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A survey of policies and practices of government agencies involved in the administration of youth justice and custodial care with respect to complaints of child sexual abuse and complaints by adults of historical child sexual abuse who were provided with government services, whether by employees of the government or by volunteers.



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Executive Summary

Child sexual abuse is considered one of the most heinous crimes in our society, in part because of the far-reaching harm it causes and the betrayal of trust it involves. Abhorrence for this crime and the universal desire to protect children has resulted in child sexual abuse becoming the object of active concern on the part of policy makers and resolute intervention by legislators in many jurisdictions. Despite current concerns around the issue of child sexual abuse, it is important to recognize that public awareness of this crime and the policies designed to respond to, and prevent, such abuse are products of the relatively recent past. The report explores current policies and practices for handling allegations of child sexual abuse made against providers of services to children and youth within the context of the youth justice sector and how these policies and practices have evolved over time. Because there is a blurring between child welfare and youth justice services, responses in respect to foster care and group homes, residential care facilities, non-profit providers and related volunteer services are included.

The report begins with a brief history of the Canadian response to the phenomenon of child sexual abuse, highlighting key events. Responses to child sexual abuse progressed in increments, beginning with increased awareness of child physical abuse in the 1960s and the introduction of mandatory reporting laws; followed by heightened awareness of the issues surrounding child sexual abuse in the 1980s and 1990s; and concluding, most recently, with the evolution and implementation of more sophisticated policy structures that outline the processes which should be followed when responding to allegations of abuse in different settings. This process of historical evolution provides the underlying framework for the present research which explores policies in Canada, focusing on those adopted in Nova Scotia and British Columbia, as

well as those which have been implemented in a select group of other countries with a similar legal system. More specifically, this report sets out to meet the following objectives:

1. Explore the responses made to allegations of child sexual abuse which have been directed at individuals who provide services to children or youth. Specifically, the report considers the responses made by child protection agencies, police, foster parents, group homes or residential care facilities, youth justice, and non-profit service providers.
2. To review the literature review from jurisdictions that may be a reasonable comparator for Canadian jurisdictions and includes: the United States, Australia, and England and Wales.
3. Compare the policies and practices of the Canadian provinces of British Columbia and Nova Scotia.
4. Compare two jurisdictions in British Columbia and Nova Scotia in order to ascertain whether practice varies between large cities and smaller urban centres. The four jurisdictions considered are Halifax and Truro, in Nova Scotia, and Vancouver and Kelowna, in British Columbia.
5. Explore how policies and practices have changed and evolved in Nova Scotia and British Columbia from the 1960s to the present.

The present report documents a common history of the evolution of responses to child sexual abuse committed by service providers throughout B.C. and Nova Scotia, as well as internationally. Child abuse and neglect went largely unrecognized in Canada and the western world until 1962 when an American doctor, Dr. Kempe, coined the phrase ‘battered child syndrome’. Kempe’s work on this topic is viewed as the catalyst for heightening public concern and awareness of child abuse in North America and other western countries. At this time, child abuse was principally conceived of as physical abuse or neglect.

Early definitions of child abuse in legislation in both B.C. and Nova Scotia make no mention of sexual abuse or of abuse occurring outside of a child’s home. It appears that sexual abuse was either not acknowledged or considered another form of physical abuse. Gradually, child sexual abuse was recognized as an issue of public concern and child abuse was redefined to include sexual abuse. In 1976, Nova Scotia changed its definition of child abuse to include sexual abuse. British Columbia did not make this change until 1981. However, there is evidence that

child sexual abuse was considered separately from physical abuse prior to the amendment of the child protection legislation in B.C.. Official documents counting incidents of child abuse in the province counted sexual abuse separately and the 1979 *Child Abuse/Neglect Policy Handbook* included a definition of sexual abuse. Child sexual abuse was first understood as a form of family dysfunction and not something that occurred outside the home. Evidence of this perception is apparent in government documents and reports from both B.C. and Nova Scotia. Since there is a limited amount of information available in relation to responses to child abuse in the 1960s and 1970s - both from written documents and from our interviews with service providers - we cannot comment on whether there were regional differences between Vancouver and Kelowna or Halifax and Truro.

In the early 1980s, a federal commission was convened to determine the extent of child sexual abuse in Canada and to make recommendations concerning the adoption of the most appropriate responses to the problem. The commission, which was chaired by Robin Badgley, was the first major study of child sexual abuse in Canada and was a key turning point in Canadian understanding of child abuse - an understanding that included child sexual abuse. The commission's report found that sexual victimization during childhood was common for both girls and boys. A subsequent federal report, the 'Rogers Report' or *Reaching for Solutions* (1990), further reinforced the perception that there was a marked need to reform child protection activities, to increase government funding, and to implement changes to existing legislation in order to more effectively address the issue of child sexual abuse.

Child sexual abuse by service providers was not an issue in the public consciousness until after the period in which child sexual abuse was established as a child welfare concern distinct

from physical abuse. As was noted above, this largely happened in the 1980s. We have found no specific evidence from Nova Scotia or B.C. of any formal response to abuse by service providers prior to 1985, when B.C. issued the second version of the *Inter-Ministerial Handbook on Child Abuse*. The original version of this handbook was issued in 1979 but did not mention abuse by service providers. This is consistent with trends elsewhere; for example, abuse by service providers did not become an issue of public concern in England and Wales until the mid-1980s. Australia was even slower to acknowledge abuse by service providers: indeed, inquiries into past abuse of children in state care did not begin until the 1990s in that country.

Despite the absence of formal policies for handling abuse by service providers prior to the mid-1980s, it is clear from commissions of inquiry into abuse scandals or other investigations of historical abuse that child sexual abuse by service providers did occur and was, at times, reported. Reports of abuse in both B.C. and Nova Scotia were often not believed or were responded to quietly and discretely by the organization involved so as to avoid tarnishing their reputation. This also occurred elsewhere in Canada as well as internationally. In England and Wales, abuse was often discounted or disbelieved prior to the 1980s. Transferring abusive employees to other institutions or positions appears to have been a common response. Similar responses have also been noted in reports by Australian inquiries into historical abuse.

Large-scale investigations into historical abuse have traditionally involved residential institutions, which one author from England suggests gives the impression that abuse by service providers is a problem of residential institutions (Gallagher, 2000). To some extent, this may account for the lack of literature, and information in general, concerning child abuse in community settings, such as abuse by social workers, probation officers, or foster parents prior to

1980: however, there have been a number of high-profile cases of historical abuse within the community by teachers and religious leaders. Further, there appear to have been few safeguards in place to prevent abuse by service providers prior to 1980 - in B.C. or Nova Scotia or internationally. Pre-employment/volunteer screening was not widely used until the 1980s and 1990s. Social workers and others providing services to children and youth had little training and background checks were not used. Also, as interviewees from B.C. suggested, children placed in state care were not monitored. This was also noted as a concern in the literature from Australia. As such, it is unlikely that abuse would be detected and, even if it was detected, it is unlikely that it would be recorded or made public.

This report includes a detailed overview of the procedures adopted in England and Wales in response to sexual abuse by service providers as well as a brief overview of the corresponding procedures which have been implemented in Australia and the United States. Again, significant commonalities include a similar historical evolution of the development of awareness of child sexual abuse by service providers, the passage of mandatory child abuse laws, and the placing of an emphasis on interagency cooperation. The adoption of a multidisciplinary approach to responding to child sexual abuse also appears to be a common theme across all countries considered in this report. In the United States, multidisciplinary teams have been created in many jurisdictions to provide a less stressful, more comprehensive response to child sexual abuse. Similar teams are also active in some Canadian jurisdictions. However, there are nevertheless some noteworthy distinctions between the legislative and policy approaches which have been embraced in these countries. For example, Some Australian states and territories have made it an offence to work with children after receiving a negative background check and, in England and

Wales, it is illegal to apply to work with children after being convicted of a crime against a child. Neither B.C. nor Nova Scotia has enacted similar offences.

As is the case in Canada, public awareness of abuse by service providers first came to light in England and Wales in the mid-1980s. Heightened awareness of the issue led to a number of high profile scandals in the country which often focused on abuse in residential schools, creating the impression that abuse by service providers is associated with institutional care. However, the research literature generated in England and Wales has pointed out that community-based service providers, such as social workers and foster parents, have also been charged with abusing children in their care. In response to various high-profile commissions of inquiry into alleged abuse by service providers and the concomitant intense public interest in child sexual abuse, the authorities in England and Wales have periodically strengthened strategies designed to prevent child sexual abuse and to enhance interagency cooperation and the effectiveness of investigations. The need to implement specialized training for police and social workers investigating child abuse has also been emphasized to an ever-increasing extent. One point of difference between England and Wales and the other countries considered here is that child protection policies are a national, rather than a regional, responsibility: as a result, there is more coherence in the policy which is implemented in England and Wales than in the corresponding policies which have been developed by the Canadian, American, or Australian authorities.

Following the discussion of international policy and practice for responding to abuse by service providers, the report returns to Canada for a more detailed examination of policies in British Columbia and Nova Scotia. Both in Canada and abroad, awareness of child abuse

appears to have risen dramatically after 1980, focusing initially on abuse within the family but later expanding to include extra-familial abuse. Interviewees from both B.C. and Nova Scotia suggested that, in the 1980s and 1990s, there was a state of hyper-vigilance around the issue of child sexual abuse. With this awareness and hyper-vigilance came formal policies and the provision of more information concerning the issue of abuse by service providers. Province-wide policies addressing abuse by service providers appeared in B.C. in 1985 but were generally not implemented in Nova Scotia until the early 1990s: however, there are some draft policies dating back to the late 1980s. Responses to child abuse continue to be remarkably similar in B.C. and Nova Scotia but there is sufficient information available to highlight some key differences in policy and practice from 1980 onwards.

Table 1 provides an overview of key features of B.C.'s and Nova Scotia's response to child abuse. Very generally, Nova Scotia has adopted the approach of issuing a number of policies for addressing abuse in specific settings, whereas B.C. has one key policy document for all service providers and only one specific protocol for investigating abuse in foster care. The *Child Abuse/Neglect Policy Handbook* has constituted the backbone of B.C.'s response to child abuse since the late 1970s. Child abuse investigations are also addressed in practice standards for child protection and group homes/residential care in both provinces as well as regional protocols between police, child protection services, and other organizations. B.C.'s approach of articulating a general policy to guide the making of a response to child abuse appears to be similar to the British approach, where two key documents provide the basis of the country's response to abuse by service providers - *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* and *What to do if you're worried a child is being abused*.

Table 1: Key Issues in Responding to Abuse by Service Providers – B.C. and Nova Scotia

| | British Columbia | Nova Scotia |
|---|---|--|
| Current Child Protection Legislation | <i>Child, Family, and Community Service Act, 1996</i> | <i>Children and Family Services Act, 1990</i> |
| Definition of a Child | Under 19 years | Under 16 years |
| Mandatory Child Abuse Reporting Provisions | <ul style="list-style-type: none"> • Enacted in 1967 • Penalty for failure to report • Applicable to general public • Specific to parents, no third party abuse requirement | <ul style="list-style-type: none"> • Enacted in 1967 • Penalty for failure to report added in 1984 • Applicable to general public • Provisions for abuse by parents as well as third party abuse |
| Child Protection Investigation Responsibilities | <ul style="list-style-type: none"> • If child is at risk or in danger • In case of abuse by parents/guardians/foster parents • Allegations against MCFD service providers | All reports of child abuse |
| Child Abuse Protocols | <ul style="list-style-type: none"> • General • Handbook for Action on Child Abuse and Neglect • Specific • Foster care • Regional protocols | <ul style="list-style-type: none"> • Specific • DCS Staff (child protection workers) • Foster Care • Residential Care/Group Homes • Youth Custody |
| Joint Investigations (police-child protection) | Encouraged when there is immediate risk to children | Required in all child abuse cases |
| Specialized police investigators | Yes – use when ever possible | Yes – use when ever possible |
| Joint police – child protection training | Yes | Yes |
| Historical Abuse | Issue addressed in provincial policies | No formal policies |

The Ministry of Children and Family Development largely guides British Columbia's approach to child abuse, including abuse by service providers. The *Child, Family, and*

Community Services Act (1996) authorizes child protection workers and the police to investigate child abuse and apprehend children when necessary. The provincial medical health officer also investigates incidents of abuse in group homes and other licensed residential facilities. Individual organisations can also investigate allegations of abuse made against their staff. As this indicates, a variety of different actors can play a role in a child abuse investigation involving service providers. In both Nova Scotia and B.C., investigations typically involve an external investigation led by the police or child protection services in order to decide if a child is in need of protection or if criminal charges will be laid. In addition, there will be an internal investigation which will be conducted to decide how to respond to the alleged perpetrator or how to address the needs of an alleged victim. However, the exact form of the investigation will depend upon the nature and identity of the different agencies involved.

Nova Scotia's historical response to child abuse initially reflected the response adopted in British Columbia insofar as the major focus was on physical abuse and abuse within-the-home. However, child abuse by service providers was not addressed by policy makers in Nova Scotia until much later. Policies which were specific to abuse by service providers did not begin to surface until the late 1980s. Rather than having a single provincial protocol that acts as a framework for local responses to abuse in a range of different situations, Nova Scotia has fashioned a series of province-wide protocols for addressing abuse in various situations. For instance, there are draft provincial guidelines for responding to abuse by child protection workers or other staff members of the Department of Community Services as well as protocols for investigating abuse in group homes and foster homes. The *Children and Family Services Act*, 1990, provides the legislative basis for all of the province's child abuse policies. In addition to child protection policies and standards, all police investigations into child abuse are governed by

provincially-prescribed standard operating procedures. In comparison to British Columbia, Nova Scotia places greater emphasis on the involvement of child protection services in all child abuse investigations and also requires that these investigations be conducted jointly by police and child protection services.

In the conclusion of this report, the similarities and differences between Nova Scotia and British Columbia are explored in more detail, focusing on the distinctions between current and past practices as well as policies and protocols. In this section, the differences and similarities between the four jurisdictions within these provinces (Vancouver and Kelowna and Halifax and Truro) are also identified and discussed. It is concluded that, although some jurisdictional differences are readily apparent, a more extensive exploration of this topic would be needed to draw any conclusive conclusions. Moreover, it is noteworthy that the jurisdictional differences which are highlighted in the report appear to be associated with the culture of individual organizations or departments. Any differences which were observed do not appear to be a function of the size or locality of the jurisdiction in question. Ultimately, this research suggests that there is a striking degree of similarity in the responses which the various jurisdictions have adopted over time in order to prevent, and respond to, child sexual abuse committed by service providers. Any differences which have been identified in the report are located in the specific details of the various local policies rather than in the general policies and procedures adopted at the provincial level.

With regard to international comparisons, it is apparent that some jurisdictions have more developed approaches to dealing with abuse by service providers. The approach of England and Wales is particularly well developed. It includes comprehensive guidelines concerning

interagency cooperation, a national organization empowered to investigate abuse independently of the police or child protection services, regional oversight bodies, and a centralized system for pre-employment screening. However, it should also be noted that each jurisdiction considered in this report has implemented innovative initiatives that strengthen its approach to dealing with abuse by service providers. For instance, Nova Scotia's requirement that all allegations of abuse against a service provider be investigated by a neighbouring child protection jurisdiction helps ensure the investigation will not be biased or clouded by personal and professional relationships. Responding to abuse by service providers involves multiple organizations and a complex array of policies, legislation, and protocols within any given jurisdiction.

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1.0 INTRODUCTION

Child sexual abuse is considered one of the most heinous crimes in our society, in part because of the far-reaching harm it causes and the betrayal of trust it involves. Abhorrence for this crime and the universal desire to protect children has resulted in child sexual abuse becoming the object of active concern on the part of policy makers and resolute intervention by legislators in many jurisdictions. Despite current concerns around the issue of child sexual abuse, it is important to recognize that public awareness of this crime and the policies designed to respond to, and prevent, it are products of the relatively recent past. The present report explores current policies and practices for handling allegations of child sexual abuse made against providers of services to children and youth within the context of the youth justice sector and how these policies and practices have evolved over time. Since there is a blurring between the responses of child welfare and youth justice services to foster care and group homes, residential care facilities, non-profit providers and related volunteer services are included in the analysis. More specifically, this report sets out to do the following:

1. Explore the responses made to allegations of child sexual abuse which have been directed at individuals who provide services to children or youth. Specifically, the report considers the responses made by child protection agencies, police, foster parents, group homes or residential care facilities, youth justice, and non-profit service providers.
2. The report includes a literature review of jurisdictions that may be a reasonable comparator for Canadian jurisdictions and includes: the United States, Australia, and England and Wales.
3. Compare the policies and practices of the Canadian provinces of British Columbia and Nova Scotia.
4. Compare two jurisdictions in British Columbia and Nova Scotia in order to ascertain whether practice varies between large cities and smaller urban centres. The four jurisdictions considered are Halifax and Truro in Nova Scotia and Vancouver and Kelowna in British Columbia.
5. Explore how policies and practices have changed and evolved in Nova Scotia and British Columbia from the 1960s to the present.

The focus of the report is on Nova Scotia and British Columbia and abuse allegations made against service providers. These two provinces were chosen as comparators for this report because the collection of information from both a western and eastern province adds to the overall body of knowledge already gathered by the Cornwall Commission of Inquiry in relation to policies and practices in Ontario. Like Ontario, B.C. is a larger jurisdiction with major urban centres as well as outlying small towns and rural areas. Conversely, Nova Scotia is more rural with only mid-sized cities. Therefore, both B.C. and Nova Scotia are provinces which are representative of the diversity of populations in Western and Eastern Canada. Furthermore, in both Nova Scotia and British Columbia, public policy responses have been informed by inquiries into child abuse in residential institutions and by reviews of their child welfare systems.

It is useful to consider a more general history of Canada's response to child abuse as a means of acquiring an understanding of the broader context in which the responses by B.C. and Nova Scotia to abuse by service providers have evolved. To begin with, it is important to recognize that both federal and provincial legislation play a significant role in shaping the response to child abuse. The federal *Criminal Code* contains a number of provisions which render it a serious offence to physically or sexually abuse a child or young person. However, it is provincial child protection legislation which authorizes social services to intervene on behalf of a child when there are incidents of suspected abuse or neglect. Provincial and federal legislation constitute the foundation stone of all of the Canadian provinces' policies and protocols for responding to, and preventing, child sexual abuse. Another important point to take into account is that policies and protocols for responding to child abuse are not specific to child sexual abuse but are meant to address any type of child abuse, including physical abuse, sexual abuse, emotional

abuse, and neglect. Rarely are there any provisions which are designed to target child sexual abuse *per se*.

Recognition of the unique rights and needs of children was first evident in Canada in 1893, which was the year that witnessed the enactment of legislation establishing Children's Aid Societies. However, many of the basic needs of children continued to be unmet and unacknowledged in legislation for several decades. As such, it is clear that child abuse is a behaviour that has a long history but it has only been acknowledged as an issue of public concern in recent times. This is particularly true with regard to sexual abuse perpetrated by persons other than parents or family members (See Figure 1 at page 9) for an overview of the history of child abuse in Canada). Child abuse and neglect went largely unrecognized in Canada until 1962, when an American doctor, Dr. C. Henry Kempe, coined the phrase 'battered child syndrome'. Kempe's work on this topic is viewed as the catalyst for heightening public concern and awareness of child abuse in North America (Loo, *et. al.* 1998; Wachtel, 1989). It was not until the mid-1960s that legislation with provisions for the mandatory reporting of child abuse was drafted, first in Ontario and then in other provinces and territories over the next ten years (Mian, Bala, & MacMillan, 2001; Bessner, 1999). At this point, the *Criminal Code* was also amended to facilitate the prosecution of child abuse and the *Canada Evidence Act* was revised to give the testimony of children more weight. Up until this time, information from child witnesses was not viewed as credible (Law Commission of Canada, n.d.; Department of Justice Canada, n.d.). Moreover, sexual abuse did not receive much attention by legislators or childcare workers until the 1980s, after adults who experienced sexual abuse in childhood came forward to disclose their experiences (Mian *et al.*, 2001). Not surprisingly, Aboriginal people have comprised the largest proportion of individuals coming forward to report cases of institutional abuse. It has been

estimated that approximately 12-15% of all survivors of residential schools will file a claim that they have experienced institutional abuse (Mian *et al.*, 2001).

Early concerns about child abuse were focused on physical abuse and neglect or what was often referred to as ‘cruelty towards children’. As was mentioned above, little attention was paid to child sexual abuse until the early 1980s (Wachtel, 1994, 1989; Mian *et al.*, 2001). At this time, persons who had been victims of abuse, professionals, and feminists all raised awareness of the problem of child sexual abuse and advocated changes to the child welfare system and the enactment of protective legislation. Eventually, a federal commission was convened to determine the extent of child sexual abuse in Canada and to make recommendations concerning the adoption of the most appropriate responses to the problem. The commission, which was chaired by Robin Badgley, was the first major study of child sexual abuse in Canada. The report generated by the commission, commonly referred to as the ‘Badgley Report’ (1984), found that sexual victimization during childhood was common for both girls and boys (Mian, *et al.*, 2001). The Badgley Report and growing concern over child sexual abuse resulted in amendments to the federal legislation governing the prosecution of child sexual abuse cases and the giving of testimony by child witnesses. Two new offences were added to the *Criminal Code* in 1988 in order to prohibit any sexual contact between adults and children less than 14 years of age: these offences are ‘sexual interference’ and ‘invitation to sexual touching’ (Pilon, 1999). A subsequent federal report, the ‘Rogers Report’ or *Reaching for Solutions* (1990), further reinforced the perception that there was a marked need to reform child protection activities, to increase government funding, and to implement changes to existing legislation in order to more effectively address the issue of child sexual abuse.

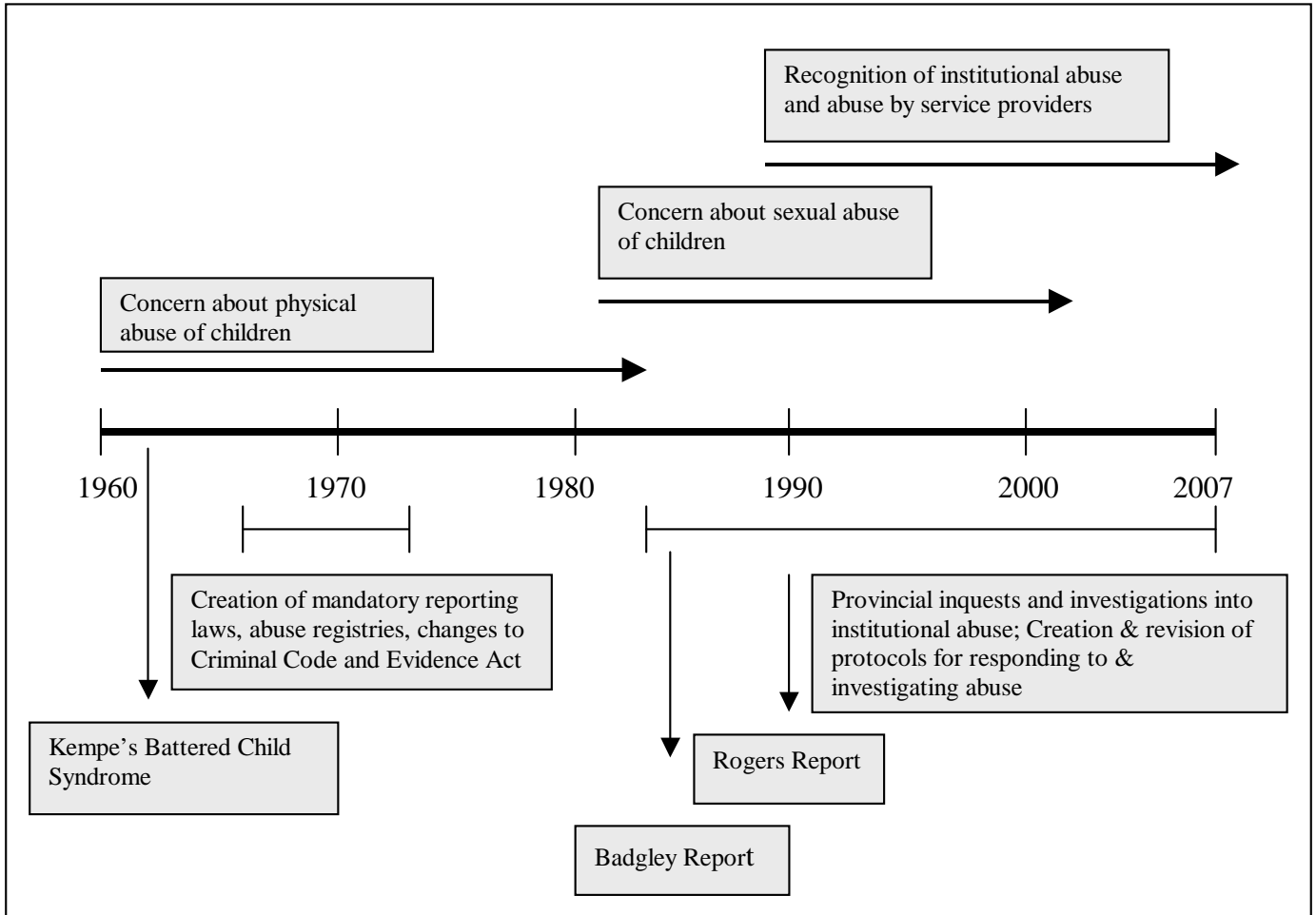
Despite increased awareness of child sexual abuse in the early-to-mid 1980s, the issue was largely constructed as being a problem which occurred within the family. Third-party abuse, or abuse by persons other than members of the child's immediate family, was generally not given much attention. There was little acknowledgement that sexual abuse also occurred outside the home and was occasionally perpetrated by persons entrusted with the care and protection of children (Wachtel, 1994). However, by the late 1980s and early 1990s, increased public awareness of child sexual abuse prompted the emergence of allegations that abuse had occurred in a variety of institutions across Canada, including churches, residential schools, custodial institutions for young offenders, and residential facilities for special-needs children. There also emerged allegations of abuse having occurred while children were involved in recreational activities (Mian, *et al.*, 2001; Law Commission of Canada, n.d). Throughout the 1990s and into the 2000s, a number of Commissions of Inquiry and investigations into incidents involving institutional abuse were held in a number of provinces, including both British Columbia and Nova Scotia. The Inquiries significantly increased public awareness of the phenomenon of child abuse occurring outside the home. They also inspired large-scale changes to child welfare services, the promulgation of government policies regarding the conduct of abuse investigations, and the publication of detailed guidelines providing direction to those individuals who work with children and youth.

In recent years, the courts have also been making significant strides with respect to sexual abuse cases. For example, several recent court decisions have ruled that organizations can be held vicariously liable for sexual abuse perpetrated by an employee (Wolfe *et al.*, 2001). Vicarious liability does not require the organization to have wilfully ignored or indirectly inflicted the abuse. Instead, it is essentially a question of whether or not the organization

materially increased the risk of sexual abuse (Wolfe *et al.*, 2001). Decisions that organizations can be held vicariously liable provide an incentive for those in charge of organizations to ensure that children in their care are safe from abuse.

The interests of children are further protected throughout the court process by means of the application of relevant statutory provisions and the implementation of programs designed for child victims. For example, section 486(2) of the *Criminal Code* of Canada stipulates that victims under age 18 who are alleged to have suffered sexual abuse are permitted to testify out of court, or behind screens (Canada, 2004). This helps to reduce the feelings of intimidation and stress that are commonly experienced by victims when they are in close proximity to their abusers. Innovations in technology also allow children to testify in another room on videotape that is transmitted through closed circuit television (Mian *et al.*, 2001). Taped interviews are also admissible as evidence, but their use does not eliminate the need for the alleged victim to testify; it simply provides for a more complete account of the alleged abuse (Mian *et al.*, 2001). Special programs designed for children testify have also been developed to reduce the stress of victims. These programs are designed to provide children with information about the court process and the role of each participant in the court room (Mian *et al.*, 2001). Within this broad context, the policies, procedures and guidelines for responding to allegations of abuse against service providers in British Columbia and Nova Scotia have gradually developed into the shape and form which exist at the present time and are documented in this report.

Figure 1: The Evolution of Awareness of Child Abuse in Canada



References

- Badgley, R.E. (1984). *Sexual offences against children : Report of the Committee on Sexual Offences Against Children and Youths*. Ottawa, Ont: Minister of Supply and Services Canada.
- Bala, N. (1998). Reforming child welfare policies: Don't throw out the baby with the bathwater. *Policy Options – La Famille*, September 1998, 28-32.
- Bessner, R. (1999). The duty to report child abuse. *The Canadian Family Law Quarterly*. 17, 277.
- Canada (2004). Canada's response to the UN questionnaire on violence against children. <http://www.ohchr.org/english/bodies/CRC/docs/study/responses/Canada-E.pdf> [On-line].
- Department of Justice Canada (n.d.) Child Abuse: A Fact Sheet From the Department of Justice Canada. Retrieved May, 2007 from <http://www.justice.gc.ca/en/ps/fm/childafs.html>
- Law Commission of Canada (n.d.) Institutional Child Abuse in Canada – Introduction. Retrieved March, 2007 from, http://www.lcc.gc.ca/research_project/ica/pubs/besrep/intro-en.asp.
- Loo, S.K., Bala, N.M., Clarke, M.E., & Hornick J.P. (1998). *Child Abuse: Reporting and Classification in Health Care Settings*. National Clearinghouse on Family Violence. Health Canada.
- Mian M., Bala N., & MacMillan H. (2001). Child abuse and neglect in Canada: Increasing awareness and changing responses. In B.M. Schwartz-Kenney, M. McCauley, & M. Epstein's (eds) *Child Abuse: A Global View*, 17-33. Westport, CT: Greenwood Publishing Group, Inc.
- Pilon, M. (2001). *Canada's Legal Age of Consent to Sexual Activity*. Library of Parliament. Parliamentary Information and Research Services. Retrieved May, 2007 from <http://www.parl.gc.ca/information/library/PRBpubs/prb993-e.htm>
- Rogers, R. (1990). *Reaching for solutions – the Report of the Special Advisor to the Ministry of National Health and Welfare on child Sexual Abuse in Canada*. National Clearinghouse on Family Violence. Health and Welfare Canada.
- Wachtel, A. (1994). *Child Abuse And Neglect: A Discussion Paper and Overview of Topically Related Projects*. Prepared for the National Policy Circle on Child Abuse Family Violence Prevention Unit. The National Clearinghouse on Family Violence. Health Canada
- Wachtel, A. (1989). *Child Abuse: A Discussion Paper*. Prepared for Working Together: 1989

Wolfe, D. A., Jaffe, P. J., Jetté, J. L., & Poisson, S. E. (2001). Child abuse in community institutions and organizations: Improving public and professional understanding. Centre for Children and Families in the Justice System [On-line]. Available: <http://www.lfcc.on.ca/institutional.html>

National Forum on Family Violence. The National Clearinghouse on Family Violence. Health Canada.

2.0 METHODOLOGY

2.1 Literature Review

There is a dearth of academic literature dealing with the nature and scope of official responses to allegations of child abuse which have been made against individuals who provide services to youth and children. Consequently, it was necessary to conduct a broad search which extended well beyond the confines of a traditional examination of library catalogues and scholarly journals. Library searches were carried out in public and university libraries. Internet searches were also conducted to find relevant information from each country considered in the literature review (the United States, Australia, and England and Wales). Government websites also provided an important source of information on regional policies, legislation, and reports. In addition to library and internet searches, literature on this topic was identified through contacting academics who had undertaken research in the field of child abuse, child protection, or family law and asking them to direct us to any literature they might have on this topic or to people they knew who had studied this area. Individuals contacted in this regard were identified through professional contacts, preliminary searches of academic journals (e.g., authors who had published on this or a related topic) or through searches of faculty members associated with social work and law faculties in British Columbian and Nova Scotian universities. Academics from the United States, Australia, and England and Wales were also contacted.

2.2 Legislation and Policy Document Review

The information for the legislation and policy review was obtained by one of three methods – (1) requests for information from interview participants and potential interview participants, (2) internet searches of government and community organization websites, and (3)

library searches. When a request for an interview was made to a potential participant in the present research project, he or she was also asked whether they could identify or provide any printed materials which they thought might be relevant to our research objectives. Printed materials were also requested when the interviews took place. Significantly, many of the protocols which are reviewed in this project were obtained in this manner. Unfortunately, some key protocols were not available either over the Internet or in the libraries to which the researchers had access. Other documents were obtained through Internet searches, with particular emphasis on government or non-profit-organization websites, or through library searches. Public and university libraries were searched in both Vancouver and Halifax. The most recent versions of legislation, policy documents, or protocols were sought, as well as any earlier editions. In many instances, protocols were revised on a number of occasions and relevant legislation was amended or replaced during the past four decades. Whenever possible, each version of the legislation or policy was examined in order to track the changes which occurred over time.

2.3 Interviews

2.3.1 The Interviewees: Selection and Profile

A variety of public servants were interviewed in order to collect information for this report: the pool of interviewees included individuals working in the fields of child protection, youth justice, and policy development as well as individuals working for non-profit organizations and police officers. The interviews were semi-structured and qualitative. Qualitative, semi-structured interviewing is a flexible approach to interviewing where the researcher has a set of pre-determined questions to guide the interview process. Depending on the course of the interview, the researcher may modify these questions, ask for further elaboration, or ask related

questions derived from the interviewee's responses but which are not included in the original set of questions. Questions are typically open-ended and require detailed responses or are a mix of open-ended and closed questions (Silverman, 2000; May, 1997; Creswell, 1998). Whenever possible, interviews were carried out in-person but it was necessary to conduct four of the interviews over the phone. In-person rather than telephone interviews are preferred because non-verbal information is not only an important source of information *per se* but may also assist the interviewer to respond to the interviewee in an appropriate manner and ultimately elicit more information from the conversation. Telephone interviews are more difficult to conduct and can more easily result in miscommunication (Hermanowicz, 2002; Creswell, 1998).

Two different interview instruments were used to guide the course of the interview – the general version and the police version (see appendix A). The general version of the interview was used for all interviewees, except police officers, and posed questions in the following four areas: (1) employment background; (2) current complaints procedures and guidelines for investigating allegations of child abuse, as well as the available responses to such allegations; (3) changes to the complaints and investigation process over time; and (4) practice and experience dealing with allegations of child abuse. Each interview took approximately one hour.

The police interview addressed the following three topics: (1) employment background; (2) current and past guidelines/protocols for investigating child abuse allegations; and (3) practice and experience handling child abuse allegations. The interview did not elicit information concerning police complaints procedures or how the police would respond if an officer was accused of child sexual abuse. For this reason, the interviews with police officers were less detailed and shorter, typically lasting between 20 to 30 minutes. Police officers were not asked

about the process they would follow if an officer was accused of abusing a child during the course of their duties because they were not one of the organizations of interest under the mandate of this report and because they do not provide services that are *primarily* geared towards children or youths.

In total, 9 individuals were interviewed from Nova Scotia and 16 individuals from British Columbia (see Table 2). The majority of the individuals interviewed from youth justice and child protection were not frontline workers but were supervisors, although many of them had worked as frontline workers in the past. The police officers, who were interviewed, were specialists in the investigation of sex crimes or were part of the major crimes unit, which is responsible for investigating allegations of child abuse. Most of the interviewees still worked in child protection, youth justice, or as provincial bureaucrats and police officers, with the exception of one individual who had moved on to a different career. The amount of time the interviewees had spent in their fields of work varied considerably. The majority had worked there for over five years, although a few had moved to their current position in the past year. Six of the interviewees had worked in their field for over 20 years. The majority of the interviewees worked in the cities, or their suburbs, identified as the locations to be considered in this report (Vancouver, Kelowna, Halifax, and Truro). However, in British Columbia, two of the provincial bureaucrats who were interviewed had worked in Victoria rather than Vancouver and one youth justice worker interviewed from Nova Scotia worked in Sydney rather than in Truro or Halifax.

Interviewees were recruited through snowball or network sampling techniques. Snowball sampling is a technique used to recruit participants where initial participants are identified through personal or professional contacts or other methods and are asked to identify other

individuals who would be appropriate participants in the research. Each new interviewee or potential interviewee is asked to recommend other potential participants (Onwuegbuzie & Leech, 2007; Silverman, 2000; Creswell, 1998). In the present research, the names of potential interviewees were identified by various methods: namely, through professional contacts known to the researchers; searches of government directories, websites and documents; and access to the websites of non-profit agencies. In some instances, particularly in the case of Nova Scotia, where the researchers lacked any professional contacts, potential interviewees were identified by contacting university faculty members from law schools, social work programs, or criminology departments and requesting that they provide us with the name and contact information of persons who would be appropriate to interview for the research project. Once a potential interviewee was contacted by this method, he or she was also requested to recommend other persons whom the researchers might approach for the purpose of seeking their participation in the project.

Table 2: Interview Type by Location

| | British Columbia | Nova Scotia |
|--------------------------------------|------------------|-------------|
| Police Officers | 5 | 2 |
| Child Protection | 4 | 2 |
| Youth Justice | 2 | 1 |
| Non-profit | 3 | 1 |
| Bureaucrat/Policy Development | 2 | 1 |
| Child's Advocate | 0 | 2 |

2.4 Data Analysis

The purpose of conducting interviews for this report was to collect information about the policies, protocols, and practices in place over time at different locations rather than to assess the nature of the relationship between networks of factors, as is often the goal in other types of

research. As such, the information gathered in the interviews was primarily used for descriptive purposes. However, a limited amount of analysis was carried out for the purpose of making relevant comparisons. Indeed, certain common themes were identified in the interviews obtained from participants in each of the locations selected for this project: namely, Vancouver, Kelowna, Halifax, and Truro. The similarities and differences between each location were assessed in terms of a basic comparison of the common themes identified in the preliminary analysis. Two levels of comparison were undertaken: comparisons between provinces and comparisons between cities within a province. In other words, Nova Scotia and British Columbia were compared, Halifax and Truro were compared, and lastly, Vancouver and Kelowna were compared. Comparisons between provinces took into account both policy and practice, as each province has its own legislation, policies, and protocols to guide their official responses to allegations of child sexual abuse. In the process of comparing the situations in the two provinces, the interview data was not considered in isolation. Indeed, information collected by means of the literature review as well as the survey of the applicable provincial legislation and policy were also incorporated into the comparative analysis. The comparisons drawn between cities focused primarily on the similarities and differences in the realm of practice because the relevant policies and protocols for handling allegations of abuse were generally documents which were applicable to an entire province rather than to a specific city.

References

- Creswell, J.W. (1998). *Qualitative Inquiry and Research Design – Choosing Among Five Traditions*. Thousand Oaks, CA: Sage Publications.
- Hermanowicz, J.C. (2002). The great interview: 25 strategies for studying people in bed. *Qualitative Sociology*, 25(4), 479-499.
- May, T. (1997). *Social Research – Issues, Methods, and Process* (2nd ed.) Philadelphia, PA: Open University Press.
- Onwuegbuzie, A.J. & Leech, N.L. (2007). A call for qualitative power analysis. *Quality and Quantity*, 41, 105-121.
- Silverman, D. (2000). *Doing Qualitative Research: A Practical Handbook*. Thousand Oaks, CA: Sage Publications.

3.0 LITERATURE REVIEW

3.1 *Scope of the Literature Review*

The literature review is, of necessity, limited to published materials emanating from a highly select number of jurisdictions that are reasonable comparators to Canadian jurisdictions: namely, the United States of America, Australia, and England and Wales. The review of literature published in the U.S.A. is very general and brief since it would be impractical to attempt to examine legislative and policy-related developments in more than 50 different jurisdictions. The analysis of the literature from England and Wales is considerably more detailed than the analyses of the literature from the other jurisdictions which are highlighted in this literature review. The relevant legislation, protocols, and guidelines are applicable in all parts of these two countries, which have a combined population of some 52 million, and the comprehensive nature and scope of these measures renders them a particularly useful model for comparative purposes. Finally, literature from Australia is included in this review because Australia, like Canada, is a federal state which has historical links to the United Kingdom and a shared legal tradition. Also, like Canada, Australia has a history which has led to the identification of child abuse within residential settings.

3.2 *United States of America*

Over the past 20 years, American policy relating to the investigation of child abuse has evolved significantly. Early legislation relating to children typically focused on neglect. One of the first legislative measures which were designed to focus on child abuse was passed as part of the *Social Security Act* of 1935. The enactment of this legislation marked the first time that the federal government provided funding for child welfare services. The Act also contained

provisions stipulating that cases of abuse could be reported to child protection agencies: however, mandatory reporting was not legislated for several more decades (McCauley, Schwartz-Kenny, Epstein & Tucker, 2001).

However, concern about child abuse did not shift to recognize sexual abuse until the mid-1960s. This shift was propelled by the research of Dr. Kempe, who identified battered-child syndrome and identified objective medical definitions for various forms of child abuse. He also communicated the importance of reporting signs of abuse that appear during medical examinations (Pence & Wilson, 1994). Discussions generated by this research led to the legislation of mandatory reporting of suspected child abuse, which all states had enacted by 1966. The U.S. is essentially the birthplace of mandatory reporting legislation (*McCauley et al.*, 2001). Nevertheless, it was another 20 years before research into child abuse began to focus on sexual abuse, and so the American public remained unaware of the prevalence of sexual abuse for many years (*McCauley et al.*, 2001).

Prior to discussing the process of investigation into cases of abuse perpetrated by service providers in the community, it should be useful to provide some background information on the organizational structure of American government as it relates to child services. The United States of America is a federal country, and as such, has a unified federal government, state governments and local governments. As is the case in Canada, both of the higher levels of government have a role in securing the protection of children. In addition to passing the *Social Security Act* of 1935, the federal government was responsible for the development of the *Child Abuse Prevention and Treatment Act* in 1974. This Act provided a definition of child abuse and neglect, which included sexual abuse. States quickly adopted the stipulated definition, as doing so was required as a

condition of eligibility for federal funding to develop services for abused and neglected children (McCauley *et al.*, 2001). However, legislative responsibility for the protection of children typically falls within the jurisdiction of state governments and almost every jurisdiction has a state-funded agency that is responsible for investigating reported cases of abuse (McCauley *et al.*, 2001).

As previously mentioned, each of the states has responded to the challenge of protecting children by legislating the mandatory reporting of all suspected cases of neglect and abuse. Professionals who work with children are now required by state and federal laws to report all cases of suspected child abuse (McCauley *et al.*, 2001). To encourage professionals to report cases of suspected abuse, child protection legislation contains provisions to protect the identities of informants (Carbino, 1991). In most states, reports are directed to Child Protective Services (CPS) and the responsibility for investigating criminal cases typically falls within the jurisdiction of local law enforcement (Pence & Wilson, 1992). However, the investigation process does vary among states. For example, in California, child protective services are responsible for investigating all reports of sexual abuse perpetrated by a family member or formal caregiver, which includes teachers (Pence *et al.*, 1994). In contrast, child protective services in Tennessee investigate all cases of sexual abuse perpetrated against a child, including those perpetrated by a stranger (Pence *et al.*, 1994).

After receiving a report that any form of abuse has occurred, investigators must interview the victim and other potential victims or witnesses in order to seek corroborating or conflicting information (Pence *et al.*, 1992). In recognition of the fact that the interview process can be very difficult for children, many American jurisdictions have introduced policies to make the process

less stressful. For example, there has been a general trend towards recognizing the need for those who interview children, who are alleged to have suffered sexual abuse, to attain a certain level of skill and sensitivity. As such, many training programs have been developed to increase the interviewing skills of law enforcement and CPS workers. Such programs include those offered by Corner House, which began by training investigators in Minneapolis and now offers training sessions across the country, and the Finding Words course, offered by the American Prosecutor Research Institute (Jones, Cross, Walsh, & Simone, 2005). However, it is likely that many interviewers still lack this training (Jones et al., 2005).

In addition, increasing efforts have been made to coordinate investigations between local law enforcement and CPS. This reduces the number of occasions during which victims are subjected to interviews and forced to tell their stories (Jones et al., 2005). One method used to improve coordination includes the use of multidisciplinary teams (MDTs), comprised of law enforcement and CPS workers. Multidisciplinary teams were practically non-existent 25 years ago: however, by 1999, some 36 states had enacted legislation requiring the involvement of MDTs (Jones et al., 2005). The goal of MDTs is to enhance inter-agency collaboration in order to reduce the degree of stress experienced by victims. In practice, the nature and extent of collaboration varies widely among jurisdictions (Jones et al., 2005).

After the alleged victim has been interviewed, a medical practitioner must conduct a medical examination in order to search for evidence of abuse on the victim's body (Pence, *et al.*, 1992). At this point, law enforcement officers search the alleged crime scene for physical evidence of a crime. Physical evidence in sexual abuse cases is particularly important because, if found, it increases the likelihood that the perpetrator will confess and thus the child will not be

subjected to the stressful experience of participating in the court process (Pence *et al.*, 1992). Regardless of whether evidence is found, the alleged abuser must be interviewed after the crime scene investigation has taken place (Pence *et al.*, 1992). The investigation process can yield three possible outcomes: (1) substantiated, (2) not substantiated, and (3) inconclusive (McCauley *et al.*, 2001).

Some states require that child abuse reports should be responded to and investigated within specific time frames. For example, in Alaska, the Department of Social Services must investigate reported abuse within 72 hours, but there is no requirement that the alleged victim be interviewed within that period (Kopels, Charlton, & Wells, 2003). By way of contrast, in Pennsylvania, the investigation process must begin immediately upon receipt of a report and a CPS worker must meet with the alleged victim within 24 hours (Kopels *et al.*, 2003). Some states allow for a much longer investigation period, as in West Virginia, where a face-to-face interview must be conducted with the alleged victim within 14 days of the report. However, in cases of imminent danger of serious abuse, West Virginia child care workers must interview the child within 72 hours (Kopels *et al.*, 2003). It is noteworthy that legislation in 20 states refers to time requirements for the initiation of an investigation in general, non-specific, terms that use words such as “prompt” or “immediate”. In most states with such legislation, agency regulations or policies modify the state legislation by creating specific time lines for responding to abuse allegations (Kopels *et al.*, 2003). However, Hawaii uses non-specific terms in both its statutes and agency regulations (Kopels *et al.*, 2003).

The actions which are required in order to respond to abuse reports also vary among different jurisdictions. In some states, the investigation process begins with the first phone call to

gather information about the report: however, in other states, the preliminary phone call is part of the screening-and-intake process and the actual investigation does not begin until face-to-face contact has been established between the alleged victim and an interviewer (Kopels et al., 2003). Similarly, required investigation-completion periods vary among states. In most states, investigations must be completed within 30 days, but some states require completion within 24 hours, as is the case for investigations relating to children in immediate danger in Massachusetts, or as long as 90 days, as is the case in Washington (Kopels et al., 2003). There are currently 10 states that have no legislated completion times for investigations (Kopels et al., 2003).

Investigations for alleged abuse cases in foster homes are slightly different from the investigation process for general abuse. Once a report suggesting abuse in a foster home is filed, there is immediate CPS intervention. Communication is typically cut-off between the foster family and the agency during the investigation and all foster children are removed from the house, while biological children of the foster parents are left in the home (Carbino, 1991). If the report is not substantiated, the children are returned to the foster home at the discretion of the CPS worker. It is possible that the children will not be returned or that the agency will hesitate to place more children in that home (Carbino, 1991).

Investigation into alleged abuse in foster homes is particularly difficult, as it often involves children with a previous history of abuse. In such cases, it is sometimes difficult for the victim to cognitively separate the details of previous abuses from those of the current case (Pence et al., 1992). To help overcome this problem, it is important to compare details of previous cases with those of the current case in order to determine whether there are common details that can alert investigators to the victim's confusion (Pence *et al.*, 1992). It is also important that other

children in the foster home are interviewed about their perceptions of the alleged victim and perpetrator and of the nature of their relationship (Pence *et al.*, 1992).

Once the investigation process is over, law enforcement officers working on the case will recommend whether it should be prosecuted. The decision as to whether or not to pursue a case in court is based upon medical evidence (which is extremely rare), the admission of the perpetrator, the presence of credible witnesses, and the victim statement (Pence *et al.*, 1992). With regard to the victim statement, investigators must be able to articulate *why* they find the statement to be credible or lacking (Pence *et al.*, 1992). It is important that cases going to court are based upon strong evidence, as research indicates that district court judges are apt to believe that alleged victims are dishonest and have not in fact experienced the abuse in question (Everson, Boat, Bourg, & Robertson, 1996). The extent to which these beliefs influence court outcomes is unclear, but disbelief in the honesty of victims suggests that fair dispositions may be unlikely (Everson *et al.*, 1996).

In recognition of the fact that the investigation and prosecution of child abuse are not perfect processes, community-based programs have been developed in many states. These programs, which are referred to as Children's Advocacy Centres, draw on the knowledge of many disciplines (including law, mental health, and child protection) with a view to improving the institutional response to abuse. These programs have been developed with the specific goal of preventing further victimization and trauma by establishing guidelines for the process of responding to allegations of abuse in the investigation, treatment and prosecution phases. The programs also provide families with remedial services (McCauley *et al.*, 2001). Some communities have also adopted programs, similar to those in Canada, which provide children

with information about the trial process in order to help reduce their levels of stress and to improve their recall of the event (McCauley *et al.*, 2001). These programs hold great potential to effect significant change and it will be interesting to see how they help to shape future policies.

3.3. Australia

Abuse perpetrated by community service providers is possible in any country which maintains a child welfare system or provides services which are specifically directed towards children. However, some domestic policies may increase the likelihood of such abuse, as was the case with the policies developed in Australia during the mid-1900s. In 1937, following the Conference of State and Federal Aboriginal Affairs Authorities, a policy was initiated to absorb Aboriginal children into the dominant white culture through the adoption of education and childrearing techniques that emphasized 'white standards'. To accomplish this task, Aboriginal children were often removed from their families and placed in the custody of the state (Hawkins & Briggs, 1997). By 1946, the Australian government also began to receive disadvantaged children who were sent from Britain. This was mutually beneficial to both countries, as Britain sought to reduce the number of children in its orphanages and Australia desired to populate the country with people from Britain (Hawkins et al., 1997; Hatty & Hatty, 2001).

Working in combination, the policies for absorbing both Aboriginal and British children into state custody placed an increased number of children at heightened risk of victimization by the state. It is estimated that more than 500,000 Australians have been placed under the care of the state within the past 100 years (Senate Community Affairs Reference Committee, 2004). This is indicative of Australia's heavy reliance on institutional care as the primary response to child protection concerns until the 1950s. Tomison (2001) suggests that Australia's child protection system has oscillated between institutional care and some form of family-based community care, such as foster care. By the 1950s, there was considerable concern about the quality of care which children were receiving in the nation's institutions and there was a gradual shift to family-based care and community care (smaller group homes and foster homes).

However, institutional care nevertheless continued as the primary response to child protection concerns throughout the 1950s and 1960s (Tomison, 2001).

As was the case for many other western countries, the pioneering work on the battered child syndrome, carried out by Dr. C. Henry Kempe in the United States, sparked an interest in combating child abuse in Australia during the 1960s. This interest evolved throughout the 1970s, 1980s, and beyond. Child sexual abuse, however, did not elicit widespread concern until the 1970s, primarily owing to the efforts of child advocates and the emerging feminist movement (Tomison, 2001). Awareness of child sexual abuse coincided with increased professionalization of the child protection system and a greater emphasis on developing systems for investigating and managing child abuse cases in the 1970s and 1980s. This development was also accompanied by a desire for a greater degree of accountability on the part of child protection services (Tomison, 2001).

Historically, staff in children's homes (which were originally set up as orphanages) were generally unaccountable for their actions because inspections by child welfare authorities were infrequent and ineffective (Beyer, Higgins, & Bromfeild, 2005). Furthermore, most of these homes were operated by religious institutions and a strong trust in the inherent purity and goodness of these institutions resulted in expressions of disbelief when children alleged wrongdoing, even in the face of strong evidence suggesting the existence of sexual or physical abuse (Beyer et al., 2005; Human Rights and Equal Opportunity Commission, 1997). Faced with this reality, many children were afraid to report abuse because they feared that it would fail to provide any remedy to the situation and would potentially intensify the abuse to which they were being subjected and (Senate Community Affairs Reference Committee, 2004). Those who were

brave enough to report the abuse sometimes had their deepest fears realized, as there have been cases where these children suffered subsequent incidents of maltreatment perpetrated by the very individuals to whom they had reported the original abuse (Senate Community Affairs Reference Committee, 2001). As such, Australia has a long history of abuse perpetrated by community service providers: however, such abuse went largely unacknowledged until the 1990s.

The late 1990s witnessed the first in a series of federal inquiries into the abuse of children in state care. In 1997, the Australian government's Human Rights and Equal Opportunity Commission released its report, *Bringing Them Home*, which documented the practice of forcibly removing Aboriginal and Torres Strait Islander children from their families. The report estimates that approximately 13% of children who were removed from their families were sexually abused. This abuse occurred in both institutions and home-like organizations, such as foster homes (Irenyi, Bromfield, Beyer, & Higgins, 2006; Human Rights and Equal Opportunity Commission, 1997). Shortly thereafter, the Australian Senate's Community Affairs Committee investigated the experiences of child migrants coming to Australia, many of whom were abused while living in state institutions or in family homes. In its report, *Lost Innocents* (2001), the Senate Committee found that, of the 207 submissions from child migrants, 38 persons reported experiencing sexual abuse. Likewise, another Senate inquiry into the abuse of children while in state care reported that 21 per cent of the persons making submissions to the Committee had been sexually abused while in care. As was the case with the two previous inquiries, the Senate Community Affairs Committee found, in their report, *Forgotten Australians*, that abuse was more prevalent in religious institutions than in secular-care facilities (see Senate Community Affairs Committee, 2004; Irenyi et al., 2006).

These Commissions, along with regional investigations into child abuse, heightened awareness of the abuse of children while under state care. Despite such an increased willingness to recognize the nature and extent of the problem, of a subsequent report by the Senate Community Affairs Committee, *Protecting Vulnerable Children*, suggested that children were still being abused while in state care and that this was not simply a problem of the past. Many of the recommended changes to state and church care which had been made in previous inquiries were not implemented (see Irenyi et al., 2006; Senate Community Affairs Committee, 2005). Furthermore, statistics relating to child abuse do not include information on the location of the abuse or the relationship between the offender and the victim. As such, there is no reliable information on the prevalence of current sexual abuse incidents involving community service providers in Australia (Beyer, et al., 2005).

Prior to discussing the processes used to prevent or investigate cases of abuse perpetrated by community service providers in Australia, it might be helpful to provide a brief overview of the relevant government structures. Australia is a federal state and, as such, is comprised of three levels of government: federal (Commonwealth of Australia), state and territory, and local governments (Hatty & Hatty, 2001). With regard to child services, the Commonwealth of Australia deals mostly with issues relating to custody, child support, and the nation's international obligations (Hatty & Hatty, 2001). In contrast, local governments typically adopt a more hands-on approach to child services and are likely to operate community childcare centres. Despite their involvement with child services, local governments have no role in framing legislation related to child welfare (Hatty & Hatty, 2001). As a result, the primary responsibility for protecting the rights and interests of children lies with state and territory governments (Hatty & Hatty, 2001).

Each state and territory has similar legislation that addresses the prevention of abuse and delineates the process of intervention in those cases where abuse has already occurred (James, 2000; Hatty & Hatty, 2001; James, 2000). Regular meetings between state/territory and federal stakeholders have facilitated the homogeneity which is evident in state/territorial legislation across Australia. The National Child Protection Council was established, in the early 1990s, as a forum for information sharing and, in 1992, the Council launched a National Strategy for preventing and responding to child abuse (Hatty & Hatty, 2001). Despite many common features in state/territorial child protection legislation, the responsibility for children varies among jurisdictions (James, 2000). One constant theme which is emphasized by state and territorial governments is that the formal determination of whether there has been child abuse and the decision as to whether to lay criminal charges are state or territorial matters and that prosecution is always the responsibility of law enforcement officers (James, 2000).

Since 2002, there has been a considerable amount of governmental activity related to child protection services. Many states have held inquiries and investigations into abuse that took place in out-of-home care services and the findings have influenced organizational changes. Several state and territorial departments have been broken down or entirely replaced (Ainsworth & Hansen, 2006). New legislation has also been enacted; for example, the Northern Territory replaced the *Community Welfare Act, 1983* with the *Care and Protection of Children Act, 2007* and Western Australia enacted the *Children and Community Services Act* in 2004 (Ainsworth et al., 2006). Additionally, Queensland has restructured its criminal justice system to encourage abused persons to come forward and report incidents (Crime and Misconduct Commission, 2003).

Following the American model, all Australian states have enacted legislation to make the reporting of suspected abuse and neglect mandatory (Senate Community Affairs Reference Committee, 2005; Higgins, Bomfield, and Richardson, 2007). In 1977, New South Wales became the first Australian state to pass mandatory reporting legislation (Ainsworth, 2002). By 1998, New South Wales also became the first state to legislate significant financial penalties, which could be imposed on professionals who work with children and yet fail to report cases of suspected abuse. These penalties are outlined in the *Children and Young Persons (Care and Protection) Act* (1999), which specifies that a maximum fine of 200 penalty units (\$22,000) can be applied in cases where suspected abuse is not reported.

Mandatory reporting of suspected cases of abuse is now in effect in all Australian states and territories (James, 2000; Higgins et al., 2007). Many commentators state that Western Australia does not have mandatory reporting legislation but Higgins et al. (2007) surmise that this is not correct. Western Australia has targeted legislation that requires court personal, mediators, and councillors to report incidents of abuse that come to light in the course of family court cases. Licensed childcare providers are also required by law to report abuse. In addition to targeted legislation, there are guidelines and protocols in effect in Western Australia that require various government employees and those employed by government-funded agencies to report suspected abuse. Legislation has also been introduced in Western Australia that would make it mandatory for doctors, nurses, teachers, and police officers to report abuse (Senate Community Affairs Reference Committee, 2005; Higgins et al. 2007). As is the case with Western Australia, some states and territories only require certain professional groups to report child abuse whereas others, such as the Northern Territory and Tasmania, require all adults to report any circumstances which give them reason to believe a child is being abused (Higgins et al., 2007).

Although mandatory reporting is fairly well received in other nations, this system has recently become the object of criticism in Australia for being costly, overburdened, and time-consuming. Supporters of mandatory reporting argue that it increases public awareness of child abuse, provides symbolic acknowledgement of the seriousness of abuse, and pushes reluctant professionals to report abuse (Higgins et al., 2007). A great deal of this controversy has been propelled by research into the differences in reporting and case substantiation between Western Australia and the rest of the country (Ainsworth, 2002).

In addition to jurisdiction over child protection services, state and territories are also responsible for the administration of juvenile justice. In their 2005 report, the Senate Committee on Community Affairs, provided a brief overview of the country's juvenile justice system and noted that Australia has endorsed the *Standards for Juvenile Custodial Facilities*, a set of standards based on the United Nations rules for the protection of juveniles. These standards are designed to ensure that juveniles are housed in safe and secure environments while in custody. Because juvenile justice is a state responsibility, mechanisms for investigating abuse vary across Australia. For instance, in Queensland, complaints from young offenders are investigated, resolved, and monitored by the Commission for Children and Youth. The Commission is responsible for monitoring the care of young offenders in both government and non-government organizations. Western Australia has a somewhat different approach. Allegations of abuse (sexual and physical) are investigated internally by the Department of Justice. In their submission to the Senate Committee, Western Australia's Department of Justice insisted that there were many 'checks on the system', arguing that detainees in youth custody facilities have contact with a variety of community representatives such as volunteers, mentors, case managers, and health care providers. Also, Western Australia has a program in place whereby representatives from the

Office of the Ombudsman visit all detainees monthly (Senate Committee on Community Affairs, 2005).

More generally, Australia has recently taken steps to prevent abuse by persons working with children. For instance, in 1997, Hawkins et al. noted that criminal records were not checked when an individual was appointed to teach. As a result, it was possible that school boards were selecting individuals with previous sexual offences to work with children. More recent information suggests there have been significant improvements in the procedures for screening employees who work with children. Currently, there are no national laws requiring screening for people working with children but all states and territories have enacted their own legislation that requires criminal records checks for persons working in specific occupation involving children, such as teachers and child care workers. Many non-governmental and private organizations that provide services to children also have their own policies and procedures for screening new employees or volunteers (National Child Protection Clearing House, May 2007).

Some Australian states and territories have taken the additional step of legislating 'Working with Children Checks' for persons working or volunteering with children. For instance, in 2004, Western Australia made Working with Children Checks compulsory for paid employees, volunteers and unpaid persons, self-employed individuals, employers and organizations working with children. Western Australia's Working with Children Check involves a review of adult and juvenile criminal records, pending charges, and charges which did not result in conviction. The checks can also include information about the context of an offence from police records, court records, and medical or treatment reports. The Working with Children Screening Unit, which is a branch of the Department of Child Protection, carries out the checks (Working with Children

Screening Unit, August 2007). A person who undergoes a Working with Children Check is given a card, with the person's picture and signature, which certifies they have received a positive assessment and are able to work with children. The card is valid for three years and the person need not apply for an additional check if they change their place of employment. It is an offence for an individual to work with children without having a current Working with Children Check or when a negative assessment from a check is received. The maximum penalty for both of these offences is a fine of \$60,000 or five years in prison. It is also an offence for an employer or organization to employ a person to work with children without a valid check or a negative assessment, again with a maximum penalty of \$60,000 or five years in prison (*Working With Children (Criminal Record Checking) Act*, 2004). In New South Wales, a Working With Children Check also includes a review of any Apprehended Violence Orders (similar to restraining orders) that were issued to protect a child and any past employment proceedings that involved behaviour that could be considered child abuse or neglect or violence in the presence of a child (NSW Commission for Children and Young People, n.d.).

Beyer et al. (2005) argue that employment screening is an essential tool for the prevention of abuse in child-based organizations but efforts to prevent abuse must encompass a wider range of safeguards. Employment screening is not a guarantee against abuse as unsuitable persons may already be employed in an organization or existing workers may become unsuitable in certain conditions. Further, employee screening often relies on past offences or incidences and as such may overlook potential first time abusers or abusers who have escaped past detection. Other prevention strategies must be employed alongside employee screening. For instance, the risk of abuse can be minimized through appropriate supervision, training, organization registration and

accreditation, comprehensive policies and procedures, egalitarian management styles, and so on (Beyer et al. 2005).

On a national level, Australia has made an effort to reduce the risk of abuse perpetrated by service providers by creating an agreed-upon framework for prevention through the promotion of child-safe environments. In 2005, a national conference of federal and state/territorial ministers for community and disability services was held to address issues around child abuse and produced the *National Framework for Creating Safe Environments for Children – Organizations, Employees, and Volunteers*. The overarching goal of this framework is to increase the safety of children and to strengthen the capacity of organizations providing services to children in a comprehensive and cohesive manner across the country. To achieve this goal, this – and subsequent - conferences, have developed four schedules of guidelines which the individual states and territories are responsible for implementing. The schedules include guidelines for: 1) building the capacity of child-safe organizations, 2) using evidenced-based guides for risk assessment and decision-making when undertaking background checks, 3) excluding persons from employment or volunteering in child-related areas, and 4) sharing information across jurisdictions.

Many of the employment screening requirements of individual states and territories predate the *National Framework for Creating Safe Environments for Children* but they nonetheless facilitate the goals of the framework. Some states and territories have taken this a step further and have enacted legislation that provides guidelines for ensuring child safe-environments. For instance, in New South Wales, the ombudsman's office provides guidance to both government and non-government agencies and the Commission for Children and Young

People provides guidance to all employers as to how to create child-safe environments. The Ombudsman also investigates any allegations of abuse from designated government and non-governmental organizations. Similarly, in Western Australia, the Working with Children Screening Unit provides guidance concerning best practices in promoting safe environments for children. Agencies working with children are not required by legislation to act on the Screening Unit's guidance but public funding may not be available if the Unit's standards are not implemented (Beyer et al., 2005).

In addition to preventing child abuse by service providers, efforts have been made to improve the investigation process in Australia, when an allegation of abuse is made. As is the case with other countries, interagency cooperation and coordination are considered pivotal to the effectiveness of an investigation as well as necessary in order to minimize distress to victims during the course of an investigation. However, a lack of interagency cooperation continues to be a problem in many regions of Australia (Beyer et al. 2005). For instance, in 1996, South Australia established Interagency Child Abuse Assessment Panels. These panels included representatives from the Division of Family and Children Services and the Police as well as consultants from the public prosecutor's office and the health commission. The panels are responsible for reviewing and overseeing all referrals, investigations, and court outcomes for allegations of child abuse (Boltje, 1998). In 1997, South Australia also introduced *Child Protection Interagency Guidelines*. Despite these initiatives, a review of South Australia's child protection system, in 2003, identified interagency cooperation as a continuing problem. The review identifies a lack of common understanding of responsibilities and issues around confidentiality and inadequate procedures for information sharing as areas in need of improvement (Layton, 2003).

Many organizations are trying to minimize the harm which may be inflicted by certain elements of the investigation and prosecution processes by opting to use mediation in order to resolve allegations in-house as opposed to pursuing them through the court system (Beyer et al., 2005). Although this process spares the victim from the stressful and sometimes emotionally harmful court process, mediation is a confidential process that can be used to cover-up abuse (Beyer et al., 2005). It is probable that organizations that opt for mediation do so to protect their own interests and not those of the child.

Australia is a nation with a long history of abuse perpetrated by community service providers that continues to the present day (Senate Committee on Community Affairs, 2005). Australia's history of responding to child abuse has largely unfolded in a manner similar to that of other western countries, with an initial concern for child abuse being focused on physical abuse and neglect and a failure to acknowledge the widespread incidence of child sexual abuse until the 1970s and 1980s. Mandatory reporting laws and increased professionalization and accountability of child protection services are features of Australia's history that are also observable in the history of other countries. In light of the increased public awareness concerning child sexual abuse and the legacy of public inquiries into past abuse scandals, Australia has introduced a variety of initiatives to improve the safety of children receiving services within the community. Employment screening, prevention, and interagency cooperation are all examples of such initiatives.

3.4 England and Wales

3.4.1. Introduction

Since the mid-1980s, the phenomenon of professionals exploiting their work with children as a means of targeting them for sexual abuse has become a central focus of “public, media and legislative concerns” in England and Wales (Sullivan and Beech, 2002, at p. 153). The term, “institutional abuse” is frequently employed in the context of this public debate (Stanley, Manthorpe, and Penhale, 1999) and Gallagher (2000) has succinctly defined this term as “the sexual abuse of children by persons who work with them” (at p. 795).

According to Gallagher (2000), policy makers have tended to perceive institutional abuse as being “a problem of children’s homes or of social work or public services” (at p. 814). This perception has, to some extent, been moulded by a series of public scandals which resulted in a number of highly publicized inquiries during the late 1980s and the 1990s: significantly, the main focus of many of these inquiries was the abuse of children in residential care (Corby, Doig and Roberts, 1998). However, as Gallagher (2000) suggests, the phenomenon of institutional abuse permeates “all institutions, sectors and occupational groups” (at p. 814). Therefore, policies for the protection of children in care must pay equal attention to the needs of those children who are placed in community-based institutions, including those in the voluntary and private sector (see also Cawson, et al., 2000).

3.4.2 The Nature and Extent of Institutional Abuse

While there has been considerable public disquiet concerning the possibility that children may be sexually abused by the very individuals who are entrusted with the responsibility of protecting and caring for them, it is important to compare the incidence of institutional abuse in

England and Wales with the incidence of other forms of sexual abuse involving children and youths. For example, in a literature review, Gallagher (1999) noted that, in the Greater Manchester area, 60 cases of alleged institutional abuse by professional social workers and foster carers were investigated by the police in 1994 (Greater Manchester Police, 1995). Extrapolating from this statistic, Gallagher estimated that, on a national basis, 1200 such cases would have been investigated by the police in the same year. However, Gallagher also noted that institutional abuse involving individuals, such as social workers and foster parents, account for only some 4 per cent of all child protection investigations.

In a subsequent empirical study, Gallagher (2000) examined a sample of 65 cases of institutional abuse which occurred over the five-year period, 1988 to 1992, across eight local authorities in England and Wales. Although social workers constituted the majority of the abusers in residential establishments, they were involved in only 8 per cent of the total number of cases of institutional abuse. By way of contrast, as many as 25 percent of the total number of institutional-abuse cases involved an abuser who had a formal connection with the education system (ten community-based teachers, three residential teachers, three community-based 'support staff'). Gallagher (2000) asserts that institutional abuse is not a phenomenon which occurs only in children's homes, nor is it an issue which only concerns social workers (at p. 802). Indeed, Gallagher indicates that the largest single occupational group among the sample of institutional abusers consisted of foster parents.

In a similar vein, Hobbs and Hobbs (1999) reported that professionals in England reported high levels of child abuse in foster care placements. They conducted a retrospective study of 191 episodes of alleged physical and/or sexual abuse which were assessed and reported by

pediatricians between 1990 and 1995 in the northern city of Leeds. It was found that 42 children in foster care had been physically abused, 76 had been sexually abused and 15 had been subjected to both types of abuse. 60 per cent of the sexual abuse involved female children. However, only it is significant that only 41 per cent of the abuse was perpetrated by foster care givers themselves (23 per cent was committed by natural parents and 20 per cent by other children). Foster children were 7 to 8 times more likely to be assessed by a paediatrician for abuse than children in the general community.

A study conducted by Sullivan and Beech (2004) sheds some valuable light on the motivations of professional individuals who have engaged in the institutional abuse of children. The authors interviewed 41 professional individuals who had admitted to having sexually abused children in the context of the organizations or institutions in which they worked or operated as volunteers. The interviewees were adult men who attended a specialized assessment and treatment centre in Epsom, Surrey. Significantly, it was found that 15 per cent of the participants chose their profession for the primary purpose of locating and sexually abusing children. Another 41.5 per cent admitted that, while gaining access to children for the purpose of abuse was not their primary motivation for pursuing their particular profession, it was nevertheless part of their motivation for doing so. It is particularly striking that Sullivan and Beech found that many of the professional abusers targeted children who were involved in activities organized by voluntary or charitable organizations rather than children who came into contact with them in the context of their own chosen profession. Perhaps, one of the most important findings was that as many as 36.6 per cent of the professional abusers had never been convicted of a sexual offence. In all but two of these cases, the abusers were “Roman Catholic priests or religious” (at p. 44). Of the group which had never been convicted of a sexual offence, 64 per cent of the professional

individuals had been reported to their superiors by their victims, who responded by stating that they would not make a formal complaint to the police. In the remaining 36 per cent of such cases, the police had investigated the complaints but concluded that there was insufficient evidence to prosecute.

In a review of the relevant literature, Sullivan and Beech (2002) identified a recurring theme in the published research relating to the institutional abuse of children: namely, that staff members have frequently “ignored signs of abuse and have dismissed or failed to act upon disclosures by children” (at p. 162). Furthermore, Sullivan and Beech noted that all of the recent official inquiries, which were established to investigate reports of the institutional abuse of children, “have identified instances where abuse was not reported, as managers attempted to protect the reputation of the institution or cover the lack of procedures within the organization (at p. 162).

Sullivan and Beech (2002) also pointed out that a review of the literature indicates that there are certain characteristics of professional perpetrators of child sexual abuse which render them a particularly serious threat. For example, these individuals take advantage of the institutional environment in order to facilitate their acts of abuse and create a situation in which it is difficult for their victims and even other professionals to report the abuse (Brannan, Jones and Murch, 1993). Furthermore, the literature suggests that professional perpetrators are particularly adroit at adapting to their surroundings, often have more than one form of paraphilia and commit more than one type of offence (Sullivan and Beech, 2002, at p. 163). In addition, Sullivan and Beech (2002) reported that the literature suggests that there is a significant likelihood that the abuse of children

by professionals who work with them will involve more than one abuser (at p. 164). These characteristics ensure that combating institutional abuse constitutes a major challenge for child protection agencies and the police in England and Wales.

3.4.3 The Evolution of the Governmental Response to Institutional Abuse in England and Wales

A series of scandals, which first started to come to light in the mid-1980s, became the subject of several official inquiries which, in turn, led to far-reaching reviews of the child care system in the United Kingdom as a whole. Parliament responded to intense public concern by enacting legislation to improve childcare practices and to prevent convicted sex offenders from gaining access to children through their work or through their involvement in voluntary organizations or charitable societies. In addition, the United Kingdom government promulgated a number of publications which contained clear and detailed guidelines for the conduct of investigations into the institutional abuse of children and youths.

The first of the official inquiries in England and Wales concerned allegations of abuse in the London Borough of Lewisham (Lawson, 1985). By 2001, there had been a further seven such inquiries, all of which attracted considerable public interest (Sullivan and Beech (2002, at p. 157). Of particular interest is the Warner inquiry (1992) which was prompted by the imprisonment of a Leicestershire social worker for having sexually abused children in the child care system (D'Arcy and Gosling, 1998).

In 1987, the first general review of the child care system was released. This was an independent review undertaken by Lady Wagner (1987) and was entitled, *Residential Care – A Positive Choice*. This was followed by two influential reports by Sir William Utting, *Children in*

the Public Care (1991) and *People like us: the Report of the Review of the Safeguards for Children Living Away from Home (1997)*. Sullivan and Beech (2002) note that there were at least three other general reviews between 1992 and 1994 (at p. 157).

The first step which was taken to combat institutional abuse was the release of a set of guidelines by the Home Office in a 1986 circular, *Protection of children: disclosure of criminal background of those with access to children* (Home Office, 1986 and 1993). The circular addressed one of the major mechanisms for the protection of children – namely, preventing sex offenders from entering a work situation or care-giving situation (such as fostering or child minding) in which they may gain access to children. In 1994, this system of checking for a criminal background was later extended to individuals who might encounter children in the context of their work with voluntary agencies (Thomas, 2001). In addition to strengthening these preventative measures, the United Kingdom government issued guidelines which were designed to enhance the efficacy of the investigative procedures which come into effect in response to an allegation of child abuse. In 1988, a government publication established the basis for the police to conduct joint investigations into child abuse with other agencies entrusted with the promotion and protection of child welfare (Department of Health and Social Security and Welsh Office, 1988), *Working together: a guide to arrangements for inter-agency co-operation for the protection of children from abuse*.

The first legislative response to the problem of institutional abuse was the *Children Act, 1989*, which established not only a detailed statutory framework for the effective investigation of allegations of abuse but also a comprehensive process for

intervention by child protection agencies to ensure that children and youths are shielded from the risk of abuse and/or neglect. Subsequently there followed a series of measures to further enhance the standards of practice in both residential and daycare facilities (Gallagher, 2000). For example, in 1991, the Department of Health released *Working Together under the Children Act 1989: A Guide to Arrangements for Inter-Agency Co-Operation for the Protection of Children from Abuse* (a revised version of the document which was first issued in 1988). This publication contained a set of guidelines which were explicitly designed both to standardize the methods of investigation required by the *Children Act*, 1989, and to ensure that the various agencies concerned cooperate effectively both with each other and, where necessary, with the police.

In the mid-1990s, the sexual abuse of children became a topic which attracted an exceptionally high degree of public concern and attention. Public apprehension in this regard had been fuelled by a series of high-profile cases involving abuse against children and an “explosion of interest” in the topic of pedophiles in the newspapers (Soothill, Francis and Ackerley, 1998). The United Kingdom Parliament responded to public fears by strengthening the preventative measures which were designed to protect children from becoming the victims of institutional abuse. Legislation enacted in 2000 rendered it an offence for an individual who has already been convicted of offences against children even to apply to work with children (Thomas, 2001). The *Criminal Justice and Court Services Act* 2000 made provision for “disqualification orders” to be imposed on such individuals and renders it an offence to apply to work with children in contravention of such an order. In addition, strong measures were taken to enable agencies to obtain easy access to an efficient criminal records system. Indeed, the Criminal Records Bureau, an agency of the Home

Office, now functions as a “one-stop-shop” for organizations in the public, private and voluntary sectors seeking to acquire accurate information about individuals applying for employment with children. Under the auspices of the Bureau, police records may be checked and disclosure may be made of information maintained by the Department of Health and the Department for Education and Skills. The Bureau was established under Part V of the *Police Act, 1997*, and came into operation in March, 2002 (Criminal Records Bureau, 2007).

Government guidelines for the investigation of allegations of child abuse have continued to evolve in recent years. Two of the most important government publications which currently articulate some very detailed guidelines are (i) *Framework for the Assessment of Children in Need and their Families* (Department of Health (UK), 2000) and (ii) *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (H.M. Government, 2006b). These two major sets of guidelines have been simplified in a particularly “user-friendly” manual for the benefit of individuals who work in the field of child protection. The manual is entitled, *What to do if you’re worried a child is being abused* (H.M. Government, 2006a), and its stated purpose is to “assist practitioners to work together to safeguard and promote children’s welfare” (at p. 5).

3.4.4. National Guidelines for the Conduct of Investigations into Allegations of Child Sexual Abuse

The United Kingdom Government has issued a series of evolving guidelines which clearly articulate the steps which should be taken in the situation where there is a concern that a child may have been subjected to sexual abuse. One of the main themes which permeate these guidelines is the need for effective inter-agency cooperation. More specifically, the guidelines

underscore the critical importance of exchanging relevant information between all of the agencies involved (including the police) and stipulate that, where there is concern that there is a risk of significant harm to a child, there must be a series of inter-agency conferences to develop an appropriate child protection plan. The guidelines also indicate which agencies should assume primary responsibility for the protection and promotion of child welfare and prescribe a “serious case review” where there has been a particularly severe case of sexual abuse: the objective of this review is for the professionals involved to take stock of the situation and act on any lessons which may be learned from reviewing the relevant events in depth.

As noted above, the guidelines are succinctly summarized in the publication, *What to do if you're worried a child is being abused* (H.M. Government, 2006a). This volume incorporates the relevant statutory provisions and policy guidelines, which are set out in two more detailed government publications: (i) *Framework for the Assessment of Children in Need and their Families* (Department of Health (UK), 2000) and (ii) *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (H.M. Government, 2006b).

These Government publications are concerned with identifying the appropriate responses which child welfare agencies should make in response to concerns that a child has been abused or neglected. Child abuse is divided into three categories: physical, emotional and sexual.

According to the definition provided by the guidelines, *sexual abuse*:

Involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, on-line images, watching sexual activities,

or encouraging children to behave in sexually inappropriate ways. (H.M. Government, 2006a, at p. 9)

3.4.5. Inter-Agency Cooperation

In England and Wales, a significant degree of priority has been assigned to the goal of achieving effective inter-agency cooperation in the investigation of “out-of-home” allegations of child abuse (Barter, 1999). In 1988, a government publication established the basis for the police to conduct joint investigations into child abuse with other agencies which are entrusted with the promotion and protection of child welfare (Department of Health and Social Security and Welsh Office, 1988), *Working together: a guide to arrangements for inter-agency co-operation for the protection of children from abuse*. This publication has been revised on an ongoing basis and the current version is entitled, *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* (H.M. Government, 2006b).

The basic elements of the collaborative approach among the various agencies concerned with child welfare are (i) the creation of *children’s trusts*, which have the task of ensuring cooperation; (ii) the establishment of Local Safeguarding Children’s Boards; and (iii) the imposition of a duty on all agencies to “safeguard and promote the welfare of children.” In *Working Together to Safeguard Children*, it is emphasized that, if children are to be protected from harm and their welfare promoted, it is necessary to establish a “shared responsibility and the need for effective joint working between agencies and professionals that have different roles and expertise” (H.M. Government, 2006b, at p. 10). To this end, “constructive relationships” must be fostered between individual practitioners and these must be “promoted and supported by the commitment of senior managers to safeguard and promote the welfare of children” and by “clear lines of accountability” (H.M. Government, 2006b, at p. 10).

Local authorities have the legal responsibility to protect children from harm. They must do so by working in partnership with other public organizations, the non-profit sector, children and young people, parents and caregivers as well as the broader community. The police have apparently embraced the need for inter-agency cooperation in combating child abuse. For example, the police have engaged in joint training programs with social work colleagues. Furthermore, every police force has established a specialized child abuse investigation unit. According to *Working Together to Safeguard Children*, the police have been committed to sharing information and intelligence with other agencies and the latter are required to inform the police immediately when it is suspected that a criminal offence has been committed against any child (H.M. Government, 2006b, at p. 11).

The Local Safeguarding Children's Boards (LSCBs) are required to implement a protocol between the local authorities and the police in order to create guidelines which will assist both organizations in making decisions concerning the initiation of child protection enquiries and in determining the circumstances in which joint enquiries should be undertaken. Under the relevant provisions of the *Children Act, 2004*, The LSCB constitutes the “key statutory mechanism for agreeing how the relevant organizations in each local area will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do” (H.M. Government, 2006b, at p. 74). The LSCB also has the primary responsibility for identifying training needs and opportunities for individuals who work in the various agencies concerned with child protection and child welfare. The membership of the LSCB comprises senior managers from the various agencies and organizations in a particular local area, including both independent and non-profit bodies.

The emphasis on the need for inter-agency cooperation is also designed to enhance the independence of investigations of institutional abuse. In commenting on the guidelines, Barter (1999) confirms that they emphasize the significance of independence in the implementation of procedures for the protection of children from abuse. According to Barter, the necessity of preserving investigatory independence is reflected in the recommendations of two influential reviews commissioned by the United Kingdom Government in the late 1990s (Utting, 1997; Kent, 1997). Barter (at p. 394) lends weight to this observation by quoting from the Utting report, which addressed the safeguards for children living away from home in England and Wales:

Investigations into allegations of abuse in foster care or residential settings differ significantly from investigations into allegations against parents or others in the child's own home. Social workers find themselves examining the actions of people regarded as co-workers or professional colleagues. If they are members of the same department, its management may wittingly or unwittingly obstruct the investigation because it is reluctant to have failures or weaknesses exposed or is unable to acknowledge the possibility of harmful misconduct by its employees.' (Utting, 1997, pp.182-183).

The goal of achieving a high degree of independence in the investigative process is critically important since there may be a tendency for agencies which investigate themselves to place the lion's share of the blame for institutional abuse on the shoulders of individual staff members and to avoid scrutinizing the conduct of agency managers in order to ascertain whether they contributed to an environment in which such abuse could occur (Baldwin, 1990).

3.4.6. Guidelines for Police Investigations

Since the early 1990's, considerable weight has been placed in England and Wales on the need to promote specialist training for police officers who are assigned to interview child victims of sexual abuse (Lloyd and Burman, 1996). It has been suggested (Oxburgh, Williamson, and

Ost, 2005, at p. 3) that two public inquiries (Pigot, 1989 and Clyde, 1992) laid the basis for significant legislative reforms (*Criminal Justice Act 1991* and *Youth Justice and Criminal Evidence Act 1999*) which, in turn, created the underlying framework for the promulgation of official interviewing guidelines by the Government (Great Britain, 1992 and 2002). As a consequence of these developments, interviews with child victims were recorded and the courts began to admit such video recordings as evidence in criminal trials. The interviewing guidelines were designed to enhance the quality of evidence obtained from child victims and, in particular, to ensure its accuracy and clarity.

There is some concern that the promulgation of guidelines does not necessarily effect the desired change in police practices. For example, Sternberg et al. (2001) examined the extent to which forensic interviews of alleged child-abuse victims were conducted in accordance with the guidelines which were articulated in the *Memorandum of Good Practice* (Home Office and Department of Health, 1992). The study was based on an examination of 119 videotaped interviews of complainants aged between 4 and 13 years of age. Sternberg et al. found that the guidelines had not had the impact on investigators' practices which was originally envisaged. Indeed, about 40% of the information which was obtained from the complainants was derived from "option-posing and suggestive prompts which are known to elicit less reliable information than open-ended prompts do" (at p. 677). This type of questioning is strongly discouraged by the guidelines.

3.4.7. The Independent Investigative Role of the N.S.P.C.C.

It is significant that the *Children Act, 1989*, empowers the National Society for the Prevention of Cruelty to Children (NSPCC) to independently initiate child protection proceedings

(NSPCC, 2007). Indeed, it is the only “authorized person” with the statutory power to apply on its own initiative to a family court for Care and Supervision Orders. The independent investigative role may be exercised in isolation or in conjunction with investigations being conducted by the local authorities (Barter, 1999).

Barter (1999) studied the experiences and perceptions of NSPCC child protection practitioners and managers, who had been involved in an investigation of institutional abuse of children during the period, 1994 to 1996. Barter found that all of the research participants believed that their involvement had provided an additional degree of independence to local authority investigations. However, the special status of the NSPCC did not alleviate all concerns about the degree of independence manifested in its investigations. Barter reported that some interviewees expressed their uneasiness concerning the fact that the NSPCC had entered into service agreements with the local authorities and this situation “sat uncomfortably alongside notions of independence” (at p.399). In addition, Barter found that the most frequently expressed concern was the difficulty of investigating other professionals within their own geographic area. This difficulty was compounded if the NSPCC personnel were required to investigate individuals with whom they came into contact in their everyday work. Barter concluded that “independence is not simply an issue between agencies but also between individuals, and the importance of geographical separation in respect to this should not be ignored” (at p. 402).

Although total independence may be somewhat elusive, it is nevertheless noteworthy that the statutory power entrusted to the NSPCC undoubtedly provides an alternative mechanism for launching an investigation into an allegation of child sexual abuse, where the government authorities and/or the police may be unwilling or reluctant to proceed. Since 1986, the NSPCC

has operated the only national 24-hour “ChildLine” to assist children who are victims of abuse. The role of the NSPCC as an independent source of support and advice is of particular importance in light of research findings which indicate that children are very reluctant to take their concerns to their local authorities (Bridge and Street, 2001).

3.4.8. Investigation, Assessment and Action

According to the guidelines, there are four key processes which constitute the basis for safeguarding and promoting the welfare of children (H.M. Government, 2006b, at p. 101). These processes are assessment, planning, intervention and reviewing.

When a case involving an actual or suspected crime (such as a sexual assault against a child) is referred to a Local Authority, “social workers or their managers should always discuss the case with the police at the earliest opportunity” (H.M. Government, 2006b, at p. 104). When other agencies encounter such a situation, they are required to consider sharing the information with the police or with the local authority if there is a risk of significant harm to the child concerned and/or other children. If they do not do so, the reasons must be recorded in writing. When dealing with a child victim, the police must normally work in partnership with the other interested child care agencies.

The manual reminds practitioners that an allegation of child abuse may lead to a criminal investigation and exhorts them not to jeopardize a police investigation in any way (by, for example, asking a child leading questions or attempting to investigate allegations of abuse themselves). Practitioners who have reason to believe that a child is being abused are enjoined to refer their concerns to the Local Authority’s social care services or the police ((H.M. Government, 2006a, at p. 11). Practitioners are encouraged to consult with their managers and if

they conclude that a crime may have been committed, they are required to “discuss the child with the police at the earliest opportunity, as it is their responsibility to carry out any criminal investigation in accordance with the agreed plan for the child” (H.M. Government, 2006a, at p. 14). The manual instructs police officers who entertain concerns about a child’s welfare to “refer to children’s social care and agree a plan of action.” If the police decide to initiate a criminal investigation, they should “undertake the evidence gathering process whilst working in partnership with children’s social care and other agencies.” Furthermore, the police are reminded to “take immediate action where necessary to safeguard a child, consulting with children’s social care and agreeing a plan of action as soon as practicable” (H.M. Government, 2006a, at p. 15). Under section 40 of the *Children Act*, 1989, the police have the authority to take action unilaterally: however, the manual indicates that police powers should only be resorted to “in exceptional circumstances where there is insufficient time to seek an Emergency Protection Order or for reasons relating to the immediate safety of the child” (H.M. Government, 2006a, at p. 25).

Where a child has been referred to the Local Authority’s children’s social care, the first stage in the process is an *initial assessment*, which should be completed by a “qualified and experienced social worker” within seven working days. However, this period will naturally be very brief, where there are serious concerns for the child’s welfare and/or safety (H.M. Government, 2006b, at p. 108). If there is “reasonable cause to suspect that (the) child is suffering, or is likely to suffer significant harm,” then an enquiry under the provisions of section 47 of the *Children Act*, 1989, will be launched. Where there is a “likelihood of serious immediate harm,” the Local Authority, the Police, and the NSPCC have statutory child protection powers which may be used in order to “secure the immediate safety of the child” (H.M.

Government, 2006b, at p. 115). In most cases, the Local Authority will apply to a court for an *Emergency Protection Order*.

When there is reasonable cause to believe that a child either is, or is likely to, suffer significant harm, the policy is that there should be a “strategy discussion” which embraces the Local Authority’s children’s social care, the police and other bodies as appropriate (in particular, any referring agency). Among the issues to be discussed are whether a “core assessment” under section 47 of the *Children Act, 1989* should be launched and, if so, how the Enquiry should be undertaken (H.M. Government, 2006b, at p. 116). A section 47 Enquiry may run concurrently with a police investigation (H.M. Government, 2006b, at p. 117). Whether or not police officers uncover sufficient grounds to instigate criminal proceedings, they are encouraged, in the context of a section 47 Enquiry to “make available to other professionals any evidence that (they) have gathered, to inform discussions about the child’s welfare” (H.M. Government, 2006a, at p. 28).

The purpose of the section 47 Enquiry is to “determine whether action is required to safeguard and promote the welfare of the child.” The various professionals concerned in the conduct of the Enquiry are exhorted to “do their utmost to secure willing cooperation and participation from all professionals and services” (H.M. Government, 2006b, at p. 118). In child sexual abuse cases, any interviews with the child concerned must be “conducted in a way that minimizes any distress caused to them and maximizes the likelihood that they will provide accurate and complete information” (H.M. Government, 2006b, at p. 119). Interviews with children should be conducted by individuals with specialized training and experience in dealing with children (H.M. Government, 2006b, at p. 120).

If the outcome of the Enquiry is a determination that the child is considered to be running a continuing risk of harm, a *child protection conference* will be convened (H.M. Government, 2006b, at p. 123). If the conference arrives at the judgment that a child is at “continuing risk of significant harm,” a formal child protection plan will be formulated. The decision should reflect the “views of all agencies represented at the conference” (H.M. Government, 2006b, at p. 128). If a child is made the subject of a child protection plan, the conference is required to “consider and make recommendations on how agencies, professionals and the family should work together to ensure that the child will be safeguarded from harm in the future” (H.M. Government, 2006b, at p. 129). Either the Local Authority’s social care or the NSPCC will be charged with the responsibility of ensuring the future welfare of a child under a protection plan and is required to designate a qualified and experienced social worker to act as the “*key worker*.”

The key worker heads the “*core group*” which is responsible for formulating, implementing and refining the child protection plan: the “core group” consists of the key worker, the child (where appropriate), family members and professionals or foster carers who have direct contact with the family (H.M. Government, 2006b, at p. 132). A child protection review conference will be held within three months of the initial conference and further reviews will be held at six-month intervals until the child protection plan expires (H.M. Government, 2006b, at p. 136). The child protection plan will automatically be terminated when the child reaches the age of 18 years and may also be discontinued if circumstances have changed and the child is no longer at risk of significant harm.

Where a child has been subjected to “particularly serious sexual abuse,” the LCSB may conduct a “*serious case review*.” The purpose of the review is to “establish whether there are

lessons to be learned from the case about the way in which local professionals and organizations work together to safeguard and promote the welfare of children; identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and as a consequence, improve inter-agency working and better safeguard and promote the welfare of children” (H.M. Government, 2006b, at pp. 169-170). In general, a serious case review should not be delayed because criminal proceedings may have been initiated or are being contemplated: “(m)uch useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings” ((H.M. Government, 2006b, at p. 173).

3.4.9. The Investigation of Complex (Organized or Multiple) Abuse

Special considerations apply when there is an allegation of *complex abuse*, which is defined as abuse “involving one or more abusers and a number of children” (H.M. Government, 2006b, at p. 149). Abusers may be acting in collusion with each other or may be taking advantage of a position of authority or exploiting their access to a particular institution or organization. The police and social workers who investigate complex abuse may need to call upon specialist skills in light of the number of individuals and locations involved and the possibility that the abuse occurred over an extended time frame.

Working together to safeguard Children notes that, while much attention has been paid to abuse in residential institutions, complex abuse may also “occur in day care, in families, and in other provisions such as youth services, sports clubs and voluntary groups” (H.M. Government, 2006b, at p. 149). The policy guiding the investigations of this type of abuse is articulated in detail in *Complex Child Abuse Investigations: Inter-agency Issues* (Home Office and Department

of Health, 2002). Emphasis is placed on effective inter-agency cooperation, comprehensive planning and the need to focus on the welfare of the sexually abused children or adult survivors of such abuse. The most important aspect of inter-agency cooperation is the routine exchange of information. The responsibility for the investigation of complex cases of sexual abuse should be undertaken as a joint operation by the police and social services, with the early involvement of the Crown Prosecution Service (CPS) (Home Office and Department of Health, 2002, p. 5). Although the CPS is an independent agency and is not directly involved in day-to-day police operations, it may offer valuable advice to the police concerning the legal ramifications of police actions in the event of a criminal trial. It is emphasized that there should be “continuous advice and interaction between each agency throughout the investigation and any resulting prosecution” (Home Office and Department of Health, 2002, p. 5).

3.4.10. Investigation of Allegations of Sexual Abuse Made against Individuals who work with Children

Of particular interest in the context of this report is the existence of government guidelines concerning the investigation of allegations of sexual abuse made against persons who work with children. *Working together to safeguard Children* explicitly stipulates that “all allegations of abuse or maltreatment of children by a professional, staff member, foster carer or volunteer must therefore be taken seriously and treated in accordance with consistent procedures” (H.M. Government, 2006b, at p 152).

The guidelines note that, where allegations of this type are made, there may be up to three different investigative processes occurring simultaneously: (i) a police investigation of a possible criminal offence; (ii) an enquiry or assessment by children’s social care services in order to determine whether a child is in need or protection and/or services; and (iii) a consideration by the

agency concerned of possible disciplinary action against the staff member who is the subject of the allegation (H.M. Government, 2006b, at p. 239).

The LSCBs are charged with the responsibility of ensuring that appropriate inter-agency procedures are in place in order to respond to such allegations in an expeditious manner and to monitor and evaluate the effectiveness of the measures taken. Furthermore, each organization which provides services to children directly or which supplies staff or volunteers to work with, or care for, children is required to establish and implement an appropriate procedure for dealing with allegations of sexual abuse which may be made in this context. Any procedure which is developed for this purpose must be consistent with guidelines which are articulated in Appendix 5 of *Working together to safeguard Children*. Furthermore, each member organization of the LSCB should designate a specific senior officer who will assume the overall responsibility of ensuring that the organization actually operates a procedure which complies with these guidelines. *Working together to safeguard Children* also states that police departments should appoint specific officers to carry out similar functions. A senior police officer should oversee the operation of any arrangements which are made in this respect, liaise with the LSCBs in his or her policing area, and secure compliance (H.M. Government, 2006b, at p. 152).

Most significantly, the guidelines emphasize that the procedures established by other agencies should designate a senior manager (as well as an alternate) to whom any allegations concerning a member of their staff or one of their volunteers should be reported (H.M. Government, 2006b, at p. 242). Furthermore, every staff member or volunteer must be made aware of the identity of the individual who is designated for this purpose. In order to ensure that allegations of abuse are responded to in a timely, consistent and comprehensive manner, each

agency's procedures should include how to contact the designated officer in the Local Authority who carries the responsibility for furnishing advice, maintaining liaison, and monitoring the progress of cases.

The guidelines make it clear that it is vital that all allegations are seen to be acted upon and that they are examined by an individual who is independent of the agency concerned. To this end, the Local Authority's designated officer should be kept informed of all allegations brought to the attention of an agency and he or she will then be in a position to consult with police and social care colleagues as necessary (H.M. Government, 2006b, at p. 242). The Local Authority's designated officer should be notified whenever an allegation is brought directly to the attention of the police or to children's social care services. The designated officer will also ensure that an appropriate process is implemented for informing the parents or carers of a child of an allegation made against an employee or volunteer. Where the police or social care workers are likely to become involved, the designated officer should consult with these individuals as to the best method of informing parents or carers of allegations made against individuals caring for their children (H.M. Government, 2006b, at p. 242).

It is certainly noteworthy that government guidelines emphasize the need to provide appropriate levels of support to children who are at the centre of allegations of sexual abuse by persons who work with, or care for, them (H.M. Government, 2006b, at p 153). Wherever possible, sufficient information should be furnished to enable children and their parents or carers to understand the nature and outcome of an enquiry or disciplinary process. The guidelines (H.M. Government, 2006b, at p 153) also address the rights of those individuals who are the subject of allegations of sexual abuse:

Staff, foster carers, volunteers and other individuals about whom there are concerns should be treated fairly and honestly, and should be provided with support throughout the investigation process, as should others who are involved. They should be helped to understand the concerns expressed and the processes being operated, and be clearly informed of the outcome of any investigation and the implications for disciplinary or related processes. However, the police and other relevant agencies should always be consulted before informing a person who is the subject of allegations that may possibly require a criminal investigation.

If an employee has been suspended during an investigation, the agency concerned is required to implement a process whereby the employee is kept abreast of developments in the work place and, if he or she is a member of a union or professional association, he or she should be advised by the agency to contact that body (H.M. Government, 2006b, at p. 240).

The need for individuals who are accused of having engaged in child abuse to receive meaningful support during the process of investigation has been underscored by a study by Nixon (1997), who examined the support furnished to foster carers who had experienced an allegation of abuse against a member of their immediate family. The foster carers, who were questioned about their emotional responses to an allegation of abuse, expressed “shock, anger, bitterness and a sense of isolation” (at p. 918). About three-quarters of the foster carers indicated that they did not use the formal support offered by the relevant child care agency (at p. 919). For these individuals, there was a “lack of congruence between the type of support they needed and the support provided by the child-care agency” (at p. 926). Foster carers were more likely to seek support from family members or other foster carers. The study concluded that foster carers need to be prepared in advance for the possibility that allegations may be made by children in their care and that the most useful role which may be played by social workers is to “encourage and enable foster carers to establish their own close network of personal support in anticipation of such events” (at p. 913).

In general, the government guidelines emphasize that every effort must be made to ensure confidentiality while the investigative process is continuing (H.M. Government, 2006b, at p. 240). An investigation should not be terminated merely because the employee concerned resigns or no longer offers his or her services to the agency involved (H.M. Government, 2006b, at p. 152). It is considered important to reach a conclusion concerning an allegation even if the person against whom it has been made refuses to cooperate. Similarly, the guidelines proscribe the use of so-called “compromise agreements” in such cases. These are arrangements “by which a person agrees to resign, the employer agrees not to pursue disciplinary action, and both parties agree a form of words to be used in any future reference.” Such agreements will have no effect in relation to any investigation by the police and they cannot override an agency’s statutory duty to make a referral where the circumstances dictate it (H.M. Government, 2006b, at p. 241).

The standard procedures, endorsed by the guidelines, enshrine an important element of monitoring. Indeed, the Local Authority’s designated officer has a central role to play in monitoring the progress of cases by engaging in review-of-strategy discussions with the agencies involved or by maintaining contact with the police and children’s social care services or with the agency which is responsible for the individual who is the subject of an allegation. The guidelines dictate that review sessions should occur at biweekly or monthly intervals, according to the complexity of the case concerned.

When a strategy discussion or an initial evaluation determines that a police investigation is warranted, the police are required to name a specific date for reviewing the progress of the investigation and consulting with the Crown Prosecution Service to determine whether to charge the alleged abuser, continue with their inquiries or drop the case. Whenever it is feasible to do

so, this review should take place within one month of the initial meeting between the interested agencies (H.M. Government, 2006b, at p. 244).

Either the police or the CPS should inform both the agency whose employee or volunteer has been the subject of allegations and the Local Authority's designated officer of the final outcome of a criminal investigation, whether or not it culminates in a trial which produces a final verdict. Furthermore, agencies are required to keep appropriate records of any allegations made against an employee, including a comprehensive summary of the action taken as well as the resolution or outcome of the case (H.M. Government, 2006b, at p. 241).

The guidelines also deal with cases of historical abuse, which generally arise after adults have reported sexual abuse which they experienced as children. It is stipulated that allegations of historical abuse should be dealt with in the same manner as current allegations (H.M. Government, 2006b, at p 153).

Finally, the guidelines accentuate the need to ensure that the broader implications of specific cases are duly taken into account. If an allegation of abuse is substantiated, the senior managers of the organization(s) concerned are exhorted to ponder any lessons which may be learned from the case and whether any remedial action is required. In certain cases, the "serious case review" procedure should be implemented (H.M. Government, 2006b, at p 154).

Overall, the guidelines in England and Wales have established a strikingly detailed framework for the protection of children and youths from abuse. They ensure that all allegations of abuse are treated seriously while simultaneously protecting the rights of those individuals against whom such allegations have been made. The various agencies concerned as well as the

police are required to cooperate closely and, where appropriate, to share information to the fullest extent possible. The guidelines also articulate, with considerable clarity, the lines of responsibility in the ongoing task of protecting children from abuse. In addition, the guidelines identify specific individuals who are responsible for ensuring that there is an efficient information flow between relevant agencies as well as the police. Furthermore, the guidelines create a child protection framework within which there are well-defined review sessions involving the various agencies concerned and a formal process for reviewing the implications of specific cases for the general operating procedures of agencies whose employees have been the object of allegations of child abuse. In addition to underscoring the need for effective inter-agency cooperation, the guidelines also place great emphasis on the requirement that investigations into allegations of institutional abuse of children be transparently independent. Finally, the relevant statutory provisions and guidelines have created a unique role for the National Society for the Prevention of Cruelty to Children, which has the statutory power to launch independent investigations into child abuse and to apply directly to the family court for Care and Supervision Orders in order to protect children who are at risk for abuse.

References

Australia

- Ainsworth, F. (2002). Mandatory reporting of child abuse and neglect: Does it really make a difference? *Child and Family Social Work*, 7 57-63.
- Ainsworth, F. & Hansen, P. (2006). Five tumultuous years in Australian child protection: Little progress. *Child and Family Social Work*, 11 33-41.
- Beyer, L. R., Higgins, D. J., & Bromfeild, L. M. (2005). *Understanding organisational risk factors for child maltreatment: A review of literature*.
- Boltje, C. (1998). The Interagency Child Abuse Assessment Panel: Future Directions in Child Protection for Southern Australia. South Australia Police. Paper presented at conference on Partnerships in Crime Prevention.
- Crime and Misconduct Commission (2003). *Seeking justice: An inquiry into how sexual offences are handled by the Queensland criminal justice system*. Brisbane: Crime and Misconduct Commission.
- Hatty S.E. & Hatty, J. (2001). Australia. In B.M. Schwartz-Kenny, M. McCauley, & M.E. Epstein (2001). *Child abuse: A global view*, pp. 17-32. Westport: Greenwood Press.
- Hawkins, R. M. F. & Briggs, F. (1997). The institutionalised abuse of children in Australia: Past and present. *Early Child Development and Care*, 133 41-55.
- Higgins, D., Bomfield, L., & Richardson, N. (2007). Mandatory reporting of child abuse. National Child Protection Clearinghouse, Resource Sheet No. 3. Institute on Family Studies. Retrieved May, 2008 from <http://aifs.gov.au/nch/pubs/sheets/rs3/rs3.html>
- Human Rights and Equal Opportunity Commission (1997). *Bringing them home: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Sydney: Human Rights and Equal Opportunity Commission.
- James, M. (2000). Child abuse and neglect: Part 1 - Redefining the issues. Australian Institute of Criminology [On-line]. Available: www.aic.gov.au/publications/tandi/tandi146.html
- Layton, R. (2003). Our Best Investment - A State Plan to Protect and Advance the Interest of Children. Child Protection Review. Government of South Australia.
- National Child Protection Clearinghouse. Australian Institute of Family Studies. (May, 2007). Police Clearances and Checks. Retrieve on May, 2007 from <http://www.aifs.gov.au/nch/resources/police/policechecks.html>

- NSW Commission for Children and Young People (n.d.) Working With Children Check. Retrieve on May, 2008 from <http://www.kids.nsw.gov.au/kids/check.cfm>
- Senate Community Affairs Reference Committee (2001). *Lost Innocents: Righting the Record - Report on child migration*. Canberra: Parliament House.
- Senate Community Affairs Reference Committee (2004). *Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children*. Canberra: Parliament House.
- Senate Community Affairs Reference Committee (2005). *Protecting vulnerable children: A national challenge*. Canberra: Parliament House.
- Working With Children (Criminal Record Checking) Act 2004. Retrieved on May, 2008 from <http://www.checkwwc.wa.gov.au/checkwwc/About+WWC+Check/Publications+and+Forms/Legislation.htm>
- Working With Children Screening Unit. Department of Child Protection (August, 2007). Working With Children (Criminal Record Checking) Act, 2004 - Summary of Key Features. Retrieved on May, 2008 from <http://www.checkwwc.wa.gov.au/checkwwc>

England and Wales

- Baldwin, N. (1990). *The power to care in children's homes*. Aldershot: Avebury.
- Barter, C. (1998). *Investigating Institutional Abuse*. London: NSPC. Summary at http://www.nspcc.org.uk/inform/publications/downloads/investigatinginstitutionalabuseofchildren_pdf_gf25461.pdf
- Barter, C. (1999). Practitioners' experiences and perceptions of investigating allegations of institutional abuse. *Child Abuse Review*, 8, 392-404.
- Brannan, C., Jones, R., and Murch, J. (1993). *Castle Hill Report: Practice Guide*. Shrewsbury: Shropshire County Council.
- Bridge, G., & Street, C. (2001). When Things Go Wrong: Being an Independent Person under the Children Act 1989 Complaints Procedure. *Social Policy & Administration*, 35, 716-731.
- Cawson, P., Wattam, C., Brooker, S. and Kelly, G. (2000) *Child maltreatment in the United Kingdom: a study of the prevalence of child abuse and neglect*. London: NSPCC. ISBN: 1842280066. Executive summary available at: http://www.nspcc.org.uk/Inform/Publications/Downloads/ChildMaltreatmentInTheUKExecutiveSummary_pdf_gf25453.pdf

- Clyde, J. J. (1992). *The Report of the Inquiry Into the Removal of Children From Orkney in February 1991*. London: Her Majesty's Stationery Office.
- Corby, B., Doig, A., and Roberts, V. (1998). Inquiries into child abuse. *Journal of Social Welfare and Family Law*, 20, 377-395.
- Criminal Records Bureau (2007). Web site: <http://www.crb.gov.uk>.
- D'Arcy, M. & Gosling, P. (1998). *Abuse of trust: Frank Beck and the Leicestershire children's homes scandal*. London: Bowerdean.
- Department of Health (UK). (2000). *Framework for the Assessment of Children in Need and their Families*. London: Her Majesty's Stationery Office. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256
- Department of Health and Social Security and Welsh Office. (1988). *Working together: A guide for arrangements for Inter-Agency Cooperation for the protection of children from sexual abuse*. London: Her Majesty's Stationery Office.
- Department of Health. (1991). *Working Together under the Children Act 1989: A Guide to Arrangements for Inter-Agency Co-Operation for the Protection of Children from Abuse*. London: Her Majesty's Stationery Office.
- Gallagher, B. (1998). *Grappling with Smoke: Investigating and Managing Organised Abuse - A Good Practice Guide*. London: NSPCC.
- Gallagher, B. (1999). The abuse of children in public care: Invited literature review. *Child Abuse Review*, 8, 357-365.
- Gallagher, B. (2000). The extent and nature of known cases of institutional child sexual abuse. *British Journal of Social Work* (2000) 30, 795-817.
- Great Britain. Home Office and Department of Health. (1992). *Memorandum of good practice on video recorded interviews with child witnesses for criminal proceedings*. London: Her Majesty's Stationery Office.
- Great Britain. Home Office. (2002). *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, Including Children*. London: Her Majesty's Stationery Office.
- Greater Manchester Police (1995). *Family Support Section VA 3/7. Departmental Child Abuse Statistics, 1994*. Manchester: Greater Manchester Police.
- Hobbs, G., & Hobbs, C.J. (1999). Abuse of children in foster and residential care. *Child Abuse & Neglect*, 23, 1239-1252.

- Home Office. 1986. *Protection of children: disclosure of criminal background of those with access to children*. Circular HOC (86) 44.
- Home Office. 1993. *Protection of children: disclosure of criminal background of those with access to children*. Circular HOC 47/93.
- Home Office and Department of Health. (1992). *Memorandum of good practice on video recorded interviews with child witnesses for criminal proceedings*. London: Her Majesty's Stationary Office.
- Home Office and Department of Health. (2002). *Complex Child Abuse Investigations: Inter-agency Issues*. London: HMSO. http://police.homeoffice.gov.uk/news-and-publications/publication/operational-policing/child_abuse_guidance.pdf?view=Binary
- H.M. Government. (2006a). *What to do if you're worried a child is being abused*. London: The Stationery Office. <http://www.everychildmatters.gov.uk/files/34C39F24E7EF47FBA9139FA01C7B0370.pdf>
- H.M. Government. (2006b). *Working together to safeguard children: A guide to inter-agency working to safeguard the welfare of children*. London: The Stationery Office. <http://www.everychildmatters.gov.uk/files/AE53C8F9D7AEB1B23E403514A6C1B17D.pdf>
- Kent, R. (1997). *Children's Safeguards Review*. Edinburgh: Scottish Office.
- Lloyd, S., & Burman, M. (1996). Specialist police units and the joint investigation of child abuse. *Child Abuse Review*, 5, 4-17.
- National Society for the Prevention of Cruelty to Children (2007). *Independent Child Protection Action*. London: NSPCC. Online. http://www.nspcc.org.uk/inform/publications/downloads/core15icpa_pdf_gf25248.pdf
- Nixon, S. (1997). The limits of support in foster care. *British Journal of Social Work*, 27, 913-930.
- Nunno, M.A. and Motz, J.K. (1988). The development of an effective response to the abuse of children in out-of-home care. *Child Abuse and Neglect*, 12, 521-528.
- Oxburgh, G., Williamson, T., & Ost, J. (2005). Police officers' use of emotional language during child sexual abuse investigations. University of Portsmouth web site: http://www.port.ac.uk/departments/academic/psychology/staff/downloads/filetodownload_62636.en.pdf
- Pigot, T. (1989). *Report of the Advisory Group on Video Evidence*. London: HMSO.

- Soothill, K., Francis, B.J., & Ackerley, E. (1998). Paedophilia and paedophiles. *New Law Journal*, 148: 882-83.
- Stanley, N., Manthorpe, J., and Penhale, B. (1999). *Institutional Abuse: Perspectives across the Life Course*. London, Routledge.
- Sternberg, K.J., Lamb, M.E, Davies, G.M., & Westcott, H.L. (2001). The Memorandum of Good Practice: theory versus application. *Child Abuse & Neglect*, 25: 669-68.
- Sullivan, L., & Beech, A. (2002). Professional Perpetrators: Sex Offenders Who Use Their Employment to Target and Sexually Abuse the Children With Whom They Work. *Child Abuse Review*, 11: 153-167.
- Sullivan, L., & Beech, A. (2004). A comparative study of demographic data relating to intra- and extra-familial child sexual abusers and professional perpetrators. *Journal of Sexual Aggression*, 10, 39-50.
- Thomas, T. (2001). Preventing Unsuitable People from Working with Children -the Criminal Justice and Court Services Bill. *Child Abuse Review*, 10: 60-69.
- Utting, W. (1991). *Children in the Public Care: A Review of Residential Child Care*. London: HMSO.
- Utting, W. (1997). *People like us: The report of the review of the safeguards for children living away from home*. London: HMSO.
- Wagner, R. (1987). *Residential Care – A Positive Choice*. London: HMSO.
- Waterhouse Report. (2000). *Lost in care: report of the Tribunal of Inquiry into the abuse of children in care in the former county council areas of Gwynedd and Clwyd since 1974*. London: The Stationery Office.

United States:

- Carbino, R. (1991). Consequences of child abuse allegations for foster families: Report of a symposium University of Wisconsin-Madison: School of Social Work.
- Everson, M. D., Boat, B. W., Bourg, S., & Robertson, K. (1996). Beliefs among professionals about rates of false allegations of child sexual abuse. *Journal of Interpersonal Violence*, 11, 541-553.
- Jones, L. M., Cross, T. P., Walsh, W. A., & Simone, M. (2005). Criminal investigations of child abuse: The research behind "best practices". *Trauma, Violence & Abuse*, 6, 254-268.
- Kopels, S., Charlton, T., & Wells, S. J. (2003). Investigation laws and practices in child protective services. *Child Welfare League of America*, LXXXII, 661-685.

- McCauley, M, Schwartz-Kenny, B.M., Epstein, M.A., & Tucker, E.J. (2001). United States. In B.M. Schwartz-Kenny, M. McCauley, & M.A. Epstein's (eds) *Child Abuse: A Global View*. Westport: Greenwood Press.
- Pence, D. & Wilson, C. (1992). The role of law enforcement in the response to child abuse and neglect. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, National Center on Child Abuse and Neglect.
- Pence, D. M. & Wilson, C. A. (1994). Reporting and investigating child sexual abuse. *The Future of Children*, 4.

4.0 BRITISH COLUMBIA

4.1. Introduction: The Provision of Services to Youth and Children in B.C.

In British Columbia, as in other Canadian jurisdictions, a variety of agencies may respond to, and undertake an investigation of, allegations of child abuse against an individual who is providing services to youth and children. Which agencies are responsible for handling allegations of abuse largely depends on the nature of the abuse and the specific context within which the alleged abuse occurred. Very generally, the province's child protection services are responsible for responding to, and where appropriate, investigating allegations of child abuse both in residential situations (i.e. abuse by parents, other family members, or caregivers) and in any circumstances in which, while the abuse occurs outside of the child's home, the parent or caregiver is unable, or unwilling, to protect the child from the abuse. For the purposes of this report, it is noteworthy that, in British Columbia, child protection agencies will investigate allegations of abuse in foster homes. However, it is less likely that they will investigate an allegation of abuse in a non-residential or community setting. In this instance, the police would be the principal agency responsible for investigating the allegation, provided that the abuse would be considered a crime under the *Criminal Code* of Canada. However, the police may also become also involved in a child protection investigation that involves a potential criminal offence, even in a residential setting. In these situations, there will be a joint investigation involving both the police and child protection services. Other parties may be involved in an investigation as well. For instance, individual service providers or non-profit organizations may be directly or indirectly involved as well as First Nations bands or representatives and medical professionals. In B.C., 'Suspected Child Abuse and Neglect (SCAN)' teams - which can include doctors, nurses,

mental health workers, and social workers - can be involved in investigating cases of suspected child abuse (Jarchow, 2004). Before examining how allegations of sexual abuse against government or non-profit employees or volunteers are handled, it is important to consider who is providing services to youth, how these services are being administered, and what types of services are available.

4.1.1. The Ministry of Children and Family Development

In British Columbia, the Ministry of Children and Family Development (MCFD) is responsible for providing services to youth and children, with the exception of education. The Ministry was established in 2001, replacing the Ministry of Children and Families, which was created only a few years earlier in 1996. The creation of the Ministry of Children and Families resulted in a significant reorganization of the process by means of which the province administers services to youth and children by transferring services provided to children and youth by the Ministries of Education, Health, Social Services, the Attorney General, and Women's Equality to the newly created Ministry of Children and Families (CFS, 2002). The current ministry's (MCFD) general responsibilities include the following:

- Child protection and family development
- Adoption
- Foster care
- Early child development and child care
- Child and youth mental health
- Youth justice and youth services
- Special needs children and youth
- Adult community living services

The ministry's authority to provide and oversee services in these areas is rooted in a variety of different statutes and regulations: for the purposes of this report, the most important statute is the *Child, Family, and Community Services Act* (1996), which furnishes the ministry with its child

protection powers. Child protection services are provided to communities in five different provincial regions – Vancouver Island, Vancouver Coastal, Fraser, Interior, and North (MCFD website, 2007). In each region, the ministry delegates child protection powers to regional directors as well as to Aboriginal child welfare agencies, which, in turn, delegate the authority to investigate child abuse allegations and other child protection concerns to ministry staff members.

Children may fall under the guardianship of the ministry either voluntarily (the family agrees to place their children in the care of the ministry because they are no longer able to care for them) or if there is a child protection concern. When a child is placed under ministry care, the ministry is responsible for meeting the child's entire needs through the provision of foster homes, group homes, and specialized resources. A crucial component of B.C.'s child protection system is the network of foster homes which care for the children who can no longer remain with their families. There are approximately 10,000 children in government care in B.C. and 4,000 foster or group homes (MCFD, 2007). The level of care which a foster home provides depends on the particular child's needs and the home's qualifications. Foster homes can be designated either as 'regular homes', which care for children who do not need extra supervision, or as 'specialized homes'. Specialized homes are categorized as offering care at levels one, two or three, thereby rendering it possible to provide a level of care which best meets an individual child's needs. Restricted homes consist of families which care for children with whom they have a pre-existing relationship - typically a member of the child's extended family. Respite or relief homes provide short-term care for children whose parents or guardians need a brief break from their parenting duties.

Departing to some extent from the practice followed in other Canadian provinces, British Columbia's MCFD is responsible for the administration of youth justice in the province, along with the Ministry of Public Safety and the Solicitor General and the Ministry of the Attorney General. More specifically, the MCFD provides youth-custody services and community-youth-justice services. The ministry employs approximately 130 youth-probation officers who are responsible for the supervision of young offenders in the community.

4.1.2. Non-Profit Service Providers

Non-profit service providers may provide a wide variety of services to children and youth, ranging from recreation and leisure activities to mentoring and child welfare services. Child welfare services are often contracted out to non-governmental organizations by the MCFD. For example, non-profit organizations operate group homes, oversee foster homes, and provide youth-probation services. Organizations which are contracted to provide services for the MCFD are expected to follow provincial policies and guidelines for responding to, and preventing, child abuse and they are also encouraged to have their own policies in place. Larger community organizations which provide services for the MCFD must be accredited to ensure that they have reached an appropriate level of competence, have accountability mechanisms in place, and can provide quality services to clients.

4.1.3. The Office of the Representative for Children and Youth and the Office of the Ombudsman

British Columbia has two independent offices that can receive and investigate complaints about provincial public services. The Office of the Ombudsman is the province's general body for investigating and hearing complaints that citizens may have concerning the services which are provided to them by the provincial government. Complaints about rudeness, delays in service,

oppressive or unlawful behaviour on the part of service providers, etc., may be investigated by the Ombudsman. It is, therefore, possible that the Ombudsman could hear a complaint about the abuse of a child while receiving services from the provincial government. However, the province also has an advocacy office specifically for children and youth in the care of the provincial government, the newly-created Office of the Representative for Children and Youth. This office supports children, youth, and families who need help dealing with the child-welfare system and can hear complaints about that system. The staff members of the Office are also empowered to hear complaints from youths in detention centres. The Representative has the authority, under the *Representative for Children and Youth Act (2006)*, to review the conduct of investigations into child deaths and injuries and may, in certain circumstances, undertake his or her own investigations into child deaths and critical injuries. The Representative also reviews, monitors, and audits programs and services provided to children and youth and advocates for improvements to the system itself. Both bodies are responsible to the provincial legislature but are independent of any political party or ministry.

In her report on child advocacy, McBride (2006) suggests that child advocacy was not offered as a provincial service in B.C. until 1995, notwithstanding earlier recommendations by the province's Ombudsman that an office be created for this purpose. In 1989, the City of Vancouver created a Child and Youth Advocate Office but this service did not extend to other regions of the province. In 1995, the *Child, Youth, and Family Advocacy Act* was passed and the Office of the Child, Youth, and Family Advocate was created. The office was created to ensure the rights and interests of children and their families were protected, that children and families had access to complaint procedures and reviews, and to provide governments and communities with advice on service for children and youth. Shortly after the Child, Youth, and Family

Advocate's office was created, a Children's Commission was appointed to monitor services provided to children and youth and make recommendations for how to improve those services. The role of this organization was not to advocate for any single child but it did review deaths and serious injuries to children while in state care. It is also noteworthy that, prior to the enactment of *Child, Family, and Community Services Act* in 1994, there was no complaints process for children and youth under the care of the state. Complaints had to be made to individual staff members or supervisors of an organization (McBride, 2006).

In the years between 1995 and 2002, the Office of the Child, Youth, and Family Advocate was increasingly critical of the provincial government's lack of progress in meeting the needs of the provinces children and youth. In 2002, the Office for Children and Youth replaced the Child, Youth and Family Advocate and the Children's Commission. This change was made to consolidate the oversight and advocacy functions previously provided by the Child, Youth, and Family Advocate and the Children's Commission. The new Children and Youth Office was meant to facilitate self-advocacy, provide advice, and help children and families get in touch with local advocates rather than act as direct advocates themselves (McBride, 2006). The subsequent creation of the Office of the Representative of Children and Youth in 2006 was initiated by the release of an independent review of B.C.'s child protection services. *The B.C. Children and Youth Review* (Hughes, 2006) recommended wide-scale changes to the province's child-welfare system. One change which emerged from this review was the creation of the Office of the Representative of Children and Youth.

4.2. Overview of Relevant Legislation

As noted previously, the authority to investigate and intervene in instances of suspected child abuse is derived from the *Criminal Code* and provincial child protection statutes. British Columbia's current child protection legislation is embodied in the *Child, Family, and Community Services Act (CFCSA)*, enacted in 1996. Under the provisions of the Act, the MCFD is mandated to protect children from harm and to intervene when there is reason to believe that a child is being harmed or is likely to be harmed. The Minister of MCFD delegates child protection authority to the Director of Child Protection who, in turn, delegates this authority to child protection agencies throughout the province. The Act, along with the *Criminal Code*, authorizes the police to intervene when an officer suspects a child is in immediate danger or is a victim of a crime. The *CFCSA* is also the legislative foundation for provincial child abuse protocols and policies.

The *CFCSA* is premised on the general principle that the safety and well-being of children are the paramount concerns in any action arising from the legislation. More specifically, the *Act* recognizes that children are entitled to protection from abuse, neglect, harm, and the threat of harm. The *Act* is also premised on the principle that kinship ties are important and that the family is the preferred environment for a child, that a child's Aboriginal identity must be preserved, and that decisions concerning children need to be made in a timely manner and should consider the opinion of the child. Under this *Act*, a child is defined as any person who is under the age of 19 years.

The *CFCSA* specifies the circumstances in which a child is to be considered as being in need of protection and imposes a corresponding duty to report child abuse and neglect. In this respect, Section 13 of the *Act* states as follows:

13 (1) A child needs protection in the following circumstances:

- (a) if the child has been, or is likely to be, physically harmed by the child's parent;
- (b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
- (c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;

This section also outlines a number of additional circumstances in which a child needs protection from emotional abuse, neglect, and a failure to provide necessary medical treatment.

Section 14 of the *CFCSA* establishes the legal duty to report to child protection services any situations where there is reason to believe that a child is in need of protection. This duty applies equally to both members of the public and professionals and it must be performed even in situations where confidentiality is typically assured (lawyer-client relationships are the exception). Failing to carry out this duty is an offence. The duty, offence, and penalties are as follows:

14 (1) A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director.

(2) Subsection (1) applies even if the information on which the belief is based

- (a) is privileged, except as a result of a solicitor-client relationship, or
- (b) is confidential and its disclosure is prohibited under another Act.

(3) A person who contravenes subsection (1) commits an offence.

(4) A person who knowingly reports to a director, or a person designated by a director, false information that a child needs protection commits an offence.

(5) No action for damages may be brought against a person for reporting information under this section unless the person knowingly reported false information.

A person who commits an offence under this section is liable to a fine of up to \$10 000 or to imprisonment for up to 6 months, or to both.

(7) The limitation period governing the commencement of a proceeding under the *Offence Act* does not apply to a proceeding relating to an offence under this section.

Taken together, sections 13 and 14 establish a legal duty to report to child protection services child any abuse which has been perpetrated by a parent. Abuse by someone other than a parent only needs to be reported when the child's parent is unable or unwilling to protect him or her from harm or the likelihood of harm. In other words, there is only a limited legal duty to report third-party abuse in British Columbia and third-party abuse falls outside the mandate of child protection services, unless a parent has failed to protect their child. This is a different legal situation from that which exists in Nova Scotia, where there is a legal duty to report third-party abuse and it has important ramifications in terms of determining who will be held responsible for investigating and responding to allegations of abuse against service providers. The following discussion of current protocols and policies will outline the roles and responsibilities of the different agencies and organizations involved in responding to abuse by service providers.

4.3. Current Policies and Protocols

The development of policies or protocols is the responsibility of an individual organization, agency or ministry. However, the provincial government has issued province-wide guidelines for the conduct of official responses to child abuse and neglect. *The Handbook for Action on Child Abuse and Neglect* (2003) and the 2007 version of the *Handbook* for service providers are directed towards all service providers who work with children and youth and

outline the reporting requirements, the responsibilities of different agencies in an investigation, intervention services, and prevention strategies. Some aspects of the *Handbook* are specific to different agencies that play a key role in preventing - and responding to - child abuse, such as the police, child protection services, and schools. Table 1 provides an overview of the agencies/organizations which are responsible for investigating child abuse in different scenarios. These will be discussed in more depth in the corresponding subsections of this report. In addition to protocols for specific agencies, the *Handbook* also includes general provisions which are applicable to all service providers. The following discussion constitutes a brief overview of these provisions.

The Handbook is an inter-ministerial document¹ and was created with the help of different community organisations and agencies. It is designed to ensure that responses to child abuse are effective, consistent and sensitive to the needs of children. It is also meant to ensure that service providers are aware of the relevant provincial laws and government policies and that service providers work collectively with one another when responding to allegations of child abuse. This represents a manifestation of the philosophy that child protection is the responsibility of all persons working with children and youth and that a multidisciplinary approach to preventing and responding to child abuse is the most effective course to pursue.

¹ The authors of the Handbook include the Ministry of Children and Family Development, the Ministry of the Attorney General, the former Ministry of Community, Aboriginal, and Women's Services, the Ministry of Education, the Ministry of Health Services, and the Ministry of Human Resources.

Table 1: Agency/Organizations Responsibility for Investigating Child Abuse¹

| Purpose | Agency or Organization Responsible |
|--|--|
| To determine if a child needs protection | Child protection workers |
| To determine whether a criminal offence has occurred | The police |
| To investigate where there has been a report of child abuse or neglect by an employee, contracted, service provider, volunteer or student at an educational institution | The superintendent of schools or appropriate senior authority of the educational institution |
| To review the status of a facility's licence when there is a report of child abuse or neglect in a facility that is or should be licensed under the <i>Community Care Facility Act</i> , such as a child care facility or group home | The medical health officer |
| To investigate when there is a report of child abuse or neglect in other settings (e.g. hospitals, volunteer organizations such as athletic teams, etc.) | The head of the organization |
| To investigate where there has been a report of child abuse or neglect by an employee, contracted service provider, or volunteer at a youth custody centre | The director of the youth custody centre |
| To investigate professional conduct of a member belonging to a regulated profession | The registrar of the regulated profession |

1) Source: Adapted from *The Handbook for Action on Child Abuse and Neglect*, 2003

4.3.1. Child protection Investigations and Responses

As noted above, the *CFCSA* gives child protection agencies the power to intervene on the behalf of children whose safety and well-being are at risk. Very generally, the role of child protection services is to assess reports of abuse, provide support services, investigate, and collaborate with other services to promote the safety and well-being of children (MCFD, 2007). However, the *CFCSA* does not contain any provisions governing child abuse by third parties.

Roughly translated, the principal mandate of the province's child protection agencies is to ensure the safety of children where the child's parent or guardian either fails to do this or personally poses a danger to the child. For the purposes of this report, this means that child protection workers investigate abuse or neglect perpetrated by a parent or guardian. According to the service providers who were interviewed for this report, child protection services would typically not be involved in an investigation of abuse by a service provider outside of the MCFD, such as a teacher or counsellor, unless there was reason to believe that, while the parent could have reasonably intervened to prevent or stop the abuse, he or she nevertheless failed to do so. In situations where the MCFD is not authorized to formally respond, child protection workers can take on a supportive role by providing advice and assistance to the persons who are responsible for conducting an investigation by ensuring that the information is received by the appropriate person(s) (*Handbook*, 2007). It is the responsibility of the police to investigate third-party abuse (if the abuse constituted a criminal offence), as well as the responsibility of the service provider's organization or agency. Child protection workers may be involved in a secondary fashion to assist the police or organization/agency. They would not lead the investigation, but would rather act in advisory role and lend their expertise and skills (*Handbook*, 2007).

Child protection workers are responsible for investigating abuse in foster homes as well as abuse perpetrated by persons contracted to provide a service to by the ministry. The Ministry will also investigate its own employees, such as an administrator or a social worker. In this instance, there would be an internal investigation by the Ministry, although this would not necessarily be conducted under the auspices of their child protection mandate but rather from a human resources perspective. Any Ministry response will be guided by the *Child and Family Development Service Standards* (2003), which include standards for Child and Family Services

and for Children in Care Services. These standards are applicable to any agency or organization providing services to children or youth under the *CFCSA*, including contracted service providers. The *B.C. Handbook for Action on Child Abuse and Neglect for Service Providers* (2007) is another important source of information on the role of child protection services in investigating and responding to abuse by service providers.

According to the *Service Standards*, child protection investigations are carried out in order to collect information on an alleged incident and to assess the risk of future harm to a child. The investigation begins with a determination as to whether a child is in danger or vulnerable to serious harm because of their age or developmental level. If a child is in danger, the investigation will begin immediately. If the child is not in danger, the investigation will begin within five days. All investigations are to be completed within 30 days and should include seeing and interviewing the child and other children in contact with the alleged perpetrator, as well as interviewing the child's parents and any other individuals who might have information about the abuse. Information from existing client files and any other information relevant to the reported abuse should also be taken into consideration. When an investigation is complete, the results should be reported to the child's family and the person who made the report, when it is considered appropriate and safe to do so.

The *Service Standards* clearly recognize the importance of a multidisciplinary response to child abuse. Where appropriate, and when possible, investigations are to be coordinated with the police and other agencies which might be involved. If the child protection worker has reason to believe that the child has been physically or sexually abused, he or she must immediately report the incident to the police. If the incident involves an Aboriginal child, the investigation must be

carried out in cooperation with the appropriate Aboriginal community or agency. Regional and local child protection offices are expected to create – and develop - protocols for sharing information and coordinating responses during an investigation with police, schools, health authorities, First Nations communities or organizations, and any other groups which work with children. The use of regional protocols opens up the possibility that policy and practice will vary across jurisdictions. It is, therefore, possible that there are differences between interagency protocols for Vancouver and Kelowna. However, we were not able to obtain copies of any regional protocols so we were unable to assess any differences. To mitigate such differences, the MCFD issues guidelines to specify what should be included in regional protocols.

4.3.2. Police Investigations

Unlike child protection workers, the police in B.C. are not limited to responding to abuse perpetrated by parents or service providers under the direction of the MCFD. Police authority to respond to child abuse is drawn from both the *CFCSA* as well as the *Criminal Code*. As such, the police are authorized to respond to incidents of child abuse which constitute *Criminal Code* violations, no matter what the relationship may be between the child and the alleged abuser. Almost all incidents of child sexual abuse are considered a crime. Under the *CFCSA*, the police are granted the authority to assist child protection workers in various duties as well as to take charge of children whom they believe are in immediate danger.

Both municipal police forces and the Royal Canadian Mounted Police (RCMP) operate in B.C. In the Lower Mainland, municipal forces undertake the policing of Vancouver, New Westminster, and Delta and the RCMP are responsible for the remaining districts. The RCMP also provides policing services in Kelowna. Officers from Delta Police, New Westminster Police,

Langley RCMP, and Kelowna RCMP were interviewed for this report. We contacted the Vancouver Police Department but an interview was not forthcoming. The co-existence of multiple municipal police forces alongside RCMP detachments opens up the possibility that a variety of strategies for investigating and responding to child abuse may be employed. For instance, one officer suggested that the manner in which police respond to abuse allegations and the nature of their working relationship with the MCFD would be different for each department. As far as we were able to determine, there is no provincial protocol for investigating child abuse for the police. This circumstance constitutes a significant difference from the situation in Nova Scotia, which issues standard operating procedures for all police forces working in the province.

The set of operating procedures and principles which most closely approximates to a provincial protocol for police is contained in the *Handbook for Action on Child Abuse and Neglect* (2007). The *Handbook* suggests that police and child protection workers should have complementary roles. The role of the police is to ensure the safety of children who are in immediate danger - as they can respond quickly and are trained to handle dangerous situations - and to conduct criminal investigations. Nonetheless, the *Handbook* offers little guidance to police in terms of exactly how they should approach child abuse cases. Joint interviews of the child concerned are recommended when there are concurrent criminal and child protection investigations. It is also recommended that police and child protection workers collaborate, if a medical examination is needed, in order to avoid subjecting the child to a procedure that is more intrusive than is necessary.

Although there appear to be no provincial protocols for police investigations, the *Handbook for Action on Child Abuse and Neglect* implies - and some interviewees from the

MCFD also suggested - that protocols between regional offices and police have been implemented. However, none of the officers from the Lower Mainland who were interviewed appeared to be aware of any such protocols. This suggests that these protocols will have little impact on practice if the officers charged with investigating abuse are unaware of them. The Kelowna RCMP indicated that there were guidelines in place for working with child protection workers and that they were mandated to report all incidents of current child abuse that came to their attention to the MCFD. The Delta Police mentioned that the *Freedom of Information and Protection of Privacy Act (FOIPPA)* governed the process of information sharing with child protection workers as well as other agencies or organizations which might have an interest in the investigation. The police have considerable leeway in relation to the sharing of information about their investigation with child protection workers, but they are unable to simply hand over their files. The Police can also inform other organizations that one of their employees or volunteers is being investigated as well as providing them with the results of the investigation - for example, whether there was insufficient evidence for a criminal charge or, alternatively, that a charge would actually be laid. If an organization wishes to acquire further information about the investigation, it would need to make an access-to-information claim under the *FOIPPA*.

Government-issued policy or service agreements between police and the MCFD are not the only source of policy concerning the conduct of child-abuse investigations. Police forces typically issue standard operating procedures or policing manuals. The officers who were interviewed for this report indicated that there were no specific protocols for investigating child-abuse allegations against service providers and that there were few guidelines for child-abuse cases in general. The Langley RCMP mentioned that there were guidelines for investigating alleged abuse of children under the age of 12 and the Delta and New Westminster Police

indicated that there were procedures for investigating sexual assaults which are applicable to children. The New Westminster Police suggested that these guidelines did not specify how to carry out an investigation – there are general investigation procedures which are the same for any crime – but they simply state that the investigation must be done as judiciously as possible and consider the unique needs and status of the victim, as well as the situation surrounding the crime. Rather than discussing the details of departmental policy, most officers simply gave examples of what they would typically do in a child-abuse investigation.

The Vancouver Police Department publish their *Regulations and Procedure Manual* (2006) online. This manual has specific provisions for investigating sexual assaults, the details of which are not available to the public under the *FOIPPA*. Information that is available suggests that the two most important considerations during a sexual assault investigation are the victim's emotional and physical needs and the preservation of evidence. Investigators should attempt to obtain signed statements from the victim, the person who made the complaint, and any other persons who observed the victim's demeanour and injuries. The Department's specialized sexual assault unit are supposed to conduct the investigation whenever possible and Victims Services can be involved. The *Manual* also contains provisions for the removal of children in situations where their safety is in danger. These provisions outline when an officer can apprehend a child, what paper work they need to complete after an apprehension, and when - and how - they should involve MCFD workers and parents. However, these requirements are not specific to child sexual abuse or situations involving abuse by service providers.

4.3.3. Foster Care

British Columbia has a comprehensive policy for responding to current allegations of child abuse in foster homes. The primary policy document for investigating an allegation of child abuse in foster care is the *'Protocols for Foster Homes'* (1999), which was created by the (then) Ministry of Children and Families in conjunction with the British Columbia Federation of Foster Parents Associations. Other relevant policy documents include the *'Standards for Foster Homes'* (1998), *'Foster Family Handbook'* (1997), *'Practice Standards for Child Protection'* (2003), and *'The B.C. Handbook for Action on Child Abuse and Neglect'* (2007) as well as the pamphlet, *'Dealing with Difficulties in Foster Homes: A Guide for Foster Parents'*.

The provincial guidelines also constitute a framework within which each MCFD region may negotiate individual protocols with foster parents within the region and the B.C. Federation of Foster Parents Association and the Federation of Aboriginal Foster Parents (Human Resources and Social Development Canada, 2006). Both the Vancouver Coastal and Interior (Kelowna) Regions have implemented regional protocols for approximately the past year and a half. Regional protocols include the same information as the provincial protocol but also provide information specific to the region. An interviewee from Vancouver described the Vancouver Coastal Region's protocol as being more streamlined and user-friendly, with few substantive differences from the provincial protocols.

The *Protocol for Foster Homes* (1999) includes procedures for investigating allegations of abuse, for quality-of-care reviews, and for resolving disputes between foster parents and ministry staff. In keeping with the purpose of this report, the following discussion is limited to the protocol for investigating suspected incidents of abuse. However, the protocol begins by

outlining a number of guiding principles for all three sub-protocols. In accordance with the principles outline in the *CFCSA*, the principal purpose of the protocol is to promote the best interests of children in care, to act for their benefit, and to ensure their safety. Beyond this principle, the protocol recognizes that foster parents are a valuable resource to the community and must be treated with respect.

The protocol outlines the duties and responsibilities of all parties involved in an investigation of abuse in a foster home. To begin with, the protocol makes it clear that the same duty to report child abuse and neglect perpetrated by parents also exists in relation to foster parents. Although a protocol does not have the force of law, the investigation protocol suggests that the words, ‘foster parent,’ may be substituted for the word ‘parent’ in s. 13 of the *CFCSA*. This means that child protection workers have the same power to intervene in incidents of suspected abuse and neglect in a foster home as they do in relation to any other residence. The *CFCSA*’s definition of a parent is wide enough to support this interpretation. Section 1 defines a parent as a mother, father, legal guardian, or person with whom the child resides and who stands in the place of the child’s mother or father. In addition to being accorded the status of parents under s. 13 of the *CFCSA*, foster parents are held to a higher standard of care than other parents. For instance, foster parents are not permitted to use any form of physical discipline and the MCFD may intervene in a foster home even if a child protection order is not justified under s. 13 of the *CFCSA*.

Investigating allegations of abuse in foster homes is a complex process that involves a variety of ministry workers and, potentially, the local police, B.C.’s Federation of Foster Parents Associations’ (B.C.FFPA) representatives, contractors, and others. When a child is in foster care,

a social worker is assigned to them and a manager is made responsible for the social worker. Similarly, each foster home has a resource worker who reports to a resource manager. When an allegation of abuse is made against a foster parent, an investigating social worker (not the child's social worker or resource worker) conducts the investigation in accordance with the *Practice Standards for Child Protection* and a protection manager coordinates the investigation. Protection managers are responsible for deciding whether the alleged incident warrants an investigation and whether the child's safety is at risk. They also decide whether or not the child should be removed from the home. Resource managers are responsible for reviewing the investigation findings and deciding whether the foster home should be closed or remain open. If their decision is to keep the foster home open, they must also determine whether the foster family needs additional training, supports, or services. The resource worker acts as a support person for the foster family and keeps them informed about the progress of the investigation. The child's social worker and his/her manager are responsible for supporting the child during the investigation, reviewing their care plan, and assisting in the relocation of the child if they are removed from the foster home.

In addition to ministry workers, B.C. FFPA members can become involved in an abuse investigation in the capacity of a support person. The foster parent under investigation can also ask any other person to participate as a support person. Both a B.C. FFPA member and an independent support person are expected to maintain the confidentiality of the foster parents and their biological and foster children. Contractors are also expected to support the foster family during an investigation and to assist in moving a child, as well as providing additional training, supports, and services when needed. Contractors are not involved in carrying out the investigation or in interviewing individuals involved. Alleged incidents of sexual abuse must be reported to the police who will then decide whether a criminal investigation is warranted.

When an allegation of abuse is made in a foster home, a six-stage process is followed. During the first stage, the reported incident is assessed and the protection manager decides whether the protocol is applicable and if there is any risk to the child. If the manager decides an investigation is necessary, he or she will immediately assign a social worker to the case, take all necessary steps to protect the child, and inform the foster parent of the investigation. Stage two is the investigation stage. The investigation is to be completed within 30 days. An investigation typically involves assessing the safety of other children involved with the alleged perpetrator, interviewing the child, family members, the person who made the initial complaint and others who may have pertinent information. The third stage involves making a decision based on the findings of the investigation as to the care of the child and the status of the foster home. The fourth stage is to inform the foster parent, the child and their social worker, and the contractor of the decision which has been made. The results of the investigation are included in both the foster parents' and the child's files. Following this process, a foster parent who is unhappy with the decision and how the investigation was conducted can request a review of the investigation. The Office of the Director of Child Protection will review the investigation within 30 days. The final stage is to carry out a quality-of-service assurance. Within 30 days, a meeting between ministry staff and the B.C. FFPA is held to decide how to avoid similar incidents in other foster homes and to recommend methods for the prevention of abuse and abuse allegations.

4.3.4. Residential Facilities and Group Homes

The policy structure and organizational framework for handling allegations of abuse in group homes or residential facilities are different from those which apply to foster care. The

difference largely arises out of the requirement that residential care facilities need a licence from the Community Care Facilities Branch of the Ministry of Health. The *Community Care and Assisted Living Act* (CCALA) (2002) requires any facility caring for three or more persons, who are unrelated to the caregiver, to be licensed. Similarly, the MCFD distinguishes between foster care and staffed residential care facilities. Foster care is provided in a family home with no more than one full-time employee (or the equivalent of one full-time employee). Any other type of residential care which is provided to children and youth under the *CFCSA* in the community is considered to be staffed-residential facilities. This includes parent-model group homes² and specialized residential services, but not institutional care such as youth custody facilities. Essentially, this means that both the Ministry of Health, through medical health officers and licensing officers, and the MCFD are responsible for residential services provided under the *CFCSA*. The MCFD is responsible for the safety and well-being of the children they place in residential care as well as for deciding whether the Ministry will continue to use a particular facility. The Ministry of Health has overlapping duties and is responsible for monitoring the quality of care provided to residents and the safety and condition of the physical place.

In addition to licensing requirements from the Ministry of Health, the MCFD has issued standards for residential care and the *Handbook for Action Child Abuse and Neglect* contains guidelines for responding to abuse in residential facilities. The 2003 version of the *Handbook* requires reciprocal notification between the police, child protection services, and medical health officers. As is the case in any child abuse investigation, the police are responsible for any criminal investigation and child protection services determine if there is any risk to children. The

² A parent-model group home is essentially a group home in a family residence which has only one staff member and only cares for a small number of children (four or less). This definition closely resembles the definition of foster home and the distinction between the two is not entirely clear but it is suspected that the distinction may relate to the clients accepted, how the home is funded, and licensing requirements for a parent-model group home.

medical health officer investigates whether the *CCALA* has been contravened and what consequences will be imposed if there has been a contravention of the Act. The medical health officer will also investigate unlicensed facilities and decide what must be done to prevent unlicensed facilities from operating. If needed, the medical health officer can request the help of a child protection worker to assist them in their investigation. A request would typically be made for the purpose of interviewing abused children or other residents in a facility. The operator of a facility is responsible for ensuring the safety of all its residents during an investigation. If the medical health officer feels that they are unable to do this, their licence can be suspended and the residents can be moved. Once the investigation is complete, the medical health officer will decide if the facility can remain open and what, if any, restrictions or requirements will be placed on the facility. It is the responsibility of the organization operating the facility to investigate an accused staff member or volunteer in accordance with the applicable labour-relations or human-resources procedures and to decide which internal response is appropriate in the particular circumstances. This process will be discussed in the following section on non-profit and community organizations. Many residential-care facilities in B.C. are run by community organizations.

The '*Standards for Staffed Children's Residential Services (1998)*' are provisions issued by the MCFD to ensure that children in residential facilities are provided with quality care. The *Standards* are mandatory for any facility providing services under the *CFCSA* and specify the rights of children and youth in care as well as the nature and scope of the complaints processes that must be in place. According to the *Standards*, residential services must also ensure that their clients are free from harm. They must have written policies in place for preventing harm to their clients and they must specify the actions which must be taken if a child or youth is harmed. They must also have written policies which regulate the reporting of abuse allegations to child-

protection services and for screening staff, students, volunteers, or others visiting the facility. Proper documentation and record keeping is mandated and daily safety and wellness checks must be carried out and recorded. The *Standards* require residential facilities to provide their clients with information as to how to contact the police, their social workers, the Children's Help Line, the local licensing body, the Children and Youth Representative, the Ombudsman, their parents when appropriate, and any other relevant contacts, as well as the means to do so.

4.3.5. Youth Justice and Youth Probation

As noted above, the MCFD is responsible for youth justice as well as child protection services in B.C. Despite being housed in the same ministry, child protection workers play a limited role in investigating youth-justice employees who have been accused of abusing a client. In the 2003 version of the *Handbook for Action on Child Abuse and Neglect*, it is specified that, if a child protection worker receives a complaint of abuse in a youth-custody facility, he or she is required to inform the director of the facility, who is then responsible for responding to the allegation. Likewise, if an employee of the custody facility becomes aware of abuse, he or she must inform child protection services. Child protection investigators are responsible for determining if the residents of the facility are at risk, but would typically not become involved if the facility was capable of ensuring the safety of the youths concerned. Similarly, so long as a community corrections agency can demonstrate that it has taken the necessary precautions to protect youths from accused employees, child protection services will not become involved. British Columbia's 2003 *Youth Justice Act* gives the minister of MCFD, or a person appointed by the Minister, the power to investigate a probation officer or an employee or volunteer of a youth custody facility. They have the power to call witnesses and to compel records to be handed over. Furthermore, the *Act* also makes it an offence to obstruct an investigation.

As with any child abuse investigation, the police may become involved if they believe that a crime has been committed. One interviewee suggested that the police are informed of almost any allegation, even if it is not particularly serious in nature, believable, or likely to result in a criminal investigation. Once the police are informed, it is within their discretion to decide if the incident warrants a criminal investigation. Interviewees from both Kelowna and Vancouver suggested that, when there is a complaint of child abuse against an employee, there can be two investigations – a criminal investigation and a civil or internal investigation carried out by the MCFD. The *Handbook for Action on Child Abuse and Neglect* (2007) recommends cooperation between the MCFD, the police, and other relevant organizations in any child abuse investigation. In a slightly different approach, one interviewee from Kelowna suggested that, although youth-justice organizations would cooperate with the police, whenever there are simultaneous police and internal investigations, the latter will often be postponed until the police investigation has been completed.

An internal investigation is carried out even if there is no criminal investigation. It is the responsibility of the supervisor or regional manager of the accused employee to conduct the internal investigation. An investigation would typically involve interviewing the youth concerned and their friends and acquaintances, as well as the accused staff member(s), their co-workers, and current or previous clients. B.C. public servants, including youth justice workers directly employed by the ministry, are unionized. Unions' collective agreements and provincial labour relations legislation, therefore, guide internal investigations. This means that the employee under investigation has the right to union representation and that any course of action decided upon by the ministry is subject to arbitration. There are a variety of responses to an allegation of abuse which will depend upon the outcome of both internal and external investigations, the seriousness

of the allegation, the strength of the evidence, as well as more political concerns such as the reputation of the ministry. Possible responses to employees range from no action, to restricted duties, suspension with or without pay, and, ultimately, dismissal. An employee can dispute any of these responses through the union, in which case the ministry will have to prove the abuse on the balance of probabilities and justify their response in arbitration. Alternatively, a mutually acceptable response may be negotiated between the union and the ministry without resorting to arbitration.

The *Handbook for Action on Child Abuse and Neglect* (2003) outlines the role of the director of a youth-custody facility when a complaint of abuse is made. The director is responsible for the safety of the alleged victim and other youths in the facility. They must also ensure that youths are not interviewed more than is necessary and that their parents or guardians are provided with information about the investigation process and its results. Follow-up plans must be developed to deal with the aftermath of the incident for both the alleged victim(s) and any other persons impacted by the incident, such as staff members or residents. This can involve providing access to counselling, critical incident debriefing, or referrals to different services. In terms of the investigation itself, the director must ensure all persons involved are clear about their roles, mandate, and responsibilities and that the persons under their authority do not interfere with, or compromise, any investigation. They are also responsible for documenting the findings of an internal investigation. Although the *Handbook* does not specifically discuss how an allegation of abuse against a probation officer should be handled, it would presumably follow a similar procedure. Information garnered from interviewees supports this conclusion. Other than the *Handbook for Action on Child Abuse and Neglect* and labour relation's guidelines, we have found no evidence that there are specific protocols for responding to abuse allegations against

probation officers. However, one interviewee suggested that individual custodial institutions have internal policies for handling abuse complaints.

If youth-justice services are provided under contract by a community agency, it will be the responsibility of that agency to carry out the internal investigation and decide on the most appropriate response to the incident. However, this is not to say that the provincial government will have no influence over how an allegation is handled. The MCFD can make suggestions as to how it would prefer an agency to respond to an allegation. For instance, they can suggest that the agency cooperate with the police or that the accused employee or volunteer be dismissed. The community organization is not obligated to follow the Ministry's suggestions; however, it then runs the risk that their contract will be terminated or not renewed, if the ministry believes it no longer provides quality services or is failing to protect the youth with whom they work.

4.3.6. Non-Profit or Community Service Providers

Non-profit or community-service providers can be drawn from a wide variety of organizations. In B.C., government services to children and youth are often contracted out to community organizations. For instance, the MCFD contracts with community organizations to provide and oversee residential facilities, addiction and mental health services, foster care services, etc. Other organizations may be completely independent of the government and may provide services such as addiction treatment, care for disabled children, or leisure and recreational activities. Organizations contracted by the MCFD are expected to abide by the ministry's policies and requirements articulated in legislation such as the *CFCSA* and the *Community Care and Assisted Living Act*. Furthermore, organizations which receive contracts valued at over \$500,000 annually must be accredited by either the Council on Accreditation for

Children and Family Services or the Commission on Accreditation on Rehabilitation Facilities. Obtaining accreditation means that organizations must meet the relevant international practice standards for the provision of quality services. To gain accreditation, an agency needs to demonstrate that it has a policy structure in place to deal with various challenges, including preventing and responding to abuse by employees and volunteers (MCFD website, 2007). Organizations which are not accredited have the discretion to decide whether or not to implement child-abuse protocols. Since individual organizations create their own policies, there can be a wide variety of approaches within given jurisdictions, such as Kelowna or Vancouver; however, the accreditation process will ensure a degree of continuity across jurisdictions and organizations for larger service providers.

Community service providers, who were interviewed in Kelowna and Vancouver for this report, were accredited and had formal complaints procedures and policies for responding to child abuse allegations against staff and volunteers. Both agencies distinguished between day-to-day complaints and allegations of abuse and their policies appeared to be remarkably similar. When an employee received a complaint of abuse, they were required to take the allegation to their supervisor or manager. Generally, the complaint would move up the ranks of management. It is the responsibility of management to assess the credibility of the allegation and to ensure that reporting requirements to the MCFD, police, and licensing bodies or the medical health officer are fulfilled. The child's parent or guardian would also be informed, if appropriate. Both organizations would then carry out internal investigations in order to determine the best course of action for responding to the needs of the accused staff member and the alleged victim as well as for preventing such incidents in the future. If the police, MCFD, or medical health officer carried out an investigation, both organizations suggested they would cooperate fully. The organization

from Vancouver suggested that, where external investigations were conducted, they would do as little as possible themselves in order to avoid interfering with the investigation and the Kelowna organization suggested they would postpone their investigation until the external investigations were complete. An internal investigation would be similar to any other investigation and would include reviewing relevant records, interviewing the staff member who received the allegation, the staff member accused of perpetrating the abuse, any witnesses, and the alleged victim(s).

How the organization responds to the allegation would depend on not only the outcome of any external investigation but also on its own internal investigation. One interviewee from Vancouver suggested that the results of internal and external investigations were not always the same. For instance, in some situations, there might not be enough evidence to prove that a crime was committed but an internal investigation might still find that an employee acted inappropriately. Furthermore, the Kelowna organization suggested that they might not always be informed of the results of an external investigation or be provided information as to how the conclusion of the investigation was reached. It was the responsibility of the service provider to decide how to respond to an allegation but the Vancouver organization suggested that they would often consult with the MCFD. The Kelowna organization appears to have more independence in this regard. Both organizations suggested that responses to staff would be the same as any other organization and would depend on the circumstances surrounding the allegation: however, any response would include taking action to ensure that the accused staff member no longer had contact with clients during the investigation, suspension with or without pay, and disciplinary action or dismissal depending on the outcome of the investigation. One distinction between the Vancouver and Kelowna organizations was that the Vancouver organization's employees were unionized and, therefore, had the support of the union during an investigation and the

organization's response to the incident. Kelowna employees who disagreed with their organization's decision would need to resort to more general labour dispute mechanisms.

The Kelowna and Vancouver community-service providers reported that, if they received an allegation of abuse, clients would receive counselling if needed. The Kelowna organization mentioned that they have a policy which prevents any retaliation against clients who have made a complaint or allegation and would probably not move the client if they were in a residential facility. Reflecting a somewhat different emphasis, the Vancouver organization appeared to be more willing to move children but also mentioned that MCFD staff (e.g., the child or youth's social worker or probation officer) often made this decision.

4.4. Historical Policies and Protocols

The body of policies and protocols discussed above is the product of close to 30 years of policy development in this area. British Columbia issued its first provincial protocol – the *Child Abuse/Neglect Policy Handbook* – in 1979. Over the years, this document has been revised on a number of occasions and is the predecessor of the *Handbook for Action on Abuse and Neglect for Service Providers*, 2007. British Columbia began to develop child abuse policies significantly earlier than Nova Scotia, which did not begin to issue provincial protocols until the late 1980s and early 1990s. As a number of interviewees from both Kelowna and Vancouver mentioned, although public concern about physical abuse and neglect had increased throughout the 1960s and early 1970s, child sexual abuse did not become an issue of public concern until the late 1970s and most initiatives to prevent and respond to this form of abuse did not occur until the 1980s. We have found no evidence that there were provincial policies in place in order to address the issue of child sexual abuse prior to 1979.

The 1979 *Child Abuse/Neglect Policy Handbook* is similar to the 2007 version in that it was the result of a collaborative effort on the part of a number of government ministries and organizations that provided services to children. This collaboration demonstrates B.C.'s early commitment to a multi-disciplinary approach that is similar to that embraced by Nova Scotia as well as other regions in Canada. The original version of the *Handbook* suggested that a collaborative approach to child abuse involving police, child protection workers and other professionals should be adopted. Somewhat unlike the present-day version of the *Handbook*, the original version is a collection of four protocols for different ministries (the Ministries of Education, Health, Human Resources, and Attorney General) and one for other professionals. The introduction of the *Handbook* provides a definition of sexual abuse which illustrates the historical understanding of this crime. Child sexual abuse was defined as “molestation or incest by family members or due to neglect on the part of the parent in supervising the child” (pg. xiii). In this way, the original *Handbook* constructed child sexual abuse as a form of family dysfunction rather than a wider societal or community problem. This limited understanding of child abuse was not unique to B.C.; Nova Scotia and the rest of Canada also adopted this view. It is no surprise, therefore, that the protocols are geared towards abuse by parents and do not directly address the issue of abuse by third parties, such as service providers. This was not addressed in the *Handbook* until it was revised in 1985. The following section of the report will briefly discuss how responses to child sexual abuse have evolved since the 1960s.

4.4.1. Child Protection Investigations and Responses

British Columbia has an eventful child welfare history that provides important background information as to who is, and has been, responsible for administering services to children and youth. The province enacted its first child welfare legislation – the *Infants Act* – in

1901 and the provincial government became involved in child protection in 1919. The provision of early child welfare services was somewhat different in Vancouver compared to other parts of the province, including Kelowna. Outside of Vancouver and Victoria, the provincial Superintendent of Neglected Children was responsible for investigating complaints, apprehending children, and finding homes for neglected children. Vancouver's Children's Aid society was responsible for child protection services in the province's largest city (Gove, 1995). Child welfare services expanded in B.C. throughout the 1960s. At this time, the last of the province's large orphanages were closed and there was an increased emphasis on community care, thereby heralding an early beginning to B.C.'s extensive system of contract community service providers. By the early 1970s, child protection services were administered by the provincial government through the Department of Human Resources as well as by some municipal governments. The Vancouver Children's Aid Society was active until the early 1970s, when it was replaced by the Vancouver Community Resource Board, which took over the Children's Aid Society's child protection mandate and assumed the responsibilities of the city's Welfare and Rehabilitation Society. Community Resource Boards operated outside of Vancouver but these boards did not have the statutory authority to deliver child protection services. Instead they administered grants to non-profit service providers (Gove, 1995).

By 1977, the province had abandoned the system of Community Resource Boards, which had been established just a few years earlier, and replaced them with regional offices that administer a variety of child welfare services including child protection. In the early 1980s, the provincial government made substantial cutbacks in the Ministry of Human Resources (formerly,

the Department of Human Resources). Many social worker positions in child abuse teams were eliminated and the government also closed group homes and specialty treatment services for children. Since these services were still needed, the government began to contract with private organizations to provide them. The government's role became increasingly limited to crisis intervention (Gove, 1995). Contracted service providers have played a significant role in child welfare from this time onward. In 1986, the Ministry of Human Resources was renamed the Ministry of Social Services, which underwent a major re-organization in 1988. Rather than administering Ministry programs through one regional office, services were provided through a number of specialized offices, one of which was dedicated to children and family services (Gove, 1995). Over the next few years, changes to the framework of management were also implemented and the ministry was restructured once again in 1996 into the Ministry of Children and Families. As noted above, this restructuring moved all children's services from different ministries and housed them under the roof of a single ministry, which eventually became the current Ministry of Children and Family Development. Restructuring children's services into the Ministry of Children and Families was largely motivated by a Commission of Inquiry headed by Thomas Gove, which reviewed the province's child welfare services following the murder of a young boy by his mother. The family had made extensive contact with child welfare services but the boy was never removed from his home.

In addition to changes in the administration of services to children and youth, the legislation governing child protection was also revised on a number of occasions. In 1939, the *Protection of Children Act* replaced the earlier *Infants Act* and was B.C.'s principal child

protection statute until 1981. The *Act* was amended on a number of occasions throughout this time. The 1960 version of the *Act* granted child protection workers, police officers, and probation officers the authority to intervene when a child was in need of protection. The *Act* defined numerous scenarios in which a child might need protection, many of which centred on inadequate supervision or delinquent activities, but the legislation made no specific mention of sexual abuse. Physical and sexual abuse would presumably have been covered by s. 7(1)(k) which states that a child is in need of protection if their “home by reason of neglect, cruelty, or depravity is unfit for a child....or whose parent or parents are unfit, unable, or unwilling to care properly for him”. Perhaps, the most important amendment to the *Protection of Children Act* was the introduction of mandatory child abuse reporting provisions in 1967, the same year in which Nova Scotia introduced similar legislative provisions. This amendment was motivated by a greater degree of social awareness of child abuse in B.C. and Canada as a whole (Gove, 1995). British Columbia’s original reporting provisions were not very different from the provisions which are in place today and they were not limited to specific professionals but, instead, were applicable to the general public. They also included a penalty for failing to report incidents of suspected neglect or abuse: this provision distinguishes British Columbia from Nova Scotia, which did not penalize a failure to report until the 1980s.

In 1973, the Royal Commission on Family and Children’s Law, headed by Thomas Berger, was formed: it ultimately recommended that the *Protection of Children Act* be replaced and children’s rights enshrined in legislation. These recommendations were not adopted and the *Protection of Children Act* was not replaced until 1981. The *Family and Children Services Act* was enacted in 1981: however, it was criticized for failing to protect children’s rights, to make preventative services mandatory, or to clarify when a child was in need of protection (Gove,

1995). In addition, the *Act* did not make specific reference to sexual abuse. The current child protection legislation replaced the *Family and Children Services Act* in 1996.

As awareness and understanding of the problem of child abuse increased in B.C., the provincial government refined and revised its policies for responding to abuse. The *Child Abuse/Neglect Policy Handbook* was first introduced in 1979 and was subsequently revised in 1985, 1988, 2003, and 2007, with slight variations in the name of the document. For the remainder of this report this document will simply be referred to as the '*Handbook*'. In some respects, there has been surprising continuity in child abuse protocols as they apply to child protection services. Procedures for investigating abuse have remained the same and largely address the collection of information through interviews, observations, and documents. The safety of the child is specified as the principal concern of any investigation in all versions of the *Handbook*. Minor changes have been introduced, such as the introduction of step-wise interviewing techniques, and the use of audio and video recording equipment during interviews. The 1979 version of the *Handbook* required an immediate investigation of all complaints of abuse, whereas the newer versions only require an immediate investigation if the child is in danger. One key difference between earlier and subsequent versions of the *Handbook* is that the earlier versions did not include provisions for conducting integrated investigations, although they did acknowledge the need for inter-agency cooperation. Such provisions were not introduced until 1985 and became more detailed in 1988. As is the case with the current protocol, the original provisions recommended joint interviews of the alleged victim as well as other children and witnesses; cooperation; planning and information sharing throughout the investigation; and collaboration in relation to any medical examinations. However, the earlier versions did not include the requirement that child protection workers report complaints of abuse to the police and

any other organizations that might be involved. This does not appear to have been included as a requirement until after the 1979 version of the *Handbook* was published.

Other key milestones in B.C.'s approach to child abuse are reflected in changes to the *Handbook*. Unlike the 1979 version, the 1985 *Handbook* included specific provisions for responding to sexual abuse. Although the prior version recognized sexual abuse as a distinct form of abuse in its definitions section, it did not include guidelines which were specific to sexual abuse. This version of the *Handbook* also includes provisions for responding to abuse that occurred outside the family home and makes specific reference to abuse by service providers. Unlike the 1979 version of the *Handbook*, the 1985 version included a much more expansive definition of child sexual abuse. Sexual abuse was defined as "any sexual touching, sexual intercourse, or sexual exploitation of a child and may include any sexual behaviour directed towards a child" (1985, p.6). As is the case with procedures that are followed today, the 1985 version of the *Handbook* suggested that it is the primary role of parents to keep their children safe. Investigations of abuse by service providers would primarily be the responsibility of the police and the organization overseeing the service provider. Child protection workers would become involved if they felt that either the parents or the organization responsible for the alleged abuser were not providing adequate protection for the victim(s) or other children. Another significant development in child protection protocols was the requirement that all service providers working under the ministry (both government service providers and contracted service providers) be screened prior to being employed. This requirement was put in place in 1988. The 1988 *Handbook* also included specific protocols for dealing with abuse in different situations, such as in day cares, schools, or situations in which there were multiple victims.

Prior to the creation of the *Handbook* in 1979, the provincial government had implemented other initiatives to prevent child abuse, although these initiatives were not specific to child sexual abuse or abuse by service providers. For instance, the Children's Help Line, the province's 24 hour emergency line for children, predates the introduction of the *Handbook* and, in the mid-to-late 1970s, informal Children-in-Crisis Committees were organized to coordinate services to children and youth (McBride, 2006; Federal-provincial consultation on child abuse, 1978). Since 1965, the province has maintained a Child Abuse Registry and, in 1974, the registry was renamed the Registry of Child Protection Complaints; it records all complaints of abuse and neglect. The Registry provides information concerning the frequency and type of abuse as well as a system for determining if abuse has been reported in the past (Federal-provincial consultation on child abuse, 1978). Unlike Nova Scotia's child abuse registry, abuse in B.C. is tracked on the basis of the alleged victim rather than the alleged perpetrator.

4.4.2. Police Investigations

With respect to changes in the nature of police investigations during the period considered in this report, it is noteworthy that one officer from Vancouver suggested that the investigative process itself had not changed significantly – physical evidence has always been collected and victims, witnesses, and offenders have always been interviewed. However, the officer did acknowledge that the approach of police departments to child abuse had evolved and that the relations with other professionals involved in responding to child abuse had changed significantly. Changes in the provincial child abuse protocols provide evidence of changing attitudes towards the role of the police. The 1979 *Handbook* suggests that the principal role of the police is to assist child protection workers in child apprehensions to 'prevent a breach of the peace'. This vision of police involvement is clearly influenced by the view that child abuse is a

family problem. It was not until abuse by third parties, or service providers, was acknowledged that the role of the police became defined in substantially broader terms. It is also suggested that the police have an important role to play in responding to child abuse because they provide round-the-clock service and, therefore, maybe the first agency to respond to the abuse. Criminal investigations were not listed as one of the police's principal roles until 1985: this would suggest that, prior to this date, abuse was dealt with as a child protection, rather than a criminal, matter or a combined criminal and child protection matter. This assertion is supported by an interviewee from Kelowna who suggested that, although the Ministry of Human Resources had been initiating a variety of responses to child abuse from the late 1970s, the criminal justice system did not entirely come on board until the mid 1980s, when one began to see more charges and longer sentences for those individual who committed sex offences involving children. Another police officer from the Lower Mainland suggested that, in the past five-to-ten years, the police were increasingly taking on a more caring role.

Interestingly, prior versions of the *Handbook* provide more detailed information concerning police child abuse investigations than the 2003 or 2007 versions. The 1979, 1985, and 1988 versions of the *Handbook* provide guidance in relation to consultation with other agencies, interviewing the child, dealing with the alleged perpetrator, victims assistance, staffing, records checks, and so on. The 2003 and 2007 protocols do not provide any guidance as to how police should deal with alleged perpetrators. In the 1985 *Handbook*, it is suggested that - where possible - officers with specialized training in child abuse should conduct the investigation and that police departments should develop local protocols for cooperating with different community agencies in child abuse investigations. Such protocols should provide information concerning planning

investigations, sharing information and may differ depending on the needs of individual communities.

4.4.3. Foster Care and Group Homes

The closure of large institutions caring for children in the 1960s meant that foster homes and group homes became increasingly prevalent. Annual reports from the Vancouver Children's Aid Society (1963, 1966, 1968, 1969/70) from the 1960s indicate that most children requiring residential care were placed in foster homes. The Gove Inquiry (1995) suggested that the de-institutionalization of services to children with disabilities continued throughout the 1970s and 1980s. Private group homes or community-based residential facilities became more common. Despite B.C.'s extensive use of group homes and foster care, we found no evidence that, prior to the current set of protocols and standards, there existed any province-wide protocols, which specifically addressed responding to abuse or implementing standards for the provision of quality service in either type of care. There is also no mention of investigating or preventing abuse in foster homes or group homes in the *Handbook* (1979). Interviewees from both Vancouver and Kelowna, whose organizations had provided residential services under contract with the MCFD, indicated that, since the early 1980s, they had complaints processes in place to respond to clients' concerns and policies in place for handling abuse allegations. They suggested that these complaints processes and abuse protocols had not changed significantly but had simply become more refined and streamlined.

This interpretation is supported by information which is presented in the *Handbook* itself. References to investigating abuse in group homes and foster care first appeared in the 1985 *Handbook*. This version of the *Handbook* includes provisions for investigating abuse allegations

for group homes that are remarkably similar to current provisions. These provisions outline the need for mutual reporting and co-operation between Medical Health Officers, the police, and child protection workers. By this time, medical health officers were authorized to investigate incidents of abuse in licensed childcare facilities. This version of the *Handbook* also indicates that child protection workers will play a lesser role in such investigations than in an investigation of a parent; however, it states that they will become more fully involved if the Ministry of Human Resources enters into a contract with the group home to provide residential care. The 1988 version of the *Handbook* included a separate protocol for investigating abuse in licensed group homes. Despite providing detailed information concerning the appropriate response which should be made to abuse in group homes and general information about responding to abuse which occurs outside the child's home, the question of how to respond to abuse in foster care is only briefly mentioned: this suggests that it was accepted that the appropriate course of action would be to refer the complaint to the regional manager and the Deputy Superintendent of Family and Children Services. One interviewee did mention that, in 1988, the Ministry of Social Services and Housing introduced a resource policy manual which was principally focused on foster care and which might have included information in relation to investigating allegations of abuse in this setting. Other interviewees, who had worked in child protection since the early 1990s, suggested that protocols for responding to abuse in foster care had been in place during the entire period of their employment in this field.

4.4.4. Youth Justice

Youth justice has not always been housed in the same ministry as child protection services. Prior to the creation of the Ministry of Children and Families in 1996, youth justice was primarily the responsibility of the Ministry of the Attorney General. As mentioned above, the

MCFD does not appear to issue detailed, province-wide protocols for dealing with allegations of abuse made against youth justice workers, above and beyond general provisions which address third-party or out-of-home abuse. The *Handbook* (2003 & 2007) does provide limited guidance concerning the question of how to respond to abuse in youth-custody facilities. When the Ministry of the Attorney General was in charge of youth justice, the role of Corrections in responding to child abuse was outlined in the three earlier versions of the *Handbook* (1979, 1985, 1988). However, these provisions did not address what should occur if a youth justice worker was accused of abusing a child. They discussed what should be take place if a youth justice worker became aware that one of his or her clients was being, or had been, abused and how to work with sex offenders. All three versions of the *Handbook* indicated that any form of abuse must be reported to child protection services. Presumably this would apply to abuse by youth justice workers as well. These protocols stressed the need for inter-agency cooperation and provided guidelines for interviewing victims. Such provisions indicate that Corrections had an active role to play in responding to child abuse. Interestingly, the *Protection of Children Act* afforded probation officers the same powers to investigate child neglect and cruelty in the 1960s and 1970s as those granted to social workers and police officers. This may be a reflection of the perceived link between a lack of appropriate supervision of children, juvenile delinquency, and child protection concerns.

All three of the earlier versions of the *Handbook* refer to regional youth corrections policy manuals, which may have included information concerning the prevention of abuse and the implementation of an appropriate response to abuse allegations. Interviewees who worked in the field of youth justice suggested that, when staff members were accused of abuse, the allegations would principally be dealt with by management and internal, labour relations mechanisms -

except if the police became involved. These interviewees suggested that this approach had not changed throughout the duration of their employment (from the late 1980s). One interviewee suggested that, today, more policy and mechanisms are in place to prevent abuse from occurring in youth custody facilities than there had been in the past. For instance, various staffing regulations have been introduced, such as not allowing staff to work with clients alone; employing more staff at night; and ensuring the continuous presence of some female staff members in youth custody facilities for female offenders. Furthermore, specific guidelines have been promulgated for the carrying out of activities that might otherwise be construed as being abusive, such as specific procedures which must be followed during strip searches. This interviewee suggested that the risk of sexual abuse by staff had been substantially reduced in youth custody facilities because of these changes and that community corrections might pose a greater risk of abuse because probation officers often worked with youth alone and, at times, out of the office. Another important policy change, which was designed to prevent potential abuse by staff members, was introduced in the 1990s: this was the requirement that all youth should be informed of their rights while in custody and should be provided with information as to how to make a complaint both internally as well as to an outside agency (McBride, 2006).

4.4.5. Non-Profit or Community-Based Service Providers

British Columbia has a long history of administering child welfare services through non-profit or community-based organizations, particularly in Vancouver, where the Children's Aid Society was principally responsible for child welfare in the city during the 1960s and early 1970s. We found no formal policy documents governing the practices of the Children's Aid Society but it is likely that there were general policies governing their practices. However, it is equally as likely that they did not have policies specific to child sexual abuse, given the general lack of

public awareness about this issue at that time. Annual reports from the organization do not mention child sexual abuse. The *Handbook* (1979) was applicable not only to government agencies but also to community-based organizations. The *Handbook* set out the reporting requirements and guidelines for interviewing children to be followed by outside agencies. Interviewing the victims of suspected abuse was recommended if the service provider was in a remote area and did not have access to child protection services. Abuse by service providers was not addressed until the 1985 version of the *Handbook*. However, this version no longer included provisions specific to community-based service providers. The 1988 version included protocols for responding to abuse in residential facilities and schools.

As was mentioned above, the government increasingly began to contract out services to children and youth throughout the 1980s. Since this time, non-profit, or community-based, service providers have been responsible for implementing their own policies and protocols: however, during this period, the government also extended provincial policies, such as the *Child Abuse Handbook*, to organizations which provided contracted services. Our interviewees from community-based organizations in Kelowna and Vancouver indicated that their organizations had provided services under contract since the early 1980s. Both interviewees suggested that, since this time, their organizations have been required to put in place an internal complaints procedure. They also were obliged to provide information to clients concerning their rights and how to contact the provincial ombudsman. In the case of the Vancouver organization, this was a requirement specified by their funding contract. Similarly, these organizations have had a policy structure in place since their creation. One interviewee mentioned that the *Handbook* was widely distributed in the 1980s and 1990s. Agencies were given a sufficient number of copies so that all staff members would be expected to be familiar with its contents. Community-based agencies

would incorporate what was outlined in the *Handbook* within their own internal policies. The Vancouver service provider mentioned that this policy structure was not overly sophisticated for a long time. This changed when the accreditation process was introduced. Accreditation requires organizations to have a comprehensive set of policies. Emphasis on the *Handbook* appears to have faded and the current approach of government towards community-based service providers is to place a greater onus on the agency to implement appropriate internal policies, while simultaneously emphasizing the need to acquire knowledge of the relevant legislation and to implement its provisions. One interviewee suggested that they had not seen the *Handbook* for a number of years. This is likely a function of the government requiring large service providers to be accredited. Another change which was mentioned was that current policies are more focused on preventing abuse than they have been in the past. Agencies now have screening, recruitment, and staff-training requirements written into policy as well as formal codes of professional ethics.

4.5 Practice: Investigating and Resolving Abuse Allegations

Acquiring a basic knowledge of legislative requirements and policies provides one with an official or formal view of B.C.'s historical and current approach to child sexual abuse. However, studying the perspectives of persons who have been responsible for transforming policy into practice and executing agency and legislative mandates provides a complementary, as well as more pragmatic, view of how B.C.'s response to abuse perpetrated by service providers has evolved. As one interviewee mentioned, policy cannot cover all possible situations or abuse scenarios and is simply a guide for practice. Furthermore, policies are often premised on tried and tested practices. Considering the question of how practice has evolved will provide insight into the motivation underlying the implementation of different policies or protocols. Understanding practice is particularly important in B.C. in light of the province's decentralized child welfare

system and its history of reliance on contracted services, along with a blend of municipal police departments and RCMP detachments. As a consequence of these circumstances, there is a significant potential for variations in everyday practice to occur between different jurisdictions, agencies, or organizations. A number of interviewees mentioned that an organization or agency's philosophy, inter-agency relationships, and local folklore influenced how child sexual abuse would be approached. The following section, dealing with current and past practice, is principally based on information gleaned from interviews with police, employees of the MCFD, and other service providers. This discussion should not be treated as a definitive view of how child sexual abuse is, or has been, handled in practice: instead, it should be viewed as a basic introduction to current and past practice.

4.5.1. Historical Versus Current Abuse Allegations

As noted previously, public awareness of child sexual abuse, particularly by service providers, did not develop until the 1980s. As one interviewee from Kelowna suggested, this created a situation in which the abuse that occurred prior to the 1980s was often not reported. However, when the issue became a concern of professionals, feminists, and the public, victims came forward with reports of abuse that had occurred in the past. However, this interviewee suggested that historical abuse reports had died out in recent years. Occasional incidents of historical abuse continue to be reported but not to the extent that they were received in the 1980s and 1990s. Historical abuse is the term that is used to denote abuse that occurred in the past and where the victim is no longer in the abusive situation. In many instances, the victim is no longer a child. B.C. experienced two abuse scandals centred on abuse in the past, as well as abuse perpetrated against First Nations persons in residential schools. Numerous incidents of physical and sexual abuse by staff and students in the Jericho Hill School for the Deaf were reported. The

abuse is thought to have occurred from the 1950s to the 1980s. Similarly, past abuse of residents by staff at the Woodlands Institute for mentally handicapped and troubled youth came to light in the 1990s.

The earliest reference to historical child abuse in provincial documentation is to be found in the 1988 version of the *Handbook*. The role of child protection services in the context of alleged historical abuse is to notify police and determine if any children other than the alleged victim are at risk. The 2003 and 2007 versions of the *Handbook* place more emphasis on reporting issues which may arise in relation to alleged historical abuse. If an individual is aware of the historical abuse of a person who is still a child, they are required by law to report it. Similarly, if an adult has been abused in the past and has reason to believe that the perpetrator is abusing other children, he or she must report this belief to child protection services.

Despite the existence of policies indicating how one should respond to historical abuse, interviewees from both Kelowna and Vancouver did not appear to be aware of the provincial policy concerning this issue. Police officers from both jurisdictions suggested that their approach to historical abuse would largely be the same as in the case of an investigation into current abuse. However, finding sufficient evidence to support a criminal charge would be significantly more difficult in the case of alleged historical abuse since there is unlikely to be any physical or medical evidence and finding witnesses may well prove to be impossible. If the victim were now an adult, they would no longer have to employ interviewing techniques specific to children. Child protection workers suggested that they would not be involved in investigating historical abuse because it would not fall under their child protection mandate. Any involvement on their part would be limited to providing information to the police in order to assist them in the

investigation. The exception to this principle would be if the alleged perpetrator were still in contact with children. In this instance, they would determine if other children were at risk. One protection worker, who had worked in various locations across the province, suggested that their involvement would depend on the perceived seriousness of the case. If the case was high-profile, child protection workers might be seconded for their expertise. Similarly, non-profit or community-based service providers suggested that they would not have any role to play in historical abuse investigations unless the alleged perpetrator continued to work for them. In this case, they would respond in a manner similar to their response in any other abuse investigation.

4.5.2. Current Practice

As is the case with our research in Nova Scotia, the majority of persons interviewed in British Columbia suggested that there was not a large gap between policy and practice. Many interviewees felt that policies protected them from misunderstanding, from being accused of not responding to abuse allegations in an appropriate fashion, and from unjustified legal action. Significantly, community-based service providers seemed to endorse the position that policies were followed precisely during an investigation of an allegation of abuse. This opinion was probably influenced by the fact that their continued status as community-service providers depended on impeccable practice. Police departments and child protection workers do not face the same pressure. Despite the expression of confidence that there was little difference between policy and practice, a word of caution is necessary. According to the interviewees in this report, allegations of abuse against service providers are rare events. Many of our interviewees did not have extensive practical experience with this. Typically, an interviewee would only have been involved in one or two such investigations throughout the course of his or her career.

Interviews with police officers suggested that policies and procedures might not have been as important to them as the nature of the working relationships which exist between officers and child protection workers, school boards, and the other professionals who are commonly involved in responding to child abuse. For instance, one officer from the Lower Mainland felt that their longstanding rapport with ministry workers had streamlined the process of responding to abuse allegations. In light of their close relationship with the officer, child protection workers could contact him directly with their concerns rather than going through the regular police reporting process. Other officers noted that, when working with ministry workers in their jurisdiction, investigations ran smoothly. However, when they were investigating a case that involved child protection workers from other jurisdictions, co-operation could become more challenging. As a brief aside, it is clear that various police departments have different practices for responding to child abuse. Generally speaking, the differences are to be found in the specific details rather than in the general policies. For instance, one officer mentioned that they preferred to be involved in an investigation from the beginning and, as such, it was the department's practice to delay taking a statement from a victim or other complainant until he was available to do this. However, other departments sent out patrol officers to take initial statements, after which the investigator would become involved. Differences between departments might be linked to staffing levels and the workload of the department as well as to the department's individual philosophy. There is little evidence that the size of the city in which the police department was located had an impact on practice. The practices of police departments in the Lower Mainland varied as much between themselves as they did between themselves and the Kelowna police department.

Interagency co-operation is emphasized in many policies and it appears to be an accepted practice by all of the police officers we interviewed. For instance, one interviewee suggested that the police currently assume a caring role rather than simply being concerned with the criminal investigation and also acknowledged that the police need help from other agencies. The relationship between police and child protection workers appears to be well-defined. Both of these groups agreed that, in a joint investigation, the police would take the lead during the investigation, except in some cases where young children were involved and the child protection worker had more experience interviewing children. In this instance, the child protection worker would lead the interview. Interagency cooperation is less apparent in the relationship between non-profit or community-based services and youth justice, on the one hand, and the police and child protection workers on the other. When an allegation of abuse is received in the community or the youth justice context, any child protection or police investigation appears to be conducted separately from an internal investigation and there is the expectation that the organization will not become involved nor be privy to all information collected in the course of the police or child protection investigation.

Just as police practice can vary from one department to another, so can child protection practice vary from one regional office to another. One interviewee who had worked in a variety of locations across B.C. suggested that regional offices varied in their approach to child protection in terms of their philosophy, record-keeping practices, and so on. Other interviewees mentioned that there were practices which were employed occasionally but not in all investigations. For example, a number of interviewees mentioned that some cases involving an abuse allegation against ministry staff or foster parents were referred to outside agencies in order to place some distance between the investigating and the home agencies. Unlike Nova Scotia, this

is not a formal requirement. Others suggested that, during an investigation of a service provider, supervisors often became more heavily involved than was mandated by policy owing to the potentially sensitive nature of these investigations.

Although most interviewees suggested that they followed policies, some nevertheless pointed out the existence of discrepancies between policies and practice. One interviewee suggested that, while child protection workers tried to implement the applicable policies, this was not always possible. One example provided by this interviewee concerned the failure to meet the ministry policy of completing investigations within 30 days. In the interviewee's experience, most investigations took longer to complete. Ministry employees, working in the field of child protection in both Vancouver and Kelowna, also agreed that the 30-day time limit was not met. Another interviewee suggested that they believed that many child protection workers were not familiar with the ministry's policies or had never read them thoroughly. The interviewee also mentioned that, in times of fiscal restraint, staff training was often one of the first areas to be cut so training was not always as extensive as it should be. Another interviewee suggested that social workers entering the field of child protection now had a specialization in child protection through their education and received extensive on-the-job training, including field placements and mentoring. Non-profit or community-based organizations appeared to place a significant degree of emphasis on continuing training as a means of preventing abuse by staff. One organization had monthly training modules that staff members were expected to complete and offered a yearly refresher course on the organization's code of ethics.

4.5.3. Changes in Practice – 1960 to present

Exploring practices surrounding child abuse during the 1960s and 1970s constitutes a difficult task given the lack of awareness of the issue in B.C. and the rest of Canada at this time. One interviewee, who had worked in a variety of locations throughout B.C. from the 1970s, suggested that child sexual abuse was not ‘invented’ until the 1980s. The *Protection of Children Act* (1960) did not refer to ‘child abuse’, but was rather concerned with neglect and cruelty to children, which is essentially physical abuse. Incest was acknowledged to a limited degree but was not a primary concern for child protection workers. In light of this situation, information is scarce concerning the handling of sexual abuse cases prior to the late 1970s. The longest period during which any of our interviewees had worked in an area where they had - or might have had - to respond to abuse allegations dated from the 1970s. Despite not working in the area during the 1960s and the first half of the 1970s, some interviewees nevertheless had insight into the nature of past attitudes during this era. One interviewee mentioned that the attitude would have been one of disbelief if a child had reported abuse prior to the 1970s or if the alleged victim had been a youth involved in the justice system. Apparently, the attitude was often expressed that the abuse was somehow the fault of the youth for having been in a custodial facility. Another interviewee suggested that an early concern was that of ‘saving face’. Reports of abuse were dealt with quietly and through an internal investigation. The police or outside authorities would not have been informed. This interviewee also mentioned that the internal investigation was not really concerned with getting to the bottom of the complaint but simply with making it disappear. In such cases, the alleged perpetrator might quietly resign and nothing more would be done about the incident. Information about historical abuse that occurred in various childcare institutions or residential schools in the province suggests that this was, indeed, the case. Adults who have

come forward with allegations of abuse when they were residing in the Woodlands institution for mentally disabled and troubled children suggested that there was a code of silence in the institution and that, if a youth made a complaint to police or relatives, staff members would retaliate against them. As such, few complaints of abuse ever reached police or relatives. When the institution responded to abuse complaints or incidents, they often moved the perpetrators to different positions rather than dismissing them (CTV, October 21st, 2006). This response of either failing to acknowledge sexual abuse or dealing with incidents quietly when they could not be ignored entirely is similar to the approach adopted in Nova Scotia during the 1960s and 1970s.

According to one interviewee, child protection workers did not begin to investigate child sexual abuse until the 1980s. The province did have a child abuse team since 1974 but the team had an advisory rather than an investigatory role. When concern about child sexual abuse increased during the early 1980s, there was a general lack of knowledge about sexual abuse. Effective interviewing techniques for children had not been developed and there was confusion in the courts as to the application of the criminal law to the phenomenon of child sexual abuse. Interviewees from both Vancouver and Kelowna suggested that there was an ‘ad hoc’ or ‘fly-by-the-seat-of-your-pants’ approach to allegations of child sexual abuse. In the late 1970s and early 1980s, social workers did not receive training that was specific to the field of child protection. Although provincial protocols for dealing with child abuse in general were in place from 1979, there appears to have been confusion as to how best to respond to child sexual abuse in particular. For instance, there was considerable confusion over the legal duty to report abuse and confidentiality. Many professionals would not report abuse if reporting would violate their professional commitment to confidentiality (Beck, 1996; Beck *et al.*, 2001).

Another concern mentioned was that record-keeping practices for child protection services at this time were dismal, particularly with respect to resources such as foster care or group homes. A tracking system was in place but it was rarely completed. As such, it was difficult - if not impossible - to track whether a service provider had multiple allegations made against them or if a specific child had made multiple complaints of abuse. Record-keeping practices would vary from office to office. Furthermore, according to one interviewee, child protection workers did not begin to visit children, who had been placed in foster care or residential facilities, until 1980. As a consequence, if a child wanted to make a complaint against their foster parent or staff member of a residential facility, he or she would not necessarily have access to an external person. The position of an independent advocate for children in the child welfare system was not created until 1989, in Vancouver, and until 1995 for the rest of the province. Social workers and their supervisors dealt with complaints informally at this time and specific complaints procedures were not established until 1994 (McBride, 2006). Similarly, one police officer suggested that, 25 years ago, the police “would not want to know” about sexual abuse. Generally, the police were not available to children wishing to report abuse by their service providers. A victim or other concerned party would need to actively seek police involvement.

Practice in relation to organizational responses to allegations of child abuse began to solidify in the mid-to-late 1980s. A number of interviewees mentioned 1988 as the year when the child welfare system really crystallized their approach to sexual abuse. As noted above, this was the year in which the Ministry of Human Resources was reorganized and the Ministry of Social Services and Housing was created. Their mandate included child protection. Changes from this time onwards have largely been confined to refining practices so as to make them more efficient

or responsive to new information concerning child sexual abuse. Interviewing techniques were refined and the method of step-wise interviewing was introduced. The practice of recording interviews in video or audio format was adopted. Training for social workers and police became more sophisticated and joint training was introduced. Another important change for preventing abuse by service providers is the introduction of requirements for screening new employees working with children and youth. Currently, new service providers are required by law to undergo an extensive records check and policy is currently being developed to require all service providers working with children to renew their records check every five years.

A number of interviewees suggested that the 1980s and 1990s constituted a period of hyper vigilance around the issue of child sexual abuse. At this time, if an employee of the Ministry of Human Resources, or the later Ministry of Social Services and Housing, was accused of abusing a child, he or she would immediately be suspended without pay. However, changes to the union's collective agreement resulted in the rejection of this approach and employees are no longer automatically suspended: instead, they may be reassigned to duties where they no longer have contact with children. It is no longer assumed that any employee accused of abuse is guilty. This change in attitude also seems to have occurred with respect to contracted service providers. Interviewees from community-based services in both Kelowna and Vancouver mentioned that, in the past, employees accused of abuse would automatically have been suspended but this is no longer the case. Likewise, one police officer suggested that the police are currently aware not only of the danger of disbelieving an allegation of abuse but also of the potential for wrongfully convicting someone of child sexual abuse. One suggestion made by a number of interviewees was that the agencies and individuals responsible for responding to child abuse appear to have settled on a more balanced approach that considers not only the rights of children but also the

rights of the accused service provider. However, all interviewees seemed to agree that the safety of the child was their paramount concern.

References

- Federal-Provincial Consultation on Child Abuse (1978). Ottawa, Ont.: Canadian Intergovernmental Conferences Secretariat.
- Gove, T. (1995). Report of the Gove Inquiry into Child Protection in British Columbia. Victoria, B.C.: Ministry of Social Services
- Martin, M., McRae, B., & Reid, L. (1986). The Child Protection Law. The Public Legal Education Society.
- McBride, M. (2006). Report on Child Advocacy and Complaint Resolution Process. B.C. Children and Youth Review.
- Ministry for Children and Families & British Columbia's Federation of Foster Parent Associations. Dealing with Difficulties in Foster Homes: A Guide for Foster Parents. (Pamphlet).
- Ministry of Children and Family Development. Website. Accessed on March 2007 at www.mcf.gov.B.C..ca
- Ministry of Children and Family Development (2003). Child and Family Development Service Standards – Child and Family Service Standards & Child in Care Service Standards. Victoria, B.C..
- Ministry of Children and Families (1999). Protocols for Foster Homes. Victoria, B.C.
- Ministry of Children and Families (1998). Standards for Foster Homes. Victoria, B.C..
- Ministry of Children and Families (1998). Standards for Staffed Children's Residential Services. Victoria, B.C.
- Ministry of Children and Family Development (2003). The B.C. Handbook for Action on Child Abuse and Neglect. Province of British Columbia
- Ministry of Human Resources (1985). Inter-Ministry Child Abuse Handbook – A Co-ordinated Approach for Professionals Dealing with Child Abuse in British Columbia. Province of British Columbia.
- Ministry of Human Resources (1979). Child Abuse/Neglect Policy Handbook. Province of British Columbia.
- Ministry of Social Services and Housing (1988). Inter-Ministry Child Abuse Handbook – An Integrated Approach to Child Abuse and Neglect. Province of British Columbia
- PLEA (2005). Responding to your concerns and complaints at PLEA (Pamphlet).

Legislation:

Children, Family, and Community Services Act, RSC. 1996, Chapter 46

Community Care and Assisted Living Act, SBC. 2002, Chapter 75

Family and Child Services Act, RSBC. 1981, Chapter 11

Protection of Children Act, RSBC. 1960, Chapter 303

Representative for Children and Youth Act, SBC. 2006, Chapter 29

Youth Justice Act, SBC. 2003, Chapter 85

5.0 NOVA SCOTIA

5.1. Introduction: The Provision of Services to Youth and Children in Nova Scotia

As is the case in British Columbia, Nova Scotia supports a multidisciplinary response to child abuse. Although police and child protection workers are the principal agencies responsible for investigating and formally responding to allegations of abuse, the resources of other professionals are drawn upon to support the police and child protection workers. For instance, most jurisdictions have medical practitioners who are routinely consulted about abuse cases. The Faculty of Medicine at Dalhousie University operates a child protection team, similar to B.C.'s SCAN team, that treats victims of child abuse, provides medical assessments and consultations in alleged incidents of child abuse, and advises government agencies and committees how to investigate, prevent, and respond to incidents of child abuse. The services of the child protection team are available province-wide. Similarly, non-profit and non-governmental organizations who work with children are encouraged, and in some instances required, to screen new volunteers and employees through criminal records checks, child abuse registry checks, and recommendations from respected members of the community, such as an individual's family physician. These organizations are also encouraged to implement internal policies to prevent child abuse from occurring as well as procedures for responding to allegations against employees and volunteers when they arise. At the level of policy, little distinction is made between sexual and physical abuse in either the internal policies of individual organizations or province-wide government policies. Similarly, neglect, physical abuse, and sexual abuse are often addressed by a general policy. However, as one interviewee from Halifax mentioned, policy surrounding neglect versus physical abuse or sexual abuse can be different because neglect typically only involves a child's

parent, guardian, or caregiver and not third parties. The police are also less likely to be involved in cases of neglect. Before exploring the policies and practices pertaining to allegations of abuse against employees or volunteers, the role of government departments and non-profit organizations in the provision of services to children and youth will be briefly explored.

5.1.1. Department of Community Service

The Department of Community Services is responsible for providing a variety of social services to the residents of Nova Scotia. Throughout its history, the Department underwent a number of changes. Originally named the Department of Public Welfare, it was created in 1944 in order to provide a range of social services such as old-age pensions, family and children's services, public charities, mother's allowances, children's aid societies, juvenile court, and reform schools. In 1973, the department was renamed the Department of Social Services and, in 1987, the Department of Community Services. The current department provides services in conjunction with other government departments and community-based, non-profit organizations in the following areas:

- Family and community supports
- Services for persons with disabilities
- Employment supports and income assistance
- Housing services

These services are administered through approximately 40 community-service offices under the department's philosophy of promoting "the independence, self-reliance, and security" of all the people they serve. Services specific to youth and children include:

- Child protection
- Funding for child care and children with special needs in child care
- Early intervention services for young children with special needs

- In-home and respite-support programs for families caring for children with physical and developmental disabilities

In addition to these general services, the department is responsible for a secure-care facility for troubled youth, the provincial child-abuse register, and licensing residential care facilities. The department also develops policies and programs and ensures that the services are delivered in accordance with the relevant legislation.

5.1.2. Department of Justice

Unlike British Columbia, youth criminal justice in Nova Scotia is not administered under the aegis of the same department as other services for children and youth. Instead, the Department of Justice provides both custodial and community correctional services for youths. More generally, the department is responsible for the administration of justice (both civil and criminal proceedings), policing, and adult correctional services. The Department was created in 1993, when services provided by the former Departments of the Solicitor General, the Attorney General, and the Provincial Secretary were amalgamated. Although the Department of Justice is now responsible for youth justice, this was not always the case. Prior to 1994, youth justice was under the mandate of (what was then) the Department of Community Services, and its two predecessors, the Department of Social Services and Department of Public Welfare. When, in 1984, the *Young Offenders Act* replaced the *Juvenile Delinquents Act*, the Department of the Solicitor General was responsible for administering youth justice services to delinquent youth over the age of 16 (Department of Community Services, 1992). Currently, there are two custodial facilities for young offenders in Nova Scotia – the Nova Scotia Youth Centre, which holds male young offenders who have received a custodial sentence and remanded youths, and the Cape Breton Young Offender Detention Centre, which is a short-term facility for remanded youths and

youths waiting for transfer. Staff members in these facilities are expected to take on a variety of roles including counsellor, life skills/social skills educator, security officer, and recreational officer. Community corrections provides probation and parole services as well as supervision of conditional sentences and works in conjunction with other agencies, such as the police, schools, and restorative justice programs.

5.1.3. Non-profit service providers

In Nova Scotia, many services for children or youths are provided by non-profit organizations. Independent organizations, such as Children's Aid Societies, are contracted to provide children and family services and function in a manner which is similar to that of a regional government office. More specifically, these organizations provide child protection services to the regions which they serve. They are run by a board of directors, consisting of community volunteers, and have their own constitutions and by-laws. As of 2006, 14 out of Nova Scotia's 20 regional Children and Family Services Offices were independent organizations. However, some of these organizations are currently being brought under the management of the Department of Community Services. The Department of Community Services also contracts out more specific services to non-profit organizations. For instance, non-profit service providers operate many of the province's residential facilities for children and youth. Other organizations, which have no direct link to the Department of Community Services or other government ministry, provide a range of services to the province's children and youth, including recreational activities, mentoring, emergency shelters for street youths, substance-abuse treatment, and so on.

5.1.4. The Office of Ombudsman – Youth Services

The Youth Services Branch of the Office of the Ombudsman acts as an independent advocate for children and youths in government care or custody in Nova Scotia. Empowered by the *Ombudsman Act*, representatives from the Youth Services can investigate and resolve concerns and complaints which children and youth may express concerning their treatment while in government care. The service also monitors conditions in provincial facilities and provides outreach services in youth correctional facilities, secure care facilities, and residential caring facilities. The Youth Services Branch of the Office of the Ombudsman was created in 2000 in response to a recommendation made in the Stratton Report (1995) that there should be an independent presence in youth facilities to respond to complaints. The Stratton Report was an investigation into allegations of abuse in Nova Scotia's youth custody centres and residential facilities throughout the 1950s, 1960s, and 1970s. Stratton investigated the locations of alleged incidents of abuse, what practices and procedures were in place that may have helped or hindered the detection of abuse, who was aware of any abuse that might have occurred, and what steps were taken to respond to allegations of abuse. Stratton concluded that many of the complaints of abuse he received were accurate and reliable and that, in some incidents, facility employees and public officials were aware of this abuse but did little to stop it. He suggested that Nova Scotia had a moral responsibility to address the victims of historical abuse but recommended that a commission of inquiry was not necessary. Many persons received financial compensation from the province of Nova Scotia for past abuse on the basis of the Stratton report.

5.2. Overview of Relevant Legislation

Nova Scotia's principal child protection statute is the *Children and Family Services Act* (CFSA), 1990. The legislation regulates both child protection and adoptions and also governs the

relationship between children, families, and the agencies authorized by the state to provide publicly-funded services (Thompson, 1991). The Act outlines the province's abuse-reporting and investigating requirements, provides a definition of who is considered a child, and addresses a variety of other issues related to child protection. The overall intention of the Act is set out in s. 2(1), which states, "The purpose of this act is to protect children from harm, promote the integrity of the family and assure the best interests of children". The *CFSA* defines a child as anyone under the age of 16. The Act does provide for the continuation of child protection services for youths over the age of 16 if they are in the care of the province at the time of their 16th birthday. In this instance, care can be continued until the youths are 19-years-old or until they are 21-years-old, if they have a disability or are enrolled in an educational program (Gough, 2006).

Sections 22 to 25 of the *CFSA* specify when children are in need of protection as well as the Act's mandatory reporting provisions. According to s. 22, children are in need of protection when their parent or guardian is abusing or neglecting them, are at substantial risk of abusing or neglecting them, or have failed to prevent another individual from abusing them. With regard to sexual abuse, the *CFSA* stipulates that a child is in need of protection when:

S. 22(2)(c) the child has been sexually abused by a parent or guardian of the child, or by another person where a parent or guardian of the child knows or should know of the possibility of sexual abuse and fails to protect the child;

(d) there is a substantial risk that the child will be sexually abused as described in clause (c);

All individuals, including professionals receiving confidential information, are under a legal duty to report to a child protection agency when they have reason to believe a child is in need of protection. It is an offence to fail to carry out this duty. Not only are the residents of Nova Scotia required to report incidents, when they believe that a parent or guardian is abusing or neglecting a

child, but also when they have reason to believe that a third party has abused a child. Section 25 reads as follows:

25 (1) In this Section, "abuse by a person other than a parent or guardian" means that a child

(a) has suffered physical harm, inflicted by a person other than a parent or guardian of the child or caused by the failure of a person other than a parent or guardian of the child to supervise and protect the child adequately;

(b) has been sexually abused by a person other than a parent or guardian or by another person where the person, not being a parent or guardian, with the care of the child knows or should know of the possibility of sexual abuse and fails to protect the child;

(c) has suffered serious emotional harm, demonstrated by severe anxiety, depression, withdrawal, or self-destructive or aggressive behaviour, caused by the intentional conduct of a person other than a parent or guardian.

(2) Every person who has information, whether or not it is confidential or privileged, indicating that a child is or may be suffering or may have suffered abuse by a person other than a parent or guardian shall forthwith report the information to an agency.

(3) Every person who contravenes subsection (2) is guilty of an offence and upon summary conviction is liable to a fine of not more than two thousand dollars or to imprisonment for a period not exceeding six months or to both.

Section 25 is of particular importance in terms of the mandate of the present report because, when a child is in the care of the province (e.g. in foster care, a young offender facility, or a group home), the state is considered their guardian (e.g. the Director of Child Protection) rather than the individuals who are actually providing the care, such as the foster parents or group home staff. As such, s. 22 is not applicable and any abuse that occurs while the child is in the care of the state is considered third-party abuse.

5.3. *Current Policies and Protocols*

In Nova Scotia, as in other provinces, child protection agencies and the police are the principal organizations responsible for investigating, and responding to, any allegations of child abuse. Unlike the situation in British Columbia, these two organizations are under a province-wide mandate to conduct their child-abuse investigations jointly in all circumstances which

involve a child under 16-years-of-age and which could potentially be considered to constitute a criminal offence. They receive joint training concerning the correct conduct of these investigations and, in particular, the appropriate techniques which should be employed when interviewing child victims. Both the police and child protection agencies have developed their own general investigation protocols, which are applicable to all child-abuse investigations. However, the Department of Community Services has also implemented a number of protocols for specific circumstances, such as when abuse occurs in a group home, a foster home, or a regulated childcare setting. It is important to note that these protocols are not specific to child sexual abuse, but include physical and emotional abuse, as well as neglect. Another noteworthy characteristic is that these protocols are province-wide and are not limited to a specific jurisdiction. For the purpose of the present report, this characteristic has the effect of ensuring that service providers in Halifax and Truro are governed by the same protocols. Exceptions to this general situation are the various internal protocols or policies which an individual agency might implement in order to supplement not only relevant government policies but also the policies of non-profit organizations which are not affiliated with government.

5.3.1. Child protection Investigations and Responses

The Department of Community Services (DCS) is responsible for child protection services in Nova Scotia, including the creation of the policies which allow the Department to carry out its mandate under the *CFSA*. The DCS has created a number of policies for responding to child abuse. The principal policy is set out in the *Child Protection Service Manual* (1996), which provides a set of procedures for social workers to follow when they receive an allegation of child abuse. The social worker must assess the validity of the allegation, the immediate safety of the child, and the risk of future harm. Ultimately, the social worker must make a decision as to

whether an intervention is warranted and, if so, what type of intervention will promote the best interests of the child. Any intervention upon which the social worker decides requires the approval of a supervisor. Guidelines for intervening and conducting an investigation are provided in the manual. Some key features of the guidelines are the requirement that the police be notified and the stipulation that there should be a joint investigation in instances of physical or sexual abuse; the specification of appropriate techniques to be employed when interviewing child victims; the stipulation that there should be an audio or video recording of joint police-protection-worker interviews with child victims; and the requirement that there should be a search of the provincial child-abuse register when an alleged perpetrator is identified. In the case of child sexual abuse, the decision to have a medical practitioner examine the victim is to be made on a case-by-case basis. The appropriate timelines for beginning an investigation or intervention depend upon an assessment of the seriousness of the incident and the risk to the child. Where the life of the child is threatened, action must begin within one hour; non-life-threatening, but dangerous, incidents within one working day; damaging, but non-life-threatening, within two working days; and no risk - or little - risk within 21 working days.

Child protection services' principal role is often understood as intervening in situations where parents or guardians are believed to be abusing or neglecting their children. However, Nova Scotia's child protection services also have the mandate to investigate allegations of third-party abuse (abuse by someone outside of the child's family). In instances of third-party abuse, child protection workers must work with the police to determine if the parent or guardian is unable or unwilling to protect the child from abuse. They must also assess whether other children, including the alleged perpetrators' own children, are at risk. Responding to allegations of third-party abuse by a service provider can become complicated if the child is involved with

the child protection system or is being abused while receiving services from the government. Government-sponsored agencies are expected to provide quality services free from any abuse or inappropriate behaviour on the part of staff. Furthermore, when abuse occurs within a government-sponsored agency, particularly an agency associated with the DCS, the unfortunate situation arises in which the agencies responsible for investigating abuse are also responsible for the conduct of the service provider who has been accused of perpetrating the abuse. In light of this added layer of complexity, specialized protocols have been developed concerning the appropriate response which should be made to allegations of abuse in a variety of government-service areas, such as foster care, residential care, and government-regulated daycare.

In addition to having a specific protocol for the Department's supporting services, the DCS also has a draft protocol to deal with the situation in which one of their internal or agency staff is accused of abusing a child client – for instance, a social worker or agency executive director. The *Administrative Guidelines Concerning Allegations of Child Abuse against Staff* (1999) outlines the steps to be taken if an allegation of abuse is made against staff or if a staff member is accused of failing to report an alleged incident of abuse. The protocol begins with the acknowledgement that, while DCS have an overriding duty to act in the best interests of a child, it also has duties as an employer. With this in mind, the protocol is meant to promote the following four principles, listed in order of importance:

- The protection of alleged victims and all children an accused employee has contact with in the course of their duties;
- The preservation of evidence;
- The presumption of the accused employee's innocence until the allegation is substantiated; and
- The importance of maintaining confidentiality in order to reduce further trauma to the victim, to preserve evidence, to protect the reputation of the accused and to minimize disruptions in the work environment.

The protocol outlines six steps that the directors of an agency must take when they receive an allegation against one of their employees. If the Director of the agency is the alleged perpetrator, then the next most senior manager must carry out the procedures detailed in the protocol. A general overview of the six steps is as follows:

- If the employee may pose a risk to children, he or she must be excused from their duties or re-deployed so that there is no longer any risk to children.
- The Director must determine if there are grounds to believe that there is a reportable allegation by reviewing the available information. If the facts on-hand conflict with the details of the alleged incident or the allegation is too vague for the purpose of determining whether the purported abuse is physical, emotional, or sexual, then the Director may speak to the alleged victim or perpetrator in order to gather sufficient information to clarify the allegation. If an allegation is not investigated, the Director must complete a report explaining why this decision was made.
- When an allegation is received by the director of an agency, he or she is required to refer the allegation to an outside agency for the purpose of carrying out the investigation, except in instances where the Director is convinced that the allegation is not supported by any credible information. If this is the case, the Director must advise the alleged victim that he or she has the right to report the allegation to an outside agency or the police. The Director is to refrain from conducting internal reviews or interviews with the employee or the alleged victim until he or she has consulted with the relevant children service agency and the police who will actually carry out the investigation.
- Unless directed not to do so by the investigating agency or the police, the Director should contact the employee and arrange a meeting with him or her and should advise the employee to bring a union representative or a lawyer if that is the employee's preference.
- At the meeting, the Director should inform the employee that there has been an allegation of abuse made against them and that an outside agency and/or the police have been notified. However, the Director should not disclose the nature of the allegation, when it occurred, or the alleged victim(s). The employee should also be informed of any administrative action that is taken on the part of the agency, such as re-assigning the employee or placing him or her on leave with pay.
- Lastly, if the alleged victim is a child at the time of the allegation, the Director must inform the child's parents or the agency which is caring for the child concerned and indicate what steps are being taken to protect the child and what services are being provided to improve the child's well-being.

Similar procedures are followed when a staff member is accused of failing to report suspected child abuse. Failing to report suspected abuse brings into question an employee's suitability for

any type of employment which involves the care of children and may result in administrative discipline, even where there is insufficient evidence to proceed with a charge under the *CFSA*.

The procedures set out in this protocol, as well as those outlined in the foster care and residential care protocols, are only applicable to allegations of abuse of children or youth under the age of 16. There is no mandatory duty under the *CFSA* to report the abuse of young persons over the age 16. However, in 2004, the DCS issued a memorandum to all agencies indicating how to proceed if they should receive an allegation of abuse of a young person who is in care and over 16-years-of-age. If an allegation of abuse is disclosed, youths are encouraged to report the abuse to their foster parent, a youth worker in a residential facility, and their social worker. The foster parent or youth worker will cooperate with the social worker to ensure that the youth receives the necessary counselling and/or medical attention and the youth will be advised that he or she may bring their complaint to the police. If the youth decides to make a formal complaint to the police, then the foster parent, youth worker, or social worker should assist them with this process. The social worker should monitor the youth's progress to see if there are any further issues that need to be addressed.

In addition to implementing policies which articulate a framework for responding to allegations of abuse, the DCS provides joint training for police and social workers in the process of investigating child sexual abuse. The department also has implemented a complaints procedure, *when you disagree*, which outlines the process by means of which children or their parents may make a complaint about an agency employee or the services which they provide. A succinct version of this procedure is provided in a brochure which is available in facilities and agencies which provide services to children and youth. The department also publishes a brochure

which explains the nature and scope of children's rights while they are in care. Printed copies of both brochures are offered to children entering care, when they are considered sufficiently mature to understand them. The *CFSA* also requires the DCS to establish advisory committees consisting of a variety of stakeholders with an interest in child protection issues in order to monitor the department's performance in terms of the services it provides under the *CFSA*. Such committees have been in place since the 1990s.

5.3.2. Police Investigations

The RCMP and municipal police provide policing services in Nova Scotia. Both Halifax and Truro have their own municipal police forces. Within these two police departments, there is no internal protocol specific to the investigation of allegations of abuse against persons providing services to children and youth. However, unlike many B.C. police departments, there are specific guidelines for investigating child abuse in general. These are not specific to child sexual abuse but are meant for any type of abuse, including physical abuse and neglect. The guidelines are set out in the *Standard Operational Procedures for Policing Services* (1996), which apply to all policing services in the province – both RCMP and municipal police. The *Standard Operational Procedures* (SOPs) are intended as a general source of information for police and are to be supplemented by more detailed procedures established by each police department. The SOPs are also meant to ensure that policing services are carried out in accordance with the *Police Act* (Department of Justice, 2002).

According to the SOPs, when the police receive a complaint of child abuse, they should immediately arrange for any necessary medical attention, ensure the child is safe, and report the alleged abuse to the local child protection agency. Under the provisions of the *Children and*

Family Services Act, the police are required to report child abuse to the DCS, as is the case for any citizen. Once this has been done, an investigation may proceed. The police are expected to conduct their investigation with the child protection caseworker who has been assigned to the case. Throughout the investigation, the police investigator is expected to maintain contact with the caseworker. In addition to conducting a joint investigation with Children's Services, the SOP recommends working with a multidisciplinary team, including the Crown Attorney, medical professionals, and anyone else who might assist in advancing the investigation. Ideally, the investigating officer should be trained in investigating child abuse: however, if this is not possible, then a senior investigator should carry out the investigation.

During the investigation, police investigators and child protection caseworkers need to make arrangements for any medical examinations that are necessary and determine who should be interviewed. Prior to carrying out any interviews, both parties must decide whether or not the interview will be conducted jointly, and if so, who will take the lead in the interview. They also need to arrange practical details such as where the interview will be conducted and the availability of video equipment. When a child victim is being interviewed, the interview is to be videotaped and arrangements are made for the child's parent, guardian, or other support person to be available to monitor the interview, provided that this individual is not the suspected perpetrator.

When an alleged offender is identified, the investigating officer should search the available data bases for past criminal records or involvement in criminal activities and investigate the alleged offender, in the same manner as any other criminal investigation. If a criminal charge is laid, the investigating officer should file the necessary forms with the court to report the

individual to the provincial child abuse register. This task must be undertaken even when the victim is currently no longer a child but was so at the time of the alleged abuse. When investigating an alleged offender, a joint investigation with a child protection caseworker is no longer required and the police carry out the investigation in the same manner as any other criminal investigation. The involvement of child protection workers in an investigation of an offender is left to the discretion of the investigating officer: however, if they are involved, they will play only a limited role.

5.3.3. Foster Care

The Department of Community Services has devised a specific protocol for responding to allegations of abuse in foster care. The most recent version of the Department of Community Services' *Protocol for Investigating Allegations of Abuse and Neglect of Children in Care Residing in Foster Care or Adoption Probation Homes* came into effect in February, 2007. The protocol documents the procedures to be followed when an investigation is carried out as well as the principles the protocol is meant to promote. The protocol is designed to promote the protection of children and youth in care by upholding the principles espoused by the *CFSA*, which essentially means acting in the best interest of the child or youth. The protocol is also meant to ensure foster families or adoption probation homes³ are treated with respect and are given support and assistance throughout an investigation. This is premised on the view that foster homes are a valued resource in the community.

The protocol is very detailed in its description of the roles of various actors and agencies in an investigation as well as specific events that need to take place and the timelines associated

³ An adoption probation home refers to the placement of a child in a home for the purpose of adoption where the adoption order has not been granted.

with these events. The following is a very general description of the procedures outlined in the protocol. To begin with, an allegation of abuse in a foster home is governed by s. 25 (third-party abuse) of the *CFSA* rather than s. 22 (abuse by a parent of guardian). Under the terms of *CFSA* (s. 3(1)(r)), a foster parent is specifically excluded from the definition of “parent” or “guardian.” This is somewhat different from the provisions of the statutory framework in British Columbia, where foster parents are equated with a guardian or parent for the purpose of an abuse investigation. In Nova Scotia, the head of the Department of Community Services is considered the legal guardian of a child in foster care.

When an allegation of abuse is received, the foster family’s home agency (e.g. the agency responsible for funding, licensing, and operating the home) must refer the allegation to a neighbouring agency within 24 hours of receiving the complaint. The reason for referring the allegation to a neighbouring agency (the investigating agency) is to avoid actual or perceived bias in the investigation process. The investigating agency is responsible for deciding whether an allegation needs to be investigated. If the allegation involves physical or sexual abuse, the police will be notified and duly included in the investigation process. The investigating agency – more specifically, the designated investigating social worker and his or her supervisor - must decide whether an investigation is warranted and, if the decision is in the affirmative, the investigation must commence within 24 hours of the receipt of the allegation from the home agency. The investigation must be complete within six weeks. At the conclusion of the investigation, the investigating agency informs the home agency of its findings and assesses the risks associated with various alternative responses to the allegation (e.g., leaving the foster child in the care of the foster family or removing all children from the foster home). However, the home agency decides

how to respond to the investigation's findings in terms of the status of the foster home. The police decide if any criminal charges should be laid.

An investigation may result in a finding that the abuse is either unsubstantiated or substantiated or that, while there was no abuse, there was nevertheless a violation of other policies or standards of care, such as those set out in the *Foster Care Policy and Practice Manual* (2006)⁴: alternatively, there may be no conclusive findings to report. Although they are not set out in the investigation protocol, the home agency has a variety of options available to it for the purpose of responding to the findings of an investigation. During the course of an investigation, a foster home is placed on hold, which means the home will receive no new placements. Any other children will be removed from the home - if it is believed that they are at risk, should they remain there. Once an investigation is complete, the responses available to the home agency may range from closing the foster home and removing all foster children (and, potentially, any birth children), to placing the home on probation, to requiring the foster parents to undertake additional training, and to taking no action at all. The nature of the response will depend upon the seriousness of the allegation, the circumstances surrounding it, and the findings of the investigation. The appropriate response will be decided in the Foster Home Status Meeting. If a foster home continues to operate after an allegation of abuse has been made, a subsequent review is conducted within 30 days of the Foster Home Status Meeting in order to explore the foster family's continuing interest in undertaking their fostering role, any supports it might need, and any barriers to becoming an effective foster family which might be encountered in the particular case concerned.

⁴ Foster parents are held to a higher standard of care than parent or caregivers who are not acting on behalf of the state. For instance, foster parents are prohibited from using any physical discipline.

When an investigation is initiated, not only will the foster family be informed of the investigation but also the child's birth parents, if they continue to be involved with the child. During an investigation, a child may be removed from the foster home, depending on the nature of the allegation and the circumstances surrounding it. The child's social worker facilitates any contact between the child and investigators. Likewise, the foster home's social worker acts as a liaison between the foster family, their home agency and the investigating agency: in addition, it provides assistance and support to the foster family throughout the investigation. Besides receiving support from the foster home's social worker, the foster family can also seek assistance from the Federation of Foster Families Nova Scotia (FFFNS). The FFFNS employs a fulltime social worker who acts as an advocate for foster families who are being investigated under the protocol. If authorized by the foster parents to do so, the FFFNS's social worker can also act as a liaison between the foster family and the home or investigating agency and may also provide information about the investigation protocol as well as advice as to what they can expect during an investigation. The social worker also has access to legal counsel, should the foster family require legal advice. The current protocol specifies that any foster family which is under investigation must be informed of this service.

5.3.4. Residential Care and Group Homes

Similar to B.C., which has separate investigation protocols for foster homes and group homes, Nova Scotia also has a separate protocol for each type of facility. The *Provincial Child Abuse Protocol: Residential Child-Caring Facilities* (2004) delineates the procedures which should be followed when investigating an allegation of abuse of a child in residential care by their parent, guardian, third party outside of the facility, or by another resident or a staff member. The procedures for responding to an allegation against a staff member will be the focus of this

section of the report. As is the case with the foster care protocol, the residential child-caring protocol clearly states that the protection and best interests of the child are the most important priorities in any investigation: however, it also acknowledges that an alleged perpetrator's interests and rights are important considerations to take into account. The purpose of the protocol is to provide a set of standardized procedures which can be followed by residential facilities, social service agencies, and Department of Community Services' employees.

A secondary function of the protocol is to provide clear direction concerning the "who, what, where, and when" questions which arise when making a report of child abuse. Furthermore, the protocol provides not only information about the roles and responsibilities of different actors in an investigation (e.g. staff members, the investigating social worker, and the police) but also guidance in relation to the important task of ensuring that the child abuse does not re-occur. Facility personnel are responsible for ensuring that all staff members are aware of the protocol and its procedures as well as the mandatory reporting provisions of the *CFSA*. Facility personnel must also ensure that all new residents understand how to make a complaint and report abuse, as well as how to contact the youth ombudsman and the police, should they believe that staff members have not taken their complaint seriously. The protocol also requires that internal policies be set in place for dealing with staff against whom an allegation has been made. In the event that an allegation is made, it is the responsibility of the facility to ensure the protocol's procedures are followed and their staff members are expected to cooperate with any investigation. The facility concerned must also ensure that any alleged victims are kept safe and that the accused staff member has no contact with them. The roles and responsibilities of the investigating social worker and the police are similar to those which are present in any type of child protection investigation.

As is the case with foster parents, when an allegation is made against a staff member of a residential facility, the home agency must immediately refer the complaint to a neighbouring agency. This agency will then decide whether the complaint warrants an investigation and carry out any investigation that is needed. When a staff member or administrative personnel receive a complaint of abuse, they must refrain from interviewing either the alleged victim or perpetrator. They should not inform the child's parents of the abuse. These are the responsibilities of the investigating agency and the police. The staff member who receives the complaint should file the report personally and ensure that the alleged incident is properly documented.

Facility personnel are required to make sure that the accused staff member does not have contact with residents during the investigation and to inform the alleged perpetrator that an allegation has been made against him or her. The alleged abuser must also be informed of the right to remain silent and the right to contact a lawyer or union representative (if their facility is unionized): significantly, it must be made clear that this communication of the staff member's rights is not to be interpreted as an indication of guilt. The accused staff member is not entitled to be informed of the details of the allegation or the identity of the victim. However, he or she must be informed not only of the specific steps which the facility is taking under its internal personnel policy in order to reduce any potential risk to the facility's residents but also of the available disciplinary action, should the allegation be substantiated. Information about an allegation or an investigation must be kept confidential and will only be disclosed on a need-to-know basis to other staff member. Accused staff members are to be informed of the outcome of the investigation. The timelines for initiating an investigation range from one hour to 21 days, depending on the seriousness of the incident and the level of perceived risk to the facility's residents.

5.3.5. Youth Justice

In Nova Scotia, youth probation services are provided by the Department of Justice and are governed by the *Correctional Service Act*. Allegations of sexual abuse by probation officers should be investigated jointly by a child protection caseworker and a police officer, in the same manner as a case involving an allegation of third-party abuse. However, since Youth Corrections only deals with children who have reached the age of 12 years or more, child protection workers would typically play a less active role in the investigation. The expertise which child protection workers typically bring to an investigation is their experience of interacting with young children. Child protection investigators would not be involved if an alleged victim is more than 16 years-of-age. In this situation, the police would conduct the investigation alone. In instances where the alleged victim was in the care of the DCS, the youth's social worker might become involved but not in the capacity of an investigator.

From the vantage point of children's services, there is no specific protocol in place for responding to allegations of abuse against probation officers. However, the Youth Corrections service branch has an internal policy which guides its responses to allegations of abuse against their workers. However, this document is not publicly available and we were not able to obtain a copy of it: therefore, the precise details of the policy are unknown. The policy was developed in consultation with the Department of Community Services and is similar to the Department's protocol for responding to an abuse allegation against a staff member. The policy is not specific to probation services but is applicable to all Youth Corrections' employees and was just revised this year (2007).

In addition to a formal protocol for responding to allegations of abuse made against employees, there are also internal human-resources policies which outline how staff members should be treated during an investigation. Depending on the nature of an allegation and whether there is any substance to it, staff members might be re-assigned to a position where they will have no contact with youths or they may be suspended with or without pay. If a staff member disagrees with their treatment during the course of an investigation or with the outcome of an investigation, that individual may request that his or her union become involved in the case.

Protocols for responding to allegations constitute only one piece of the puzzle when dealing with the issue of abuse by persons who provide services to children or youth. Youth Corrections also has in place an employee's code of conduct and procedures to be followed in instances where an action might be misinterpreted as abuse. For instance, there are detailed guidelines about how to search a young offender or what should be done when a staff member is working alone with a youth. Furthermore, Youth Corrections has implemented an internal complaints process. It also has established a special arrangement with the Youth Services Branch of the Office of the Ombudsman. Youth Services undertakes outreach functions in residential and custodial facilities for youth. Representatives of the Ombudsman's Office routinely visit youth custody centres and group homes to inform incoming youths about their services. They educate youths about their rights while they are in custody or residential care and ensure that the youths understand that they may contact the Ombudsman's Office, should they have any complaints or concerns. They also try to make follow-up visits with youths in these facilities. Contact information for Youth Services is available in all custodial and residential facilities in 'youth friendly' brochures and youths are free to call at anytime. The Youth Services brochure is also

available in probation offices, although they do not carry out outreach work with youths who are not in a custodial or residential facility.

5.3.6. Non-Profit Service Providers

Nova Scotia has a long history of contracting out children's services to non-profit agencies. When this occurs, these agencies are expected to implement and follow the policies and protocols issued by the Department of Community Services. In other words, the protocols for handling allegations of abuse will be the same for both government offices and non-profit agencies. However, if the non-profit agency is not under contract to the Department of Community Services but, instead, simply provides services to children and youth (such as mentoring, substance-abuse treatment, emergency shelters, or recreational activities), they are still expected to cooperate with any police or child protection investigation. They are also encouraged to develop a protocol for handling employees who have been the target of an allegation of abuse. Ultimately, it is the responsibility of the individual organization to undertake this task. Some organizations have done so – not only to protect children and youth from abuse but also to protect the organization itself from liability for any abuses perpetrated by its employees or volunteers. For instance, Sports Nova Scotia, an organization which co-ordinates a variety of sports programs for youth, has an extensive policy setting out how the organization will respond to an allegation against one of its volunteers as well as the steps it has taken to prevent child abuse from occurring within the context of the organization. The policy outlines the organization's screening process for new employees and volunteers, boundaries for acceptable behaviour for employees and volunteers, and information concerning provincial legislation requiring the reporting of child abuse. Other organizations or service providers which have similar protocols in place include school districts and religious institutions.

More general complaints procedures constitute another avenue which service providers may pursue in order to ensure that the voices of children and youth are heard and that abuse allegations are not overlooked or discouraged. Complaints processes promote a culture wherein children and youth feel comfortable about voicing their concerns. Many organizations have implemented some type of general complaints process. It is also common practice for agencies which provide services to children and youths to require all their employees and volunteers to undergo a criminal records and/or abuse-registry checks.

5.4. *Historical Policies and Protocols*

The preceding discussion documents legislation, policies, and protocols that Nova Scotia currently has in place for dealing with allegations of abuse against service providers. Such policies are the product of the recent past. Just as in B.C. and other Canadian provinces, responding to allegations of child sexual abuse, by those who are entrusted with the provision of services to children and youths, constitutes a relatively new policy area. Indeed, none of the protocols mentioned above date back more than 20 years. The majority of these protocols were first implemented in the mid-1990s. However, the establishment of this body of policy is part of a much larger trend. One interviewee from Nova Scotia aptly described this trend as an “evolution of awareness of responsibility [that] continues even today”. The focus of the next section is on this process of ‘evolution’ and how it led to a veritable flurry of policymaking in the 1990s.

5.4.1. Child protection Investigations and Responses

As in other Canadian provinces, child abuse was not an issue of public concern in Nova Scotia until approximately the 1960s. Although the Department of Public Welfare was established in 1944 and child protection legislation existed prior to this, the focus of early child

protection work was primarily on orphaned and abandoned children. Increasing concern about child abuse prompted legislative reform, such as the enactment of mandatory reporting provisions and statutes that acknowledged the existence of emotional and sexual abuse (Howe, 2001). As in B.C., the duty to report child abuse and neglect has been a legal duty in Nova Scotia since 1967, when the *Child Welfare Act* was passed. The original mandatory reporting provisions were enacted in response to growing concerns about child neglect and physical abuse. In 1976, the *Child Welfare Act* was replaced by the *Children's Services Act*, which was later supplanted by the current *Children and Family Services Act*.

The 1960s also witnessed an increase in the numbers of child protection workers, both in Halifax and elsewhere in the province (Halifax Children's Aid Society, no date; Department of Social Services, 1987). In 1973, the first study investigating the prevalence of child abuse in the province was published (Fraser, et al., 1973). This study focused on what we now call 'physical abuse' as well as neglect. It did not appear to distinguish between physical and sexual abuse, which offers a significant insight into perceptions of child abuse at that time (Fraser et al., 1973). Indeed, the *Child Welfare Act* of 1967 defined child abuse as "the abandonment, desertion, physical ill-treatment or emotional deprivation of a child" (Department of Social Services, 1974). Presumably, sexual abuse would fall under 'physical ill-treatment'.

The report emanating from this research was entitled '*Child Abuse in Nova Scotia*': it made a number of recommendations which were designed to address the problem of child abuse in the province and a task force was appointed to assess the feasibility of implementing these recommendations. The publication of this report undoubtedly reflected a growing concern about child abuse (Department of Social Services, 1974). A principal recommendation of the report was

the establishment of a child-abuse register to address inconsistent reporting and recording practices and to keep better track of incidents of abuse in the province. The task force accepted this recommendation and the registry was finally implemented in 1976. The establishment of the child-abuse register is an important landmark in Nova Scotia's history of developing appropriate and effective responses to allegations of child abuse and of implementing procedures designed to prevent further incidents of such abuse. Initially, the abuse register was utilized as a central database for child protection workers which enabled them to share information amongst themselves and only included information about perpetrators who were either parents or guardians convicted of child abuse in criminal or family court (Howe, 2001; Department of Social Services, 1974). This constitutes fairly convincing evidence that child abuse was largely viewed as a family problem. Common understanding of child abuse at this time did not appear to include abuse by service providers or other community members.

The first report in the child abuse register suggests that there was an important change in perceptions of child abuse. Incidents of sexual abuse were counted separately from physical abuse. However, sexual abuse appears to be constructed in terms of female victims only. There was no discussion of the sexual abuse of boys (Department of Social Services, 1978). When the *Children's Service Act* replaced the *Child Welfare Act* in 1976, child sexual abuse was recognized as being distinct from physical abuse. Child abuse was defined as "acts of commission or omission on the part of the parent or custodian of a child which result in injury to a child. This includes, but is not necessarily restricted to, physical beating, parental deprivation, cutting, burning, physical assault, sexual abuse, and failure to provide reasonable protection for the child from physical harm" (Department of Social Services, 1987, p. 65).

Another recommendation made by Fraser and his colleagues (1973) in their report on child abuse was the establishment of a children's advocate to uphold children's rights. The Task Force on Child Abuse rejected this recommendation because they felt that this was the responsibility of existing child protection agencies. Apparently, they saw no need to monitor the actions of these, or other state agencies, or to provide an independent advocate to hear children's concerns or complaints, while they were in the care of the state. The rights of children were viewed as coming into conflict with parental rights, at times, but it was assumed that the state would always act in the 'best interests of the child' (Department of Social Services, 1974). Confidence in child protection workers' ability to protect the best interests of children did not contradict the view that other professionals needed to be involved in Nova Scotia's response to child abuse. The Task Force recommended a multidisciplinary approach to detecting and treating child abuse which involved health professionals, school officials, and other service providers.

The 1980s brought with them further awareness of child abuse. Many media reports focused on horrific incidents of abuse and reports to child protection agencies increased dramatically, to the point where these agencies were struggling to keep up with the demand for their services. This was particularly true for reports of child sexual abuse. Increased reporting was largely the result of changes to mandatory reporting laws in 1984, which made it an offence not to report abuse. This change was accompanied by a large-scale public education campaign aimed at informing the public about their duty to report child abuse (Department of Social Services, 1987; Ottawa Citizen, January 4th, 1986). At this time, reports of abuse by prominent community members and persons entrusted with the care of children and youth began to reach the public. By the mid- 1980s, there was an increasing degree of recognition that steps needed to be taken to ensure that service providers did not abuse children and youth in the course of their

duties. A Task Force commissioned to review the provision of services by the Department of Social Services recommended that the abuse register be reformed to include perpetrators other than parents and that it be made available as a screening tool for new foster parents, prospective adoptive parents, and persons who worked with children. These changes were eventually implemented in 1991 (Department of Social Services, 1987; Howe, 2001).

The Task Force also recommended that standard provincial protocols for all agencies and professionals involved in the provision of services to children and youth be implemented in order to co-ordinate their responses to child abuse and neglect. They also recommended that this action should be supported by interdisciplinary training sessions. These recommendations arose out of the observation that there was no co-ordinated, standard approach to investigating or responding to allegations of child abuse, particularly child sexual abuse. The Task Force also noted a severe lack of staff training in agencies that provided service to youth. Some regions of the province had formed committees on child sexual abuse and developed regional protocols for responding to allegations of abuse, as well as training sessions for professionals. Halifax was one jurisdiction which adopted this course of action, whereas we found no evidence that Colchester County - the jurisdiction in which Truro is located – had taken similar steps. By the late 1980s, the Halifax Children Aid Society had finalized protocols with the city's children's hospital, the city policy, city school boards, and the Halifax archdiocese (Halifax Children's Aid Society, no date; Department of Social Services, 1987).

Increased awareness of child abuse also brought Nova Scotia's Child protection services into the public spotlight. In the late 1980s, the Department of Community Services was criticized for not believing and failing to adequately investigate allegations of child abuse in a number of

high profile cases. This criticism became very public and one interviewee suggests it was the catalyst for wide-scale changes to child protection services. The Department of Community Services acknowledged that the existing child protection legislation did not adequately define child abuse and neglect and there was confusion over what was to be considered as child abuse. The Department also acknowledged that there needed to be standards and procedures in place for responding to allegations of abuse so that no child would fall through the cracks in the system. Liability also became a concern for the first time as the Department realized that it could be held responsible for any abuse perpetrated by its employees and for any failure to provide good service.

Replacing the *Children's Services Act* with the *Children and Family Services Act* in 1991 was a particularly influential reform. The new act was more legalistic and included considerably more detailed investigation requirements. It also created a separate offence for third-party abuse as well as introducing mandatory reporting requirements for third-party abuse. Most incidents of child abuse committed by service providers are considered to be third-party abuse. This reform firmly established that third-party abuse falls within the mandate of child protection services. This represents a major difference between legislation and practice in Nova Scotia and B.C. In B.C., third-party abuse is only considered to lie within the mandate of child protection services if there is evidence that the child's parents have refused, or are unable, to protect their child. The implementation of the *CFSA* was accompanied by public education campaigns which raised the issue of what forms of behaviour should be considered as child abuse. Coincidentally, reports of child abuse continued to increase in frequency along with the number of child protection workers.

The Department of Community Services took further action by implementing a number of protocols for responding to allegations of abuse, namely the foster care and residential care protocols. In 1991, they replaced the *Protection Services Manual* with the *Child Protection Service Manual* to bring procedures in line with the new CFSA. This manual was revised again in 1996, which is the version currently being used. The Department's (draft), *Administrative Guideline Concerning Allegations of Child Abuse against Staff*, was not implemented until 1999 and has not been revised to date. However, in 1993, the Department issued a memorandum which addressed the question as to how agencies should respond to allegations of abuse against board members of private Children's Aid Societies or Family and Children's Services agencies: this action reflected the Department's concern in relation to allegations against agency members.

5.4.2. Police Investigations

Neither of the police officers interviewed in Nova Scotia had worked as a child abuse investigator for an extended period (there is a high turn-over rate in this position). In addition, neither of them had acquired more than 20 years of experience in policing. As such, the information they provided concerning past policies, protocols, and practices was inevitably somewhat limited. Furthermore, policing manuals and protocols are not publicly available. The little information which was available through interviews with police and others, printed material, and information available on the internet strongly suggests that there were no province-wide police operating procedures in place prior to 1992. The current Standard Operating Procedures (SOPs), which include guidelines for investigating child abuse, were implemented in response to a recommendation made by a commission of inquiry into the wrongful conviction of Donald Marshall, Jr. They were later revised in 1996 (Department of Justice, 2002). Prior to this time, there had been no requirement that investigations be conducted jointly between police and Child

protection workers. For instance, one interviewee suggested that, in 1990, when the police received an allegation of child abuse, they would investigate the allegation and then make a decision as to whether or not to inform children's services rather than immediately doing so. Similarly, child protection agencies would not automatically notify the police but would investigate the allegation and decide if the police should be involved. Prior to the requirement of joint investigations and training, the police and social services shared little information and when an investigation did take place, the police interviewed child victims on multiple occasions and in the same manner as any other victim. Each party with an interest in the investigation would interview the child separately – for instance, police, social workers, and employers.

Although there was no province-wide protocol for investigating child-abuse allegations, individual police departments had nevertheless implemented guidelines prior to the 1990s. For instance, in 1983, the Dartmouth branch of the Department of Social Services and the Police Department issued a protocol, which recognized the protection and safety of the child as the pre-eminent goal of both the police and social workers. The guidelines recommended that, if police officers received a complaint of physical or sexual child abuse, they should contact children's services and decide whether the police or the assigned caseworker should investigate in the first instance or whether they should conduct the investigation on a joint basis. The agency which investigated first was required to share information with the other agency. The guidelines also recommended that joint decisions be made about removing children from their home, laying charges, and whether to provide assessment and treatment to the child. It is clear that these guidelines conceptualized child abuse as a phenomenon which occurs within the family and there was no acknowledgement of the fact that child abuse occurs in other situations as well. However, the guidelines indicate that child sexual abuse was an issue of concern in the early 1980s. There

was also a mutually recognized need for cooperation between police and social service providers. It is unknown how many departments had similar guidelines in place across the province or if the Truro or Halifax police implemented any similar measures.

Despite this policy being in place, a study by a master's student – Valerie Naslund – from the Maritime School of Social work suggests that this policy, and others like it, were not followed in practice. According to Naslund (1984), the police and social workers viewed their respective roles as being in conflict with one another. It was the perception among police officers that social workers often interfered with, or even contaminated, evidence which was needed for the investigation of a criminal case. Involving social workers appeared to be a last resort and was only undertaken when the police had exhausted their own authority and needed the additional investigative powers granted to social workers.

5.4.3. Youth Justice

As mentioned above, the Department of Community Services and its predecessors were largely responsible for the administration of youth justice until the Department of Justice assumed this responsibility in 1994, shortly after it was created. Therefore, the previous historical discussion of child welfare policy is equally relevant to youth justice. Indeed, until 1984, when the *Young Offenders Act* replaced the *Juvenile Delinquents Act*, the line between child welfare services and what was referred to as 'special protection services' (youth justice) was blurred. The *Juvenile Delinquents Act* was closely aligned with child protection legislation and was based on the philosophy that juvenile delinquents were misguided children who needed help and guidance and that the role of the state in this context was that of the caring parent (Department of Community Services, 1992). This had important ramifications for the manner in

which young offenders were treated and for the nature of their relationship with youth justice service providers. Youths might be kept under the care of the state for an indefinite period and there was little recognition of their due process rights. When the *Young Offenders Act* was implemented in 1984, the Solicitor General became involved in the administration of youth justice to youths over 16-years-of-age and there was a greater emphasis on the rights of youths. The child welfare approach to youth justice was abandoned in favour of a system that was more akin to the adult justice system.

The available information concerning the historical reactions to allegations of abuse against probation officers and, particularly, staff members working in custodial facilities can be found in various government reports that emanated from Nova Scotia's largest sexual-abuse scandal. In the late 1980s and early 1990s, reports of physical and sexual abuse in Nova Scotia's youth custodial facilities began to surface. The allegations related to events in the mid-1950s through to the 1970s. In 1991, the RCMP began to investigate three staff members of the Shelburne School for Boys and the Nova Scotia School for Girls. All three men were convicted of various charges relating to inappropriate sexual behaviour towards youths (Kaufman, 2002). This sparked an investigation into all residential facilities in the province, an audit of current practices in youth-custody facilities, the creation of a compensation program for victims, and eventually a review of the initial investigation, audit, and compensation program. This abuse scandal also appears to be a motivating force underlying the development of various protocols in the Department of Community Services, which were designed to prevent and investigate allegations of abuse against service providers. It also resulted in the establishment of the Youth Branch of the Office of the Ombudsman. For the first time, there was a process in place whereby

youths could launch complaints about their treatment in the youth justice system to an independent agent rather than to a designated youth worker or manager.

Protocols establishing appropriate mechanisms for responding to allegations of the sexual abuse of young offenders do not appear to have been implemented in Nova Scotia until the 1990s (Kaufman, 2002; Stratton, 1995). As early as 1948, youth-custody facilities had established guidelines concerning the appropriate use of force, which slowly became more detailed and restrictive over time. In the late 1980s, procedures were developed for the purpose of involving the police in an investigation of alleged physical abuse. However, the policy did not appear to extend to inappropriate sexual behaviour or abuse (Kaufman, 2002).

Despite the absence of any formal policy or protocol for handling allegations of sexual abuse, incidents of sexual abuse and sexually inappropriate behaviour by youth justice workers were nevertheless reported as early as the 1960s. The Kaufman and Stratton reports provide evidence as to how allegations of sexual abuse in custodial facilities were dealt with in the 1960s and 1970s. For the most part, reports of sexual abuse by staff members appear to have been dealt with internally, unless the incident was reported directly to the police. Senior management determined whether the allegation had any merit. When management felt the allegation was true, staff members could be reprimanded, transferred to another position within the ministry, or dismissed. In line with current practice, the response depended on the seriousness of the alleged offence. However, in many instances, it also appears that youths were often not believed, or little was done even if their allegations were given some credence. In some instances, the accused staff member was simply transferred to another facility or position (Kaufman, 2002; Stratton, 1995).

Furthermore, there is evidence of managers having dismissed employees and the Ministry later undermining this action and reinstating the employee in another facility or position.

The sole instance in which a probation officer was accused, and subsequently convicted, of sexually abusing the youth with whom he worked did not come to light until the late 1980s. Cesar Lalo began work with (what was then) the Department of Public Welfare in 1971 and became a probation officer in 1975. In response to an allegation of historical abuse, the RCMP began to investigate Lalo in 1989 and informed the Department of Community Services of the investigation: however, the police also asked the regional administrator to keep the allegation confidential. The administrator complied with this request and did not report the allegation to her supervisors, who only became aware of the allegations after Lalo himself commented to a co-worker that he was being investigated. Once the existence of the allegation became known, an internal investigation was ordered and Lalo was moved from his position as a probation officer to a situation where he would no longer have any contact with youths. The internal investigation was not conducted in conjunction with the police but it was discussed with them. The investigator believed the allegations to be true and Lalo was eventually dismissed. However, Lalo fought the dismissal through his union and he was eventually reinstated on the understanding that he would resign and the Department would provide him with a good reference for any job not involving contact with children or youths. This case appears to have been handled in a manner which is similar to the procedures which would be followed at the present time. Potential differences would be that, today, the police and internal investigations might be conducted on a joint basis, although this would not necessarily be the case if the alleged victim were now an adult. However, the request to keep the allegation confidential would be rejected because it constitutes a violation of the *Children and Family Services Act*.

5.4.4. Foster Care and Group Homes

The history of official responses to allegations of child abuse in the context of foster and residential care follows a similar path as the more general history of child protection and youth justice. In Nova Scotia, children in the care of the province were traditionally housed in residential facilities. This began to change in the early 20th century, when foster care emerged as an alternative model of care giving. By the mid 20th century, the philosophy of child protection services began to change and foster care became the preferred placement for children in care. The remaining residential facilities and group homes became more specialized and housed only children who had problems that precluded them from receiving foster care. This switch in philosophy was largely driven by the increasing acceptance of the view that the best place for children was in a family environment within the community (Department of Social Services, 1987). Despite a lengthy history of both residential care and foster care in the province, formal policies for responding to allegation of abuse do not appear to have been implemented until the 1990s. A province-wide protocol for responding to allegations of abuse in residential facilities was first implemented in 1990. The foster care protocol was implemented shortly afterwards in 1991 (Hillier & Koster, 1994). It is unknown whether individual group homes, residential facilities, or jurisdictions implemented their own protocols prior to this. We found no mention of any such protocols in any of the documents we reviewed and none of our interviewees were aware of prior protocols.

The implementation of the abuse protocol for residential care marked the beginning of a period of intense scrutiny of residential care in Nova Scotia, particularly in relation to the province's larger residential facilities for disabled children. At this time, there was an impetus towards the de-institutionalization of disabled children in favour of small, community-based

facilities (Dawson, 1995b). This movement coupled with concerns of abuse in residential facilities – which were linked to the youth custody sexual-abuse scandal – led to a number of reviews of the province’s large institutions and the eventual closure of the province’s children’s training schools (residential facilities for disabled children) in favour of smaller group homes (Kaufman, 2002). The Stratton report investigated alleged incidents of sexual and physical abuse and three government-sponsored reviews were conducted in relation to the programming, operations, and safeguards which were put in place in order to protect children in residential institutions from abuse. In 1999, Andrew Koster reviewed the adequacy of the protocol and its implementation.

The result of this scrutiny was not overly negative. Generally, the abuse protocol was viewed as being progressive. Only relatively minor suggestions were made to implement changes (for example, requiring employees to report allegations of abuse directly to the police or child protection workers rather than to their supervisors and to make the protocol more widely available to child protection workers themselves). In order to render it more effective, the protocol was revised on a number of occasions prior to promulgation of the latest version in 2004. Staff in residential facilities received training regarding the protocol and how to respond to allegations of abuse. Similarly, residents were educated concerning the issue of abuse and were informed of their rights while in residential care. New staff underwent an extensive screening process that included checking the child-abuse registry in order to determine whether they had a history of child abuse. Criminal record checks were not carried out (Dawson, 1995b; Koster, 1999). Investigations into alleged incidents of abuse seemed to be carried out in a fashion which reflects current practice. The allegations were reported to the Department of Community Services and the police and Child protection caseworkers carried out joint investigations. Internal

investigations were also executed and, in one instance where a staff member was identified as a potential perpetrator, that member was suspended until the investigation was complete (Stratton, 1994). Staffing shortages were identified as one feature of the province's residential facilities which could undermine other efforts to prevent abuse (Dawson, 1995a & b; Koster, 1999).

The province's foster care system does not appear to have been subjected to the same level of scrutiny as residential care during the 1990s. The initial protocol for responding to abuse in foster care was implemented in 1991 and was subsequently revised in 1996 and 1998. The most recent version of the protocol was implemented in 2007. Revisions to the protocol were largely undertaken to clarify the roles of the investigating child protection agency and the home agency as well as to implement a mechanism to resolve disagreements between the two agencies⁵. When Andrew Koster (1999) reviewed the adequacy and implementation of the protocol in 1999, training in relation to the protocol had been conducted with both staff and child protection workers. The protocol was generally found to comply with the *Children and Family Services Act*. Potential foster parents are screened through criminal records checks and abuse registry checks.

We found only one government report into abuse by a foster parent (see Hiller and Koster, 1994). However, the report focused on one incident and did not look into the issue more generally. In 1987, Debbie Stevens made a complaint that the foster father was sexually abusing her son. This initial complaint was followed by a series of other complaints by the mother and the boy's aunt. These complaints were largely ignored and little effort was made on the part of the

⁵ As was mentioned above, when an allegation of abuse is made against a foster parent, the complaint is referred to a neighbouring agency to investigate, rather than having the agency responsible for the home conduct the investigation. This procedure is designed to reduce any actual or perceived bias in the investigation process.

local child protection agency to investigate them. Indeed, records of the complaints and how the agency responded were often missing (or never recorded) or incomplete. Hiller and Koster (1994) conclude that this was because the mother was viewed as a nuisance and the foster parents were viewed as the ‘superstars’ of foster care, despite the fact that there had been an earlier allegation of abuse against the foster father. The authors of the report also suggest that the agency did not handle the allegations appropriately because it attributed the complaints to the mother’s disagreement over the placement of the children with the foster family. This may also indicate reluctance on the part of the child protection agency to lose a valuable resource. There has been a shortage of foster parents in Nova Scotia from at least the mid 1980s and, as one interviewee suggests, investigating foster parents involves the tricky task of ensuring the safety of children while simultaneously attempting to avoid alienating foster parents who are falsely accused.

5.5. Practice: Investigating and Resolving Abuse Allegations

As can be ascertained from the above discussion, Nova Scotia has a comprehensive body of policy for responding to allegations of child abuse in a variety of settings. This body of policy has slowly developed over the period considered in this report from the introduction of the province’s mandatory reporting laws in 1967 to the 2007 version of the *Protocol for Investigating Allegations of Abuse and Neglect of Children in Care Residing in Foster Care or Adoption Probation Homes*. Equally important as the contents of policies themselves is the evidence as to how these policies are actually implemented and put into practice. Moreover, the slow development of policy in Nova Scotia, as well as in other provinces across Canada, makes a review of practice particularly important, as it will provide insight into how abuse was dealt with prior to the implementation of policies for preventing and investigating child abuse. The following section of the report will examine both current and past practice. However, a note of

caution in this regard is necessary. There is a very limited amount of printed information available in relation to historical practices for responding to abuse in Nova Scotia (and elsewhere) and the longest any of the interviewees from Nova Scotia had worked in a position where they provided services to children and youth was 25 years or from the early 1980s.

5.5.1. Historical Versus Current Abuse Allegations

Interviews from both Truro and Halifax suggested that there would be little difference between an investigation of historical abuse and an investigation of current abuse. Evidence would be gathered in the same manner. There might well be some differences owing to the passage of time. For instance, there would not be as much physical evidence and not as many witnesses or the witnesses' recall of the event might be different. The most notable divergence in the nature of the investigation would be the involvement of child protection workers. When there has been an allegation of current abuse, there will always be a joint investigation involving both police and child protection workers. However, where an allegation of historical abuse is made when the complainant is no longer legally considered a child (e.g. over 16-years), the police would typically conduct the investigation alone. Child protection would only become involved in an investigation if the accused individual still worked (or volunteered) with children or had access to children through their family: for instance, if the accused person's own children were under the age of 16 or if they had grandchildren. The rationale for this situation is that the purpose of an investigation by Child protection services is to assess risk to children and their mandate is to protect children under the age of 16 years. One interviewee from Truro suggested that child protection workers might be consulted even if the accused person no longer had continued access to children but their role would be to consult rather than to conduct the investigation themselves.

It is important to note that the various protocols for investigating and resolving abuse claims make no mention of specific considerations for handling allegations of historical abuse. These protocols are designed for current abuse allegations. If child protection services became involved in an allegation of historical abuse, it would be dealt with on a case-by-case basis. For instance, the practice of referring an abuse investigation to a neighbouring district in order to avoid the perception of bias in the investigation would not occur automatically: in an allegation of current abuse, the implementation of this practice would depend upon the particular circumstances surrounding the case.

In terms of responding to allegations of historical abuse, the options are limited to initiating criminal charges or civil action by the victim against the alleged abuser and/or the relevant organization. If the accused person still works for the agency or is a foster parent, the administrative responses available would be the same as those which are available for an allegation of current abuse. Responses could range anywhere from no action, being moved to a position where the employee has no contact with children, or being subjected to further training, to terminating employment or closing the foster home, in the case of an accused foster parent. The action taken would depend upon the investigation's findings as well as the seriousness of the alleged incident.

5.5.2. Current Practice

There seems to be a general agreement among all interviewees that various protocols for responding to child abuse are closely followed and that there is not a large gap between policy and practice. This, in part, appears to be a function of the view that the protocols are in place not only to benefit children and the larger society, but also to protect workers, agencies, and

investigators themselves. Despite this general perception that there is a close relationship between policy and practice, a number of policy breaches were mentioned. When an investigation takes place, ideally it should be conducted by a police officer who has received joint, specialized training in the most effective techniques for conducting child-abuse investigations. However, because many police officers, especially RCMP members, frequently change their assignments or are transferred to different locations across Canada, this goal is not always possible to attain. Therefore, officers who have not received any specialized training sometimes carry out child-abuse investigations. This was a subject of considerable concern in both Halifax and Truro.

In a similar vein, while some protocols specify specific timelines for the completion of various stages of an investigation, the reality is that it is not always possible to follow these timelines. Similarly, there are some circumstances in which an investigation may be launched without all of the key actors being in place. For example, the Department of Community Services' protocol specifies that an investigation should begin within 24 hours of receiving a complaint of child abuse. However, given the busy schedule of the police, they are not always able to accomplish this and, in some instances, child protection services will begin the investigation without the police, who will join in at a later date. This was mentioned as being an issue in Halifax but not in Truro. Conversely, some interviewees mentioned that finding an available child protection worker from a neighbouring jurisdiction to carry out an investigation could be challenging at times.

In 1999, the Department of Community Services commissioned Andrew Koster to review its child protection protocols and their implementation. Koster's report identifies a number of gaps between policy and practice. In this report, the problem of adhering to set timelines was also

highlighted. Koster suggested that low staffing levels undermine the ability of both child protection agencies and the police to initiate an investigation in a timely manner. Furthermore, low staffing levels and a lack of sufficient resources may undermine the efficacy of the training provided to social workers who not only conduct child abuse investigations but also provide services to children and youths. Resource issues may also hamper the Department of Community Service's ability to ensure not only that all agency workers are adequately educated concerning relevant protocols but also that the relevant policies and procedures are correctly implemented and that children and workers who are involved in an abuse investigation receive adequate support during the process. On a more positive note, Nova Scotia has set up committees to oversee various abuse protocols. These committees are charged with the task of monitoring the implementation of the protocols and they actively seek input from various agencies and stakeholders.

Despite limited resources, the screening and appropriate training of staff constitute key elements of the province's strategy for preventing abuse by service providers. The province has minimum education requirements in place for social workers and managers, as well as probation officers. As was mentioned above, new foster parents and group home workers are required to undergo criminal records and abuse registry checks. Foster parents are expected to undergo training before becoming assuming this role and are also expected to complete further training in their first two years as foster parents or if they are being upgraded to care for children who need a higher level of care. The Federation of Foster Parents, Nova Scotia (FFFNS) administers this training as well as two information sessions on the topic of safeguarding against abuse allegations. Recognizing that abuse often occurs when foster families are under stress, respite care is available for foster families who need time away from their responsibilities. Regular visits

to group homes and foster homes by the child's social worker, or the foster home's social worker, is also another mechanism that is designed to prevent abuse and encourage children to come forward when they are being abused. Some interviewees and government reports suggested that this did not occur as often as it should do, in light of the heavy caseload borne by many social workers.

5.5.3. Changes in Practice – 1960 to present

Changes in practice involving the response to allegations of child abuse by service providers are driven by changes in awareness of, and concern about, the issue. As noted earlier, the phenomenon of the sexual abuse of children by service providers was not publicly acknowledged in the 1960s and 1970s; this circumstance influenced the manner in which the issue was dealt with at the time. It appears that, historically, complaints of abuse were often not believed and, as a consequence, they were not reported. When an incident of sexual abuse did come to the attention of a representative of the Department of Public Welfare or Social Services, and it was determined that there was some substance to the allegation, the matter would often be dealt with internally. The alleged perpetrator's supervisor seems to have been responsible for determining whether or not the abuse took place and administrators within the Department of Public Welfare or Social Services would decide, in conjunction with the supervisor, what action should be taken (Kaufman, 2002; Stratton, 1994). Current practice is almost the complete opposite of this. In the past, it appears that, when an employee became aware of an incident or allegation of abuse, they would bring this concern to their supervisor who would then decide how to handle the situation. Now, any allegation of abuse has to be reported to the police or child protection services by the person who actually receives the complaint rather than by that individual's supervisor or director. When an allegation is received at the present time, it is

automatically referred to a neighbouring agency if it involves a service provider. However, the home agency is still responsible for determining what their response to the allegation will be, after they have received the results of the investigation. Although the practice of referring allegations to neighbouring agencies did not become enshrined in policy until the 1990s, two interviewees suggested that this was nevertheless the prevailing practice prior to the policy being implemented - at least, in those cases where the alleged perpetrator had close ties with the child protection agency. The police are also now involved in all abuse investigations. In the past, it appears that the police would only become involved if the victim, or another person acting on the victim's behalf, made the complaint to the police.

Another important change is that individual agencies now have human-resource policies that guide their decision-making processes when they are called upon to respond to the situation in which allegations have been made against their employees. The existence of formal policies for responding to allegations of abuse against staff members has also meant training for staff on these policies as well as on issues surrounding abuse more generally. As such, another key change which took place during the period considered in this report concerned staff screening and training. There were few educational or training requirements in place during the 1960s. Indeed, staff members who worked in youth-custody and residential facilities were often hired on the basis of their personal connections and generally had not received any formal training which was directly related to their employment (Kaufman, 2002). Similarly, no training program was available to new foster parents and social workers themselves often lacked an education in social work (Department of Social Services, 1987). This unfortunate situation began to change in the 1980s and, at the present time, all social workers are required to have a bachelor's degree in social work. Furthermore, service providers and foster parents now receive at least some training

designed to assist them in recognizing signs of abuse and to enable them to acquire a working knowledge of provincial reporting requirements and protocols. Similarly, in the past, new employees were not screened for past histories of abuse. As noted above, the child-abuse registry was not used to screen new employees until 1991, even though it had originally been established in 1976.

The changes which have taken place since the 1960s have not always proceeded in a linear fashion. The official response to abuse allegations during the 1960s and 1970s was generally one of disbelief and/or inertia. As public concern over the issue built up in the 1980s and 1990s, the opposite reaction became common. Allegations were, at times, improperly investigated or taken at face value and service providers accused of abuse could be dismissed without adequate proof. A more balanced approach seems to have evolved and, at the present time, it appears that, while all allegations of abuse are taken very seriously, they are nevertheless investigated according to formal procedures which duly protect the rights of the employees concerned. The majority of abuse protocols in Nova Scotia recognize the significant contributions made by employees to their organizations and the need both to protect them against false allegations and to furnish them with meaningful support during the investigative process. For example, since 1999, the Federation of Foster Parents of Nova Scotia abuse has operated an allegations supports program. As one interviewee suggested, the previous practice was for an agency to immediately suspend an employee who was accused of abuse and to investigate the matter at a later point in time. However, the current practice, depending on the specific nature of the allegation and the circumstances surrounding it, is to keep the employee working but in a position where he or she has no contact with children or youths.

References

- Bessner, R. (1999). The duty to report child abuse. *Canadian Family Law Quarterly*, 17, 277.
- Blouin, B. & Currie, A. (1994). Children and Youth at Risk: Nova Scotia's Under Funded Child Welfare System. Nova Scotia Coalition for Children and Youth.
- Child Welfare Canada 2000 – The Role of Provincial and Territorial Authorities in the Provision of Child Protection Services. Secretariat to the Federal/Provincial/Territorial Working Group on the Child and Family Working Group. March 2002.
- Daley, T.T. (1978). The Nova Scotia Children's Services Act. *Reports of Family Law*, 29, 283.
- Dawson, R. (1995a). Program Review of the Nova Scotia Residential Centre – A Report to the Minister of Community Services. Institute for the Prevention of Child Abuse, Toronto.
- Dawson, R. (1995b). Safeguards for Children in Residential Care – A Review of the Nova Scotia Youth Training Centre and the Nova Scotia Residential Centre. A report to the Minister of Community Services. Institute for the Prevention of Child Abuse, Toronto.
- Department of Community Services (2007). Protocol for Investigating Allegations of Abuse and Neglect of Children in Care Residing in Foster Care or Adoption Probation Homes. Nova Scotia.
- Department of Community Services (2006). Foster Care Manual – A Manual of Policy and Procedure. Nova Scotia.
- Department of Community Services (December 29th, 2004). Memorandum – Response to Allegations of Abuse of Children in Care Over 16 Years of Age. Nova Scotia.
- Department of Community Services (2004). Provincial Child Abuse Protocol: Residential Child Caring Facilities. Nova Scotia.
- Department of Community Services (2001). Protocol and guidelines for Child Protection Workers and School Personnel in Strait Regional School Community. Nova Scotia
- Department of Community Services (January 20th, 1999). Draft Administrative Guideline Concerning Allegations of Child Abuse Against Staff – Human Resources Policy and Guidelines. Nova Scotia
- Department of Community Services (1998). Protocol for Investigating Allegations of Abuse and Neglect in Foster Homes. Nova Scotia.
- Department of Community Services (1996). Child Protection Service Manual. Nova Scotia.

- Department of Community Services (1994). Memorandum – Guidelines on Reporting and Responding to Allegations of Suspected Sexual or Physical Abuse by Clergy or Church Workers. Nova Scotia.
- Department of Community Services (March 15th, 1993). Memorandum – Policy Regarding Allegations of Abuse Pertaining to Board Members. Nova Scotia.
- Department of Community Services (1992). Young Offender/Family Children’s Services Agency Protocol. Nova Scotia.
- Department of Community Services. When You Disagree Brochure. Nova Scotia.
- Department of Justice Website (2002). Standard Operating Procedures for Police. Retrieved on May, 2007 from <http://www.gov.ns.ca/just/PolVS/sopLogin.htm>
- Department of Justice (1996). Standard Operating Procedures for Police. Nova Scotia.
- Department of Social Services (1987). Report of the Task Force on Family and Children’s Services. Nova Scotia.
- Department of Social Services (1981). Special Protection Services for Family and Children’s Service Division. Nova Scotia.
- Department of Social Services (1978). Information on Child Abuse – Prepared by Supervisor, Child Abuse Register. Halifax, Nova Scotia.
- Department of Social Services (1974). Final Report of the Task Force on Child Abuse. Presented to H.M. Huskilson, Minister of Social Services. Nova Scotia.
- Federation of Foster Families of Nova Scotia Website. www.fosterfamilies.ns.ca
- Ferrera, S. (2005). Making the Case for Youth Rights Training: A Study of Incarcerated Youth and Police Personnel’s Attitudes on Youth Rights. (Unpublished Document) Halifax, Nova Scotia: Saint Mary’s University.
- Fraser. M. et al. (1973). Child Abuse in Nova Scotia: A research Project on Battered and Maternally Deprived Children. Halifax: Department of Public Welfare.
- Gough, P. (2006). Nova Scotia’s Child Welfare System. Centre of Excellence for Child Welfare. Retrieved on March, 2007 from www.cccw.cepb.ca
- Halifax Children’s Aid Society (no date). Website. Accessed on May, 2007 at <http://www.hfxcasfoundation.org/History%20of%20CAS.html>

- Hillier, B. & Koster, A (1994). A Report to the Minister of the Department of Community Services. Nova Scotia.
- Howe, B. (2001). Implementing child's rights in a federal state: The case of Canada's child protection system. *International Journal of Children's Rights*, 9, 361-382.
- Kaufman, F. (2002). Searching For Justice – An independent review of Nova Scotia's response to reports of institutional abuse. Province of Nova Scotia. Retrieved February, 2007 from www.gov.ns.ca/just.
- Koster, A. (1999). A Review of Current Child Protection Protocols – A Report Submitted to the Department of Community Services. Nova Scotia.
- Naslund, V. (1984). The Sexual Abuse of Children: Intervention and Protection Issues (Master's Thesis). Halifax, NS: Dalhousie University.
- Nova Scotia Archives and Records Management (2007). Government Administrative Histories Online. Retrieve April, 2007 from <http://www.gov.ns.ca/nsarm/gaho/>.
- Office of the Ombudsman, Youth Services Branch (2005). We Have Time to Talk Brochure. Retrieved February, 2007 from www.gov.ns.ca/ombu/publications/ChildOmbudComServ-en.pdf
- Ottawa Citizen (January 4th, 1986). Child Abuse Reports Soar, p. G1
- Peers, M.R. (1990). A Review of the Handling of the Case of Mrs. X. Submitted to Mr. Guy LeBlanc, Minister of Community Services. Province of Nova Scotia.
- Review of Children's Training Centres in Nova Scotia (1994). A Report and Recommendations to the Minister of Community Services. Nova Scotia.
- Samuels-Stewart, V. (1995). "In Our Care" Abuse and Young Offenders in Custody – An Audit of the Shelburne Youth Centre and the Nova Scotia Youth Centre – Waterville. Minister of Justice. Province of Nova Scotia.
- Sports Nova Scotia (no date). You Can Make a Difference: A guide to preventing and responding to abuse and harassment in sport and recreation. Retrieved May, 2007 from www.gov.ns.ca/hpp/physicalActivity/publications/harrase.pdf.
- Stratton, S.G. (1995). Report of an Independent Investigation in Respect of Incidents and Allegations of Sexual and Other Physical Abuse at Five Nova Scotia Residential Institutions. Nova Scotia.
- Thompson, D.A.R. (1991). *The Annotated Children and Family Services Act*. Halifax, NS: Dalhousie University.

Legislation Cited

Children and Family Services Act, Chapter 5 of the Acts of 1990. Retrieved on April, 2007 from <http://www.gov.ns.ca/legislature/legc/statutes/childfam.htm>.

6.0. Conclusion and Comparisons

The present report documents a common history of the evolution in B.C. and Nova Scotia - as well as in the rest of Canada and internationally - of responses to allegations of child sexual abuse committed by service providers. Child sexual abuse by service providers was not an issue in the public consciousness until the 1980s. As such, we have found no specific evidence from Nova Scotia or B.C. of any formal response to this category of abuse prior to 1985, when B.C. issued the second version of the *Inter-Ministerial Handbook on Child Abuse*. This is consistent with trends elsewhere; for example, abuse by service providers did not become an issue of public concern in England and Wales until the mid-1980s and did not become an issue in Australia until the late 1980s and 1990s. Although sexual abuse by service providers is a relatively recent issue in the public consciousness, a more general history of child abuse is relevant because it provides the foundation for policies specifically directed at abuse occurring in the context of community services.

Table 3 documents key features in B.C.'s and Nova Scotia's responses to abuse by service providers. As this table shows, Nova Scotia and B.C. enacted mandatory child abuse reporting laws in the same year – 1967. Penalties for failing to report abuse were included in B.C.'s original provisions but were added to Nova Scotia's reporting laws in 1984. The enactment of mandatory reporting laws in Canada mirrored what was happening in the United States, where most states had similar laws in place by the late 1960s. Some states and territories in Australia also enacted mandatory reporting laws shortly afterwards in the 1970s. The introduction of mandatory reporting provisions signifies an increased awareness of issues of child abuse and neglect. These early concerns principally focused on physical abuse and neglect.

Table 3: Key Issues in Responding to Abuse by Service Providers – B.C. and Nova Scotia

| | British Columbia | Nova Scotia |
|---|---|--|
| Current Child Protection Legislation | <i>Child, Family, and Community Service Act, 1996</i> | <i>Children and Family Services Act, 1990</i> |
| Definition of a Child | Under 19 years | Under 16 years |
| Mandatory Child Abuse Reporting Provisions | <ul style="list-style-type: none"> • Enacted in 1967 • Penalty for failure to report • Applicable to general public • Specific to parents, no third party abuse requirement | <ul style="list-style-type: none"> • Enacted in 1967 • Penalty for failure to report added in 1984 • Applicable to general public • Provisions for abuse by parents as well as third party abuse |
| Child Protection Investigation Responsibilities | <ul style="list-style-type: none"> • If child is at risk or in danger • In case of abuse by parents/guardians/foster parents • Allegations against MCFD service providers | All reports of child abuse |
| Child Abuse Protocols | <ul style="list-style-type: none"> • General • Handbook for Action on Child Abuse and Neglect • Specific • Foster care • Regional protocols | <ul style="list-style-type: none"> • Specific • DCS Staff (child protection workers) • Foster Care • Residential Care/Group Homes • Youth Custody |
| Joint Investigations (police-child protection) | Encouraged when there is immediate risk to children | Required in all child abuse cases |
| Specialized police investigators | Yes – use when ever possible | Yes – use when ever possible |
| Joint police – child protection training | Yes | Yes |
| Historical Abuse | Issue addressed in provincial policies | No formal policies |

Early definitions of child abuse in both B.C. and Nova Scotia legislation make no mention of sexual abuse or of abuse occurring outside of a child's home. It appears that sexual abuse was either not acknowledged or considered another form of physical abuse. Gradually, child sexual abuse was recognized as an issue of public concern and child abuse was redefined to include sexual abuse. In 1976, Nova Scotia changed its definition of child abuse to include sexual abuse. British Columbia did not make this change until 1981. However, there is evidence that child sexual abuse was considered separately from physical abuse prior to the amendment of the child protection legislation in B.C. Official documents cataloguing incidents of child abuse in the province counted sexual abuse separately and the 1979 *Child Abuse/Neglect Policy Handbook* included a definition of sexual abuse. Child sexual abuse was first understood as a form of family dysfunction and not something that occurred outside the home. Evidence of this perception is apparent in government documents and reports from both B.C. and Nova Scotia. Since there is a limited amount of information available in relation to responses to child abuse in the 1960s and 1970s - both from written documents and from our interviews with service providers - we cannot comment on whether there were regional differences between Vancouver and Kelowna or Halifax and Truro.

Province-wide policies addressing abuse by service providers appeared in B.C. in 1985 but were generally not implemented in Nova Scotia until the early 1990s, although there are some draft policies dating back to the late 1980s. Although responses to child abuse continue to be highly similar in B.C. and Nova Scotia, there is sufficient information available to highlight some key differences in policy and practice from 1980 onwards. Very generally, Nova Scotia has adopted the approach of issuing a number of policies for addressing abuse in specific settings, whereas B.C. has one key policy document for all service providers and only one specific

protocol for investigating abuse in foster care. Child abuse investigations are also addressed in practice standards for child protection and group homes/residential care in both provinces. B.C.'s approach of articulating a general policy to guide responses to child abuse is similar to the British approach, where two key documents provide the basis of the country's response to abuse by service providers - *Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children* and *What to do if you're worried a child is being abused*.

Despite the absence of formal policies for handling abuse by service providers prior to the mid-1980s, it is clear from commissions of inquiry into abuse scandals or other investigations of historical abuse that child sexual abuse by service providers did indeed occur and was, at times, reported. Reports of abuse in both B.C. and Nova Scotia were often not believed or were responded to quietly and discreetly by the organization involved so as to avoid tarnishing their reputation. This also occurred elsewhere in Canada as well as internationally. In England and Wales, abuse was often discounted or disbelieved prior to the 1980s. Transferring abusive employees to other institutions or positions appears to have been a common response. Australia was even slower to acknowledge abuse by service providers. Inquiries into past abuse of children in state care did not begin until the 1990s in that country.

Large-scale investigations into historical abuse have traditionally involved residential institutions, which one author from England suggests gives the impression that abuse by service providers is a problem of residential institutions (Gallagher, 2000). To some extent this may account for the lack of information concerning child abuse in community settings, such as abuse by social workers, probation officers, or foster parents prior to 1980: however, there have been a

number of high-profile cases of historical abuse within the community by teachers and religious leaders. Further, there appear to have been few safeguards in place to prevent abuse by service providers prior to 1980 - in B.C. or Nova Scotia or internationally. Social workers and others providing services to children and youth had little training and background checks were not used. Also, as interviewees from B.C. suggested, children placed in state care were not monitored. This was also noted as a concern in the literature from Australia. As such, it is unlikely that abuse would be detected and, even if it was detected, it is unlikely that it would be recorded or made public.

Present-day responses to allegations of abuse by service providers largely appear to be incident-driven. Commissions of inquiry into past abuse and reviews of child welfare practices have served as a catalyst for many reforms in British Columbia, Nova Scotia, and abroad. Awareness of child abuse appears to have risen dramatically after 1980 in Canada as well as internationally, focusing first on abuse within the family but later expanding to include extra-familial abuse. Interviewees from both B.C. and Nova Scotia suggested that, in the 1980s and 1990s, there was a state of hyper-vigilance surrounding the issue of child sexual abuse. With this awareness and hyper-vigilance came formal policies and the provision of more information concerning the issue of abuse by service providers.

Although many jurisdictions share a remarkably similar history of initially developing awareness of child abuse in general and later constructing specific responses to child sexual abuse by service providers, it would be inaccurate to suggest that different jurisdictions are at the same stage of developing comprehensive strategies for responding to abuse by service providers. Taken in its entirety, the information collected for this report suggests that any response to abuse

by service providers should have two components: a strategy for preventing abuse and a strategy for responding to allegations of abuse. Strategies for responding to abuse allegations need to identify children's needs and safety as their central concern but must also be fair to alleged perpetrators. Both prevention and response strategies need to be continuously revised and improved in light of new information. The review of the policies of the various jurisdictions considered in this report suggest that the jurisdiction of England and Wales has developed the most comprehensive response to abuse committed by service providers, taking into consideration its strategies both for preventing abuse and for responding to allegations. This is not to say that each jurisdiction which has been examined does not have its own strengths and innovative practices. It is difficult to include the United States and Australia in this comparison because the present review of their systems of responding to abuse by service providers was far less detailed than the reviews of the policies adopted by B.C., Nova Scotia and England and Wales.

With regard to abuse prevention, the strategy which has been adopted by England and Wales includes a number of key components. To begin with, England and Wales have an employee/volunteer screening system that is designed to provide ease of access to the information which is necessary for carrying out background checks by both government and non-government agencies providing services to children. Relevant information is housed in a centralized location and pre-employment/volunteering background checks are a legislative requirement. England and Wales have also taken this a step further and made it an offence for a person convicted of a crime against a child even to apply to work with children. In addition to background checks, the policy *Working together to safeguard Children* can be viewed as a preventive tool because it requires all organizations working with children to have policies in place for dealing with allegations on abuse. Procedures for dealing with abuse must be consistent with government guidelines. All

instances of abuse must be reported to an official of the Local Safeguarding Children's Board which has been designated to process abuse allegations. Every staff member or volunteer in an organization must be informed of who the Local Safeguarding Children's Board's designate is and how to contact them. Clear policies articulating exactly how abuse will be dealt with convey the message that abuse is taken seriously and that inappropriate behaviour will not be tolerated. Furthermore, employees and volunteers may be more comfortable conveying their concerns or allegations of abuse to an independent person outside of the organization concerned rather than to their immediate manager or director.

Pre-employment screening is a common feature in any strategy to prevent abuse by service providers. However, it is less common to make it an offence for a person convicted of an offence against a child to apply to work with children, as is the case in England and Wales. British Columbia has enacted legislation requiring background checks for persons working with children and is developing a policy whereby persons working with children will have to renew their background check every five years. Nonetheless, it is not an offence for a person convicted of child abuse to apply for employment. Likewise, there is no such offence in Nova Scotia. Indeed, even background checks do not appear to be a legislative requirement in Nova Scotia. Undoubtedly, certain positions do require background checks and organizations working with children are definitely encouraged to screen their employees: however, this does not appear to be a legal obligation on the part of child-related organizations. Although Nova Scotia has not legislated background checks, the province has nonetheless taken a number of innovative steps in this regard. Background checks in the province not only use criminal records but also community referees, such as family physicians, and the province's child abuse registry. Perhaps the most innovative and comprehensive approach to employee/volunteer screening is the system of Working

with Children Checks found in some Australian states and territories. These checks use a variety of criminal justice records (convictions, charges pending, police records, and so on) and, in some instances, prior employment proceedings or violence suspension orders. Furthermore, it is not simply an offence for an individual convicted of an offence against a child to apply to work with children but rather it is an offence to work with a negative assessment from a background check or to work with children without an up-to-date background check. It is also an offence for an organization to hire someone with an expired or negative background check. Australia's Working with Children Checks place responsibility on individuals and organizations to prevent child abuse by service providers, whereas the legislation of England and Wales simply promotes individual responsibility. Furthermore, Australia's checks are more sensitive to the issue that many persons who abuse children are not convicted of a crime. On the other hand, they do less to promote procedural fairness on the part of an alleged perpetrator.

At this point in time, detailed policies delineating a system for responding to allegations of abuse are common in both government and non-government organizations in England and Wales, B.C., and Nova Scotia. However, owing to the complexity of each jurisdiction's particular approach, it is difficult to assess which system is more comprehensive or is more likely to be effective in preventing abuse. It can be argued that England and Wales have a more cohesive approach because they have a single national policy which serves as a model for all organizations working with children, whereas, in Nova Scotia for instance, there are different policies for youth justice facilities, foster homes, group homes and other residential facilities, and so on. This is a more fragmented approach, which creates the possibility that there may be more variations in standards for abuse prevention. Alternatively, it can be argued that a more fragmented strategy does make provision for a greater degree of consideration to be paid to

context (both organizational and geographical) and such an approach may well promote more effective preventive tools than would be available within the confines of a simple blanket policy. Although the jurisdiction of England and Wales does have a national policy, regional protocols have been developed between local agencies and are overseen by Local Safeguarding Children's Boards. Likewise, B.C. has an overarching policy for responding to - and preventing - child abuse (*The Handbook for Action on Child Abuse and Neglect*). It also has context-specific standards and allows regional protocols to be developed. However, organizations working with children, who are not funded by government, are not obliged to follow the provincial government's policies and guidelines.

Fashioning a policy dealing with allegations of abuse constitutes only the first step on the road towards preventing abuse committed by service providers. *How* a policy is implemented and supervised are equally as important. Translating principles articulated in policy into procedures that can be operationalized in practice represents a major strength of both B.C.'s and Nova Scotia's approach towards preventing abuse by service providers. Both provinces emphasize the need to implement adequate staff training and to inculcate general knowledge among all employees both of their duty to report child abuse and of their organization's specific policies and procedures for responding to abuse allegations. It should be noted that the concern was raised in both B.C. and Nova Scotia that these aspirations were not always achieved in practice and that training was the first aspect of service to be cut in times of financial strain. Both provinces also emphasize that the clients of a service provider should be made aware of the organization's abuse-reporting procedures and be provided with the opportunity and information necessary to make a complaint or allegation to the organization's management or outside resources, such as the child's social worker or the equivalent of the children's and youth's ombudsman. Emphasis is

placed on children knowing their rights while in state care. Nova Scotia has expanded this precept and has made it possible for representatives from the Ombudsman's Office, Youth Services, to visit youths held in custody in order to ensure that they are treated appropriately and that they are made aware of their rights while they are held in custody. Similarly, various work procedures and policies guiding staff behaviours, such as not allowing staff to work alone with children or codes of professional ethics, were mentioned in both B.C. and Nova Scotia.

Independent supervision and policy oversight constitutes a major strength of the approach embraced by England and Wales in relation to the task of preventing child abuse by service providers. Local Safeguarding Children's Boards ensure that regional protocols are followed and the National Society for the Prevention of Cruelty to Children act as an independent watch dog against abuse by both government and non-government service providers. This is a role that is reinforced by their authority to carry out independent child protection investigations and to request, and implement, court-ordered child apprehension orders. Both B.C. and Nova Scotia have similar organizations (the Office of the Representative for Children and Youth and Office of the Ombudsman, Youth Service, respectively) which can investigate allegations of abuse but they are not authorized to apprehend children. British Columbia's system of organization accreditation acts as a form of oversight that ensures that organizations have - and properly implement - abuse prevention policies. However, only large-scale, government-funded organizations require accreditation. The lack of outside or independent supervision and policy oversight appears to be one area in which Nova Scotia's approach needs further development.

As noted above, in addition to a well-defined prevention strategy, any jurisdiction's approach towards dealing with abuse committed by persons working with children should include a clear process for responding to abuse allegations. In this regard, the present report has principally focused on the process of investigation and less attention has been paid to the potential consequences of an investigation of an allegation of child abuse for the child, the alleged perpetrator, and the service provider more generally. The need for various forms of support and a range of services to be made available to alleged victims and, when appropriate, their family members constitutes an issue that was not addressed: however, it is certainly is a concern in all jurisdictions considered in this report. Similarly, the emotional and personal consequences for children who have been abused by service providers or persons wrongly accused of abusing a child were not considered but they are a principal concern in any response to child abuse. Overall, information from this report suggests that effective investigations should include the following requirements: they should be timely, independent, cooperative, promote the safety of children (both victims and others involved), and promote procedural fairness for the alleged perpetrator(s).

Timelines for responding to complaints of abuse and for completing the investigation process are common features in child protection standards of practice. Both B.C. and Nova Scotia have timelines in place to guide child protection investigations. The timelines are guided by the seriousness of the abuse and any continuing risk to the child or other children. Despite the existence of detailed timelines, interviewees for B.C. and Nova Scotia mentioned that it was not always possible to meet these timelines, particularly when there was a shortage of staff and/or resources. Linked to the issue of timely investigations is the issue of the safety of the alleged victim and any other children. Both B.C.'s and Nova Scotia's child protection standards provide

guidance in relation to the critical task of assessing the level of potential risk to victims and other children. Moreover, promoting the safety and well-being of children is a guiding principle in both provinces' policies towards abuse by service providers. This is also a major principle which has been articulated in policies developed in England and Wales as well as in Australia and the United States. Police investigations appear to be less regimented than child protection investigations but all of the officers interviewed indicated that the welfare and safety of children was their primary concern.

Achieving procedural fairness for alleged perpetrators is an area of the investigation process that appears to be more developed in B.C. and Nova Scotia than in England and Wales. England and Wales recognize that an accused service provider needs meaningful support, should be kept abreast of the investigation's progress and be encouraged to seek the advice of their union (when applicable). Similarly, policies in both B.C. and Nova Scotia specifically mention that any investigation should be conducted in a manner that is unbiased and fair and that alleged perpetrators should be informed throughout investigation process. Unions also have an advocacy role to play when one of their members is accused of abusing a client. Union involvement was mentioned in B.C. and Nova Scotia but was raised more frequently by the interviewees from B.C. Nova Scotia's *Provincial Child Abuse Protocol: Residential Child-Caring Facilities* (2004) expands on this general principle and suggests that accused employees must be informed of their legal right, namely the right to remain silent and the right to retain legal counsel. Foster parent associations in both B.C. and Nova Scotia provide a support person to foster parents when complaints of abuse have been made against them. In Nova Scotia, the foster parent association's support person can also act as an advocate on behalf of the accused foster parent and the association provides training to all new foster parents on what to expect if an abuse complaint is

made against them. B.C.'s *Protocol for Foster Homes* suggests that a foster home's resource worker is meant to be a source of support when an allegation of abuse is made against a foster parent or sibling.

Interagency cooperation is another key component in an effective response to child abuse and necessary for reducing any secondary harm to a child that might result from the investigation process and subsequent outcomes. Interagency cooperation has many manifestations. It can include team investigations involving police and child protection workers and, in some instances, medical professionals, crown prosecutors, and others. It can also include abuse-reporting agreements, information-sharing protocols, joint development of policies and investigation procedures, joint training for police and child protection workers, joint oversight or planning committees, and so on. The basis for interagency cooperation is established in child protection legislation as well as national (in the case of England and Wales), provincial, and regional policies and protocols. A brief overview of some of the distinctions between Nova Scotia's and B.C.'s child protection legislation provides some insight into their varied approach to interagency cooperation.

There are notable differences in the child protection legislation from B.C. and Nova Scotia - both in relation to the mandate of child protection services as well as the definition of child abuse. To begin with, a child is defined as anyone under 19 years of age in B.C. and anyone under 16 years-of-age in Nova Scotia (see Table 3). In other words, in Nova Scotia, child protection services will not be involved in instances of abuse of youths aged 16 years or older; the police or other organizations involved will investigate such cases. This has important ramifications in the field of youth justice because it essentially limits the involvement of child

protection workers to young offenders between the age of 12 and 15. Another key difference in child protection legislation concerns the issue of who is considered a parent. In B.C., a foster parent is considered to be a parent for the purposes of the child protection legislation, whereas Nova Scotia's legislation specifically states that a foster parent is not a parent for the purposes of the act.

The most important distinction between B.C.'s and Nova Scotia's child protection legislation is that Nova Scotia has separate provisions in place for reporting third-party abuse, whereas B.C.'s mandatory reporting provisions are specific to abuse perpetrated by parents or abuse from which parents have been unwilling, or unable, to protect their children. This creates the situation where there is only a limited duty to report third-party abuse in B.C. and has important ramifications for the mandate of each province's child protection services. In Nova Scotia, child protection workers are mandated to investigate all incidents of child abuse, whereas, in B.C., child protection services will generally only investigate instances of abuse within the home, abuse by MCFD service providers, or instances where a parent is unwilling or unable to protect their child. British Columbia's legislation clearly places a greater degree of emphasis on the responsibility of parents to keep their children safe from abuse. In this regard, Nova Scotia's legislation may support a stronger basis for action against abuse perpetrated by service providers.

In practice, B.C.'s legislation appears to have been translated into fewer joint police-child protection investigations and a greater emphasis being placed on internal investigations by the employer of the accused service provider. That being said, information from interviews in B.C. suggests that child protection workers may be more involved with investigating abuse by service providers than a review of the legislation suggests. If a child had a social worker, the social

worker would be responsible for assessing the risk to the child. Furthermore, B.C.'s *Handbook for Action on Child Abuse and Neglect* (2003, 2007) and other information published by the MCFD suggests that there is a duty to report any child abuse and does not appear to distinguish between abuse by parents versus abuse by anyone else.

The inclusion of third-party-abuse reporting provisions grants Nova Scotia's child protection services a wider mandate, which makes mandatory joint police-child protection investigations more practical in Nova Scotia than B.C. Nova Scotia has policies in place requiring joint investigations as well as standard operating procedures, that all police officers in the province must follow when investigating child abuse. In B.C., individual police departments mandate child-abuse investigation procedures and joint investigations are encouraged but are not mandatory. Although officers in B.C. reported carrying out joint investigations as well as information sharing and co-operative ventures with child protection services, it is clear that in some instances child protection services are not involved in child abuse investigations. How the police and child protection services co-operate appears to depend upon the particular circumstances of the individual case, the rapport between the officers and child protection workers involved, and the police department's philosophy. This indicates that there may be a greater propensity for regional variation in investigation practices in B.C. compared to Nova Scotia. In B.C., police departments and local service providers are expected to negotiate protocols for inter-agency co-operation. This is similar both to Nova Scotia, where individual police departments are expected to implement more detailed strategies for responding to child abuse than the general framework provided by the provincial government, as well as to England and Wales, where Local Safeguarding Children Boards are established to put in place protocols for cooperation between police and service providers.

In England and Wales, policies requiring inter-agency cooperation have advanced beyond both those in B.C. and in Nova Scotia by implementing national guidelines that include not only police and child protection agencies but also other interested agencies, such as schools or day care providers. In this regard, the response of England and Wales to abuse by service providers is likely to be holistic and inclusive because it mandates co-operation between a variety of agencies involved in providing services for children. In B.C., and to some extent Nova Scotia, professional working relationships and good will are principally relied upon to facilitate interagency cooperation between the police or child protection and other agencies. Interagency cooperation is not limited to the conduct of joint investigations in England and Wales but also includes joint action in developing child protection plans as well as the establishment of an oversight process for joint training and policy implementation.

Public inquiries into abuse by service providers have taught us that investigations need to be independent. Independent investigations, as opposed to internal investigations, are vitally necessary in order to ensure child abuse is not covered up and that an organization's interests are not placed above the interests or safety of an alleged victim. England and Wales promote independent investigations in a number of ways. As was mentioned previously, the National Association for the Prevention of Cruelty to Children has the authority to investigate service providers, independently of the police or child protection services. Local Safeguarding Children's Boards also oversee investigations to ensure that they are independent, competent, and unbiased. National guidelines on interagency cooperation and investigation procedures also stress the importance of independence in the investigation process.

It appears that investigatory independence has attained less prominence in B.C. and Nova Scotia than in England and Wales. Allegations of abuse in youth custody facilities are investigated internally in B.C., unless the police become involved in the investigation. Likewise, in B.C., some policies require staff to report any allegations of abuse they receive to management rather than directly to the police or child protection services. Nova Scotia generally requires that all abuse be reported to child welfare authorities. Another distinction between child protection investigations in B.C. and Nova Scotia is to be found in the fact that Nova Scotia has adopted the policy of referring investigations of social workers or other service providers under the responsibility of the DCS to neighbouring jurisdictions in order to avoid bias or the perception of bias in an investigation. This procedure is occasionally adopted in B.C. but it is not a specific policy requirement and its adoption appears to be left to the discretion of individual supervisors or regional managers.

Outside of these major distinctions, child protection services in both provinces appear to have adopted similar strategies for investigating abuse by service providers. Both provinces have a history of emphasizing a multidisciplinary approach to child abuse that dates back until the late 1970s. A modern manifestation of this theme is the existence of specialized child-sexual-abuse teams in Vancouver and Halifax that include child protection workers, police, and health care professionals. A multidisciplinary approach to child sexual abuse is not unique to B.C. or Nova Scotia and appears to be a common feature in the approach of other countries. Hand-in-hand with a multidisciplinary approach, there is a marked emphasis on interagency cooperation. This did not appear in Halifax until the early 1980s and, in B.C., in the late 1970s. Despite an early emphasis on interagency cooperation, data from our interviewees suggests that cooperation between agencies was not necessarily the norm until the late 1980s and, in many ways, is a

phenomenon that continues to evolve to the present day. England and Wales, the United States, and Australia also emphasize the need for inter-agency cooperation. Other similarities between B.C. and Nova Scotia include joint training for police and child protection workers, the presence of police investigators who specialize in child abuse or sexual abuse, the use of step-wise interviewing techniques, the conduct of audio or video recorded interviews with children, the adoption of fixed timelines for the completion of investigations, and the requirement of extensive background checks for individuals working with children and youth.

One objective of this report was to explore the potential differences in policy and practice between Vancouver and Kelowna and Halifax and Truro. This has proved to be exceptionally difficult for a number of reasons. To begin with, the majority of the policy documents that we reviewed were applicable province-wide. In limited instances, information concerning regional policies was available but it tended to be applicable to community-service providers operating in one location but not to others. Regional policies for police and child protection workers clearly existed in both Nova Scotia and British Columbia but they were not published or available to us. References to regional protocols were more common in printed documents and interviews from British Columbia which might suggest greater regional variation, although province-wide guidelines for regional policies were also referenced. We, therefore, turned to our interview data to make intra-provincial regional comparisons: however, this also proved to be challenging in light of the small number of interview participants in each jurisdiction and the research strategy, which involved interviewing a number of people in a variety of positions in order to acquire a more holistic view of how each province responded to child sexual abuse perpetrated by service providers. This meant that we interviewed some persons in certain positions in one location, but a person holding a similar position was not available at another location. Moreover, we also

interviewed bureaucrats who provided a more general overview of the province's response, rather than direct information as to exactly how that response was implemented in a specific location.

We did interview persons working in child protection and police officers in each location considered here. Generally, we found little evidence of regional variations but would hesitate to suggest that no regional variations existed for the reasons discussed above. For instance, there is some evidence that police acceptance of interagency co-operation began to develop in the Halifax region in the early 1980s but there is no evidence of a similar development in Truro. Similarly, an interviewee from Halifax suggested that the practice of referring abuse investigations involving a service provider to a neighbouring jurisdiction was in place prior to this becoming a policy requirement. The Truro interviewees did not mention this. In B.C., both police and child protection workers recognized organization or agency variations, rather than regional differences *per se*. For instance, differences in inter-agency working relations and record-keeping practices were attributed to differing organizational cultures and work place philosophies. The strongest support for this came from one interviewee who had worked in various child protection agencies throughout B.C. Conversely, there was a high degree of similarity between the policies and practices of two large community-based service providers – one in Vancouver and the other in Kelowna. Similarities between these organizations may be attributed to B.C.'s accreditation process.

6.1 Limitations of the Research:

The findings from this research should be interpreted in light of a number of limitations. To begin with, the research relies heavily on policy documents and government publications or website information. This limits the scope of the research to an official view of how abuse by

service providers is handled. Moreover, all interviewees, with the exception of one retired social worker, were currently working in government, for the police, or for a community-based service provider and, therefore, may be viewed as having a vested interest in how their organizations' responses to child abuse are presented. This circumstance, for example, may account for an almost unanimous agreement between interviewees that there was little distinction between policy and practice. In the present research, we did not rely on unofficial sources of information, such as the experiences of persons who had been abused by service providers or who were the subjects of an investigation. Such information might well paint an entirely different picture of the manner in which each province responds to child abuse committed by service providers.

Another limitation of the research is that our interviewees generally had limited, if any, personal experience with investigating instances of abuse by service providers. The exception to this circumstance arose in interviews with police officers. Allegations of abuse against service providers appear to be relatively rare. This meant that some interviewees could comment on the policy framework in place for responding to this category of abuse but nevertheless had little information to offer about how these policies played out in practice. This is particularly problematic when making regional comparisons within B.C. or Nova Scotia because the majority of policies reviewed for this report were applicable province-wide. One might expect to see variations in the specific manner in which these policies are implemented in different jurisdictions. Owing to the limited amount of information relating to actual practice, it is difficult to assess with any degree of accuracy whether this is, indeed, the case. The small number of persons interviewed for the report also accentuates this problem. Although the 25 interviews that were conducted for this research provided sufficient information concerning the different policies

in place, more interviews from each region would be needed for a truly representative view of how these policies are put into practice.

Asking service providers to remember policies and events that occurred over a thirty year span can also be viewed as a limitation. Clearly, the human memory is not perfect and we could not expect interviewees to provide specific dates or detailed accounts of how policy and practice developed over time. Our interviewees were able to provide us with general trends and significant events but we needed to supplement this information with archival data, which also turned out to be restricted.

Despite these limitations, we feel that sufficient information was available to provide an accurate overview of B.C. and Nova Scotia's current approach to responding to child sexual abuse by service providers as well as an introduction as to the manner in which other Canadian provinces and international jurisdictions handle the issue. Although information concerning historical responses to abuse by service providers is limited, we have been able to present a general outline of how responses have evolved from the 1960s to the present. We suggest that our inability to provide a detailed history of how responses to abuse by service providers evolved in B.C. and Nova Scotia is due to a genuine dearth of information on this topic rather than any fundamental shortcomings in our research design.

APPENDIX A: INTERVIEW INSTRUMENTS

Abuse Allegations – Interview Instrument (general Version)

Interview number:

Interviewer:

Date of interview:

Background Questions:

1. Employment organization:
2. Job title/position:
3. Is your position unionized?
4. How long have you been employed with your organization?
5. How long have you held your current position?
6. Can you provide a brief description of what your organization does or the services it provides?
7. Please provide a brief description of what your job entails (or did entail if retired), such as your duties and responsibilities in the position:

Complaints Protocol/Procedures:

8. Does your organization have a specific complaints process for allegations of child abuse against employees or volunteers? If yes, can you provide a brief description of the complaints process? (if no proceed to question 9; if yes proceed to question 11)
9. Does your organization have a formal complaints process for dealing with complaints against the organization or its employees/volunteers? If yes, can you briefly describe this process (e.g. what steps are taken when a complaint is made)?
10. Are allegations of child abuse against employees/volunteer dealt with under the regular complaints procedure?

11. Are there different protocols for handling allegations of historical child sexual abuse versus current abuse? If yes, please describe this difference and how these protocols may have changed over the period from 1960 to 2007.

12. When an allegation of child abuse is made who investigates the complaints (internal or external investigation or both)?

13. If your organization is involved in the investigation of complaints, do they have specific guidelines or policies that are to be followed when investigating a complaint of child abuse against an employee or volunteer? If yes, please describe (if no proceed to question 14; if yes proceed to question 15).

14. If no, are there general guidelines for investigating complaints? Please describe these guidelines.

15. What role, if any, do you play in your organizations response to an allegation of child abuse?

16. If complaints of child abuse are made against employees or volunteers, what is the status of the employee/volunteer while the complaint is being investigated?

17. Are there provisions in place for an employee/volunteer to respond to allegations of child abuse? If yes, please describe.

18. If a child, who is a current recipient of your organization's services, makes a complaint against an employee/volunteer what steps are taken to protect the interests of the child (what happens to the child during the complaints process)?

19. How are complainants or their guardians involved in the investigation into a complaint?

20. What responses are available when an allegation of child sexual abuse is substantiated? For the employee/volunteer? For the complainant?

21. What actions are taken if an allegation of sexual proves to be false or cannot be disproved or proven?

History and Changes to the Complaints Process:

27. How long has the current complaints procedure you described above been in place?

28. How long have the current guidelines for investigating allegations of child abuse you describe above been in place?

29. Prior to the implementation of the current complaints procedure, how were allegations of child abuse dealt with?

30. What was the motivation (reason) for implementing the current complaints process?

31. Can you give a brief synopsis of how policy and procedure for dealing with allegations of child abuse have changed throughout the duration of your employment at (organization)?

Practice and Personal Experience:

32. Have you ever had to respond to or look into an allegation of child sexual abuse against an employee or volunteer in your organization? If yes, how many times?

33. Can you briefly describe this experience (your role)?

34. How closely were policies/procedures followed during the complaints process/investigation?

35. In your experience, what is the most common outcome in an investigation into an allegation of child sexual abuse?

Abuse Allegations – Interview Instrument - Police Version

Interview number:

Interviewer:

Date of interview:

Background Questions:

1. Employment organization:
2. Job title/position:
3. How long have you been employed with your organization?
4. How long have you held your current position?

Investigation Guidelines/Protocol:

5. Are there specific guidelines or protocols for investigating a complaint of child abuse against an individual who provides services to youth and children? If yes, please describe. If no, are there general guidelines/protocols for investigating child abuse?
6. Are there guidelines for cooperating with other agencies during an investigation (ex. child protection services, the place of employment of the person under investigation)?
7. Are there different guidelines/protocols for investigating allegations of historical abuse opposed to current abuse? How do these investigations differ?
8. How long have the current guidelines for investigating allegations of child abuse you describe above been in place?
9. Prior to the implementation of the current investigation guidelines, how were allegations of child abuse handled?
10. What was the motivation (reason) for implementing the current investigation guidelines?
11. Can you give a brief synopsis of how policy and procedure for dealing with allegations of child abuse have changed throughout the duration of your employment with the police?

Practice and Personal Experience:

12. How would you characterize the role of the police in an investigation of child abuse versus other agencies who might be involved (e.g. child protection services/social workers)?

13. Have you ever had to respond to or look into an allegation of child sexual abuse against an individual who provides services to youth and children? If yes, how many times?
14. Can you briefly describe this experience (your role)?
15. Was a child protection agency also involved? If so, who took the lead in the investigation?
16. How closely were investigation guidelines followed during the investigation?
17. In your experience, what is the most common outcome in an investigation into an allegation of child sexual abuse against individuals who provide services to youth and children?