Children's Advocate Office

Child Death Review
Karen Rose Quill

June 1998

CDR-01 -KRQ

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EXECUTIVE SUMMARY

On September 13, 1997, Karen Rose Quill died. Karen was only 20 months old at the time of her death. She was living in a foster home as a child in the care of the Minister of Social Services. There were six other foster children in this home: one age nine, one age four, three age three, and one other child under age two.

This review was undertaken by the Children's Advocate in response to a request made by the Minister of Social Services. He recognized a need for an external, independent review of the Department of Social Services' (DSS) involvement in Karen's life and of the circumstances of her death.

The purpose of this review was to ascertain the facts regarding the involvement of mandated social services agencies with Karen and her family. A Child Death Multi-Disciplinary Review Team was established by the Children's Advocate. The review focused on the services provided to Karen by a variety of service providers. The review examined the cause and manner of Karen's death to determine whether the death was preventable. The review also identified systemic issues and made recommendations designed to improve services to children, to improve the protection of children and to reduce the number of child deaths. The recommendations contained in this report focus on ensuring that children in Saskatchewan are afforded the attention and protection to which they are entitled.

The Review Team operated on the principle that any review of the life and death of a child must be comprehensive and holistic. No child lives in isolation. The Review Team was committed to be as inclusive and respectful as possible of those involved.

The Review Team found that there is an immediate need to increase the amount of in-home contact between individual DSS workers and the children they serve. There is also a need for increased communication between agencies, particularly the DSS and the First Nations agencies. Communication must also be increased and improved within the structure of the DSS and between the DSS and the foster home providers.

The Review Team acknowledged that the DSS has policy, standards and guidelines that would appear to safeguard children and ensure that children in care receive safe and quality care. However, the Review Team found that these were disregarded.

The child welfare system must be able to provide children with the standard of care to which they are entitled. It was apparent from this review that there is a need for training and a monitoring mechanism to ensure that DSS workers are not only aware of the policies and standards but also of the impact on children when these standards are compromised.

Children, particularly very young children, have no direct voice in the child welfare system. Without this voice they have no capacity to question the level of care they receive. These children have no voice to demand a higher quality of care. It is essential that there is a community and government commitment to ensure that the quality of care these vulnerable children receive from society is not compromised. Those who provide services to children are not only accountable; they must be given the resources with which to meet the quality care standards.

The Review Team concluded that Karen's death was preventable. The Review Team also concluded that the lack of attention to the quality of her care was not only unacceptable, it placed her, and six other children, at risk.

The Ombudsman and Children 's Advocate Act provides that the appropriate minister shall be given the opportunity to make representations regarding any findings or recommendations of the Children's Advocate. In his response to the recommendations in this report, the Minister of Social Services clearly stated his commitment to strengthening Saskatchewan's child welfare services. He also directed the DSS "to work towards consistent compliance with these policies and practices and to develop added quality assurance mechanisms to measure such compliance." The Minister committed to providing the Children's Advocate with an update of the department's specific actions in response to the recommendations in this report within six months.

In addition, the Children's Advocate, at the request of the Minister of Social Services, will be completing a comprehensive review of the needs of children living in foster care. This review will begin in the fall of 1998 and will be completed by the spring of 1999.

PREFACE

When a child dies, particularly when the child was living in the care of the government, there is significant and justified public reaction. There is a recognized need to ensure that children are protected and that children do not die from preventable conditions. By conducting comprehensive reviews of child deaths, information is obtained that can be used to increase public understanding of child deaths and to recommend changes that, if implemented, will assist in reducing the risk of other children dying.

On September 13, 1997, Karen Rose Quill died while in the care of the Minister of Social Services. Karen, born on January *2,* 1996, was only 20 months old at the time of her death. She was living in a foster home. As Children's Advocate, I was asked by the Hon. Lorne Calvert, Minister of Social Services, to conduct an external, independent review of the Department of Social Services' (DSS) involvement in Karen's life and of the circumstances of Karen's death.

The request that the Children's Advocate Office (CAO) conduct an independent review of Karen's death prior to the DSS contracting for this to occur was a departure from the protocol between my Office and the DSS. I agreed to do this review because it was clear that the circumstances of Karen's death needed to he reviewed independent of government.

This is the first comprehensive review of a child's death by my Office. We recognize that we have much to learn. We are working to achieve a process that will ensure that every child's death is appropriately examined in such a way that we learn from it.

This report is intended to further public understanding of the needs of children who are living in foster care. Some of the issues identified in this report will be referred for further investigation to the Child in Foster Care Review to be conducted by the Children's Advocate Office commencing in the fall of 1998.

Very real and stark pain was shared with the Review Team, by members of Karen's family, the Band, and by those providing services to Karen. It is my sincere hope that this report accurately reflects the information that was shared with the Review Team. Karen's death has had a significant impact on many people. This report is intended to be a catalyst for positive change. I hope that all readers challenge themselves to strive for quality services for all children living in care.

Final Report of Findings and Recommendations
Child Death Review – **Karen Rose Quill**

June 19, 1998
Date

Deborah Parker-Loewen
Children's Advocate

PART I INTRODUCTION

A. LEGISLATIVE AUTHORITY

The Children's Advocate is an independent officer of the Legislative Assembly of Saskatchewan and acts on her own authority pursuant to *The Ombudsman and Children's Advocate Act*. Section 12.6 *inter alia* provides that:

> *(2) The Children's Advocate shall:*
>
> *(b) receive, review and investigate any matter that comes to his or her attention from any source, including a child concerning:*
>
> *i) a child who receives services from any department or agency of the government;*
>
> *iii) services to a child or to a group of children by any department or agency of the government;*
>
> *(d) where appropriate, make recommendations on any of those matters mentioned in clause (b).*

The Children's Advocate has the legislated authority to require any person to provide information, documents or things regarding any matter being investigated. She is further authorized to summon and examine under oath any person who is able to provide information relating to the matter being investigated.

Where there appears to be sufficient grounds for making a report or recommendation, in respect of any matter that may adversely affect any department, agency of the government or person, the Children's Advocate is statutorily obligated to permit them to make representation prior to the completion of the final report.

All parties adversely affected by this report were provided an opportunity to make representations. Their responses have been considered in making this report.

B. PRINCIPLES OF A CHILD DEATH REVIEW

Prior to initiating a review of Karen's death it became apparent that such a task should be guided by a set of principles that could be shared with those who would participate in the Review. The Children's Advocate is committed to increasing the quality of service being provided to children. It is imperative that the child death review process be as inclusive and respectful of those involved as possible. The following principles were adopted for this purpose:

(a) The Children's Advocate is committed to conducting a review in a manner that respects the inherent dignity of all persons.

(b) The Children's Advocate is committed to timely reviews, which are as inclusive and as accountable as possible.

(c) The Children's Advocate is committed to honouring the privacy of children and their families.

(d) The Children's Advocate is committed to promoting quality services for children and their families.

C. PURPOSE OF A CHILD DEATH REVIEW

The following statements of purpose have been adopted by the Saskatchewan Children's Advocate:

(a) Child Death Reviews will ascertain the facts regarding the involvement of mandated social services agencies with a child, the family and significant others.

(b) Child Death Reviews, through extensive cooperation between diverse agencies, will review the cause and manner of the death of a child to ascertain whether the death was preventable.

(c) Child Death Reviews will identify systemic issues and may make recommendations designed to improve services to children, better protect them and reduce the number of child deaths.

(d) Child Death Reviews will, as appropriate, result in recommendations which may affect change within every part of the child serving system including: government departments, the Royal Canadian Mounted Police (RCMP) and municipal police, the medical community, the aboriginal community, the legal community and others who provide services to children and youth.

PART II REVIEW OF THE DEATH OF KAREN QUILL

> ***States Parties shall take all appropriate legislative, administrative, social and education measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.***
>
> ***Convention on the Rights of the Child*** **(United Nations, 1991). Article 19**

On November 6, 1997, the DSS provided the Children's Advocate with their internal report regarding the death of Karen Quill. The DSS report was comprehensive and provided important background information regarding the DSS involvement with Karen and her family. The report identified a number of areas of concern. Significant recommendations were made by the DSS to improve services for children in their care. The Children's Advocate began an independent review of the services provided to Karen Rose Quill, her family and the circumstances of her death utilizing the DSS internal report as background.

A Multi-Disciplinary Review Team (see Appendix A) conducted a review of all relevant documentation produced by medical, legal and children's services providers. Team members also conducted interviews with key individuals. This examination of Karen's death occurred with the cooperation and assistance of the people who were involved in her life.

A. HISTORICAL CONTEXT

1.0 Department Of Social Services Involvement with Karen Quill's Family

In April 1997 Karen's mother contacted the DSS in Prince Albert, Saskatchewan and requested assistance in caring for both Karen and Karen's brother. No services were provided by the DSS at that time. The DSS services were not required as the two children were placed by their mother in the care of their paternal grandmother. Karen's parents were estranged and encountering personal difficulties during this period.

In May 1997, a disagreement took place between Karen's father and her paternal grandmother. Following this incident, Karen's father contacted the DSS and requested that the two children be removed from the care of their grandmother. The children were apprehended because they were determined by the DSS workers to be in need of protection. They were placed in an emergency foster home on May 28, 1997. Karen's mother was the custodial parent at the time of apprehension but felt she was unable to care for her children at this time. She signed a one-month, voluntary agreement for care of the children pursuant to Section 9 of *The Child and Family Services Act*. The paternal grandmother advised the Review Team that she asked the DSS to return the children to her shortly after they were placed in emergency foster care. The DSS worker did not consider placing the children back in the care of the grandmother because the children were apprehended from her care. Due to the DSS's historical involvement with Karen's mother's family, the DSS worker did not consider any other extended family members as potential resources for Karen and Karen's brother. The DSS records do not indicate that there was any formal individual assessment or analysis of any of Karen's extended family as caregivers. Further, Karen's mother requested that the children not be placed with extended family members without her express permission.

A DSS worker did not see the children at the emergency foster home. The emergency foster home parent advised the Review Team that when the children were placed in her care she was not told their names or how long they were expected to stay. There was telephone contact with the DSS Resource Coordinator but not the assigned DSS worker for the children.

During the 30 days the children were in foster care on voluntary status, their mother visited them on two occasions (June 5 and 12, 1997). Both visits took place in the DSS office in Prince Albert. The DSS plan for the children was to return them to their mother on June 28, 1997.

The voluntary agreement expired on June 28, 1997. The children were apprehended because the DSS worker was "unable to locate parent to make plans to return children." An application was made by the DSS for a protection hearing pursuant to Section 11 of *The Child and Family Services Act*. The application was made July 3, 1997 and a Notice of the Protection Hearing was provided to the children's mother on July 9, 1997. As Karen's parents are members of a First Nation, and in keeping with departmental practice, registered letters were sent to their respective Bands following the apprehension. There was no response from either Band prior to Karen's death. Karen's mother's Band became involved with the family following Karen's death.

Karen's mother advised the Review Team that although she was provided information when she signed the voluntary agreement, she believed that she had to appear before the Court in order to have her children returned to her.

There are no recordings to indicate that DSS workers made any attempts to locate the children's mother after the date of apprehension. Following receipt of the Notice of Protection Hearing on July 9, 1997, Karen's mother contacted the DSS on July 22, 1997 and was advised by the DSS supervisor to call her DSS worker one week later. Karen's father and mother visited the children on August 28,1997 and a discussion occurred with the DSS worker regarding the parents' long-term plans. The Protection Hearing was postponed on several occasions and had not occurred prior to Karen's death.

After 41 days in emergency care, the children were transferred to a foster home without consultation with Karen's mother or an exploration of extended family resources. No DSS worker was present when the children were transferred from the emergency foster home to the foster home. Both foster parents expressed concern to the Review Team about having children transferred between resources without the presence of a DSS worker.

There is no indication in the DSS files that an assessment or treatment plan had been developed for Karen who had been in care of the Minister of Social Services for a total of 109 days prior to her death. DSS staff reported that this was due to unusually high caseloads, staff shortages caused by summer vacations and the demands on the DSS system generally. Staff reported being reasonably able to respond to crisis situations but unable to meet the expectations of their policy and guidelines.

2.0 Critical Events Leading Up to the Death of Karen Quill

On July 7,1997, Karen Quill and her brother were transferred from the emergency foster home to a foster home in St. Louis, Saskatchewan. The children remained in this home until the day of Karen's death, September 13, 1997.

A review of the foster home file indicated that this home had been approved in 1987 for two foster children. By 1988, there were six foster children in the home despite recorded concerns in DSS files about the parents' ability to foster this many children. The home closed voluntarily in 1989 and reopened in 1995. The home was subsequently closed that same year for reasons unrelated to this Review.

Having now separated from her spouse, the foster mother reapplied for foster home status in September of 1996. Without completion of a further homestudy she was again approved for "no more than two children." By February of 1997, there were five foster children in this home. The annual foster home review, conducted in June 1997, recommended that "no further children be placed in this home." Two weeks later, Karen and her brother were placed in the foster home.

The two Quill children were placed in this single parent foster home with five other foster children. With the placement of Karen and her brother, the total number of foster children in this home was seven. Karen was the only girl placed with six boys. Two of the children were under the age of two and three were three year-olds. There was one four year old and one nine year-old. These seven children represented three separate, unrelated sibling groups.

The DSS decision to further exceed the recommended number of children in this home was based on a DSS worker's plan that two of the children currently residing in the foster home were returning to their parental home at the end of July 1997. By July 28, 1997, it was known that this was not going to occur and no action was taken to reduce the numbers of children in this home.

The foster parent advised DSS workers on various occasions during the summer that she was struggling with caring for these children. They exhibited "difficult to manage" to "highly aggressive" behaviour, had minor but contagious infections and a persistent lice infestation. DSS workers advised the foster parent to obtain domestic assistance to aid in addressing the lice problem. The foster parent obtained the help of a neighbour for eight hours a day once a week for the four weeks in August to assist in the thorough disinfectant cleaning of the home.

The foster parent advised the Review Team that she did not request additional support to assist her in coping with the number of children she had as she was not aware this was available. She was concerned that if she admitted being overwhelmed, the DSS would "view her as a failure", or worse, "unable to handle the situation." She feared she would "lose her kids" so she "tried to hang on." Representatives of the Foster Families Association and three other foster parents informed the Review Team that foster parents are generally reluctant to request assistance as many have experienced subtle forms of intimidation when they have asked for help.

For example, foster parents who have admitted to having difficulty coping with the children in their care report that DSS workers have suggested that their home "be left empty for six months" or that their "home be reviewed."

On August 28, 1997, Karen's parents visited with their children. Karen's father specifically raised concerns with DSS workers about the infestation of lice. The DSS advised Karen's father that they were aware of the lice and had approved additional home help to assist the foster parent with this issue.

At a September 8, 1997 visit, one week prior to Karen's death, Karen's mother requested that the DSS move her children out of this foster home. Karen's mother expressed concerns about the safety of her children because they both had cuts and bruises. She also expressed concerns about the number of foster children residing in this home and the care her children were receiving.

Following the mother's expression of concern, a DSS worker questioned the foster parent about the children's cuts and bruises. The foster parent provided an explanation that the DSS worker thought was consistent with normal child play. However, the questioning occurred in front of Karen's mother and her children in the hallway at Social Services. No formal investigation of the concerns expressed by Karen's mother was undertaken.

DSS workers acknowledged to the Review Team that they were aware that there were too many children in the foster home. They were concerned that the children were not being afforded a proper level of supervision by the foster mother. This was apparent not only from the concerns expressed by the biological parents but also through conversations DSS workers had with the foster parent.

The file recordings indicate an intent to find another resource for the children although no specific action was initiated. One DSS worker advised the Review Team that they were "looking for resources hut resources were very limited."

DSS workers responsible for Karen did not visit her in either the emergency home or the foster home during her entire 109 days in care. No foster home visits were conducted by the DSS workers involved with any of the seven children placed in the foster home during Karen Quill's stay. This was confirmed by the foster parent. The Review Team was informed that due to space limitations, two foster children aged nine and four were sleeping in a partially finished basement with no bedroom. While these facts do not play a direct role in the death of Karen Quill, the fact that the DSS permitted this situation to exist disturbed the Review Team.

3.0 Events on the Day of Karen's Death

On September 13, 1997, the day of Karen's death, Karen was outside without adult supervision in an unfenced backyard playing with the six other foster children who resided at the foster home.

It is important to note that it was not possible for the Review Team to completely and accurately determine the exact sequence of events that occurred on the day of Karen's death. Some information was not available or not verifiable. For periods of the day, conflicting information was provided which was also not possible to verify. Information that has been verified is reported below.

At 12:45 p.m. an independent adult witness observed the seven children playing in the yard. Karen was lying motionless on the ground. This adult advised the nine year-old to take Karen inside and put her to bed. He apparently did so.

Karen was found dead in her playpen on September 13, 1997 at 3:30 p.m. by a 14 year-old babysitter whose services had been engaged by the foster parent at 2:00 p.m.

The RCMP, Wakaw Detachment, and the Prince Albert Joint Forces Unit conducted a criminal investigation, the results of which were shared with the Review Team. No criminal charges were laid following the police investigation. The RCMP notified the DSS that "this detachment has ended the investigation and ruled the death to be accidental."

At the time of this Review, the RCMP investigation had not been formally reviewed by Public Prosecutions. At the suggestion of the Review Team, the RCMP agreed to have the file reviewed by a senior crown prosecutor. The crown prosecutor's legal opinion was that "there would appear to be no reasonable likelihood of a successful prosecution based upon the file."

An autopsy was conducted. Karen appears to have been injured on the morning of September 13, 1997. The Final Necropsy Report indicates that Karen "suffered numerous blunt injuries to her body and subsequently died from bleeding and hypovolemic shock caused by disruption of a piece of liver."

4.0 Events After the Death of Karen Quill

On September 13, 1997 Mobile Crisis and the RCMP notified the DSS and members of Karen's family that Karen had died. Mobile Crisis Services, in consultation with the RCMP and the foster parent, determined the remaining six foster children needed to be moved to various emergency foster homes later that night.

With the assistance of the Ahtahkakoop Child and Family Services Agency, Karen's brother was subsequently placed in a foster home at Sandy Lake. He was eventually returned to the care of his mother with whom he now resides. An offer of counselling and other services for both mother and son have been made by the DSS.

The other five foster children who were in the foster home at the time of Karen's death remain in foster care. No children have been placed back in this foster home since Karen's death. Counselling has been provided to one of the children.

Karen's mother, father, and grandparents advised members of the Review Team that they had not, as of the date of the interview, received full disclosure or information regarding Karen's death from either the police or the DSS.

The RCMP Joint Forces Unit advised the Review Team that an offer was made to DSS staff to provide the family with information regarding their investigation. The Review Team advised the Ahtahkakoop Indian and Child Family Services staff of the RCMP's willingness to meet with the family.

B. FINDINGS AND RECOMMENDATIONS

1.0 Family and Community

1.1 Communication Between the DSS and First Nations Agencies

DSS policy states that the Band or family services agency will be advised when one of their members is apprehended pursuant to *The Child and Family Services Act*. The practice in the Northwest Region has been to notify the Band/Agency of the apprehension by registered letter.

The Review Team was concerned by the lack of response to the registered letters that were sent to Karen's parents' respective Bands. The DSS and Bands/Agencies need to work together to ensure that suitable resources are available to meet the needs of children. Karen did not receive services that she was entitled to due to this breakdown in communication.

The DSS is committed to ensuring that children are placed with family members or with members of their own communities. Sending a registered letter is not a sufficient process. The DSS is obliged by their policy to explore all potential options for placement prior to assuming responsibility for a child. This would then indicate that a personal contact must occur between DSS personnel and the affected Band/Agency prior to placement in the DSS system.

Recommendation #1

That when a First Nations child is apprehended by the DSS, all possible placement options must be explored with the Band/Agency prior to placing the child in the DSS (non-emergency) foster care system. This necessitates that the DSS and the Band/Agency develop a process to ensure that this exploration of placement options takes place.

2.0 Family Services

States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

Convention on the Rights of the Child **(United Nations, 1991). Article 3**

2.1 Exploration of Extended Family Resources

The DSS utilizes a family centered case management model, characterized by the following principle: "the majority of services are provided in the family's home, or other natural environments. Resources in the family, extended family, Indian Band, and community are used to the fullest extent" (DSS Policy Manual).

A DSS worker informed Karen's mother that no member of her family would be considered as an acceptable resource for the children. This statement was made to Karen's mother due to previous DSS contact with members of her extended family.

The DSS worker confirmed that she made the decision not to consider Karen's extended family as a resource and that no assessment of the individual potential of extended family members was made. The Review Team also noted that the children were expected to return to the care of their mother within 30 days. As the children had already been placed in an emergency foster home, the DSS stated that it may not have been appropriate to consider an extended family placement for such a short period of time. In addition, Karen's mother requested that no extended family placements be made without consulting her first, as she wanted to he included in any planning for her children. However, when the voluntary 30 day agreement for care expired, extended family were not considered as placement options. Karen and her brother were subsequently moved to another foster home.

The DSS policy, which directs DSS workers to explore extended family placements to the fullest extent is reasonable. The Review Team concluded that no exploration or assessment of any extended family member occurred prior to the DSS worker determining that there were no suitable members of Karen's family available to care for the children. Individuals were not assessed on their own merit and a decision was made regarding placement, which failed to consider possible extended family members as resources for the children.

Recommendation #2

That all possible caregivers for children, especially extended family members, must be considered as placement options, where it is safe to do so, particularly when children are already in emergency foster care.

Recommendation #3

That an effective and accountable system be developed that ensures that extended family members are considered as placement resources and that a record of the outcomes be documented.

2.2 Contact With Children in Care

DSS policy provides that a child must be seen a minimum of twice per month for the first two months following placement and at least every six weeks thereafter. The purpose of this policy is to assist with the adjustment of the children and the foster parent and to provide relevant information and support to both. There is no direction as to where the child is to be seen.

DSS policy outlines a set of guidelines that are to be followed when a child is experiencing a change of placement, and the process that must occur when a decision is made to move a child from emergency foster care to further placement. This policy directs the case worker to transport the child to an "out of home care resource." It further outlines the importance of preparing the resource for the child and supporting the child to reduce the disruption in his or her life.

The fact that Karen Quill and her brother were placed in an emergency home nameless, and without providing the foster parent with some information as to the expected length of stay, is an indication of the lack of personal attention that was paid to these children from their first contact with the DSS onward.

Without the presence of a DSS worker when a transfer between foster homes occurs, there is limited ability to ensure that information essential to the needs of the child is relayed. The DSS abdicated their responsibility for the transfer of the children to foster parents and this is unacceptable. DSS workers are required to ensure that the foster parent and the environment of the foster home are suitable for the child who is about to be placed. The foster parent is to he provided with all relevant information about the needs of the child in question. Karen Quill was not afforded this protection and was therefore placed unnecessarily at risk.

No DSS worker saw or visited with Karen in either the emergency foster home or the foster home. This lack of direct DSS worker contact in the foster home indicates that DSS workers had no means to ensure that Karen was receiving the care to which she was entitled. Karen had no ability to care for herself and no ability to report neglect or to request the care she required. As an infant, she was entirely dependent upon the DSS to provide basic life necessities for her.

DSS workers advised the Review Team that they were not aware of the DSS policy and standards regarding the frequency of visits with children in the foster home. There was frequent telephone contact between DSS workers and the foster parent. The DSS workers and the children had direct contact only during scheduled office visits between the children and their parents. The policy and guidelines regarding the amount of contact with a child are meant to ensure the child's safety and well-being. The Review Team found that DSS staff were not sufficiently aware of the policy. Had DSS workers complied with the minimum standards respecting home visits and visited at the foster home to witness the environment in which they had placed Karen, action could have been taken to afford her the care to which she was entitled under *The Child and Family Services Act.*

Recommendation #4

That standards be developed to ensure that all children have a personal visit by a social worker, in the foster home in which they have been placed, within the first 48 hours of placement.

Recommendation #5

That the present policy stipulation that contact be "a minimum of twice per month for the first two months" also state that the contacts occur in the foster home in which the child has been placed.

Recommendation #6

That all transfers of children between emergency homes and longer term foster home placements be done by DSS workers and not left to foster parents or contract workers.

2.3 Status Change From Voluntary Care to Apprehended Status

The family centered case management model, used by the DSS, is founded on the principle that the first and greatest investment of time and resources should be made in the care and treatment of children in their own homes, where it is safe to do so, and that apprehensions would occur as a last resort.

DSS file recordings indicate that the decision to apprehend Karen and her brother was based on the DSS worker's inability to locate Karen's mother after the voluntary agreement expired.

Karen was originally placed in care under a voluntary agreement with Karen's mother. At the expiry of the voluntary agreement, the plan was to return Karen to her mother. Karen was placed on apprehended status after DSS workers were unable to locate Karen's mother. It is difficult to understand why Karen continued on apprehended status and was not returned to her mother. It is not known if Karen's mother was supportive of an extension to the voluntary agreement that she already had with the DSS. There is also no indication that Karen's mother was unable to care for the children at home. The decision to apprehend Karen was based on minimal information that was not adequately communicated between the various DSS workers involved with Karen and Karen's mother. Planning for children must be based on carefully considered options with the needs of the child as the primary focus. A meeting between DSS workers and Karen's mother to discuss planning options did not occur until August 28, 1998.

The effect was that timely case planning opportunities were missed. Karen's mother was not afforded any resources and support to care for her children nor was the potential for extended family placements explored.

Recommendation #7

That a standard process be established to ensure that parents and children receive a complete explanation of the terms and conditions of their relationship with the DSS, including appeal options.

Recommendation #8

That parents of children who are in foster care under a voluntary agreement be provided with resources and support to facilitate their children being returned to them in a timely and safe manner.

Recommendation #9

That children should be in foster care on apprehended status only under circumstances which are enumerated under "The Child and Family Services Act." Case planning must occur in a timely fashion.

2.4 Standards and Guidelines for Foster Home Approval

DSS policy outlines standards and guidelines for the approval of a foster home.

Between 1987 and 1996, this foster home was opened three times, closed voluntarily on one occasion and was formally closed by the DSS on another. The foster parents had only one homestudy completed in 1987 despite a variety of significant changes in their circumstances. The Review Team finds that the absence of a homestudy, on reapplications to foster, limits the DSS's ability to assess whether this foster parent was able to provide the necessary care for the children that the DSS placed in her care.

Recommendations regarding the number of children this foster parent was capable of caring for were made by the DSS. These recommendations were routinely and historically ignored. The foster parent was approved for two children in September of 1996 and by February 1997 there were five children in the home. An annual foster home review, completed in the foster home in June 1997, specified that no further children were to be placed in this home. Karen and her brother were placed in the home less than two weeks later. This decision contradicted the previous recommendation.

Recommendation #10

That for every foster home application, including applications to reopen a home, a formal homestudy process be completed unless the home has been granted a pre-approved leave of absence from fostering.

Recommendation #11

That the number of children approved for placement in a particular foster home by the foster homestudy and/or annual foster home review not be exceeded. It must be recognized that each foster home is approved for a defined number or age of children. This number of children may be less than the maximum number of children allowed according to DSS policy.

2.5 Appropriateness of Placement of Karen Quill in Foster Home

DSS policy states that a maximum number of four foster children can be placed in a foster home at any given time. Three exceptions are allowable under this standard and they are: the placement of sibling groups, placement of children in a home in which they have previously lived and short-term emergency placements.

An exception to the standard can be made with the Regional Director's approval. The approval must be reviewed every two weeks. Monthly reports listing the exceptions to the policy are to be submitted to the Provincial Director of Child Welfare.

This home was re-opened following a home visit on September 18, 1996. A formal homestudy was not completed. The Review Team was advised by both the foster parent and the DSS worker that the resource was approved as a two child resource in light of the single parent status and living accommodation. Two children were placed with the foster parent on September 19, 1996. Within weeks of being re-opened, three children, representing two sibling groups were placed in the care of this single parent foster home. In February 1997, following a move to a larger residence, two additional children were placed in this home. This placement was an allowable exception to the policy as the children being placed were siblings of the other children in the home.

On July 7, 1997 Karen Quill and her brother were placed in this foster home. They had not been in this home before. They were not a part of any of the sibling groups present in the home. Their placement was not an emergency.

As the DSS had already made an exception to the policy by placing two sibling groups in the home, bringing the number of children to five, there was no authority upon which to place Karen and her brother in this foster home. Karen's placement in this home was a violation of existing policy.

Furthermore, Karen's placement neither received approval from the Regional Director nor was the Provincial Director of Child Welfare advised as per DSS policy. It is further noted that management at all levels exhibited a tolerance for noncompliance with established procedures. The Review Team was repeatedly informed by DSS staff and by foster parents that there is an urgent need for more resource options for children. The Review Team was also told that the workload demands on DSS workers is, at times, overwhelming. DSS workers expressed frustration at not being able to provide an adequate level of support to children and foster families because of high caseloads, frequent staff turnover, and poor communication between work units. Crisis situations are dealt with as the first priority, leaving limited time for proactive case planning with children already in foster care. Vacation leaves further complicate the demands on DSS workers. Managers at all levels expressed similar concerns about the demands to which they are expected to respond. The Review Team did not examine resource allocation, however, it is noted here as it was a consistent theme expressed by DSS workers, managers and foster parents.

Recommendation #12

That the DSS establish an effective system of accountability to ensure that the allowable number of children placed in foster homes is not violated.

Recommendation #13

That the DSS amend their current policy to ensure that multiple exceptions to the standard regarding the number of children per foster home are not permitted.

Recommendation #14

That the DSS provide resources and organizational support to children in foster care to ensure that the care provided to these children is consistent with safe and appropriate case management practices.

2.6 Support to Foster Parent

The foster parent advised DSS workers that the children in her home were highly aggressive and required constant supervision. She also told DSS workers that due to the challenging behaviour of one of the children, she had less time for the other children in her home.

DSS workers acknowledged in interviews with the Review Team that, prior to Karen's death, they were concerned about the parenting role taken by the nine year-old, the number of children in this foster home and that the children were not being afforded a proper level of supervision.

Not only was this foster parent expected to care for too many children, the DSS failed to provide this foster parent with the support necessary to ensure that these children were being afforded the level of care to which they were entitled under *The Child and Family Services Act.*

The foster parent received some support from others in the community. An Early Childhood Intervention Program staff person visited other children in the home three times during the period of time Karen was placed there. A psychologist was in this foster home to see another child in August. These contacts are not substitutes for the DSS's responsibility to provide the children and the foster parent with an appropriate level of support.

Recommendation #15

That the DSS establish measurable standards that ensure adequate support is provided to foster parents and that foster parents are informed of all available resources.

Recommendation #16

That the DSS establish minimum standards regarding contacts and home visits with foster parents. The ongoing capacity of a foster parent to care for the children in his/her care must be assessed on a regular basis.

2.7 Response to Concerns Raised by Karen's Family

DSS policy outlines the process that must occur when a complaint concerning children in care is presented to the DSS. The policy states that "all complaints concerning the abuse or neglect of children in care shall be investigated immediately." The policy is meant to ensure the prompt investigation of all complaints concerning the abuse and neglect of children in foster care.

At a September 8, 1997 visit with her children, one week prior to Karen's death, Karen's mother requested that the DSS move the children out of this foster home. Karen's mother expressed concerns about the safety of her children because they both had cuts and bruises. She also expressed concern about the number of foster children residing in this home.

Complaints raised by Karen's mother regarding the care and safety of her children while in foster care deserved a more thorough analysis than they were given by DSS workers. By September 8, DSS workers were aware that the foster mother was having difficulty coping. There were concerns about the number of young children in the home, and concerns regarding the quality of care these children were receiving. When the safety issues were raised by Karen's parents, they were not considered in the context of the previously acknowledged concerns. DSS workers indicated to the Review Team that they "intended to find another resource for the children." This is not an acceptable response to a situation which had been escalating for weeks. The Review Team concluded that, had the DSS completed a comprehensive analysis, an immediate change in conditions for these children would have been forthcoming. The current DSS policy respecting complaints concerning children in care of the Minister directs that all complaints deserve a prompt and thorough investigation.

Recommendation #17

That the DSS ensure that all complaints concerning the treatment of children in care are completely and promptly investigated and that an accountability process be implemented which monitors DSS follow-up of these complaints.

2.8 Post Death Services

Critical incidence briefing and other support services are provided for DSS staff. The DSS does not have policies that outline any guidelines, procedures or standards in regard to post death services for either the parents or the foster parents of a child who dies.

It is of concern to the members of the Review Team that the potential impact of Karen's death on the foster children present at the time of her death has not been adequately addressed by the DSS.

Recommendation #18

That the DSS develop a policy regarding post death services to DSS clients, including families and foster families of any child who dies as per the DSS Death of Child or Youth Policy.

Recommendation #19

That the emotional and behavioural needs of the children present in the foster home at the time of Karen's death be assessed and that any recommendations arising from these assessments be acted upon.

3.0 Police/Legal Review

There were two issues identified during the review of the police investigation. The first issue dealt with the classification by police of Karen's death as "accidental." This matter was discussed with the RCMP. One quickly realizes that words hold different meanings depending upon the professional context in which they are being used. In the context of a police investigation the term "accidental" refers to someone whose demise was not the direct result of criminal intent. The discussion of terminology is acknowledged as important and will be ongoing as the Children's Advocate Child Death Review process evolves.

The second issue was the referral of the police investigation to Public Prosecutions. The Review Team concluded that all child deaths should have a legal review. The investigation of Karen Quill's death had not received a formal legal review. The RCMP presently consult with Public Prosecutions only in certain enumerated instances. The Review Team suggested, and the RCMP agreed, to submit their investigative findings to Public Prosecutions for formal review.

A Senior Crown Prosecutor at Saskatchewan Justice reviewed the police investigation of the death of Karen Quill. The opinion, based upon the file, was that "there would appear to be no reasonable likelihood of a successful prosecution."

Recommendation #20

That child deaths under investigation by all police services be referred to Public Prosecutions for a legal opinion.

Recommendation #21

That the Child Death Advisory Committee, chaired by the Children's Advocate, review and clarify terminology used by various agencies to ensure understanding and, where possible, consistency.

4.0 Medical Review

The Final Necropsy Report indicates that on September 13, 1997 Karen Quill "suffered numerous blunt injuries to her body and subsequently died from bleeding and hypovolemic shock resulting primarily from a lacerated liver."

The Professor of Pediatrics who reviewed the Final Necropsy Report along with other medical documentation concluded that:

> "The seriousness of her condition was obviously not recognized by her caregivers. If she had been hospitalized immediately the death could have been prevented by adequate fluid resuscitation and timely surgery. The injuries she sustained did not have to be fatal. In other words, her death was medically preventable if she had received medical attention."

The extent of Karen's injuries were disturbing to the Review Team. It is difficult to conceive how these injuries could have occurred if an adult was supervising the children. Children of this age and number require close supervision. On September 13, 1997 Karen and the other foster children were not provided with an appropriate level of supervision while playing in the backyard. The Review Team is of the opinion that had supervision been provided, Karen Quill's death would have been prevented.

5.0 General Findings

This review of the circumstances of Karen's death raised concerns for the general safety of other children in foster care. The following three recommendations are aimed at preventing children, living in circumstances similar to Karen's, from being injured.

Recommendation #22

That the DSS immediately review all foster care placements and that where the numbers of children in a foster home exceed the maximum of four children, ensure that the placements are acceptable and that all necessary supports are provided to foster parents.

Recommendation #23

That the DSS immediately review with all staff the contact standards regarding personal contact by DSS workers with children in foster care.

Recommendation #24

That the DSS immediately in form all foster parents that home support is available to assist them with providing appropriate care to the children in their homes.

This review also raised general concerns about DSS worker knowledge of and adherence to DSS policies, standards and guidelines. As individuals, some DSS workers were distressed that they were unable to provide the children they felt responsible for with an adequate level of service. The Review Team concluded that there is an urgent need for staff training at all levels. In addition, it appeared to the Review Team that it was difficult for DSS workers to maintain clear and prompt communications with each other, especially when different DSS workers are providing care and support to members of the same family.

Recommendation #25

That the DSS establish a comprehensive, new employee training program which must be completed by new employees before they assume responsibility for child protection or child care services.

Recommendation #26

That the DSS establish a comprehensive continuing professional education program that ensures all DSS workers receive a minimum standard of ongoing professional development.

Recommendation #27

That children in care, and their families receive services, where possible, from one clearly identified case manager who is responsible for ensuring that the children receive quality services in a timely and coordinated manner.

PART III CONCLUSION

The purpose of this review of the circumstances surrounding Karen's death is primarily to identify recommendations that will positively affect services to children. The findings and recommendations outlined in this report are intended to provide information to assist in preventing future deaths of children in Saskatchewan.

Issues and concerns emerged during the course of this review which, while not directly related to the circumstances of Karen's death, were commented upon in the report. This was done in the interests of safety and quality of care for children.

The following areas of significant concern were identified:

1. The Department of Social Services has policies and guidelines regarding:
   - the number of children to be placed in a foster home;
   - the times and frequency of contact social workers should have with children in care;
   - the supervision that foster parents and social workers should receive in order to support them in carrying out their responsibilities; and
   - the times and conditions under which assessments and care plans are to be developed for children in foster care.

These policies were consistently disregarded by DSS workers who were, in some instances, not aware of the policies and who did not believe they had the time or resources to comply with the policies. Regardless of the written policies, Karen was not treated with the consideration and thoughtfulness to which she was entitled as a child in the care of the Minister. It would seem reasonable that children in foster care should be provided with a higher than average standard of care as they are being denied the opportunity to live with their family. This foster mother was expected to care for an unreasonable number of very young children without adequate support from the DSS. Closer adherence to the policies by DSS workers may have resulted in a different outcome for Karen. Closer attention to Karen and her needs as a little girl of 20 months of age may have prevented her death.

2. The Review Team was particularly concerned that there were several opportunities for an evaluation of the quality of care provided to Karen which were not acted on in a timely manner by DSS workers. These "flags" were raised from a number of

perspectives and a review of the care plan for Karen was essentially not initiated until the end of August, many weeks after Karen first came into care.

It is recognized that DSS workers, managers, and foster parents raised significant concerns with the Review Team about lack of resources for children in care. The Review Team urges government to examine resource allocation in terms of the workload expectations and ensure that quality care is provided to all children. In addition, the complexities of the organizational structure also appear to have affected the quality of care provided to Karen. There were several different DSS workers directly or indirectly involved with Karen and yet not one of them visited Karen in the foster home during her entire time in care. This is alarming to the Review Team. The Review Team is most concerned that these case management challenges be recognized in the context of organizational challenges affecting the DSS workers who provide services for children in care.

The recommendations made in this report regarding improving contact between DSS workers and children are a priority to the Review Team. It is essential that children have frequent contact with DSS workers, particularly in their place of residence and at times when care plans are changed, such as with a move to a new residence.

3. Karen was not provided with medical attention after she was injured. There is conflicting information regarding Karen's condition at the time she was put down for her afternoon nap. The Review Team was advised that Karen's death was medically preventable had she received timely medical attention. It is clear that an adult did not adequately supervise Karen and the six other children. The circumstances on that day were such that Karen was placed in a situation which contributed to her death.

4. There was an overall failure of accountability which the Review Team found contributed to Karen's death. DSS worker and supervisor compliance with well established DSS policies was not monitored permitting an unacceptable situation to persist for seven children.

The Review Team has therefore concluded that the circumstances of Karen's placement in this foster home contributed to her death. The Review Team acknowledges that the foster care system in Saskatchewan is under stress.

A comprehensive review of the needs of children living in foster care was requested by the Minister of Social Services in the fall of 1997. Funding was allocated by the Board of Internal Economy for the Children's Advocate Office to conduct this review, commencing in the fall of 1998. It is anticipated that many of the systemic concerns identified in this report, including the concerns raised about the need for more foster home resources, will be examined during this upcoming review. The Child in Foster Care Review will focus on quality of care issues for children in foster care.

> ***It is the conclusion of The Review Team that Karen's death, on that day and in those circumstances, could have been prevented had those responsible for her care made different decisions and taken different actions.***

The Children's Advocate is required to report her opinion and reasons to the appropriate minister and to the department or agency of the government when an investigation of this nature is made. In accordance with Section 24 of *The Ombudsman and Children's Advocate Act,* these findings and recommendations were reported to the Minister of Social Services who was given the opportunity to make representations in regard to the findings and recommendations. In accordance with Section 25 subsection (1) of *The Ombudsman and Children's Advocate Act,* the DSS has been requested to notify the Children's Advocate within six months of the steps that the DSS has taken to give effect to the recommendations.

The Minister of Social Services provided his initial response to the Children's Advocate (see Appendix C for the complete response) in which he affirmed that he will be taking the conclusions of the Review Team very seriously. He stated in his response: "I want you to be assured that we are taking steps to strengthen our child welfare services. Based on your report on the death of Karen Quill I am committed to take still further steps." In addition, the Minister has given a commitment to provide the Children's Advocate with an update of the department's specific actions in response to the recommendations within the next six months.

This report is being publicly released in accordance with Section 30 subsection (3) (b) of *The Ombudsman and Children's Advocate Act* which provides that the Children's Advocate may publish reports relating to any particular case reviewed or investigated by her.

APPENDIX A

CHILD DEATH MULTI-DISCIPLINARY REVIEW TEAM

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Under the coordination of the Children's Advocate, a Child Death Multi-Disciplinary Review Team was formed.

Each team member has skills and expertise in identifying the cause and circumstances of a child's death. Each team member contributes to identifying systemic issues and proposing possible strategies for prevention.

Terms of Reference

- to provide advice on the development of the process for the Review;
- to identify issues for follow up by investigators;
- to participate in interviews and documentation reviews where appropriate;
- to advise on content and recommendations in the Children's Advocate Report; and
- to identify and describe systemic and cross-jurisdictional issues.

Members of the Child Death Multi-Disciplinary Review Team – Karen Rose Quill

Children's Advocate
Dr. Deborah Parker-Loewen

Principal Investigators

Ms. Glenda Cooney	Deputy Children's Advocate
Mr. John Brand	Advocate
Mr. Don Bird	Law Enforcement Consultant

External Consultants

Dr. Gordon Kasian	Professor of Pediatrics, University of Saskatchewan Chief Coroner, Province of Saskatchewan
Dr. John Nyssen	

Legal Counsel

Mr. Gordon Mayer	General Counsel, Provincial Ombudsman and Children's Advocate

APPENDIX B

SUMMARY OF RECOMMENDATIONS

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Recommendation #1

That when a First Nations child is apprehended by the DSS, all possible placement options must be explored with the Band/Agency prior to placing the child in the DSS (non-emergency) foster care system. This necessitates that the DSS and the Band/Agency develop a process to ensure that this exploration of placement options takes place.

Recommendation #2

That all possible caregivers for children, especially extended family members, must be considered as placement options, where it is safe to do so, particularly when children are already in emergency foster care.

Recommendation #3

That an effective and accountable system be developed that ensures extended family members are considered as placement resources and that a record of the outcomes be documented.

Recommendation #4

That standards be developed to ensure that all children have a personal visit by a social worker, in the foster home in which they have been placed, within the first 48 hours of placement.

Recommendation #5

That the present policy stipulation that contact be "a minimum of twice per month for the first two months" also state that the contacts occur in the foster home in which the child has been placed.

Recommendation #6

That all transfers of children between emergency homes and longer term foster home placements be done by DSS workers and not left to foster parents or contract workers.

Recommendation #7

That a standard process be established to ensure that parents and children receive a complete explanation of the terms and conditions of their relationship with the DSS, including appeal options.

Recommendation #8

That parents of children who are in foster care under a voluntary agreement be provided with resources and support to facilitate their children being returned to them in a timely and safe manner.

Recommendation #9

That children should be in foster care on apprehended status only under circumstances which are enumerated under *The Child and Family Services Act.* Case planning must occur in a timely fashion.

Recommendation #10

That for every foster home application, including applications to re-open a home, a formal homestudy process be completed unless the home has been granted a pre-approved leave of absence from fostering.

Recommendation #11

That the number of children approved for placement in a particular foster home by the foster homestudy and/or annual foster home review not be exceeded. It must be recognized that each foster home is approved for a defined number or age of children. This number of children may be less than the maximum number of children allowed according to DSS policy.

Recommendation #12

That the DSS establish an effective system of accountability to ensure that the allowable number of children placed in foster homes is not violated.

Recommendation #13

That the DSS amend their current policy to ensure that multiple exceptions to the standard regarding the number of children per foster home are not permitted.

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APPENDIX C

MINISTER OF SOCIAL SERVICES CORRESPONDENCE WITH THE CHILDREN'S ADVOCATE

Minister of Social Services

SASKATCHEWAN

Legislative Building
Regina, Saskatchewan S4S 0B3
(306) 787-3661

June 9, 1998

Dr. Deborah Parker-Loewen
Children's Advocate
344 Third Avenue North
Saskatoon, Saskatchewan
S7K 2H6

Dear Dr. Parker-Loewen:

I have received the report following your review of the death of Karen Rose Quill. Thank you for accepting my request to undertake this difficult task. The report is very frank and demonstrates a thorough review with thoughtful recommendations. The death of a child is always tragic. As Minister of Social Services, when a child dies while in the care of the department, this is of particular concern to me.

As you have noted in your report, comprehensive reviews assist the department in assessing how best to reduce the risk of other children dying. It is for this reason that my department developed a Child Death Review policy. Your report confirms for me that my call last October for a broader review of the foster care system was appropriate. I understand that you have needed to complete this case review before undertaking the broader review of the foster care system.

I take the conclusions drawn by the Review Team very seriously. The report speaks to four key issues related to the care and services provided to Karen and her family: workloads carried by workers at the time; availability of care resources for children; training of staff; and the organization of our services and communication between workers.

. . . 2

I want you to be assured that we are taking steps to strengthen our child welfare services. Based on your report on the death of Karen Quill I am committed to take still further steps. Many of your recommendations direct the department to the full implementation of current policies and practice. I have directed my department to work toward consistent compliance with these policies and practices and to develop added quality assurance mechanisms to measure such compliance.

Personal contact between social workers, children, families, extended family, cultural communities and foster families is one of the strongest assurances of good service. Caseload sizes at the time of Karen's death appear to have hampered social workers' ability to maintain sufficient personal contact with Karen, her family and her foster family. Our government has recently approved 50 new positions for child welfare. This will help to reduce social workers' caseloads to more manageable sizes allowing them to increase the amount of personal contact. I will be requiring a demonstrated improvement in this aspect of our work. The department will continue to monitor its performance and the adequacy of resources in the child welfare system.

The department will be increasing its emphasis on recruitment, retention and support of foster families. It is equally concerning that resources in the Prince Albert area have been so limited. The department strives to be both family-focused and centred on the safety and best interests of the child. Families need sufficient services so they can safely care for their children and, when this is not possible, alternatives to foster care such as extended family and, in the case of First Nations children, their Bands and Agencies need to be actively considered. When such alternatives are not possible, however, foster families provide the majority of residential services for children in care and will continue to be essential to the department's child welfare services. We will work to increase the number of foster homes and other resources available in order that social workers are better able to match children's needs with the foster family's skills and approved capacities.

Training is always an important aspect to assure staff have the necessary skills. A new staff training program is being introduced beginning in the fall of 1998. The purpose is to strengthen job-related skills specific to Child Welfare and Youth Services. The department is developing an implementation strategy that will assure a transference of learning to practise more effectively than traditional training approaches.

. . . 3

The department recognizes the need to insure that workers who are involved in a case are clear about their responsibilities and have the necessary information available. The department will be directed to examine the current organizational structure including how information is shared. The structure must assure roles and responsibilities of workers are clear, the work is coordinated, and communication between all concerned is timely and clear. As indicated an important element will be addressing caseload sizes to provide the capacity for effective work.

In conclusion, I again express my thanks for your work and your commitment to children. Your report reinforces the seriousness of responsibility carried by individuals and agencies who care for children in need of protection. It is never easy to receive the report from a review that expresses such concern about decisions and actions. It is absolutely imperative for the health and safety of all, however, that reviews continue and that we are prepared to learn from them and take corrective action.

Department staff at all levels are dedicated to helping families and children. I am confident that as a society and as a government we are committed to improving our child welfare system. I commit to providing you an update of the department's specific actions in response to the recommendations within the next six months.

Sincerely,

Lorne Calvert

Lorne Calvert