁸³ *Children’s Aid Society of Shelburne County v. S.L.S.*, [2000] N.S.J. No. 356 at para. 10.

⁸⁴ *Children’s Aid Society of Shelburne County v. S.L.S.*, [2001] N.S.J. No. 138 at para. 7.

A third example of earlier suspicious child deaths being a factor in decisions about a later child occurred in *Family and Children's Services of Kings County v. S.J.*⁸⁵ This case involved the third child of a mother whose first two children had died in infancy, one of Sudden Infant Death Syndrome and the other of viral pneumonitis. The child protection agency first filed a protection application for the third child when he was taken to the hospital after his mother claimed she dropped him accidentally while carrying him. The attending physician for the third child testified, expressing concerns about the "welfare of the child" and possible physical abuse, and noting that he was especially concerned because the two previous siblings had died in infancy. Medical reports about the two deaths were filed, but apparently there was no testimony from any of the attending physicians or pathologists. A psychologist's report prepared for the child protection proceedings commented that the mother's "history is an abysmal one: the fact is that she lost her first two children and used alarmingly poor judgment with her third child."⁸⁶ While this child was placed in the care of the child protection agency for a period of time, the initial decision was subject to later review, and after a period of agency support and counselling, the mother was able to regain custody of her surviving child, at first under supervision and then without supervision.

In *Winnipeg Child and Family Services v. T.L.W.*,⁸⁷ child protection services apprehended at birth a baby girl, two of whose three siblings had ingested Valium as infants. One had died as a result and the other had been apprehended by the CAS. The third sibling had also died after a short lifetime of abuse. The judge was not able to determine with certainty whether the mother or her partner had been responsible for administering Valium, but was nonetheless able to conclude that the mother had failed to protect at least one of her other children, and therefore was not an adequate parent, despite perhaps not actually having administered the drug, and the child was made a permanent ward. Little J. ordered that the child was to be placed for adoption, citing as one of the

⁸⁵ [1985] N.S.J. No. 385 (C.A.); reviewed at [1987] N.S.J. No. 519 (Fam. Ct.).

⁸⁶ *Family and Children's Services of King's County v. S.C.J.*, [1987] N.S.J. No. 519 at para. 11.

reasons that the girl's mother "surreptitiously administered the drug; or [a]ccepting her denials, she was reckless in not knowing of its administration."⁸⁸

If, despite some evidence of abuse or neglect, the child's cause of death cannot be established with any certainty, courts may have to disregard that death and consider only other aspects of the case. In *Children's Aid Society of Winnipeg v. B.I.*,⁸⁹ a mother whose first child had been placed in permanent care and whose second child had died in infancy in her care had her third child apprehended at birth. Helper J. ruled that the third child should not be returned to the mother and should be made a permanent ward. The judge noted that the order was based on the mother's general attitude and pattern of neglectful and irresponsible behaviour toward her other children, and not on the actual death of the second child, which could not be definitively labelled as natural or unnatural: "Although it is difficult to do so, one must not focus on the death of [the second child]."⁹⁰ While the judgment did rely on past parenting conduct, the death itself was not a factor in the custody order.

These cases illustrate that the previous suspicious sibling death, while not determinative, was considered in addition to evidence of other parenting inadequacies when deciding whether the child should be removed from parental care.

The Dilemma of Denial

One of the challenges for courts and agencies occurs when there are strong suspicions that a child has been abused or neglected but a parent continues to deny any responsibility. Generally, if the court finds that parental abuse or neglect did occur, the continued parental denial of any responsibility may well result in a disposition that is less favourable for the parent. There is a view

⁸⁷ [1998] M.J. No. 517.

⁸⁸ *Winnipeg Child and Family Services v. T.L.W.*, [1998] M.G. No. 517 (Man. Q.B.) at para. 25.

⁸⁹ [1985] M.J. No. 385 (Man. Q.B.).

⁹⁰ *Children's Aid Society of Winnipeg v. B.I. and Another*, [1985] M.J. No. 385 (Man. Q.B. Family Division).

that the failure to take responsibility and get assistance heightens the risk of future child maltreatment. This was illustrated by the Ontario case of *Re M.B.*,⁹¹ where the CAS filed a protection application for a young girl whose mother, while showing no signs of abusing or neglecting that child, had been found to have previously abused two foster children in her care. At the time of this protection hearing concerning her daughter, the mother still denied being responsible for abusing the other two children. Mackinnon J. noted the significant role that this lack of acceptance played in assessing her ability to parent in the future, and quoted from the judgment from *Children's Aid Society of Peel v. M.F.P.*:⁹²

It is my view that, while a person may not necessarily repeat the mistakes of the past, such a person's understanding of the mistakes of the past and of their reasons is fundamental to not repeating those mistakes. Therefore, while the court must look to the future in order to assess whether there will be a continuing need for protection, evidence of past parenting becomes very relevant in determining whether a continuing need for protection exists.

Because of not only her past parenting conduct, but also her current understanding of that previous behaviour, Mackinnon J. noted that “[i]t cannot be concluded from the excellent care received by M.B. in her first seven months of life, that she would not also be at substantial risk of physical harm, given what happened to [the other children].”⁹³ Since “the mother has not acknowledged her conduct or taken any steps to provide assurances against a future repetition,”⁹⁴ her child was removed from her care without access.⁹⁵

It is understandable that protection agencies and courts place significant weight on a parental denial of responsibility for prior incidents that are found to constitute maltreatment and an unwillingness to undertake counselling to deal with perceived parental failings. This, however, places parents in an invidious position if the agency, the external professionals, and court are

⁹¹ [2000] O.J. 4345 (Ont. Sup. Ct.).

⁹² *Children's Aid Society of Peel v. M.F.P.*, [1995] O.J. No. 2555 (O.C.J.) per Wolder Prov. Ct. J. at p. 10, quoted in *Re M.B.*, [2000] O.J. No. 4345 at para. 159.

⁹³ *Re M.B.*, [2000] O.J. No. 4353 at para. 163.

⁹⁴ *Re M.B.*, [2000] O.J. 4345 (Ont. Sup. Ct.) at para 164.

⁹⁵ For another example, see also *Re S.S.*, [1999] A.J. 1675 (Prov. Ct.).

erroneous in their assessment, and also detrimentally affects the child who is unnecessarily removed from parental care.

Judicial Decisions about a Child's Future Care

If a parent has been found guilty in a criminal proceeding for the death of one child, any surviving or later born siblings are usually made permanent wards in a child protection proceeding with a view to their adoption. In some cases, it is beneficial to the child to consider placing the child with relatives, and permitting some access to a parent, even if that parent bears criminal responsibility for the death of a sibling. However, placement with relatives can be problematic in cases such as these, and needs to be approached with caution. The potential for complications is demonstrated in the Alberta case of *Re S.S.*,⁹⁶ regarding the fate of an abused 20-month-old boy whose twin died of Shaken Baby Syndrome. Child protection services filed a protection application for the surviving twin; the boy's maternal grandmother also sought private guardianship. One of the difficulties identified by the judge in granting guardianship to the maternal grandmother was the stressful situation this would create for the child, as both his mother and grandmother appeared likely to have difficulty setting appropriate boundaries and there was a concern that the grandmother would in effect allow the mother to assume a parental role and not protect the child from the mother. Jordan Prov. Ct. J. commented that, "[a]s S.S. becomes older, it will be extremely difficult for the child to recover a sense of well-being as ongoing contact with family and extended family will occur if placed with the grandparents. Ongoing contact with family ... will possibly lead to ongoing and/or retraumatization."⁹⁷ Accordingly, the judge ordered that child welfare authorities would have permanent guardianship, and terminated all access with the biological family.

⁹⁶ [1999] A.J. No. 1675.

⁹⁷ *S.S. (Re)*, [1999] A.J. No. 1675 at para. 66.

In cases where only one parent is considered responsible for the death of a child, the court may grant custody of surviving siblings to the other parent if it is clear that the other parent will protect the surviving child or children. A custody order such as this effectively requires that the parents separate from one another, and the necessary circumstances often do not apply; in many cases, one parent will stand behind the other in an attempt to defend or maintain the innocence of his or her spouse. However, there are cases in which granting custody to the parent not found responsible for the child's death is the appropriate disposition. One instance in which this is more likely to be the case is when the parents are already separated at the time of the child's death, such as in *S.G.M. v. M.R.M.*⁹⁸ This case concerned the custody of the two surviving children of a separated couple whose third child had died "in a manner that did not appear to be accidental" while residing with the mother and her new partner. All three children had been living with the mother under an interim custody order, as the parents had not yet settled final custody arrangements. After the third child died, the father wished to have interim custody while the police completed their investigation, while the mother preferred instead that the children stay in foster care, where they were placed by child protection authorities immediately after the death of their sibling. Here, Boyle J. decided that the best available placement for the children would be with their father, but that the move "should not take place until the police have completed that part of their investigation which requires dealing with the children. The children are prospective witnesses and, when they move, their lives should be without outside interruption as far as that is reasonably possible."⁹⁹ Boyle J. also observed that, of the two surviving siblings of the dead girl, one was especially devastated by the death and would "require special expert attention and counselling."¹⁰⁰ This case illustrates the difficulty of the sometimes lengthy delay of a police investigation and the impact of that delay on surviving siblings, and the need for sensitivity and support for the surviving children.

⁹⁸ [1996] B.C.J. No. 960.

⁹⁹ *M.G.M. v. S.R.M.*, [1996] B.C.J. No. 960 at para 11.

Courts have allowed parents to regain custody of their children despite the unexplained death of a sibling if it is considered in the child's best interests to do so. In *Children's Aid Society of Halifax v. A. (R.A.)*,¹⁰¹ a 1988 case, two children had been placed for adoption by relatives outside of Canada nine years earlier following the mysterious death of their siblings. The biological parents had subsequently violated that order by taking one of the children back into their care. Although the CAS again sought custody of this child, Butler Fam. Ct. J. ruled that allowing the child to stay with his biological parents was in the child's best interests. The passage of time since the earlier death may have been a significant factor in this case.

Furthermore, if there is genuine uncertainty as to the cause of a death, even two prior deaths is not conclusive evidence that surviving siblings should be removed from their parents' care. This is illustrated in *Family and Children's Services of Kings County v. S.J.*,¹⁰² a previously mentioned Nova Scotia case from 1985. The child at issue in these proceedings had been injured by his mother, who stated that she had dropped the baby accidentally when she experienced sudden sharp back pain while carrying him. One of the factors considered suspicious by the doctor who treated the child was that his mother had had two previous children, both of whom had died as infants, one of viral pneumonitis and the other of Sudden Infant Death Syndrome. These previous deaths were mentioned by the trial judge as well. While at the initial trial the child was placed in the permanent care of the child protection agency, on appeal the court ordered that the case be remitted for a rehearing to determine whether there had been a sufficient change in circumstances in the two years since the child was in care, including an assessment of the parenting skills of the mother's new partner, to allow the child to be gradually returned to their care. This reflected the appeal court's recognition that unexplained child deaths themselves do not necessarily render a parent unfit to care for other children, and that courts must consider whether circumstances and parenting capacity have

¹⁰⁰ *S.G.M. v. M.R.M.*, [1996] B.C.J. No. 960 at para. 12.

¹⁰¹ 9 A.C.W.S. (3d) (N.S. Fam. Ct.).

improved since a prior death; in this case the reviewing court concluded that as a result of agency counselling and support the mother's parenting skills had improved and the child could safely be returned to the mother's care.¹⁰³

In some cases that do not result in a criminal conviction, it may be appropriate to have an "open adoption" for a later child, despite a finding in the child welfare proceedings of parental responsibility for prior sibling deaths. In a traditional or closed adoption, there is no contact between the birth parents (or their relatives) and the child until adulthood. In an open adoption, as in a closed adoption, the adoptive parents assume custody and have a full legal responsibility for the child; however, there is an agreement that there will be some form of contact between the child and the birth family, which might range from an occasional letter to visits every few months.

In the 1997 Alberta case of *Re J.M.*,¹⁰⁴ a child was apprehended at birth from a mother whose two previous children had died in infancy, one from head injuries and the other in circumstances "where the neurological damage and evidence medical was consistent with shaken baby syndrome as the cause of death." No charges were laid against the mother. While the child was in interim foster care awaiting a permanent custody order, the baby's parents gave consent for adoption by her uncle, who had applied for private guardianship. Brownlee Prov. Ct. J. accepted that the mother had a degree of responsibility for the death of the children and made the child a permanent ward. He also recommended that, since the uncle had been granted visits with the girl for the past year, he should be permitted to continue to have access visits with the child even though permanent guardianship would go to the child protection agency and it was expected that the child's foster parents would adopt him. The foster parents expressed a willingness to have an open adoption, allowing visitation with the uncle to continue even after the adoption, and the court expressed support for the value of continuing contact between the child and blood relatives.

¹⁰² [1985] N.S.J. No. 385 (C.A.).

¹⁰³ [1987] N.S.J. 519 (Fam. Ct.).

Reported Child Protection Cases with Dr. Charles Smith as a Witness

We were able to locate three reported child protection trials in which Dr. Smith gave evidence about the cause of death of a sibling of the child who was the subject of the proceedings.

Dr. Smith's testimony was of central importance in the 1995 case of *Children's Aid Society of Haldimand-Norfolk v. D.C.*,¹⁰⁵ which involved a newborn child. Ten years earlier, the child's father had been sentenced to five years in prison for manslaughter of one of his twin children from a previous relationship, both of whom had died suddenly in infancy. Dr. Smith testified that one of the twins had died of a head injury and the other of either a head injury or asphyxiation. Dr. Smith's testimony was the principal evidence at trial that the twins' deaths were not of natural causes. Other witnesses at the 1995 child protection hearing testified as to the father's gentle nature, and the mother of the child in question insisted that her husband was innocent.¹⁰⁶ The father consistently maintained that he did not cause the death of either twin, but did admit when cross-examined that "he must believe that [his daughter's] cause of death was an injury to her head because a qualified specialist, Dr. Smith, said it was so."¹⁰⁷ On appeal, the child at issue in the 1995 trial was removed from his parents' care; while the mother was permitted access to the child, the father was not.

In 1996, Dr. Smith provided expert medical testimony in *Children's Aid Society of Kingston v. M.T.*¹⁰⁸ This case concerned two children whose sibling had died before either was born, a death that, after an autopsy performed close to the time of death, was classified as Sudden Infant Death Syndrome. After the two later born children were abused, Dr. Smith performed an examination of the exhumed body of the first-born child and found skull fractures and a fractured femur. Dr. Smith

¹⁰⁴ [1997] A.J. No. 1135 (Alta. Prov. Ct.).

¹⁰⁵ [1995] O.J. No. 3747.

¹⁰⁶ On appeal, a new assessment of the father was done by a child abuse expert who said the father "showed evidence of the possibility of unusual and violent behavior." *Children's Aid Society of Haldimand-Norfolk v. D.C.*, [1996] O.J. No. 3471 at para. 31.

¹⁰⁷ *Children's Aid Society of Haldimand-Norfolk v. D.C.*, [1995] O.J. No. 3747, para. 36.

“expressed great concern about the credibility of the first autopsy”¹⁰⁹ and concluded that the child did not die of natural causes, but perhaps of suffocation or his head injuries. The judge noted Dr. Smith’s “impressive and extensive credentials”¹¹⁰ and ruled that the children should be placed in the care of their grandparents. In this case, despite the apparently considerable weight accorded to Dr. Smith’s opinion by the judge, he was not alone in his conclusions about the child’s cause of death; the parents themselves had also admitted that they had failed to care properly for their children, and the father, who testified under the protection of the *Canada Evidence Act*, admitted to a serious assault upon the deceased infant.

In *Children’s Aid Society of Peel v. L.P.*,¹¹¹ a 2003 trial regarding removal of two young children from the custody of their mother, the agency relied on testimony given by Dr. Smith about the deaths of two of their three older siblings. When the mother’s first child died at five months of age in 1993, the death was determined by the original pathologist as “sudden infant death syndrome.” A police investigation into the death of the first child resulted in Dr. Smith being consulted by the police. He concluded that child abuse could not be proven as the cause of death, and that the death should be classified, not as Sudden Infant Death Syndrome, but as Sudden Unexplained Death (SUD). After the mother’s second child died in 1997 in suspicious circumstances, an autopsy concluded that the cause of death was “undetermined” but not consistent with the mother’s explanation. Dr. Smith performed a second examination and also concluded “in careful words” that no cause of death could be found, though the doctor stated that the cause of death had not been found but was “consistent with asphyxial mechanism” [suffocation].¹¹² The mother was charged and found guilty by a jury of manslaughter; the jury was likely influenced not only by the expert evidence, but by the mother’s changing accounts of the death of her child. The

¹⁰⁸ [1996] O.J. No. 2444.

¹⁰⁹ *Children’s Aid Society of Kingston v. M.T.*, [1996] O.J. No. 2444, para. 12.

¹¹⁰ *Children’s Aid Society of Kingston v. M.T.*, [1996] O.J. No. 2444, para. 12.

¹¹¹ [2003] O.J. No. 2548.

mother's third child was placed in the care of his father, and three children born subsequently were apprehended at birth and made permanent wards.

Children Wrongfully Removed from Parental Care

It not known for certain by the authors of this paper whether any children who were removed from parental care due to reliance by the CAS and courts on the erroneous opinions of Dr. Smith are still in CAS care. It would appear that any children who were affected have either been placed for adoption or are in the care of parents, but it may be useful to briefly consider what should happen if any children are still in agency care, and then turn to the issues that arise if they have been adopted.

Child welfare legislation and policy require that, if any children are still in agency care, and, for example, living in a foster or group home, their cases should be resolved on the basis of an assessment of the best interests of the child or children in each individual case. If any of these children are still Crown wards, the parents should be given full information about them, and access to legal counsel and counselling services to investigate what type of reunification is appropriate. Under the CFSA s. 64, the parents would have a right to seek a review of a Crown wardship order, either to obtain access or to regain custody, with a determination to be made based on an assessment of the child's best interests. While the unmerited separation of children from their parents is a great injustice, it does not necessarily follow that returning these children to the care of their parents is in their best interests. In particular, if children are returned to their parents' custody after several years in a stable foster home, they may well be traumatized by the stress of separation from their foster families and the experience of returning to a now unfamiliar environment. It would, however, likely be in the interests of the child to have contact with the birth parent if a change in custody is not in the child's interest and the birth parents are prepared to be supportive of the adoptive placement.

¹¹² *Children's Aid Society of Peel v. L.P.*, [2003] O.J. No. 2548, para. 49.

Two highly publicized cases of reunification of children with their parents after wrongful removal arose out of the incompetent work of a prominent British forensic pediatrician, Dr. Roy Meadows.

Sally Clark was a lawyer convicted of murdering two of her sons while each was in the first few months of life, based on the testimony of Dr Meadows. Clark served three years in prison before Dr. Meadows' work was discredited and she was released. At the time of her arrest, Clark had been pregnant with a third child, who was apprehended shortly after birth and placed in foster care. While Clark was in prison, her husband regained custody of their son. When the inadequacies in the work of Dr. Meadows were revealed, Clark was released from prison and eventually exonerated, and resumed living with her husband and son.¹¹³ Her husband commented on his wife's relationship with their son in comparison to that with her two dead sons in an interview: "She can't feel about [her surviving son] the same way. But you know, she never had the chance. She couldn't bond with him in the way that mothers do with their children because he was taken from her."¹¹⁴ She was psychologically scarred by her ordeal and years in prison, and tragically died four years after her release from prison.

The case of *Angela Cannings* also illustrates the challenges of reuniting a child with a parent after a wrongful separation of this nature. Based on the expert testimony of Dr. Meadows, Cannings was convicted of killing three of her four children in infancy. However, Cannings was released after 18 months in prison and her conviction was overturned by the Court of Appeal due to problems with the testimony of Dr. Meadows.¹¹⁵ Canning's surviving daughter, who was seven years old at the time of her mother's release from jail, experienced significant difficulty in readjusting to her

¹¹³ Catherine O'Brien, "'She'll never be well again'—How Sally Clark's ordeal destroyed her." *Times Online* (June 7, 2004), at www.timesonline.co.uk/tol/life_and_style/article441984.ece?token=null&offset=0, accessed August 16, 2007.

¹¹⁴ Steve Clark, as quoted in Catherine O'Brien, "'She'll never be well again'—How Sally Clark's ordeal destroyed her." *Times Online* (June 7, 2004), at www.timesonline.co.uk/tol/life_and_style/article441984.ece?token=null&offset=0, accessed August 17, 2007.

¹¹⁵ *R v. Cannings*, [2004] EWCA Crim 01.

mother's presence in her life. After four years of separation from a mother who had been labelled as a "danger" to her, the daughter often refused to be separated from her mother to go to school, experienced mood swings, and requested to see a therapist because "I have this big knot inside me."¹¹⁶ In an interview, about a year after her release from prison, Cannings described the way in which the child welfare system failed to serve her daughter's best interests: "We went to meetings [during the investigation] where 20 or 30 people talked about what was best for her, without having met her.... It was two years after [the third] death before they organized a play therapist for her. Then, as soon as I was sent to prison, they stopped the therapy because she was no longer 'at risk.'"¹¹⁷

After the criminal appeals established that Dr. Meadows' expert opinions were unreliable, and the surviving siblings in those cases returned to parental care, child protection authorities in England were required to carry out a review of all other cases that might have been affected.¹¹⁸ In total, there were 26 cases (out of 28,867 children in care) in which there was a serious disagreement between medical expert witnesses, and after review, there were only 5 cases in which the concern about the unreliability of Dr. Meadows' opinion raised any significant doubt. In 3 of the 5 cases, the agency's assessment of the best interests of the child was that the plan of care should remain unchanged, in 1 case, the agency had already changed the plan (presumably returning the child to parental care), and in 1 case, further court review was required.

If parents are exonerated of killing a child, any attempt to reunite surviving children with their parents must be done with attention to the length of separation and with consideration of the

¹¹⁶ Cassandra Jardine, "Inside, I feel such anger and bitterness." *Telegraph.co.uk* (December 20, 2004), at www.telegraph.co.uk/news/main.jhtml;jsessionid=WZ45D55UNN2VJQFIQMGCFF4AVCBQUIV0?xml=/news/2004/12/20/ncann20.xml&page=2, accessed August 17, 2007.

¹¹⁷ Angela Cannings, as quoted in Cassandra Jardine, "Inside, I feel such anger and bitterness." *Telegraph.co.uk* (December 20, 2004), at www.telegraph.co.uk/news/main.jhtml;jsessionid=WZ45D55UNN2VJQFIQMGCFF4AVCBQUIV0?xml=/news/2004/12/20/ncann20.xml&page=2, accessed August 17, 2007.

¹¹⁸ Margaret Hodge, Minister of State for Education and Skills, Hansard, House of Commons, United Kingdom, Nov. 16, 2004. Summary Report in House of Commons Library, MUP 04139.7 10.45.

age and needs of the children; the government must be prepared to sponsor any support and counselling the children require as a result of the decision. The potentially traumatic effect of the legal proceedings and separation on surviving children should be kept in mind when assessing what course of action is in their best interests.¹¹⁹

Adopted Children

Media reports indicate that there is at least one child who was wrongfully removed from parental care and placed for adoption as a result of the erroneous opinion of Dr. Smith about the cause of death of a sibling.

Under s. 156 of the CFSA, an adoption order can only be appealed within one month of the order being made. Section 157 provides that, after an adoption order is finalized and the time for an appeal has expired, the adoption order is not subject to challenge review or appeal. Unlike for a criminal conviction, where there is always the possibility of the extension of time limits for an appeal to prevent a clear injustice or an application to the Minister of Justice under s. 696.1 of the *Criminal Code*, for an adoption the best interests and stability of a child require that the adoption order is not subject to further review, even if unjust and based on a clearly erroneous factual premise.¹²⁰ However, if it is established that a child was removed from parental custody due to an erroneous belief that the parent was responsible for the death of a sibling, it may well be in the best interests of the children to have at least some contact with their parents, depending on their age and

¹¹⁹ See also *T.M. v. Alberta (Public Inquiry into the death of J.C.)*, [1999] A.J. No. 1371 where a mother resumed care of her son after serving 16 months in jail sentence for the death of a foster child. The criminal charges were ultimately stayed after two trials and appeals. In a later case dealing with a provincial inquiry, the court noted that her then 10-year-old son tried to commit suicide after being made a permanent ward, and that, as the public inquiry approached, he “declared that he would kill himself before he would again leave his own home.” The boy had also reported to a psychologist that he was teased by other children “cause my mom and Dad’s in jail.”

¹²⁰ Arguably, if the adoptive parents engaged in fraud, this might be the basis for challenging an order even after 30 days, but even in this circumstance, a court would likely consider the best interests of the child.

wishes. At the very least, the adoptive parents, and through them the children, should be informed of the new circumstances.

If the adoption is an open adoption, with some contact between the birth parents and child, the adoptive parents and children are already likely to know that the children were wrongfully removed from parental care. All persons in this situation should have legal and psychological support to develop arrangements for contact that meet the best interests of the children while respecting the interests of the adults.

If the adoption is closed, s. 168 of the CFSA allows the Registrar of Adoption Information to disclose identifying information to the adoptive parents, child, and the birth parents if their “health ...or welfare requires the disclosure.” This would clearly seem to be a situation where such disclosure is necessary for the health and well-being of both the birth parent and child; failure to disclose this history to a child could be very traumatic to the adoptee if it is only discovered later in life, and with Ontario’s new adoption disclosure laws, the adoptee would almost certainly be able to discover this information later in life. Disclosure should occur with a view to establishing some form of open adoption that would allow for some contact between the birth parents and children involved, assuming that this is consistent with the best interests of the child and respects the needs of the adults involved. This process would have to be undertaken with the support of counsellors and legal advisors, who should be paid for by the government.

Child Abuse Register

A Child Abuse Register is a database that contains the names of individuals who have been “verified” as having abused or neglected a child in their care. Canadian jurisdictions that have Child Abuse Registers include Ontario, Nova Scotia, and Manitoba, though the criteria for being placed on the Register and the use that is made of the Register varies from one jurisdiction to another.

In Ontario, the Child Abuse Register is operated pursuant to the CFSA ss. 75 and 76. Names of individuals are placed on the Register by a local CAS if there is “credible evidence” that they have abused a child in their care.¹²¹ “Credible evidence” is a standard of proof lower than the ordinary civil standard of proof, and does not require a criminal conviction or even a civil finding in a protection hearing. The Ontario Register is not used as a screening device for potential employees or volunteers, but it is used by agencies when investigating possible child abuse cases. Although there is no legal significance to having one’s name on the Ontario Child Abuse Register, and access to the Register is tightly controlled, individuals whose names are placed on the Register are notified of this fact and understandably feel stigmatized. Individuals whose names are on the Register can apply to the Director of the Register to remove their names, and may have an administrative “expunction hearing” to determine whether the CAS is justified in concluding that abuse has been “verified” on the standard of “credible evidence” of abuse.

CONCLUSIONS

Responding to Individual Cases

While it is beyond the scope of the Commission’s terms of reference to report on individual cases in which there has been a criminal investigation, it is submitted that the Commission should make recommendations about the establishment of processes to promote the interests and rights of children and parents who may have been victimized by erroneous pathology reports prepared by Dr. Smith. In England, after the discovery that Dr. Meadows had made some erroneous reports that had been relied upon to remove children from parental care, a review was undertaken by child welfare authorities of all cases in which he had been involved. In our view, consideration should be given to a similar review of every Children’s Aid Society file that involved an opinion from Dr. Smith. If it

¹²¹ See discussion in Bala et al., *Review of the Ontario Child Abuse Register* (Ontario Ministry of Community & Social Services, 1988).

is concluded that his opinion may have been erroneous or inconsistent with other evidence, and his opinion was influential in the handling of the case, the CAS should take all steps to provide redress and promote the interests of the children involved. Some of these steps might include the following:

- If any child who has not been adopted is in agency care, the agency should assess whether a return of the child to parental care is in the best interests of the child, and take all reasonable steps to support the reunification of parents and child;
- If a child has been adopted, there is no legal basis for reversal of the adoption. Further, while profoundly unfair and psychologically distressing to the birth parents involved, it must be recognized that removal of a child from a stable adoptive home and return to the care of birth parents would likely be psychologically traumatic to the child and contrary to the child's best interests. However, s. 168 of the CFSA allows the Registrar of Adoption Information to disclose identifying information to the adoptive parents, child, and the birth parents if their "health ...or welfare requires the disclosure." These would likely be cases where such disclosure would be necessary and appropriate, if it has not occurred already, and could be done with a view to establishing some form of open adoption that would allow for some contact between the birth parents and children involved. This process should have the best interests of the child or children involved as its focus, and would have to be undertaken with the support of counsellors and legal advisors for all parties involved, who should be paid for by the government.
- Reimbursement of any legal costs incurred by parents in any child protection proceedings that were in any significant measure based on the erroneous opinion of Dr. Smith.
- Removal of names from the Child Abuse Register if there is no longer credible evidence of a history of abuse.

Future Cases: Dealing with Uncertainty

Even with the broader range of inquiry and the lower standard of proof required in child protection proceedings, there will be child protection cases where the most skilled and well-trained investigators and physicians will conclude that the cause of a child's death is uncertain, but the investigators and agency still have some suspicions and concerns about the care of surviving siblings. In some of these cases, the uncertainty is only temporary and may eventually be resolved, but in other cases there may never be certainty about the cause of death. These cases must be handled with sensitivity, as the parents should not be blamed for a death in the absence of proof of guilt, and indeed should be supported in their grief at the death of a child, but there may also be concerns about the safety and well-being of siblings.

In some of these cases there may be sufficient evidence about parental conduct not directly related to the death to allow the agency to at least obtain a supervision order for the surviving siblings that will allow for monitoring and support of the parents. These cases must be closely monitored, as they are potentially very high risk, but there must also be sensitivity as the parents have not been found responsible for the prior death. The parents may in some cases have hostility toward the CAS, and it may be appropriate to arrange for some support or supervision by an agency other than the CAS, though that agency should be made aware of the prior history, and the CAS must retain ultimate responsibility for supervision of a case and protection of children.

In some cases, there may not even be a basis for a protection order, despite lingering suspicions of parental responsibility for the death of a child. These families should be offered support on a voluntary basis, perhaps by an agency other than the CAS. While the CAS always retains the right to investigate if future concerns should arise, there must be reasonable grounds for this, based on evidence other than the unexplained death.

Systemic Issues

In addressing systemic issues to ensure that similar cases do not occur in the future, it must be appreciated that the investigation of child deaths is often very difficult. There will inevitably be some cases where, even with their special skill and training, different pathologists will have different opinions about the cause of death, and cases where there will be uncertainty as to the cause of death. Despite conflicting opinions or uncertainty, CASs and Family Courts must make difficult decisions about the siblings of children. Due regard must be paid to the different standard of proof in criminal and child protection cases, as well as the different focus of these two proceedings.

Support for Parents: Legal Aid Ontario

One way to promote fairness to parents and the best informed judicial decision making is to ensure that parents have access to effective advocates, and, in appropriate cases, to independent experts who can credibly challenge the opinions of government-retained or -employed experts. While Legal Aid does provide funding for the most indigent parents involved in the child protection process, the amount of funding per case is often inadequate, making it very difficult for parents and their counsel to effectively challenge agency decisions and experts. Further, many parents of limited means have incomes just above the very low Legal Aid ceilings but are unable to afford the often enormous costs of child protection litigation. Legal Aid must provide better support for parents involved in child protection litigation.

Accountability of Children's Aid Societies

Children's Aid Societies wield enormous state powers, and parents who are dealing with the agency sometimes feel powerless when decisions are being made that seem contrary to the interests of their children or themselves. CASs of course have a significant degree of accountability for their

involvement in individual cases through the Family Court system, but there have long been concerns that parents and children often lack effective means of seeking review of their concerns about agency actions, as the Ombudsman lacks jurisdiction over CASs. In the past few years the government has taken significant steps to increase agency accountability. In 2006, amendments to the CFSA came into effect to expand the role of the Children's Services Review Board,¹²² allowing parents, foster parents, and other persons to make complaints about services provided by a CAS; while the Board has no jurisdiction over a matter that has been decided by a court or is before the courts, there could be complaints about investigations that do not result in court proceedings and other aspects of agency handling of a case. In 2007 legislation was enacted to create a new position of Provincial Advocate for Children and Youth,¹²³ significantly enhancing the independence and powers of the office of Child and Family Services Advocacy, to allow for advocacy on behalf of children receiving services from CASs; as with the Board, the Advocate has no jurisdiction over matters that are or have been dealt with in child protection proceedings, but could have a role in advocating for the provision of services for children who are in CAS care. While there is a need for government monitoring of the effectiveness of these new accountability, review, and complaint bodies, the situation for parents or children with concerns about CAS actions has significantly improved since 2001, and it is not clear that further action is required.

The Role of the Ministry of Children and Youth Services: Training, Support, and Policies

Child protection cases involving the surviving siblings of children who die due to parental abuse or neglect or in uncertain circumstances are relatively infrequent, and few CASs have staff with experience in dealing with these especially serious and challenging cases. However, a number of these tragic, high-profile cases typically occur every year in Ontario, and on a provincial level a

¹²² *Child and Family Services Statute Law Amendment Act, 2006*. S.O. 2006, c. 5, s.26, enacting C.F.S.A. s. 68 & 68.1.

¹²³ S.O. 2007, c.9, in force Oct. 5, 2007.

commitment has been made to try to learn from these cases through the Pediatric Death Review Committee of the Office of the Chief Coroner. The Ontario Association of Children's Aid Societies (OACAS) has representation on that Committee, and disseminates information to local CASs about the work of the Committee.

There would, however, seem to be a continuing need for more training and support for supervisory staff who deal with these most challenging cases, and funding support for this training and support should be included in future budgets.

The Ministry of Children and Youth Services, either on its own or through the OACAS, should ensure that "institutional memory" is developed and available to help respond to these cases. It would be useful to have a province-wide protocol (or guidelines) for the investigation and response to cases in which there is suspicion of child homicide by a parent or guardian. The development of such a protocol should involve both the Ministry and CASs, and should recognize the role and responsibilities of CASs in particular as regards surviving children. The primary investigators into child homicide, the police and pathologists, should be aware of the need to provide timely information to CASs, and ensure that the investigators collaborate with CASs in responding to these cases.

Sharing of Information Between Agencies and Subsequent Births

The legislation and policies that govern the sharing of information between police, medical personnel, including coroners, and child protection agencies should be reviewed to ensure that concerns about the protection of children and promotion of their best interests are given priority, while respecting the right of parents. One concern is that if a parent is found responsible for the death of a child, there may not be an effective way to alert hospitals and medical personnel to ensure

that medical staff will inform the CAS if that person subsequently becomes the parent of another child so that an appropriate plan can be put in place to protect the child.

Research

The literature review carried out for this paper revealed that there is only a limited amount of research on child homicides, and almost no research has been done on the risk to siblings of children who die due to parental abuse or neglect, or even on the nature of the risk faced by siblings of children who are abused or neglected. The child protection agencies, as well as those who work in the justice system, would clearly benefit if more were known about these issues. An awareness of factors that increase or reduce the risks faced by the siblings of victims of parental abuse or neglect should help ensure that children remain in their parents' care whenever it serves their well-being to do so, while preventing children from being left in a home environment in which they are in danger of similar abuse.

There is clearly a need for more research in the child welfare field in Ontario. For example, as discussed in this paper, there is a need for a better understanding of the causes and effects of the large increase in the number of children in CAS care in the province in the late 1990s, a development with enormous human and financial implications. One important issue to research that is within the mandate of the Commission is to gain a better understanding of the extent to which siblings of victims of abuse and neglect are also at risk. One useful and relatively easy step would be for the Pediatric Death Review Committee to begin to systematically collect and disseminate information on siblings of children who die due to parental abuse or neglect, or who die in suspicious circumstances or while in CAS care.