Children's Advocate Report

A Summary of Child Death Reviews for the Year 1999

December 2003

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The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The reviews contained in this report were conducted and this report is published in accordance with this legislation.

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Table of Contents

Executive Summary

The review of child[1] deaths is one of the many methods the child-serving system uses to identify ways to better serve Saskatchewan children. Thousands of children and young people each year receive services from government departments and agencies and, for the most part, these children with their families, receive services that are supportive and helpful to them.

This report provides a summary of the themes and issues found in the reviews of 31 children who died in 1999. The Department of Social Services[2] (DSS, now the Department of Community Resources and Employment) notified the Children's Advocate Office (CAO) of 33 child deaths that occurred in 1999. Two death reviews are not included in this report (in one case due to questions regarding the jurisdiction of the CAO to obtain required information; in the other case the DSS has not yet provided the CAO with the Regional Review).

In addition, the report includes the reviews of three pre-1999 deaths that were not presented in *A Summary of Child Death Reviews: August 1996 to December1998*. These deaths are discussed in the context of the themes and issues resulting from the 62 deaths that occurred between August 1996 and December 1998, as well as the new issues and themes identified during the review of the 1999 child deaths. The CAO has now reviewed the deaths of children who died between August 1996 and December 31, 1999.

Each of these children was, at the time of their death or in the 12 months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act,* or the *Young Offenders Act* (replaced by the *Youth Criminal Justice Act* in April 2003). Where the deaths were sudden and unexpected, the Chief Coroner also notified the CAO of the deaths.

This report examined the deaths of a limited number of our most vulnerable children. The CAO reviewed 15.4 percent of the deaths of all Saskatchewan children (under age 22) in 1999. Of the 34 child death reviews included in this report (2 in 1997, 1 in 1998, 31 in 1999), nine were in the care of the Minister when they died (2 in 1997, 1 in 1998, 6 in 1999). Three of these nine died of natural causes, three deaths were accidental, one death was a suicide, one death was a homicide and the cause of one death was undetermined.

Twenty-five of the deaths reviewed were children who were not in the care of the Minister when they died. All of these deaths occurred in 1999. Of the 25 children who died, nine deaths were classified as accidental, eight deaths were from natural causes, six deaths were suicides, one death was a homicide and the cause of one death was undetermined.

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[1] Throughout this report the term child(ren) is used to refer to anyone under the age of 18 and includes a person 18 years of age or more as defined in *The Ombudsman and Children's Advocate Act.*

[2] Note: Although the Department of Social Services was renamed the Department of Community Resources and Employment (DCRE) in April 2002, for the purposes of this report, the historical name for the department, Social Services, will be used as this was the name of the department at the time that the deaths occurred.

Individual issues concerning the services provided to these children were brought to the attention of the DSS as well as other appropriate departments and agencies. This report provides an update on the themes and issues identified in the 1996-1998 Summary Report and identifies new issues that emerged from this set of reviews.

This report also recognizes that the DSS is working towards improved service delivery and has implemented a quality assurance program. However, non-compliance with existing policy was, once again, persistently observed in the review of these deaths.

Themes/Issues

The 1996-1998 Summary Report identified several themes related to cause of death. This report provides an update on these themes:

- Sudden Infant Death Syndrome (SIDS)
- Co-sleeping/Bed Sharing
- Fetal Alcohol Spectrum Disorder (FASD)
- Violence
- Suicides
- Alcohol and Drug Use

In addition for 1999, the CAO made one recommendation on one child death review regarding poisoning.

Through the review of the 1999 child deaths, the CAO identified 12 issues regarding the service provided to children:

1. **Non-compliance by the DSS to Legislated Requirements and Policy Standards.** Similar to the 1996-1998 Summary Report, the CAO continued to observe gaps between government policy and practice in these deaths from 1999. This is a very serious concern not only for the CAO, but also for government. Non-compliance was found in all three of the pre-1999 child death reviews included in this report (2 in 1997 and 1 in 1998). The CAO found that in 20 of the 31 files reviewed for 1999, compliance with policy and standards was raised with the DSS. While non-compliance directly affected the outcome for some of the children, non-compliance with policy was not found to be a direct cause in the deaths. The purpose in raising the issue of non-compliance is, therefore, primarily focused on developing a stronger child-serving system where practices reflect the policies and standards that are in place. The CAO found that there continues to be an urgent need to address the practice issues.

2. **Transfers Between the DSS and First Nations Child and Family Services Agencies.** One of the three pre-1999 death reviews included in this report identified the need for the DSS to improve relationships with First Nations Child and Family Service agencies and to implement case transfer protocols. There were no concerns reported in the 1999 files. In July 2003, the DSS announced several steps that they are taking in this area.

3. **Assessment and Intervention.** The CAO raised concerns regarding the need to regularly identify and review, at a management level, those cases where children are repeatedly subjected to neglect over a significant period of time and where there is a long history of child welfare involvement.

4. **Administration of Medication.** The CAO raised concerns regarding the need for policy regarding the tracking and administration of medications to foster children, as well as training foster parents in the administration of prescription and non-prescription medication.

5. **Provision of Information.** The CAO identified concerns regarding appropriate sharing and recording of information. The CAO made five recommendations to improve processes in the area of recording and sharing of information. Four of these recommendations were previously identified in the *Children and Youth in Care Review: Listen to Their Voices*, 2000.

6. **Contact Standards for 16 and 17-Year-Olds.** The CAO identified the need to establish, in policy, minimum contact requirements for youth under section 10 agreements.

7. **Services to Children with High Medical Needs**. In ten of the 31 deaths reviewed, the children had pre-existing medical conditions. These children required on-going support services, medical treatment or, in some cases, palliative care. The CAO made recommendations in two of these child death reviews.

8. **Quality of Medical Services.** In four reviews, questions were raised about the quality of the medical care the child or youth received. In each of these the CAO made referrals to the College of Physicians and Surgeons (College). In all four files the College found that there were factors, which could have improved the care the children received. In one review the College recommended that post-mortem examinations of children should be performed by a Pathologist who has expertise in Pediatric Pathology. The CAO restated this recommendation.

9. **Need for Integrated Services.** The need for an integrated case management approach was identified in 13 of the 1999 child death reviews, as well as in one of the three 1997-1998 reviews included in this report. Although an Integrated Case Management Model was established in1998, implementation of this model was not apparent in these 14 files. The Departments of Social Services and Health acknowledged that more work needs to be done in the development of policy and programs that address the integrated service needs of children and youth.

10. **Mental Heath Services**. There was one 1997-1998 and eight 1999 reviews where mental health services had been provided to the children and youth. In one of these reviews the CAO raised concerns regarding the level of intervention available in Saskatchewan. The CAO is currently conducting a review of the quality and quantity of mental health services to children in Saskatchewan, which is expected to be released in 2004.

11. **Services for Youth in Conflict with the Law**. Eight deaths reviewed by the CAO involved youth who were in conflict with the law. The CAO raised concerns regarding the level of supervision and contact with the youth who were serving community dispositions or serving dual orders.

12. **Educational Services.** In four of the deaths reviewed, recommendations were made regarding the lack of attention paid to the youth's connection with the school system. The CAO reviews raised concerns regarding the need to address those youth who ought to be in school and are not, as well as a number of quality assurance concerns including inconsistent and incomplete information on education files and transfer protocols.

This Summary Report once again highlights the importance of an independent review of the deaths of children. Completing these death reviews and preparing this report has also raised significant challenges and questions for the Children's Advocate Office and government. It is these challenges that we must all face in a realistic manner.

Since 1998, the Children's Advocate Office has reviewed nearly 100 child and youth deaths where there was involvement by the former Department of Social Services. We have, as this report details, found significant practice issues and made recommendations that, when implemented, improve services provided to children. We have promoted increased public accountability in the child-serving system, in some cases simply by having an independent review of the death.

With this in mind, the Children's Advocate Office is proposing a number of changes to the way in which child deaths are reviewed in Saskatchewan. We are calling on government to work with us to implement these changes. The proposed changes include:

1. File Audits to Review Compliance with Case Practice

The CAO believes that the case practice issues related to compliance with government policy and standards would be most effectively examined within clearly defined and carefully measured quality assurance mechanisms. The results of these quality assurance audits must be made public, for government to ensure increased transparency and public accountability.

2. Maintain Public Accountability in the Child Death Review Process

The CAO is committed to a comprehensive independent review of those child deaths where the child was in government care. The CAO will continue to review these deaths and will report the findings and recommendations in a public manner.

3. Review all Child Deaths

The CAO is calling for is an examination, in some systematic fashion, of the deaths of all children in Saskatchewan. An increased review of all child deaths will assist in developing greater understanding of the causes of child deaths and identify gaps that must be addressed. The CAO will be formally submitting the following recommendation to the appropriate government departments:

Recommendation CDR.63 (99)
That government develop a model to ensure all child deaths are reviewed by "an educated eye" and that this model begin to be implemented by January 1, 2005.

Essentially the CAO is calling for an improved process for reviewing child deaths in Saskatchewan. We now have several years of experience conducting child death reviews and we know that, as a province, we can do better. While we anticipate that the CAO will conduct fewer reviews, we believe that implementing all of these changes will help us to more effectively achieve our goals of preventing child deaths, impacting the child-serving system and promoting public accountability.

Part 1 Introduction

The Children's Advocate Office (CAO) in Saskatchewan conducts comprehensive reviews of the deaths of a limited number of children[3]. The reviews offer observations, findings and recommendations designed to prevent child deaths, impact child-serving systems and promote public accountability.

It is very important to note that the review of child deaths is only one of the many methods the child-serving system uses to identify how to better serve Saskatchewan children. Thousands of children and young people each year receive services from government departments and agencies and, for the most part, these children and their families receive services that are supportive and helpful to them. This review of child deaths is, in some ways, a small window into the child-serving system. These particular child deaths are reviewed due to the nature of the child's involvement with government, and are one means for public accountability in relation to child welfare and young offender services. However, the CAO recognizes that there may be more effective ways to achieve the goals of preventing child deaths and impacting the child serving systems. There is still no mechanism in Saskatchewan to review the deaths of all children.

It is further noted that we continued to observe gaps between government policy and practice in these deaths from 1999. This is a very serious concern not only for the CAO, but also for government. We do not want to give the impression in this report that the non-compliance in practice with the existing policy is linked to the deaths of all of these children. While non-compliance directly affected the services for some of the children, non-compliance with policy was not found to be a direct cause in the deaths. Our recommendations are, therefore, primarily focused on developing a stronger child serving system where practices reflect the policies and standards that are in place. We did find that there continues to be an urgent need to address the practice issues.

We also want to recognize that these deaths occurred in 1999 and in the past four years government has made a considerable investment into improvements in both the child welfare and young offender systems. The staff of the Department of Social Services (DSS, now Department of Community Resources and Employment, DCRE and the Department of Corrections and Public Safety, CPS)[4] are engaged in complex human services work; work that is not easy to describe or understand. There is a risk that by reporting publicly on deaths that occurred four years ago, the action taken by government in the past few years will be disregarded. The further risk of a report such as this one is that it will be seen only as a criticism and not as an opportunity.

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[3] Throughout this report the term child(ren) is used to refer to anyone under the age of 18 and includes a person 18 years of age or more as defined in *The Ombudsman and Children's Advocate Act.*

[4] Note: Although the Department of Social Services was renamed the Department of Community Resources and Employment (DCRE) in April 2002, for the purposes of this report, the historical name for the department, Social Services, will be used as this was the name of the department at the time that the deaths occurred.

While the review of these deaths presents significant challenges to government, it has been our experience that our recommendations are taken very seriously and are responded to in a comprehensive manner.

We appreciate the significant commitment the DSS has made to incorporate our recommendations into their very important, ongoing quality improvement process.

We believe too, that there continues to be a need to invest, not just financially but also a substantial community commitment, in our Saskatchewan children and families. This is not the sole responsibility of one or two government departments. We must find a way to support the complex work government departments and community agencies are doing to achieve positive outcomes for vulnerable children and their families.

This report adds to our growing understanding of the deaths of this small group of children and youth. We have attempted to be sensitive to this throughout this report and want to sincerely thank all of the government staff, community members, family members and others that have assisted us to complete these reviews. This is the second such report of the CAO and we have, in this report, built on the insights we gained from our review of deaths from 1996 forward. With the 31 child deaths that we reviewed from 1999 and the further 62 deaths we reviewed from 1996, 1997 and 1998, we have made, in total 63 recommendations to government. This report provides an overview of the themes and issues identified in the review of the 31 deaths that occurred in 1999. In addition, the report includes an analysis of three deaths that occurred in 1997 and 1998 and that were not included in our first report. We have provided a review of our authority to conduct these reviews; a discussion of the process we used to conduct these reviews; and general information about which child deaths are included in this report. In addition, these deaths are discussed in the context of the themes and issues identified in our first report and new issues or themes identified during the review of the 1999 deaths.

Part 2
Authority

Children's Advocate Authority and Mandate

The Children's Advocate is an officer of the Legislative Assembly of Saskatchewan and acts pursuant to *The Ombudsman and Children's Advocate Act*. The mandate of the Children's Advocate is to promote the interests of, and act as a voice for children when there are concerns about provincial government services. The Children's Advocate engages in public education, works to resolve disputes, and conducts independent investigations. The Children's Advocate also recommends improvements to programs for children to the government and/or the Legislative Assembly of Saskatchewan. The vision of the Children's Advocate Office is to ensure that the interests and well-being of children are respected and valued in our communities and in government practice, policy and legislation.

Section 12.6 inter alia of *The Ombudsman and Children's Advocate Act* provides that:

(2) The Children's Advocate shall:
- (a) become involved in public education respecting the interests and well-being of children;
- (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;
  - ii) a group of children who receive services from any department or agency of government; and
  - iii) services to a child or to a group of children by any department or agency of the government;
- (c) where appropriate, try to resolve those matters mentioned in clause (b) that come to his or her attention through the use of negotiation, conciliation, mediation or other non-adversarial approaches; and
- (d) where appropriate, make recommendations on any of those matters mentioned in clause (b).

The Ombudsman and Children's Advocate Act, Saskatchewan, Revised 2000.

Authority to Conduct Child Death Reviews

Child Death Reviews (CDRs) are conducted by the CAO in accordance with the legislated mandate of the Children's Advocate. Section 12.6 (2)(b)(iii) states that the Children's Advocate shall "receive, review and investigate any matter that comes to his or her attention from any source, including a child, concerning services to a child or to a group of children by any department or agency of the government." The Children's Advocate has the 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.

Part 3
Background

The Department of Social Services first established a child death review policy in 1992. Due to the need for increased public accountability, the Department of Social Services and the CAO recognized that independent and publicly accountable reviews of child deaths were required. In November 1996, the DSS adopted a new child death review policy. The intent of the policy was "to satisfy the department's need to be accountable in the services provided to children, youth and families, and to ensure that the public interest in protecting children and youth is met." (Saskatchewan Social Services, 2000, February-Revised).

In order to meet the need for independent external reviews of child deaths, a protocol was also established between the CAO and the DSS. The CAO agreed to provide the independent, external reviews of the death of a child when a referral was made by the DSS. The reviews would examine the deaths of children who were, at the time of their death or in the 12 months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act*, or the *Young Offenders Act* (replaced by the *Youth Criminal Justice Act* in April 2003), or were attending a facility or a family child care home licensed under *The Child Care Act*. This initial agreement was for the CAO to review the deaths of the three or four children per year that the DSS identified as particularly complex. However, this protocol was expanded to include a review of approximately 30 deaths per year and had the effect of widening the child death review policy.

Part 4
Process for Conducting a Child Death Review

1999 CDR Process

The process used by the CAO to review the deaths of children who died between August 1996 and December 1998 was, for the most part, limited to a review of the files maintained by the DSS. These reviews focused primarily on the documentation contained in the files and, on occasion, interviews were conducted with department staff or others for clarification. During the course of the 1996-1998 child death reviews, it became apparent that much could be gained from broadening the reviews to include information from other departments or agencies that provided services to the child. As a result, where it appeared that another agency had provided significant service to the child, information relating to the death was reviewed. This information was obtained pursuant to section 22 of *The Ombudsman and Children's Advocate Act* and is included in the 1999 reviews.

The CAO received notice of the death of all children who were, at the time of their death or in the 12 months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act,* or the *Young Offenders Act* (replaced by the *Youth Criminal Justice Act* in April 2003). Prior to commencing a review, the CAO sent a notice of investigation to the DSS pursuant to section 20(1) of *The Ombudsman and Children's Advocate Act*.

The CAO child death review process included an examination of:

- the DSS Departmental Review – An internal review that examines the services provided by the region or agency to that child and his or her family;
- the information provided by the Coroner's Branch, Saskatchewan Justice;
- the original DSS file materials; and
- relevant information/material from additional service providers/agencies. Staff were also interviewed where clarification was required.

The services provided were examined for consistency with existing practice, policy and legislation.

In March 2002, the CAO created a Multi-Disciplinary Review Team (MDRT)[5] to advise and assist the CAO with the review of child deaths.

[5] The MDRT was established in response to the Guiding Principles for Child Death Review adopted by the Federal/ Provincial/Territorial Working Meeting on Child Death Review in June 2000. One of the national core principles for effective child death review work is to ensure that a multi-disciplinary approach is used. In the 1996-1998 Summary Report, the CAO primarily reported on the concerns identified in the child welfare service delivery system. The CAO multidisciplinary review of the 1999 deaths provided the CAO with the opportunity to review the practice of other departments and agencies.

The MDRT was assembled to maximize the potential for improvements to child serving systems in Saskatchewan. This eight-person team (Appendix A):

- Advises on tentative findings and recommendations,
- Identifies and describes systemic and cross-jurisdictional issues, and
- Proposes strategies for prevention.

The MDRT is comprised of representatives with a variety of backgrounds who are invited by the Children's Advocate to participate, for a fixed term, on the MDRT. The current members include physicians, educators, lawyers, former police officers, social workers and youth from care. The Chief Coroner is also a member of the MDRT.

CAO staff completed a comprehensive report detailing the services provided to each child and the circumstances of the child's death, and prepared an analysis. The MDRT reviewed this report and provided their analysis and recommendations.

The CAO then provided tentative observations, findings and recommendations to the appropriate departments or agencies, or where appropriate, a person. In accordance with section 21(3) of *The Ombudsman and Children's Advocate Act*, the CAO provided these departments, agencies or persons, with the "opportunity to make representations in respect of the matter." Individual files were concluded following receipt of the department or agency's responses to the tentative findings and recommendations.

Tracking CDR Recommendations

The CAO has reviewed the deaths of 96 children who died between August 1996 and December 31, 1999. The CAO has made 62 recommendations in the review of these deaths, 27 of which were included in the review of the Death of Karen Quill.

The CAO implemented a numbering system for this report to track all recommendations made on child death review files. Beginning with the recommendations from the Quill Report, all CDR recommendations have been numbered in sequence. The year that a recommendation is made is noted in brackets. If the same recommendation is made on more than one file, or in more than one year, it is given the same CDR number and the new year is added; for example, CDR.31(97,99). See Appendix C for a complete list of all CAO CDR recommendations. (Note: where a recommendation contained information that would identify the child, the information was removed from the public recommendation.)

Part 5
This Report

Which Children are Included in this Report?

The Department of Social Services notified the CAO of 33 child deaths that occurred in 1999. Two death reviews have not been concluded and are therefore not included in this report (in one case due to questions regarding the jurisdiction of the CAO to obtain required information; in the other case the DSS has not yet provided the CAO with the Regional Review).

Each of these 31 children was, at the time of their death or in the 12 months preceding their death, receiving services from the DSS pursuant to *The Child and Family Services Act,* or the *Young Offenders Act* (replaced by the *Youth Criminal Justice Act* in April 2003). Where the deaths were sudden and unexpected, the Chief Coroner also notified the CAO of the deaths.

In addition, this report includes three child death reviews that were completed for children who died during 1997 and 1998. At the time of the 1996-1998 Summary Report, these reviews were not finalized in each case due to: outstanding civil legal proceedings, the completion of a multi-agency review, and a possible coroner's inquest in the third. The CAO findings and recommendations for all three deaths are included in this report.

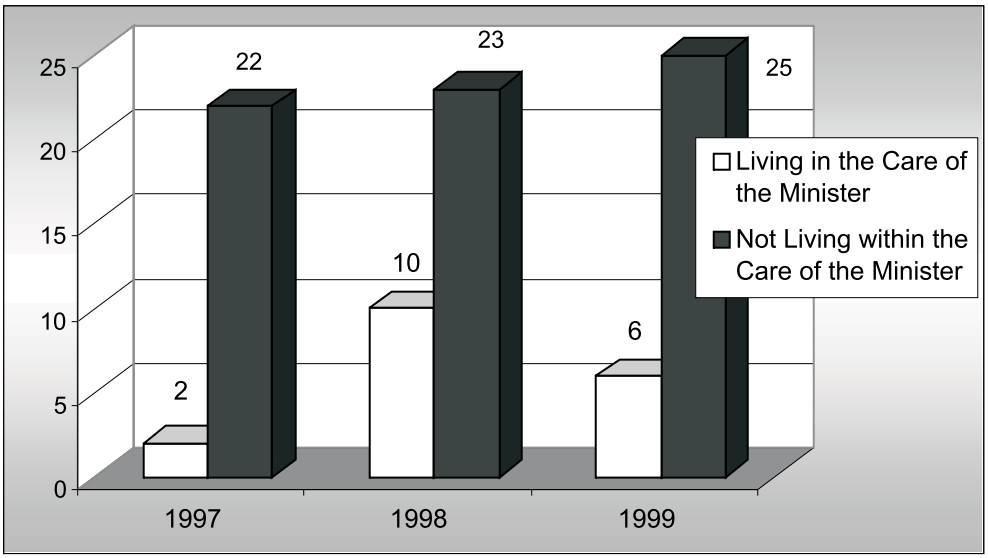
Part 6
General Findings

Who are the Children who Died in 1999?

Of the deaths reviewed for the year 1999, the following is known:

- 24 children were male, while 7 were female,
- 19 children were status First Nations children, and
- 6 were in the care of the Minister of Social Services at the time of their death, while 25 were receiving services from the DSS at the time of their death or in the 12 months preceding their death.

Figure 1. CAO Child Death Reviews showing Type of Care Arrangement with the Minister of Social Services. 1997, 1998, 1999. N=92[1,2]



[1] Note. The number of children in the care of the Minister was increased by 2 for 1997 and 1 in 1998 from the numbers reported in the 1996-1998 Summary Report to reflect the three child death reviews that were concluded since the 1996-1998 Summary Report. Of these three 1997/1998 deaths, all three children were males; 2 were status First Nations children.

[2] Note. The 1996-1998 report included information on the review of four deaths that occurred during August to December 1996. As this was not a complete year of information, these figures are not included.

Causes of Death/ Classifications of Deaths

In the 1999 child deaths, the leading cause of death was by Accident (11). The second leading cause of death was Natural Cause (10), followed by Suicide (7), Homicide (1), and Sudden Infant Death Syndrome (SIDS) (1). The cause of death was Undetermined in one case.

Chief Coroner uses five classifications of death:

- A ***Natural*** death is one primarily resulting from a disease of the body and not resulting secondarily from injuries or abnormal environmental conditions.
- An ***Accidental*** death is a death due to unintentional or unexpected injury. It includes death resulting from complications reasonably attributed to the accident. (This includes injury from chemicals, including alcohol and drugs).
- A ***Suicidal*** death is one that results from self-inflicted injury, with intent to cause death.
- A ***Homicidal*** death is a death due to injury intentionally inflicted by the action of another person. Homicide is a neutral term that does not imply fault or blame.
- An ***Undetermined*** death is one which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide.

(Source: The Office of Chief Coroner, 2003)
Note: While the Chief Coroner includes deaths attributed to SIDS in the classification of Natural deaths, for the purposes of this review the CAO has listed the SIDS deaths as a separate category.

Natural Causes

Of the 10 children that died of natural causes, nine of the children were previously identified as medically fragile or having a terminal disease. One infant died from pneumonia.

Accidents

Of the 11 children that died due to accidental causes:

- seven died in motor vehicle accidents where: one was a passenger, three were driving the vehicle, two were riding their bicycles, and one was thrown from a snowmobile at the time of death;
- three were asphyxiated where: one hung himself, the second was an infant that died by hanging in a suspended car seat, and the third was an infant who was overlaid while sleeping with an adult; and
- one died by poisoning from ingesting water hemlock.

Suicide

Of the seven suicide deaths, six children/youth hung themselves and one child/ youth shot himself. The children/youth were between the ages of 13 and 21 years. The average age was 17 years.

Homicide

The one homicide death was an 18-year-old youth who died as a result of a gunshot.

SIDS

As noted earlier, the Chief Coroner includes deaths attributed to SIDS in the classification of Natural Causes. For the purposes of this review the CAO has listed the SIDS deaths as a separate category. During 1999, there was one death attributed to SIDS.

Undetermined

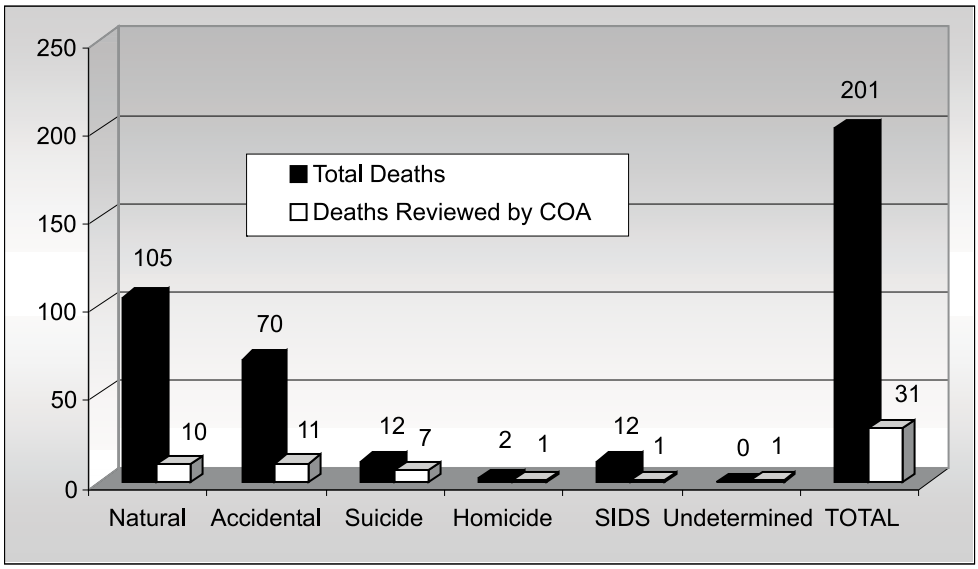
One death was undetermined.

Comparison to Provincial Child Deaths

The deaths reviewed by the CAO represent a fraction of the total number of children who died in Saskatchewan during the reporting period.

In 1999, a total of 201 children and youth under the age of 22 died in Saskatchewan. The CAO reviewed 31 of these deaths representing 15.4 percent of the total provincial child deaths. Figure 2 compares the number of provincial child deaths by cause of death with the deaths reviewed by the CAO during 1999. A complete breakdown of the deaths by age and cause of death is provided in Table 1 (Appendix B of this report). (Note the data on child deaths for the years 1997 and 1998 has also been included for comparison purposes).

Figure 2. Number of Deaths of Children From Birth to 21 Years of Age in Saskatchewan; CAO Deaths Reviewed and Total Provincial Deaths, 1999



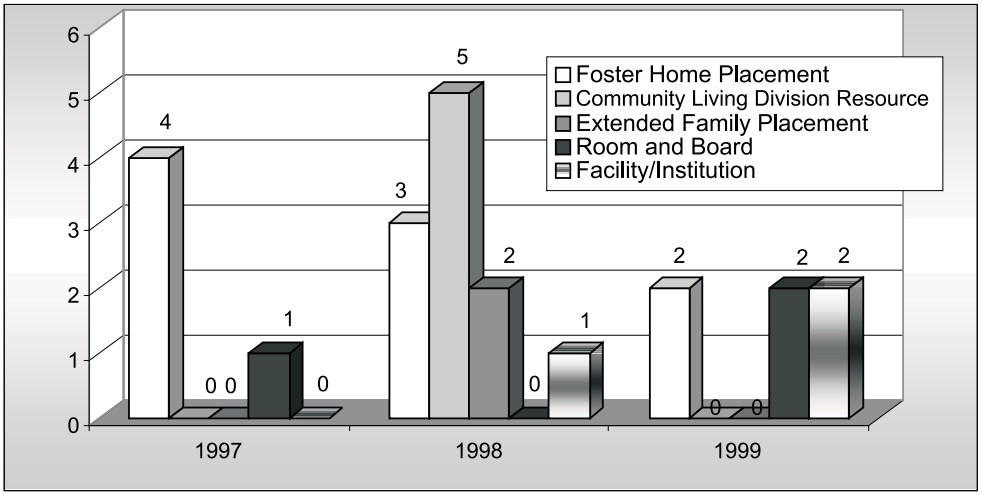
*Source: Saskatchewan Health, Corporate Information and Technology Branch (Table prepared with the assistance of the Saskatchewan Institute on Prevention of Handicaps, 2003.)
NOTE: A discrepancy occurred for the Homicide deaths of children aged 1-5 years in 1997 and aged 16-17 years in 1998, and for Undetermined deaths of children under one year in 1998 and 1999. Inconsistencies can arise when data from two different sources are compared. The series of deaths reviewed by the Chief Coroner and the CAO and the data from Vital Statistics are not the same data files. Some factors that may contribute to inconsistencies in data are:

- Potential differences in the level of detailed analysis used by the Coroner and Vital Statistics. Vital Statistics does not conduct detailed analysis of the cause of death reported by the Coroner on the medical certificate of death.
- Potential differences in the methods of classification used. The underlying cause may differ according to other factors relating to the person and circumstances of death. For example, a person who has an illness such as cancer may die in a fall, and the underlying cause will be cancer, rather than fall.
- Potential unavailability of information or delay in obtaining information. In some cases Vital Statistics may not have the information necessary to complete the cause of death coding.

Children in Care of the Minister

When a family experiences problems that are of a serious nature and safety cannot be ensured within their home, some members may be placed in out of home care or in the care of the Minister. A majority of children are placed in foster care. However, some children are placed with extended family, in group homes, or residential facilities. A snapshot for 1999 indicated that as of March 31, 1999, there were 3030 children in care under *The Child and Family Services Act* (Saskatchewan Social Services, March, 1999). Children's services were offered to 6463 children in 1999. (Community Resources and Employment, November 2003). Youth who are over the age of 16 may choose to live independently. Children are returned home when their families have addressed the risks to safety or the treatment needs. However, there are situations where children and youth remain in care until they are 21 years of age (Saskatchewan Social Services, 2000).

Figure 3. CAO Child Death Reviews showing Living Arrangement at Time of Death for Children in Care of the Minister of Social Services 1997, 1998, 1999. N=22[1]



[1] Note. The number of children in the care of the Minister was increased by 2 for 1997 and 1 in 1998 from the numbers reported in the 1996-1998 Summary Report to reflect the three child death reviews that were concluded since the 1996-1998 Summary Report.

Type of Care

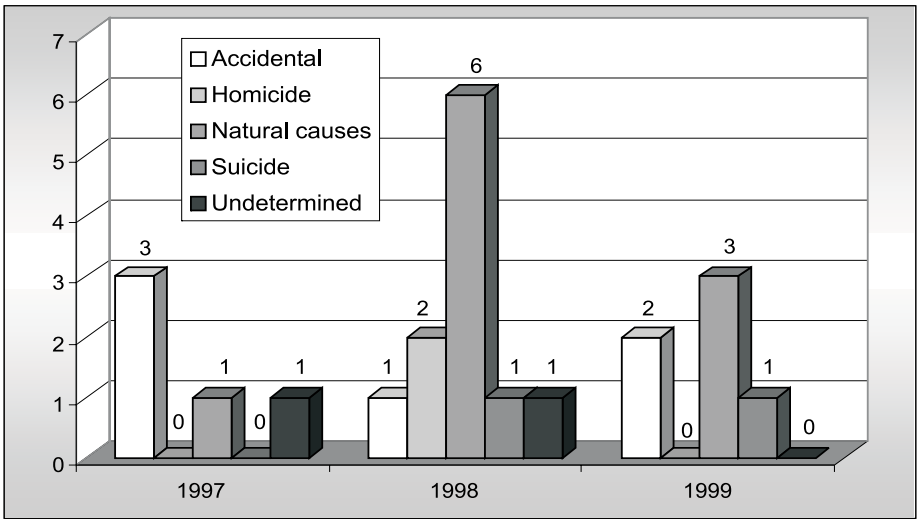
Of the 31 deaths that were reviewed for 1999, six children were in the care of the Minister of Social Services when they died. Figure 3 provides the breakdown of the type of care arrangement for each of these children. Two of these children were in DSS approved foster homes, two were placed by the DSS in a facility/ institution, and two were funded by the DSS by a section 10 agreement in a room and board situation arranged by the youth.

Cause of death

Figure 4 provides a breakdown of the cause of death for children living in the care of the Minister of Social Services. Of the children who died while living in the care of the Minister, one child accidentally hung himself in his foster home. Of the two youth living in room and board placements, one committed suicide and one was hit by a vehicle while riding his bicycle. All of the three remaining children in care were medically fragile children and died of natural causes. A referral was made to the College of Physicians and Surgeons requesting a review of the medical services provided to one of these children.

The College found that medical care was appropriate, however, made two recommendations to improve services. They recommended that an optional test become standard practice. They further recommended that vulnerable children be seen by a limited number of surgeons or paediatricians to ensure the continuity of care that provides a long term perspective, especially when children have limited communication skills.

Figure 4. CAO Child Death Reviews showing Cause of Death for Children in Care of the Minister of Social Services, 1997, 1998, 1999. N=22[1]



[1] Note. The number of children in the care of the Minister was increased by 2 for 1997 and 1 in 1998 from the numbers reported in the 1996-1998 Summary Report to reflect the three child death reviews that were concluded since the 1996-1998 Summary Report.

1997 and 1998 Child Death Reviews

As noted earlier, there are two deaths from 1997 and one death from 1998 that are included in this report. All three of these children were in care of the Minister of Social Services at the time of their death: two were residing in foster homes and one was living in a group home as a condition of a Young Offender Probation Order. Of the two in foster care, one was a one-year, nine-month-old child who died of accidental asphyxiation. The other was a five-month-old infant who died as a result of a non-prescription or "over-the-counter" drug overdose. It could not be determined how or who administered the drug overdose to the baby. The third was a homicide of a child that occurred while he was Away Without Leave (AWOL) from a group home.

Children Not in Care of the Minister

The Department of Community Resources and Employment currently provides services to children and youth residing in their own homes or with extended family. These services may include those provided by one or more programs such as Adoption, Child Protection, Community Living Division (CLD), the Teen and Young Parent Program. From January 1, 1999 to December 31, 1999, 9718 families received child protection services. (Note: A complete list of programs available from the DSS is included in Appendix D.)

For the year 1999, the Department of Social Services also provided services to 6899 children/youth receiving services under the Young Offender Program. The responsibility for services for young offenders was transferred to the Department of Corrections and Public Safety effective April 1, 2002.

Of the 31 child deaths reviewed for the year 1999, 25 children were, at the time of their death or in the 12 months preceding their death, receiving services from the DSS but were not living in the care of the Minister. Figure 5 provides a breakdown of the type of living arrangement for each of these children. The majority of the children, 19, were living in their parental home at the time of their deaths. One youth was living independently, three were living with extended family, and two died while in provincial adult correctional facilities.

Figure 5. CAO Child Death Reviews showing Living Arrangement at Time of Death for Children NOT in the Care of the Minister of Social Services, 1997, 1998, 1999. N=70

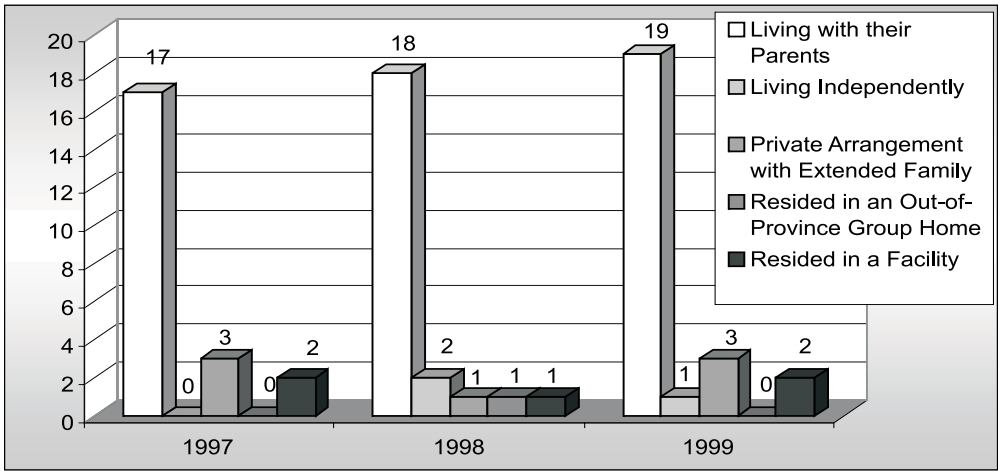
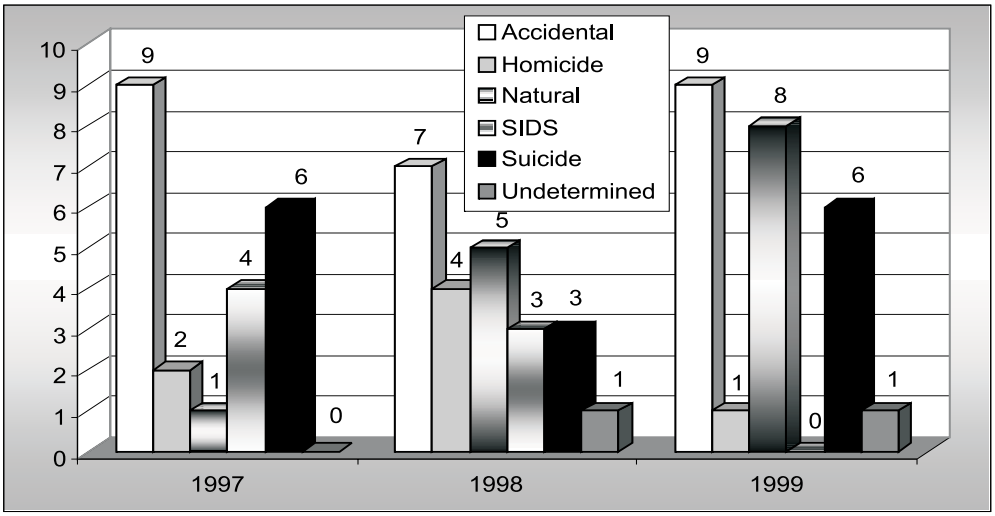


Figure 6 provides a breakdown of the cause of death for children not living in the care of the Minister at the time of their death. Of the 25 children who died in 1999, nine deaths were classified as Accidental, eight deaths were from Natural Causes, six deaths were Suicides, one death was a Homicide and the cause of one death was Undetermined.

Figure 6. CAO Child Death Reviews showing Cause of Death for Children NOT in the Care of the Minister of Social Services (now CRE), 1997, 1998, 1999. N=70



Part 7
Themes Relating to Cause of Death

A Summary of Child Death Reviews: August 1996 to December 1998 identified several themes related to cause of death.

- Sudden Infant Death Syndrome (SIDS)
- Co-sleeping/Bed Sharing
- Fetal Alcohol Spectrum Disorder (FASD)
- Violence
- Suicides
- Alcohol and Drug Use

In each of the areas identified, the CAO identified the need for increased public education or support services.

The Minister of Social Services wrote to the Children's Advocate in February 2002 and provided a detailed joint response from the Departments of Social Services, Health, Justice, Education and Aboriginal Affairs to the CAO report, *A Summary of Child Death Reviews: August 1996 to December 1998.* In their response, the Minister detailed the activities that have been undertaken to address the issues raised by the CAO.

The table on the next four pages of this report provides a brief update on these themes, and, where appropriate, new information from the review of the 1999 child deaths.

In addition to the above themes, the CAO made one recommendation on one child death review regarding poisoning.

Theme	1996-1998 Update/Findings	1999 Findings
Sudden Infant Death Syndrome	The CAO recommended that the Coroner's Branch consider developing and implementing a SIDS protocol for use by coroners in Saskatchewan.	There was one infant death classified as SIDS in the 1999 reviews.
Co-sleeping/ Bed-Sharing	The CAO wrote to the Saskatchewan Action Plan for Children Steering Committee and asked that they consider reviewing what information about co-sleeping is presently available to new Saskatchewan parents and the service providers who work with these families. The CAO was advised in the governnment response to the report that "issues relating to co-sleeping/bed sharing would be addressed in the resource material to be developed by the Saskatchewan Institute on Prevention of Handicaps and that this information would be provided to new mothers by Public Health Nurses and other health care providers as appropriate."	There was one death attributed to co-sleeping/bed sharing with an extended family member among the 1999 deaths reviewed.
Violence	Violence was a significant factor in the lives of many of the children in the 1996-1998 Summary Report. The CAO recommended that the DSS "ensure policy and practice specified in the Family Centred Services Manual (FCSM) are complied with" and that "steps are taken to ensure that children who remain in the care of their family are protected within that family unit when there are known risks to a child." The CAO also "suggested that the DSS collaborate (with appropriate department and agencies) to create a strategy that provides all child-serving agencies/institutions with information on the importance of reporting child abuse and a method with makes reporting user friendly." Of the three pre-1999 child death reviews, one was a homicide of a youth residing in a group home who was Away Without Leave (AWOL) at the time of his death. This child exhibited violent behavior from a very early age. The CAO found that in this case the child presented "a number of opportunities for the DSS to have provided more directive interventions."	Of the 31 1999 deaths reviewed, there were 12 children where violence was identified as a part of the child's life. The Risk Assessment (RA) implemented by the DSS in 2001 acknowledges domestic violence as a quantifiable risk element. However, the RA further acknowledges that exposure to domestic violence, in and of itself, does not constitute a child protection concern pursuant to Section 11 of *The Child and Family Services Act*. The CAO remains concerned about the deleterious effects of exposure to family violence on the well-being of children and the apparent limitations of the DSS to intervene in these circumstances. In addition, the DSS Regional Review recommended that there is a need to "ensure that all workers are adequately trained in domestic violence dynamics and are linked to various programs available to clients." The DSS has indicated that they are implementing training in this area.
Suicides	The CAO recommended that "the DSS, Saskatchewan Health and the Saskatchewan Health Districts (now Saskatchewan Health Regions) develop a protocol to provide for collaborative case planning for children or youth who are receiving services from both the DSS and a Health District. Further, the CAO recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child are being appropriately addressed."	▪ Seven of the 31 child deaths reviewed died as the result of suicide. Six youth hanged themselves and one shot himself. Six were male and one female. Three had been previously identified as suicidal and were provided mental health services. Two others had been provided mental health services. However, they were not previously identified as suicidal. ▪ Similarly to the 1996-1998 child death reviews, the CAO reviews found that many of these youth had been receiving services often from multiple sources. While services were offered or provided to each, the services were found to be disconnected, intermittent and not coordinated across various service agencies.

Recommendations	Progress
No new recommendations were made as a result of the 1999 child death reviews.	The Coroner has implemented a SIDS protocol checklist. Coroners in Saskatchewan have been provided with this tool to assist them in the classification of child deaths.
Recommendation CDR.45(99) **That the Saskatchewan Action Plan for Children ensure that information about the dangers of adults co-sleeping with infant children, particularly when intoxicated, be provided to all new parents.**	▪ A Provincial Co-ordinator of Perinatal/Infant Health was funded in 2000/2001 by the Department of Health. The Co-ordinator works with the Saskatchewan Institute on Prevention of Handicaps and will be addressing the co-sleeping/bed sharing issue in future public education materials.
Recommendation: CDR.46(99) **That the DSS undertake a review of *The Child and Family Services Act*, in relation to other provincial jurisdictions, to determine whether there is a need for enhanced intervention in situations where children are exposed to domestic violence.**	The DSS responded to this recommendation, stating that "it would appear that Saskatchewan's child welfare legislation (*The Child and Family Services Act)* is broader than all other Canadian child welfare legislation in this regard to situations of domestic violence…. (The DSS) would submit that our legislation is adequate in finding a child in need of protection in situations of domestic violence." (Saskatchewan Social Services, correspondence October, 2002). The CAO acknowledged the existence of other services available to provide support to "families experiencing domestic violence." The Minister's response advised that the Inter-departmental Committee on Family Violence, involving 11 departments and secretariats, meets to co-ordinate government policies, programs and services in this area and supports a number of programs and services that are targeted at education intended to reduce family violence. The Interdepartmental Child Abuse Committee (ICAC), chaired by Community Resources and Employment, and its member departments and agencies also continues to develop, update and distribute resources in this area to professionals and the public.
Recommendation: CDR.28(97) **That the Departments of Social Services and Health establish a clear protocol for collaborative case planning for children and youth who are receiving services from both departments. It is further recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child or youth are being appropriately addressed.**	▪ Recommendation CDR.28(97) was reported on in the 1996-1998 Summary Report. The need for integrated services has been identified as a new theme for this report and will be discussed in the next section of this report. See page 30, recommendations CDR.49(99) through CDR.52(99).

Theme	1996-1998 Update/Findings	1999 Findings
Fetal Alcohol Spectrum Disorder (FASD) (Previously referred to as FAS)	Concerns were identified respecting the care of children who were affected by FAS (now FASD). The report concluded there was a need for programs to prevent the disabling conditions resulting from the effects of alcohol consumption during pregnancy. Of the three pre-1999 child death reviews, one child was diagnosed with FAS. This child was in care of the Minister of Social Services at the time of his death. The DSS Regional Review was thorough and identified the need for improvements in several areas: ▪ the obligation to inform bands or FNCFS agencies when children are apprehended, ▪ the degree of support provided, and challenges put before new foster parents, ▪ the knowledge level of staff and foster parents of FAS/FAE issues." (Social Services, July 16, 1999) The CAO also identified that non-compliance with policies and inadequate support to the foster home directly contributed to this child's death.	▪ Three of the children that died during 1999 had been diagnosed with FAS. Two of these children were in the care of the Minister of Social Services at their time of death: ▪ One was a ten-year-old child who died when he unintentionally hung himself. Concerns with regard to compliance with contact standards, delays in the transfer of information including the child's medical and psychological assessments were identified. ▪ The second child died as a result of FASD related medical complications. Concerns about the quality of medical care this child received were referred to the College of Physicians and Surgeons for their review.
Alcohol and Drug Use	The CAO concluded that while valuable programming and services are available for addicted children and youth, adults in Saskatchewan have access to a greater continuum of services. The CAO was concerned that children and youth do not appear to be provided with access to the same continuum of services as adults. The government response to these concerns was that "Saskatchewan has a full continuum of services available for youth with substance abuse problems. In addition to providing direct counselling and intervention services, many agencies are involved in alcohol and drug awareness and prevention programs through the schools and other milieux." The majority of alcohol and drug problems of youth are met through community based outpatient services.	▪ Sixteen of the 31 children and youth whose deaths were reviewed lived in families where substance abuse was identified as a concern. ▪ Six of the children and youth were identified as having an alcohol or drug addiction. These children and youth were not provided with treatment or were unwilling to participate in the services offered. ▪ Five of the 16 youth died in motor vehicle accidents or motor vehicle related accidents directly attributed to misuse of drugs and alcohol. Six of youth died while exhibiting risky behavior and while under the influence of drugs and alcohol: operating a snowmobile; operating a motor vehicle; being a passenger in a motor vehicle with an intoxicated driver; and riding a bicycle. ▪ In one child death review the youth had demonstrated a pattern of under age consumption of alcohol that did not elicit intervention. Alcohol was clearly a factor in his death and a factor in two prior convictions. The youth was not referred for an addictions assessment and did not receive any treatment.
Other		One review was of an accidental death that resulted from the ingestion of a water hemlock plant. This review prompted the following recommendation:

Recommendations	Progress

Recommendation CDR.33(97)
That the DSS provide all foster parents with training and support to assist them in caring for children with special needs resulting from Fetal Alcohol Syndrome and Fetal Alcohol Effect (now Fetal Alcohol Spectrum Disorder) and that this training becomes mandatory.
 	
Recommendation CDR.34(97)
That the DSS review their policy regarding the babysitting of children in the care of the Minister with respect to ensuring that the standards reflect a suitable level of safe care.
 	
Recommendation CDR.41(99)
That the DSS ensure that the specialized services required for children diagnosed with FAS or other conditions related to prenatal exposure to alcohol be carefully and thoroughly detailed utilizing a multi-disciplinary strategy routinely provided to children in care diagnosed with these conditions.
	▪ The DSS has reported that:
	  ▪ Additional supports have been provided to foster parents in the form of a respite policy, improvements to the babysitting policy and policy providing counseling for foster parents after a traumatic event such as the death of a child.
	  ▪ Foster parent training was reviewed and revised and a FASD workshop and family connection workshop were provided in some areas and that
	  ▪ Staff and foster parents had benefited from the province's involvement in the Prairie Northern Pacific FASD Partnership.
	▪ An ad hoc planning sub committee of the Interdepartmental Committee on Fetal Alcohol Spectrum Disorder has been struck to organize provincial community discussions on FASD.
	▪ A FASD Framework for Action in Saskatchewan is beening developed. The goal is to build capacity in all service delivery systems dealing with this very complex issue and identify where existing and new resources should be targeted.

Recommendation CDR.55(99) **That the Department of Corrections and Public Safety amend the Young Offender Program, Policy and Procedures Manual (1994) to include a mandatory assessment of the youth's alcohol and drug use as a section of the initial assessment and case plan.**	▪ Effective April 2003, a risk assessment system was implemented to "identify substance abuse issues and flag cases that require follow up." Regional Health Authorities and the Native Alcohol and Drug Abuse Programs have the mandate to deliver alcohol and drug assessment and treatment services. CPS will not provide specialized drug and alcohol assessment services but in cases of substance abuse, both the treatment resources and the youth worker will work together to address the youth's needs. The CPS and the Department of Health concur that this is the practice they will now be supporting and to which their staff will be trained.
Recommendation CDR.57(99) **That Saskatchewan Health work with Saskatchewan Environment and other key partners in the north to identify opportunities to educate the public on the potential hazards of toxic plants that grow in the north and to implement such measures as appropriate.**	Saskatchewan Health, the Regional Health Authorities and Saskatchewan Environment accepted the CAO recommendation. Saskatchewan Environment has indicated to the CAO that they will continue public education activities on this issue, where appropriate, through a variety of media including conservation officer interactions and natural environment and cultural interpretative programs. In addition, a warning of the risks of wild plants was included in the *Saskatchewan Provincial Parks Guide* and the *Hunter's and Trapper's Guide* and the *Angler's Guide*.

Part 8
Issues Relating to Service for Children

Non-Compliance by the DSS to Legislated Requirements and Policy Standards

Similar to the 1996-1998 Summary Report, the CAO continued to observe gaps between government policy and practice in these deaths from 1999. This is a very serious matter not only for the CAO, but also for government. The CAO remains concerned about the continuing problem that policy requirements are not fully reflected in practice. While non-compliance directly affected the services for some of the children, non-compliance with policy was not found to be the direct cause of the deaths. The purpose in raising the issue of non-compliance is, therefore, primarily focused on developing a stronger child-serving system where practices reflect the policies and standards that are in place. The CAO found that there continues to be an urgent need to address the practice issues.

1997-1998 Findings

Non-compliance was found in the files of all three of the pre-1999 child death reviews included in this report (2 in 1997 and 1 in 1998). Therefore, non-compliance was raised with the DSS in a total of 16 out of 27, 1997 child death reviews and 19 out of 34, 1998 child death reviews. In one of the three 1999 reviews included in this report, the CAO found that "clearly, the DSS lack of adherence to existing policies and inadequate supports to this foster family were factors significant to (the child's) death." In another of these reviews, the CAO found that "the foster home's ability to diligently care for the foster children placed with them was compromised by the fact that their capacity for quality care had been over-extended by the DSS, thus placing these children at risk of harm."

1999 Findings

The CAO found that in 20 of the 31 files reviewed, issues regarding compliance with policy and standards were raised with the DSS. In these 20 files, the standards and policy requirements that were in place to provide services to children were not adhered to consistently. The CAO found that the services provided to 11 of the children and their family either met or exceeded policy requirements.

The following are examples from the reviews where non-compliance with existing policy compromised the delivery of service to the child:

- the number of children in the foster home exceeded standards;
- the contact standards with the child were not met;
- a Family Assessment and Treatment plan was not completed for a medically fragile child;
- the terms of a section 10 agreement (16/17-year-old program) to provide care, supervision and direction to the youth regarding addictions counselling, living arrangements and school attendance were not met; and
- a child with FAS was transferred to a foster home in another region and vital information regarding the child's medical, educational and social history was not provided (the transfer of the medical records was delayed, contact standards were not met, school records were not transferred to the new school and could not be located).

In addition, the CAO reviews have noted other issues that may affect compliance with policy, including staff shortages and high turnover, especially in the north; distance between service providers and clients; and multiple service providers.

The CAO acknowledges that child death reviews may not be the best means to address case management and quality assurance issues. This review of child deaths is, in some ways, a small window into the child-serving system. These particular child deaths are reviewed due to the nature of the child's involvement with government and are one means for public accountability in relation to child welfare and young offender services. However, the CAO recognizes that there may be more effective ways to achieve the goals of preventing child deaths and impacting the child-serving systems.

Progress

The CAO is initiating a follow-up report to detail progress made by government in relation to the recommendations made in the *Children and Youth in Care Review: Listen to Their Voices (2000)* report. The CAO anticipates making a public report on this in the Fall of 2004.

Transfers Between the Department of Social Services and First Nations Child and Family Services Agencies

1997-1998 Findings

The 1996-1998 Summary Report identified the need for the DSS to improve relationships with First Nations Child and Family Service agencies and to implement case transfer protocols.

In addition, one of the three pre-1999 death reviews included in this report also reinforced this need. Progress has been made with respect to the DSS's obligation to inform bands or First Nations Child and Family Services (FNCFS) agencies when children are apprehended and additional protocol agreements have been signed.

1999 Findings

There were no concerns reported in the 1999 files.

Progress

Nine First Nations Child Family Service (FNCFS) agencies have signed case transfer protocols with the DSS since 1999. These protocols establish a concrete process to co-ordinate services when both the provincial government and FNCFS agencies are involved. In addition, *The "Baby Andy" Report, Examination of the Services Provided to Baby Andy and His Family, 2003* found that "information sharing and communication between the Department of Community Resources and Employment and the Agency was not adequate to ensure that both systems were aware of complete information and that joint case planning occurred based on that information." (Review Panel, 2003) The report recommended:

1.1 That the Agency, other FNCFS agencies as required, and the Department ensure that staff are trained in the content of the Case Transfer Protocol and FNCFS and the Department develop a clear set of procedures to direct shared case planning between the two systems.
1.2 That, with the support of INAC, the Department's Information System be extended to all FNCFS agencies so that a common database exists for all families and children receiving child protection services as permitted by the current legal framework and confidentiality restrictions. (Community Resources and Employment, 2003)

The government has accepted these and all the recommendations in the "Baby Andy" Report and has outlined the steps that they are taking to address the recommendations.

Assessment and Intervention

"The circumstances and appropriate intervention for such cases with multiple reports need to be specified. … Chronic cases with multiple reports require special attention in differential response. As in traditional child protection response, differential response begins with a specific report of child maltreatment. This system of response to a current situation or "incident" tends to downplay the importance of a pattern of chronic maltreatment that may cause cumulative harm to children."

(National Child Welfare Resource Centre for Family-Centred Practice, 2002).

1999 Findings

One child death review involved a family where there was a long history of child welfare involvement. The infant died of asphyxiation by hanging in a suspended car seat.

According to the DSS Automated Client Index (ACI) system, the DSS was involved with the child's family for ten years over a 19-year period prior to the child's death. During this time, there are only five case assessments/ reports that were reviewed and signed off by a supervisor. Each of these reports only covered events that occurred within a specific review period.

The case was not identified as a chronic case and was not reviewed on a regular basis by a supervisor who considered the history and service interventions in relation to the family's problems. The DSS provided the mother with many chances to address her issues without reviewing the method of intervention, increasing the intrusiveness of the services, or pursuing alternative permanency plans for the children.

The CAO concluded that had the child received the protection service he was entitled to, he may not have been living in a family environment where his caregivers neglected his safety. The CAO found that the DSS had an obligation to re-evaluate their method of intervention to determine if more "aggressive intervention" was required. There was no documentation that this occurred. The CAO recommended:

Recommendation CDR.42(99)
That Saskatchewan Community Resources and Employment undertake to regularly identify and review, at a management level, those cases where children are repeatedly subjected to neglect over a significant period of time and where Saskatchewan Community Resources and Employment has frequently re-opened child protection files. This review would be intended to ensure that interventions are "as complete and as intensive as necessary… to bring about needed change to reduce risks and ensure the protection of the child." (Family-Centred Services Manual, Chapter 1, Section 1, p. 2)

Progress

The DSS responded to this recommendation by stating that "the revised manual will require that: 'In cases where there has been involvement over a significant period of time or frequently reopened cases, a thorough assessment of the prognosis for current services is required.'" The DSS indicated that it will be the responsibility of the child protection supervisor to ensure regular review of every child protection case.

Administration of Medication

1997-1998 Findings

Of the three pre-1999 child death reviews that are included in this report, one was the death of a child where the administration of medications to children in care of the Minister was raised as a concern. This death was classified as accidental. In this case, a five-month old infant was administered a lethal dose of a non-prescription cold medication. A thorough police investigation was unable to identify who administered the overdose of medication to the infant. However, the police were satisfied that the death was not of a criminal nature.

The CAO review found no policy respecting the administration of medications to foster children. Foster parents do not receive specific training in the administration of prescription and non-prescription medication to foster children. In addition, there was no policy regarding the recording and tracking of prescription and non-prescription medications administered to children in care.

1999 Findings

In one 1999 child death review, concern regarding the administration of medication was also raised. This child, also under the care of the Minister, died as a result of accidental asphyxiation. The child was diagnosed and prescribed medication. There were no records to indicate whether or not the child was provided the medication. There is no policy regarding the recording and tracking of prescription and non-prescription medications administered to children in care. The following two recommendations were made in both the pre-1999 and the 1999 child death reviews:

Recommendation CDR.31(97,99)
That the DSS include a section on medical care and drug administration (including both prescription and non-prescription drugs), in the pre-service training provided to foster parents.

Recommendation CDR.32(97,99)
That the DSS create an accountable method for all foster parents to record and track all medical care and drug administration. Further, that in the event of a change in placement that this information is transferred with the child and that a copy is maintained on the Child Care file.

Progress

The DSS accepted the CAO recommendations and provided the CAO with a detailed action plan in this area.

The department included a policy on Health Care/Medical Treatment in the Children's Services Manual in 2000 (CS 11.3). The policy provides general direction including guidelines for: notification and discussios with the child's caseworker of anticipated treatment, emergency situations, daily decision-making and authorization of the parents on the Agreement for Care.

The DSS indicated that they believe the best approach to address the CAO recommendations is to include them as part of a comprehensive redevelopment of foster care training. However, they stated that "while this development is underway, finalization will not occur in the immediate future." As an interim step, the DSS identified several actions they are taking, including:

- Update the current policy to include a specific section on prescription and non-prescription drugs;
- Develop a standardized form for all foster parents to record and track all prescription drug administration. This document will form part of the child's permanent file; and
- Notify all foster families of the policy change.

In addition, DSS resource development workers will be reviewing the revised Health Care/Medical Treatment policy and practice with existing foster homes and will include training on the revised policy in the pre-service training for foster parents.

Provision of Information

1999 Findings

One review involved a child who had been transferred between Social Services regions. This child was a high needs child who required special attention in most aspects of his life. There was a lack of information sharing between regions respecting his health, education and special needs. The information that was essential to providing his daily care was not provided to the care or service providers.

The *Children and Youth in Care Review: Listen To Their Voices* completed by the Children's Advocate Office in April 2000, clearly identified concerns regarding appropriate sharing and recording of information.

Several recommendations in this regard were made in the *Children and Youth in Care Review*. In addition to recommendations previously identified in this report, the CAO reiterated the following recommendations:

Recommendation CDR.37(99)
That children in care have up-to-date, accurate records that provide complete information about all aspects of the care they are receiving. These records must include a detailed plan for care that incorporates health and educational status. Children must also have access to the personal information that is kept about them. (CYICR Recommendation 2.8)

Recommendation CDR.38(99)
That foster parents must be provided with information about the children in their care in a timely manner. Health status, education, family connections and other information useful to providing daily care is required by foster parents as soon as possible. (CYICR Recommendation 2.9)

Recommendation CDR.39(99)
That children in care have their health needs carefully assessed, monitored, and fully documented. The full range of health services that parents provide to their children must be maintained by government as parent, including regular health check-ups, up-to-date immunizations, dental check-ups and follow-up, as well as any specialized care required, such as eyeglasses, mental health counselling or orthodontic work. (CYICR Recommendation 5.4)

Recommendation CDR.40(99)
That every child care plan include a plan to ensure that the educational needs of that child are being met, including special educational needs of hard to serve children. *The Education Act*, 1995, outlines the responsibility of boards of education to provide children in care with an appropriate education. There must be careful documentation of all education progress to ensure continuity when children move or are returned home. Social Services and Education must co-ordinate efforts to ensure that the educational needs of children in care are a priority. (CYICR Recommendation 5.5)

In addition, the CAO reviewed the death of one child where pertinent information was not requested during a child protection investigation. The DSS worker was made aware that the family had a history with family services in another province and did not request the information as part of the original investigation.

Upon reviewing the Family Centred Services Manual (FCSM) and the Children's Services Manual (CSM), the CAO was unable to find any policy directly related to accessing inter-provincial background information on a family as part of an investigation or assessment. There is no specific reference to the gathering of inter-provincial information to provide background and history on a child or family who transfers from another jurisdiction into Saskatchewan. The fact that inter-provincial requests are not identified as an integral part of intake, investigation, or assessment in the FCSM was noted by the CAO and it was therefore recommended:

Recommendation CDR.44(99)
That the DSS review their Family-Centred Services Manual and ensure that inter-provincial information is accessed as an integral part of the investigative process when it is known that the family has a Family Services history in another jurisdiction.

Progress

The DSS has agreed to all five of the CDR recommendations in this area.

Several sections of the Children's Services Manual (2001) have been updated to address the CAO recommendations regarding accurate record-keeping and access to information by both foster parents and children.

If followed, these policies should ensure that all aspects of a child's life are accurately and fully documented. The sections outline the responsibilities of the workers to not only document the information, but share the information with the appropriate individuals, including the child. The policy specifies that the "Life Book" is the property of the child and should accompany the child whenever he or she moves.

Regarding recommendation CDR.44(99), the department has accepted the recommendation and has notified the CAO that the information will be incorporated into the Family Centred Services Manual.

Contact Standards for 16 and 17-Year-Olds

1999 Findings

Section 10 of *The Child and Family Services Act* "authorizes services to youth 16 and 17 years of age who are in need of care and supervision and there is no parent willing or able to take responsibility for the young person or the young person cannot return to live with his or her family for reasons of safety." (DSS, Fact Sheet). Section 10 agreements for services are made "between the youth and the department, where the young person is willing to accept care, supervision and direction by the department."

Section 10 agreements require the development of a case plan that is agreed to by both the young person and the worker. The frequency of contact between the worker and the young person is negotiated on a case-by-case basis as part of the case plan. There are no minimum contact requirements defined in the policy. DSS policy does indicate that the conditions under which the Section 10 is signed must be evaluated on a regular basis.

The DSS has established four major guiding principles, which workers must follow in administering the 16/17-year-old program. The first of these is that "all 16 and 17-year-olds need adult support, guidance, and direction, at least some of the time."

In one child death review of a 16-year-old on a section 10 agreement, there was only one contact between the youth and the DSS worker. This contact occurred two weeks before the end of a four-month agreement for service.

The CAO found that the conditions of this agreement were not evaluated as required by the policy. The following recommendation was made:

Recommendation CDR.48(99)
That the DSS develop a directive or policy in the 16/17 Year Old Program Policy and Procedures Manual pertaining to contact standards with service recipients.

Progress

The DSS advised the CAO that a Case Management Standards: Support Services to 16/17 Year Old Youth directive was established and distributed at the 16/17 Year Old Conference in February 2000. It included client contact standards which state "ongoing client contact should be determined by the needs of the client as determined in the case plan. Minimum contact with any youth should be once per month." The DSS also notified the CAO that these standards will "formally be included in the manual by November 2003."

Services to Children with Disabilities or High Medical Needs

1999 Findings

In ten of the 31 deaths reviewed, the children had pre-existing medical conditions. These children required on-going support services, medical treatment or, in some cases, palliative care. The CAO made recommendations in two of these child death reviews.

Recommendation CDR.43(99)
That the DSS provide parents and caregivers of disabled children with assistance, including a comprehensive and current listing of available services, to access a full range of services for their children, including respite services.

Recommendation CDR.47(99)
That the DSS ensure that children placed in long-term residential facilities receive, in accordance with policy and best practice standards, the same level of contact and service that they would be afforded in a foster home or in other out-of-home placements.

Progress

The Community Living Division (CLD) of the DSS advised the CAO that they work with communities to determine what they identify as a priority need in the area of respite.

They further advised that they assist in funding community-based organizations in Saskatoon, Regina, Wilkie and Prince Albert to compile lists of potential caregivers and respond to requests from families to match caregivers to the presenting needs. The CLD also assisted the community of Esterhazy in developing an out-of-home respite center. However, the CAO is still unclear as to what services are available in other parts of the province.

In response to contact standards for children in long-term residential facilities, the DSS responded that "children placed in long-term care residential resources and the staff of those resources are required to have the same level and quality of contact with department staff as children in foster care or department resources. …Changes that have occurred in practice since October 1999 should reflect the commitment to following policy and practice standards relating to contacts with children."

Quality of Medical Services

1999 Findings

In four reviews, questions were raised about the quality of the medical care the child or youth received. In each of these the CAO made referrals to the College of Physicians and Surgeons (College). The College reviews such matters pursuant to *The Medical Profession Act*, 1981.

The College found that there were factors that could have improved the care that all four children received. In the four reviews completed, the College made the following findings and recommendations. (Note: Sections that relate to the specific details of the child's death, that would be identifying, have been omitted to respect the confidentiality of the child):

1. Establish guidelines provincially with respect to discharging pediatric patients on home oxygen.

   Prior to discharge a clear diagnosis should be established, and an assessment of the infant's ability to tolerate episodes of hypoxemia with a plan of response, and appropriate monitoring devices should be recommended.

2. Post-mortem examination of children should be performed by pathologists who have expertise in pediatric pathology.

3. The College will be recommending to neurosurgeons who are involved in shunt revision to send CSF (cerebral spinal fluid) and/or tubing, if available, for culture as a standard practice.

4. The continuity of care that brings long-term perspective to a case may have been better served had the child been cared for by a single medical specialist throughout his care especially given the child's limited communication abilities. (paraphrased)

5. Inadequate communication between the various caregivers and the medical staff with respect to (the child's) care. A specific consultant physician to provide ongoing assessment and coordination of medical services would have been helpful in preventing such lapses in communication. … Children with multiple medical problems would benefit from having a dedicated family pediatrician to coordinate their care.

6. There should be a protocol in place whereby non-physician healthcare providers can report any changes in the medical condition of the patient directly to the attending physician. This would ensure timely response to the concerns raised."

7. Fragmented care appears to have contributed to the ability of individual physicians to recognize the deterioration in a child's condition. When a child's condition is changing, it is important for the parent(s) to understand the importance of returning to the same assessor and/or facility where the physician can ensure adequate observation and has access to previous records of investigation and/or findings. It is also important that physicians communicate adequately with parent(s) to ensure that they understand what constitutes appropriate follow-up care."

8. The College would recommend that home visits are not appropriate in situations where a child has been seen on multiple occasions for an acute medical illness and whose condition is changing. Home visits do not allow for adequate examination and/or investigation of the condition.

9. The College would support the expansion of Teleradiology and progress on the sharing of information electronically between healthcare facilities to assist in providing optimal care to patients."

The College noted that physicians involved with the care of these children would be notified of the findings. As well, other issues noted would be raised with the appropriate agencies and departments. The CAO supports all the findings and recommendations of the College of Physicians and Surgeons and further, restated one recommendation of the College:

Recommendation CDR.61(99)
That the Government of Saskatchewan ensure that post-mortem examinations of children are performed by pathologists who have expertise in pediatric pathology.

Progress

Saskatchewan Justice responded to this recommendation indicating that it "is currently reviewing its pathology needs in relation to its mandate. This included review of the need for and feasibility of providing various types of pathology services which may assist coroners, police and prosecutions…. your recommendation…will certainly be under consideration by Justice officials."

Need for Integrated Services

1997-1998 Findings

As noted under the section on Suicides, in the 1996-1998 Summary report the CAO recommended that "the DSS, Saskatchewan Health and the Saskatchewan Health Districts (now Saskatchewan Regional Health Authorities) develop a protocol to provide for collaborative case planning for children or youth who are receiving services from both the DSS and a Health District. Further, the CAO recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child are being appropriately addressed."

In addition, one of three 1997-1998 child death reviews included in this report indicated a strong need for an integrated case management approach to children and youth who present with complex and multiple needs. The findings and recommendation for this death was not included in the previous Summary Report as the CAO review was awaiting the results of a review by an Intersectoral Committee.

In this case, following the recommendations of the Coroner's Inquest, an Intersectoral Committee was established with representatives from various provincial government departments, district health, police and not-for-profit service providers to review the services provided to this child. As the committee's report had not been finalized at the time the CAO child death review was conducted, the findings and recommendations of the CAO review were concluded without the benefit of the Committee's final report.

Recommendation CDR.35(98)
That the Intersectoral Committee established to review the recommendations of the March 8-10, 1999 Public Coroner's Inquest into the death of this child complete its review and provide a report to the Coroner and the Children's Advocate by no later than September 2003. In addition, that future reviews of this nature be completed within a specified timeline.

As of the date this report was printed, the CAO had not yet received the Intersectoral Committee's report.

1999 Findings

The need for an integrated case management approach was identified in 13 of the 1999 child death reviews. Four of the deaths were by suicide and 8 of the 13 children had received mental health services.

Although an Integrated Case Management Model was established in1998, implementation of this model was not apparent in the 13 files reviewed. In addition, the CAO found that there was a need for increased communication between the DSS and health workers and a need to ensure that parents were appropriately included in the case planning.

Recommendation CDR.49(99)
That the DSS, Saskatchewan Health and the Regional Health Authorities (Child and Youth Psychiatry Services and Addictions Services) jointly review the Saskatchewan Human Services Integrated Case Management model and create a process to ensure that it is implemented appropriately, including regular follow-up and review of identified children and youth requiring this service.

Recommendation CDR.50(99)
That the Department of Social Services work collaboratively with Saskatchewan Health and the Regional Health Authorities to provide information to health professionals regarding the philosophy and principles behind Family Centered Case Management and the importance of collectively involving parents in case planning.

Recommendation CDR.51(99)
That the Department of Social Services provide information to Saskatchewan Health and the Regional Health Authorities regarding the rights and entitlements of parents or legal guardians of children in care under the various provisions of *The Child and Family Services Act*.

Recommendation CDR.52(99)
That the Department of Social Services incorporate into policy a practice standard of advising health professionals of the legal status of any child in the care of the Minister and provide direction in regard to whom medical information is to be released.

Progress

The Department of Community Resources and Employment and Health, with representatives from Regional Health Authorities, Child and Youth Services and Alcohol and Drug Services reported to the CAO that they met in February 2003 to discuss the CAO recommendations regarding the need to implement and review the integrated case management model.

Following the meeting, the CAO was advised that "It is an expectation of DSS and Health that staff use an integrated case management approach and collaborate with other departments and agencies whenever there are several service providers involved with a family." They acknowledged that "every child or youth could benefit from integrated case management. However, it was the opinion of the group that integrated case management is very difficult to implement in every case, and especially difficult with high-risk youth who are often resistant to services and require considerable outreach to be engaged. Many also require out-of-home living arrangements. Nevertheless, we are pleased there has been significant progress in implementing an integrated case management approach in many areas." Progress was noted in many areas across the province.

However, full implementation of the model has not been achieved. In their response to the CAO, DSS and Health recognized "that more work needs to be done in the development of policy and programs that address the integrated service needs of children and youth who have serious substance abuse or addictions, mental and child welfare issues. Health and DSS have agreed to further discussions with (representatives from) the Human Services Integration Forum."

Mental Health Services

Update on 1996-1998 Findings

As noted earlier, of the three pre-1999 child death reviews that are included in this report, one was a homicide of a youth residing in a group home who was Away Without Leave (AWOL) from the group home at the time of his death. The CAO review found that while this youth had received the mental services available to youth in Saskatchewan, he did not appear to be provided with the level of care or intervention he required. The CAO raised concerns regarding the need for early intervention in the lives of children who are under the age of 12 and exhibiting behavior that would otherwise be considered criminal. Given the concern regarding the level of intervention available in Saskatchewan, the CAO recommended:

Recommendation CDR.36(98)
That a review of the need for a residential psychiatric facility for children and youth in Saskatchewan be completed.

1999 Findings

There were eight reviews where mental health services had been provided to the children and youth. In three of the reviews the youth did not participate in the services offered to them. In one particular case, the CAO found that the "documentation pertaining to the contacts the (health region) mental health staff had with the (youth) was limited and there were no clear closure notes on the file."

Progress

The CAO review of the one youth's death, where a finding about documentation and clarity of closure notes was made, prompted a review by the health region of their mental health services to children. Although the CAO made no recommendations in this case, the health region initiated two processes to address concerns raised by the CAO. These resulted in enhancement of quality assurance mechanisms. The two measures were:

- A professional file audit as a peer review to monitor quality and thoroughness of documentation; and
- A client file closure list that is generated every six months. Mental health workers are requested to review the list and close client files that are deemed inactive.

The CAO has undertaken a review of the quality and quantity of mental health services to children in Saskatchewan. The review will include a literature review and examine the services provided to Saskatchewan children and youth to determine what is available, what are the gaps and to provide recommendations on how to improve services to children and youth. The CAO intends to release the report in 2003.

Services for Youth in Conflict with the Law

1999 Findings

Eight deaths reviewed by the CAO involved youth who were in conflict with the law. Four of these deaths were suicides, two of which occurred in an adult correctional facility while the youths were serving young offender sentences. The remaining four deaths were motor vehicle accidents, all involving the misuse of alcohol. In one review, a recommendation was made to have mandatory assessments of the youth's alcohol and drug use included in initial assessment and case planning (CDR.55(99) in the section on Alcohol and Drug Use).

Findings were made regarding non-compliance with existing policy in four of the eight files. Six of the youth were serving community dispositions. In three of these six reviews, the CAO found that there was inadequate supervision and contact with the youth. In these three reviews, the CAO recommended minimum contact standards for the supervision of young persons placed on community dispositions. One of the three reviews recommended that supervision case plans be made mandatory. In one of these reviews, the youth, was serving dual orders, both as a young offender and an adult. The CAO found that the DSS did not comply with the supervision responsibilities pursuant to policy respecting probation orders. The CAO recommended clarification of policy to ensure consistency of supervision.

To assist youth in receiving the supervision and guidance that they require to comply with the terms and conditions of their community dispositions, the CAO recommended:

Recommendation CDR.53(99)
That Saskatchewan Corrections and Public Safety establish minimum contact standards with respect to the supervision of young persons placed on community dispositions.

Recommendation CDR.54(99)
That the policy regarding the supervision of dual orders (youth and adult orders) be clarified.

Recommendation CDR.55(99)
That the Department of Corrections and Public Safety amend the Young Offender Program, Policy and Procedures Manual (1994) to include a mandatory assessment of the youth's alcohol and drug use as a section of the initial assessment and case plan.

Recommendation CDR.56(99)
That a supervision case plan for Young Offender Orders be made mandatory.

Progress

Corrections and Public Safety (CPS) accepted the CAO recommendations.

On April 1, 2003 the *Young Offenders Act* was replaced by the *Youth Criminal Justice Act*. In preparation for the new legislation, the CPS produced draft policies and procedures for community dispositions. The CPS delivers supervision and support to youth sentenced to court ordered dispositions. The Department advised that their role includes general assessment, and case management. Youth workers, as part of the case management policy, are directed to assess and refer to appropriate agencies to obtain needed alcohol and drug assessments. Effective April 2003, "a risk assessment system was implemented to identify substance abuse issues and flag cases that require follow up." Regional Health Authorities and the Native Alcohol and Drug Abuse Programs have the mandate to deliver alcohol and drug assessment and treatment services. The CPS will not provide specialized drug and alcohol assessment services but in cases of substance abuse, both the treatment resources and the youth worker will work together to address the youth's needs. The CPS and Department of Health concur that this is the practice they will now be supporting and to which their staff will be trained.

The CAO was advised that action has been taken to ensure compliance with the department's policies and standards. The supervision structure was changed to include additional file reviews, enhanced staff training and closer supervision of practice. With respect to contact standards and a supervision case plan on all community dispositions, the Department has advised that policies have been drafted to address case management, standards for supervision and report writing. The new policies address evidence-based practice and services that will reflect the level of the youth's risk and need.

Corrections and Public Safety has agreed to clarify policy "governing youth transfers to adult corrections and youth liable to adult sentences." As well, the CPS has agreed to clarification of policy "addressing supervision requirements for youth serving dual orders."

Educational Services

1999 Findings

In four of the deaths reviewed, recommendations were made regarding the lack of attention paid to the youth's connection with the school system. Two of the deaths were by suicide, one was a hanging that was classified as accidental, and the fourth was a motor vehicle accident where the child was riding a bicycle at the time of death. Two of these four children were not attending school.

In one of these cases, the child left school while under a court order that required his attendance at school. There was no follow-up from either the school system or the young offender system. In the case of the second child, a nine-year-old, the CAO could not determine if the child had ever even been registered for school. For the two children that were attending school, the CAO found that the school records were incomplete. In one of these cases, school files were not transferred when the child moved and could not be located.

The CAO reviews raised concerns regarding the need to address those youth who ought to be in school and are not. As well, a number of quality assurance concerns were identified, including:

- inconsistent and incomplete information on education files;
- the development of and implementation of minimum expectations and protocols for transferring information, documentation and assessments when a child changes schools; and
- adequacy of documentation and the transferring of information between school districts.

In addition, in the case of the youth under a Court Order, the CAO review emphasized the need to examine the issue of court orders and school attendance with the view to clarifying the policies, protocols and communications responsibilities.

The issues raised by these child death reviews were also identified in the *School Plus A Vision for Children and Youth, Task Force and Public Dialogue on the Role of School* (Government of Saskatchewan, 2001). The CAO recommended:

Recommendation CDR.58(99)
That the Department of Learning address the concern of children not in school (Hidden Youth) by developing and implementing "a new student data system with the capacity to identify and track student enrolment, movement and retention" as agreed to in *Securing Saskatchewan's Future*, the Provincial Response – Role of the School Task Force Final Report (February 2002, page 12).

Recommendation CDR.59(99)
That the Department of Learning address the concern of inconsistent and incomplete information on education files that are transferred between schools. This would require developing and implementing a minimum expectation and protocol for transferring information, documentation, and assessments when a child changes schools. In addition, professional development for Administrators throughout the province would need to occur to foster understanding of the importance of forwarding key information. Consistency in the transfer of documentation would enhance the "new student data system with the capacity to identify and track student enrolment, movement and retention" as agreed to in *Securing Saskatchewan's Future*, the Provincial Response – Role of the School Task Force Final Report (February 2002).

Recommendation CDR.60(99)
That the Department of Learning create a "broad based committee to examine the issue of court orders and school attendance, with the view to clarifying the policies, protocols and communications responsibilities around this issue; and, that the results of its deliberation be published widely." (*School Plus A Vision for Children and Youth, Task Force and Public Dialogue on the Role of School*, Final Report, Recommendation 11.3).

Progress

The Department of Learning has accepted the CAO recommendations and continues to provide updates on the implementation of the *School Plus Model.*

The CAO was informed by Saskatchewan Learning that there has been a major expansion of the Student Record System which "will register all children from K-12 including students in provincially funded schools, independent schools, First Nation schools and home-schooled children. This system is to provide reports to school administrators listing students who have withdrawn from their school and not re-enrolled in another Saskatchewan school." Full implementation of the system is scheduled for the 2003-2004 school year.

The CAO was informed by Saskatchewan Learning that the Children's Services Policy Framework was updated in August 2002 to address the issue of a provincial documentation transfer policy for school boards. The *Sharing Information to Improve Service for Children, Youth and Families: A Guide to the Legislation (1997)* provides guiding principles and disclosure rules for educators, youth workers and other service providers. The CAO has been informed that a committee has been formed to review and update this document and that professional development has been provided to ensure understanding of and compliance with the policy. However, the department also noted that "ultimate responsibility for implementation and actualization of effective student record policies and practices rests at the local level." Therefore even with provincial policies in place, the issue may be one of compliance at the local level. Saskatchewan Learning has indicated that they are "committed to working with (their) educational partners to establish minimum expectations for retaining and transferring information."

The CAO was also notified by the Department of Learning that a task team was to be established in the Fall of 2002 to "examine the issues of court orders and school attendance with the view to clarifying the policies, protocols and communications responsibilities."

The CAO has since been notified by Learning that "Saskatchewan Learning and Saskatchewan Justice agree on the priority of this examination. A larger review of truancy is underway and will examine court orders as one method of addressing school attendance. In addition, the Youth Justice Core Management Committee, responsible for the implementation of the *Youth Criminal Justice Act,* will be involved in the discussion."

Additional Recommendation

The following is one recommendation that was made in the review of one child death review. The recommendation is specific to one family and was accepted.

Recommendation CDR.62(99)
That (the) District Health undertake to offer (the child's) biological parents genetic counselling.

Part 9
The Future

This Summary Report once again highlights the importance of an independent review of the deaths of children. Completing these death reviews and preparing this report has also raised significant challenges and questions for the Children's Advocate Office and government. It is these challenges that we must all face in a realistic manner.

Since 1998, the Children's Advocate Office has reviewed nearly 100 child and youth deaths where there was involvement by the former Department of Social Services. We have, as this report details, found significant practice issues and made recommendations that, when implemented, improve services provided to children. We have promoted increased public accountability in the child-serving system, in some cases simply by having an independent review of the death. We have found that our goal of preventing child deaths is less likely to be achieved when such a limited number of deaths are considered out of the context of all of the child deaths.

With this in mind, the Children's Advocate Office and government officials have been discussing options for changing the child death review process. The CAO is proposing a number of changes and these are outlined below. We are calling on government to work with us to implement these changes.

File Audits to Review Compliance with Case Practice

We believe that the case practice issues related to compliance with government policy and standards would be most effectively examined within clearly defined and carefully measured quality assurance mechanisms. Reviewing case practice issues in relation to child deaths is very limiting and does not address current practice issues, nor does it ensure transparency in the system. To this end, the Department of Community Resources and Employment has agreed to send the results of the department's annual file audits to the CAO. In the annual file audit approximately 1200 to 1500 child protection, children in care and foster home files are reviewed to identify and measure adherence to policy and standards. We believe that this annual file audit and case review could be an effective mechanism to identify compliance issues and to have these promptly addressed.

There are, of course, potential problems with this change and we are prepared to tackle these as they arise. Of greatest concern to the CAO is that action will be taken to address the compliance problems that are identified. Maintaining best practices is not just an issue of compliance with policies, but involves a range of system issues. For example, providing the necessary level of social supports for children and their families to live in a manner that reduces their risk of involvement with child protection or young offender services; recruitment, training and retention of a highly skilled and motivated workforce; and community support for vulnerable children are all factors to consider when working towards best practices.

Another issue for the CAO is that these audit results have, to date, not been made public. Clearly, as government departments accept increased responsibility for case practice compliance and quality assurance, they must also accept that increased transparency and public accountability.

Maintain Public Accountability in the Child Death Review Process

The CAO is committed to a comprehensive independent review of those child deaths where the child was in government care. This would include those children in foster or group home care, or receiving other residential support services such as those young people aged 16 and 17 who are living independently, or youth in conflict with the law who are in a secure or open custody facility. The CAO believes that these deaths require a full investigation and a review by a multi-disciplinary team. The CAO will continue to review these deaths and will report the findings and recommendations in a public manner.

Review all Child Deaths with, at Minimum, an "Educated Eye"

The CAO is calling for is an examination, in some systematic fashion, of the deaths of all children.

The CAO, with the support of a Child Death Advisory Committee, has continued to pursue the importance of an independent review of the deaths of all children. The merits of this idea have now been discussed with a number of organizations, such as the Saskatchewan Institute on Prevention of Handicaps, the Perinatal Infant Health Scientific Advisory Committee, and the Perinatal & Maternal Mortality Study Committee of the College of Physicians and Surgeons. There is general agreement that every child death presents an opportunity to learn and deserves a review by an "educated eye."

Right now, in Saskatchewan, some deaths are reviewed and to varying degrees by different organizations. There is not one organization in Saskatchewan who analyzes data regarding all child deaths. We need to gather and analyze child death data in a manner that will guide policy and decision-makers to improve the services provided to all of our children.

We are not saying that every death would benefit from a comprehensive, multi-disciplinary review. We realize that this is unnecessary and impractical. The CAO recognizes that it may be necessary to introduce this in phases, starting with groups of children determined to be particularly vulnerable, such as completing a review of the deaths of all children under one-year of age. In this way, about half of the child deaths would be considered in some independent manner and this could, potentially, help to reduce our very high infant mortality rate. Alternatively, all unexpected deaths of children under age six could be examined, as is currently the case in Quebec. These young children who are generally not monitored outside of their family home is another example of a particularly vulnerable group of children.

An increased review of all child deaths will assist in developing greater understanding of the causes of child deaths and identifying gaps that must be addressed. Without this "educated eye" on every child death, we will continue with the presently fragmented review system.

Implications

Essentially the CAO is calling for an improved process for reviewing child deaths in Saskatchewan. We now have several years of experience conducting child death reviews and we know that, as a province, we can do better.

Beginning with the deaths that occurred in 2000, the CAO will continue to review the deaths of children who were in government department or agency care/ custody, either at the time of the death or in the six months prior to the death. We will also review any additional deaths where either a government department or a community member, including a parent, identifies a need for an external independent review of the death. We have already started on the review of the deaths from 2000, 2001 and 2002 using this as our criteria.

In addition, we anticipate receiving from the Department of Community Resources and Employment the results of their annual file audits and the actions taken to rectify the issues they identify. We also trust that the Department will begin to publicly release the results of these audits. We believe this will increase accountability in relation to the case practice issues we have documented from the death reviews.

The CAO will be formally submitting the following recommendation to the appropriate government departments:

> ***RECOMMENDATION CDR.63 (99)***
> ***That government develop a model to ensure all child deaths are reviewed by "an educated eye" and that this model begin to be implemented by January 1, 2005.***

The CAO is recommending the changes outlined above to improve and enhance the child death review process in Saskatchewan. While we anticipate that the CAO will conduct fewer reviews, we believe that implementing all of these changes will help us to more effectively achieve our goals of preventing child deaths, impacting the child-serving system and promoting public accountability.

Appendix A

Children's Advocate Office Multi-Disciplinary Review Team

The Multi-Disciplinary Review Team (MDRT) was comprised of individuals who were invited to participate due to the expertise and perspective they brought to the reviews. The CAO was encouraged and challenged by their passion and commitment to Saskatchewan's children. Special appreciation is extended to the following members of the MDRT who participated in the review of the 1999 child death reviews and who gave of their time and expertise to improve the delivery of services to children in Saskatchewan.

Dr. John Nyssen
Mr. Don Bird
Dr. Pat Blakley
Ms. Nancy Mususkapoe
Mr. Bob Green
Dr. Gord Kasian
Mr. Murray Langaard
Ms. Darlene Domshy

Appendix B
Provincial/CAO Comparison of Child Deaths

Table 1. Deaths of Children From Birth to 21 Years of Age in Saskatchewan: CAO Deaths Reviewed and Total Provincial Deaths[1], 1997, 1998, 1999

Official Classification of Death	Year	Age Group												TOTAL	
		Less than One Year		1-5 Years		6-11 Years		12-15 Years		16-17 Years		18-21 Years		Birth to 21 Years	
		Total Deaths	CAO Death Reviews	Total Deaths	CAO Death Reviews	Total Deaths	CAO Death Reviews	Total Deaths	CAO Death Reviews	Total Deaths	CAO Death Reviews	Total Deaths	CAO Death Reviews	Total Deaths	CAO Death Reviews
Natural	1997	86	__	12	1	5	1	12	__	5	__	6	__	126	2
	1998	72	1	13	2	8	5	5	2	4	__	14	2	116	12
	1999	59	2	18	5	6	__	11	3	5	__	6	__	105	10
SIDS[2]	1997	6	4	__	__	__	__	__	__	__	__	__	__	6	4
	1998	13	3	__	__	__	__	__	__	__	__	__	__	13	3
	1999	12	1	__	__	__	__	__	__	__	__	__	__	12	1
Accidental	1997	3	1	9	5	13	3	11	__	13	3	26	__	75	12
	1998	1	1	10	__	5	1	4	2	6	1	29	3	55	8
	1999	3	2	9	__	10	2	8	1	14	4	26	2	70	11
Suicide	1997	__	__	__	__	2	1	4	2	2	2	11	1	19	6
	1998	__	__	__	__	__	__	1	1	6	__	18	2	25	3
	1999	__	__	__	__	__	__	4	1	4	3	4	3	12	7
Homicide	1997	__	__	1	2	2	__	2	__	__	__	1	__	6	2
	1998	__	__	__	__	__	__	__	__	2	5	3	1	5	6
	1999	__	__	__	__	__	__	__	__	__	__	2	1	2	1
Undetermined	1997	1	1	1	__	__	__	__	__	__	__	__	__	2	1
	1998	__	1	__	__	__	__	1	__	__	__	__	__	1	1
	1999	__	1	__	__	__	__	__	__	__	__	__	__	__	1
TOTAL	**1997**	**96**	**6**	**23**	**8**	**22**	**5**	**29**	**2**	**20**	**5**	**44**	**1**	**234**	**27**
	1998	**86**	**6**	**23**	**2**	**13**	**6**	**11**	**5**	**18**	**6**	**64**	**8**	**215**	**33**
	1999	**74**	**6**	**27**	**5**	**16**	**2**	**23**	**5**	**23**	**7**	**38**	**6**	**201**	**31**

[1]Source: Saskatchewan Health, Corporate Information and Technology Branch (Table prepared with the assistance of the Saskatchewan Institute on Prevention of Handicaps, 2003.)
[2]For provincial data, includes sudden deaths of infants, cause unknown.

NOTE: A discrepancy occurred for the Homicide deaths of children aged 1-5 years in 1997 and aged 16-17 years in 1998, and for Undetermined deaths of children under one year in 1998 and 1999.

Inconsistencies can arise when data from two different sources are compared. The series of deaths reviewed by the Chief Coroner and the CAO and the data from Vital Statistics are not the same data files.Some factors that may contribute to inconsistencies in data are:

- Potential differences in the level of detailed analysis used by the Coroner and Vital Statistics. Vital Statistics does not conduct detailed analysis of the cause of death reported by the Coroner on the medical certificate of death.
- Potential differences in the methods of classification used. The underlying cause may differ according to other factors relating to the person and circumstances of death. For example, a person who has an illness such as cancer may die in a fall, and the underlying cause will be cancer, rather than fall.
- Potential unavailability of information or delay in obtaining information. In some cases Vital Statistics may not have the information necessary to complete the cause of death coding.

Appendix C
Children's Advocate Office
Child Death Review Recommendations

Recommendations from the Review of the Death of Karen Quill

There were 27 recommendations (CDR.1-27(97)) in the review of the death of Karen Quill. For a complete listing of these recommendations, please contact the Children's Advocate Office or see the CAO website at www.saskcao.ca.

1996-1998 CDR Recommendations

CDR.28(97)
That the Departments of Social Services and Health establish a clear protocol for collaborative case planning for children and youth who are receiving services from both departments. It is further recommended that this protocol include a mechanism for review and follow-up to ensure that the needs of the child or youth are being appropriately addressed.

CDR.29(97)
That the Department of Social Services develop policy that outlines the department's responsibility for court ordered undertakings, particularly when these relate to the requirements to provide supervision to youth who are in the care of the Minister.

CDR.30(97)
That the Department of Social Services ensure that the policy and practice specified in the Family Centred Services Manual is complied with. In particular, that the Department of Social Services take steps to ensure that children who remain in the care of their family are protected within that family unit when there are known risks to the child.

CDR.31(97)
That the DSS include a section on medical care and drug administration (including both prescription and non-prescription drugs), in the pre-service training provided to foster parents.

CDR.32(97)
That the DSS create an accountable method for all foster parents to record and track all medical care and drug administration. Further, that in the event of a change in placement, that this information is transferred with the child and that a copy is maintained on the Child Care file.

CDR.33(97)
That the DSS provide all foster parents with training and support to assist them in caring for children with special needs resulting from Fetal Alcohol Syndrome and Fetal Alcohol Effects and that this training becomes mandatory.

CDR.34(97)
That the DSS review their policy regarding the babysitting of children in the care of the Minister with respect to ensuring that the standards reflect a suitable level of safe care.

CDR.35(98)
That the Intersectoral Committee established to review the recommendations of the March 8-10, 1999 Public Coroner's Inquest into the death of this child complete its review and provide a report to the Coroner and the Children's Advocate by no later than September 2003. In addition, that future reviews of this nature be completed within a specified timeline.

CDR.36(98)
That a review of the need for a residential psychiatric facility for children and youth in Saskatchewan be completed.

1999 CDR Recommendations

CDR.31(97,99)
That the Department of Social Services include a section on medical care and drug administration (including both prescription and non-prescription drugs) in the pre-service training provided to foster parents (previously recommended in a 1997 death).

CDR.32(97,99)
That the Department of Social Services create an accountable method for all foster parents to record and track all medical care and drug administration. Further, that in the event of a change in placement, that this information is transferred with the child and that a copy is maintained on the Child Care file.

CDR.37(99)
That children in care have up-to-date, accurate records that provide complete information about all aspects of the care they are receiving. These records must include a detailed plan for care that incorporates health and educational status. Children must also have access to the personal information that is kept about them. (CYICR 2.8)

CDR.38(99)
That foster parents must be provided with information about the children in their care in a timely manner. Health status, education, family connections and other information useful to providing daily care is required by foster parents as soon as possible. (CYICR 2.9)

CDR.39(99)
That children in care have their health needs carefully assessed, monitored, and fully documented. The full range of health services that parents provide to their children must be maintained by government as parent, including regular health check-ups, up-to-date immunizations, dental check-ups and follow-up, as well as any specialized care required, such as eyeglasses, mental health counselling or orthodontic work. (CYICR 5.4)

CDR.40(99)
That every child care plan include a plan to ensure that the educational needs of that child are being met, including special educational needs of hard to serve children. *The Education Act,* 1995, outlines the responsibility of boards of education to provide children in care with an appropriate education. There must be careful documentation of all education progress to ensure continuity when children move or are returned home. Social Services and Education must co-ordinate efforts to ensure that the educational needs of children in care are a priority. (CYICR 5.5)

CDR.41(99)
That the DSS ensure that the specialized services required for children diagnosed with FAS or other conditions related to prenatal exposure to alcohol be carefully and thoroughly detailed utilizing a multi-disciplinary strategy routinely provided to children in care diagnosed with these conditions.

CDR.42(99)
That Saskatchewan Community Resources and Employment undertake to regularly identify and review, at a management level, those cases where children are repeatedly subjected to neglect over a significant period of time and where Saskatchewan Community Resources and Employment has frequently re-opened child protection files. This review would be intended to ensure that interventions are "as complete and as intensive as necessary…to bring about needed change to reduce risks and ensure the protection of the child" (Family-Centred Services Manual, Chapter 1, Section 1, p. 2).

CDR.43(99)
That the DSS provide parents and caregivers of disabled children with assistance, including a comprehensive and current listing of available services, to access a full range of services for their children, including respite services.

CDR.44(99)
That the DSS review their Family-Centred Services Manual and ensure that inter-provincial information is accessed as an integral part of the investigative process when it is known that the family has a Family Services history in another jurisdiction.

CDR.45(99)
That the Action Plan for Children ensure that information about the dangers of adults co-sleeping with infant children, particularly when intoxicated, be provided to all new parents.

CDR.46(99)
That the DSS undertake a review of *The Child and Family Services Act*, in relation to other provincial jurisdictions, to determine whether there is a need for enhanced intervention in situations where children are exposed to domestic violence.

CDR.47(99)
That the DSS ensure that children placed in long term residential facilities receive, in accordance with policy and best practice standards, the same level of contact and service that they would be afforded in a foster home or in other out of home placements.

CDR.48(99)
That the DSS develop a directive or policy in the 16/17 Year Old Program Policy and Procedures Manual pertaining to contact standards with service recipients.

CDR.49(99)
That the DSS, Saskatchewan Health and the Regional Health Authorities (Child and Youth Psychiatry Services and Addictions Services) jointly review the Saskatchewan Human Services Integrated Case Management model and create a process to ensure that it is implemented appropriately, including regular follow-up and review of identified children and youth requiring this service.

CDR.50(99)
That the Department of Social Services work collaboratively with Saskatchewan Health and the Regional Health Authorities to provide information to health professionals regarding the philosophy and principles behind Family Centered Case Management and the importance of collectively involving parents in case planning.

CDR.51(99)
That the Department of Social Services provide information to Saskatchewan Health and the Regional Health Authorities regarding the rights and entitlements of parents or legal guardians of children in care under the various provisions of *The Child and Family Services Act*.

CDR.52(99)
That the Department of Social Services incorporate into policy a practice standard of advising health professionals of the legal status of any child in the care of the Minister and provide direction in regard to whom medical information is to be released.

CDR.53(99)
That minimum contact standards are established with respect to the supervision of young persons placed on community dispositions.

CDR.54(99)
That the policy regarding the supervision of dual orders (youth and adult orders) be clarified.

CDR.55(99)
That the Department of Corrections and Public Safety amend the Young Offender Program, Policy and Procedures Manual (1994) to include a mandatory assessment of the youth's alcohol and drug use as a section of the initial assessment and case plan.

CDR.56(99)
That a supervision case plan for Young Offender Orders be made mandatory.

CDR.57(99)
That Saskatchewan Health work with Saskatchewan Environment and other key partners in the north to identify opportunities to educate the public on the potential hazards of toxic plants that grow in the north and to implement such measures as appropriate.

CDR.58(99)
That the Department of Learning address the concern of children not in school (Hidden Youth) by developing and implementing "a new student data system with the capacity to identify and track student enrolment, movement and retention" as agreed to in *Securing Saskatchewan's Future,* the Provincial Response – Role of the School Task Force Final Report (February 2002, page 12).

CDR.59(99)
That the Department of Learning address the concern of inconsistent and incomplete information on education files that are transferred between schools. This would require developing and implementing a minimum expectation and protocol for transferring information, documentation, and assessments when a child changes schools. In addition, professional development for Administrators throughout the province would need to occur to foster understanding of the importance of forwarding key information. Consistency in the transfer of documentation would enhance the "new student data system with the capacity to identify and track student enrolment, movement and retention" as agreed to in *Securing Saskatchewan's Future,* the Provincial Response – Role of the School Task Force Final Report (February 2002, page 12).

CDR.60(99)
That the Department of Learning create a "broad based committee to examine the issue of court orders and school attendance, with the view to clarifying the policies, protocols and communications responsibilities around this issue; and, that the results of its deliberation be published widely." (Final Report, Recommendation 11, page 121).

CDR.61(99)
That the Government of Saskatchewan ensure that post-mortem examinations of children are performed by pathologists who have expertise in pediatric pathology.

CDR.62(99)
That (the) District Health undertake to offer (the child's) biological parents genetic counselling.

CDR.63 (99)
That government develop a model to ensure all child deaths are reviewed by "an educated eye" and that this model begin to be implemented by January 1, 2005.

Appendix D

Services Available to Children Not in the Care of the Minister of Social Services

The DSS provides services to children and youth residing in their own homes or with extended family. These services may include the services provided by one or more programs such as Adoption, Child Protection, Community Living Division (CLD), Teen and Young Parent Program, 16 and 17 year-old Program. (Note: This list of programs was provided to the CAO by the DSS for the Summary of Child Death Reviews: August 1996 to December 1998. See below for a description of these programs.)

Adoption
Services assist and support families who apply to establish a legal family relationship or "adopt" a child.

Child Protection (Child protection provided services to 9718 families in 1999). Services are provided to families when a child is found to be in need of protection as defined by section 11 of *The Child and Family Services Act*. This includes situations of physical, sexual or psychological abuse, failure to provide essential medical treatment, failure to address serious developmental needs, domestic violence, child abandonment and children under 12 years who commit an offence.

In the majority of situations, the DSS works with families who are caring for their children in their own homes to improve the quality of parenting and ensure safety. When a family experiences problems that are of a serious nature and safety cannot be ensured within their home, they may be placed in the care of the Minister.

In addition, 17 Indian Child and Family Services Agencies are in operation across the province and provide child protection services to First Nations children and families living on-reserve.

Community Living Division (CLD)
The CLD provides services to families who are caring for children and youth with intellectual disabilities. Programs support the physical, emotional, and social needs of clients and assist them to live and function as independently as possible within their own communities.

Teen and Young Parent Program
This is a voluntary program that assists young adults who are pregnant or parenting children.

Young Offender Programs (Young offender services were provided to 6899 youth in 1999) Services are provided to youth 12 to 17 years of age who have been convicted of a criminal offence and sentenced to a period of probation or custody. The program consists of secure and open custody as well as community-based programs. Youth may remain involved in the program beyond the age of 18 if their period of probation or custody has not been completed.

16 and 17-Year-Old Program (2052 youth received service in 1999 under the 16/17-year-old program.) The program assists youth to gain independence and provides counselling and residential services to youth that are at risk. The program combines child welfare, youth programming and income security.

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