SASKATCHEWAN advocate
a Voice for Children and Youth

MEDIA RELEASE
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Advocate for Children and Youth releases investigation of toddler's death in foster care

REGINA—Bob Pringle, Saskatchewan's Advocate for Children and Youth, released his report *Lost in the System: Jake's Story* today. It is an investigation into the death of a child in foster care who died shortly before his second birthday.

This child, who is referred to as "Jake," was found unresponsive in his bed by a staff member on the morning of December 10, 2009. In a post-mortem exam, the Coroner determined that he had passed away sometime before midnight the previous evening. The Coroner was unable to determine either the cause or the manner of Jake's death. A police investigation found no evidence of foul play.

Jake's real name was not used in the report as *The Advocate for Children and Youth Act* prohibits the disclosure of names to protect the privacy of the children and families involved.

The primary focus of the report is an examination of the services that Jake and his family received from the Ministry of Social Services and other child-serving agencies, to determine if they received the services to which they were entitled. The 32 page report includes seven recommendations, which are reprinted in full in the attached backgrounder.

Jake and his older brother were taken into foster care when he was five months old, following a domestic dispute in which his mother was hospitalized and his father was taken into custody. In the next ten months, Jake moved 11 times.

For the last nine months of his life, Jake lived in a high-capacity emergency foster home alongside his brother and 10 other children under five. Throughout his time in care, health professionals and one of his foster parents raised concerns about his health and development, which were not followed up sufficiently by the Ministry of Social Services.

"I am troubled by the number of times that Jake moved while he was in care, and why he spent so long at an overcrowded foster home," Pringle said. "I was also concerned to learn that when he died, he was recovering from an unexplained leg fracture, and he had never learned to talk."

"While it is too late for Jake, telling his story can help us improve systems for other children."

Pringle said that he has noticed the perception that the child welfare system lacks accountability for what happens to children in care, which he is addressing by making and following up on recommendations to child and youth-serving ministries and agencies. He is "disappointed that the Coroner could not determine both how and why Jake died."

Pringle acknowledges that the Ministry of Social Services has made significant changes in the years since Jake's death, conducting a joint child death review with Sturgeon Lake Child and Family Services Inc. and implementing many of its recommendations. Recommendations in this report emerged from this

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investigation's findings and reflect what the Advocate feels still needs to change to ensure better outcomes for children in foster care.

"Jake did not get the good start in life to which all children are entitled," Pringle said. "He spent the better part of his short life in foster care, and the many caregivers he had made it difficult for him to feel secure and form healthy attachments. His mother was the most constant presence in his life."

"As signatories to the United Nations *Convention on the Rights of the Child*, which we have simplified into the *Saskatchewan Children and Youth First Principles*, we need to make sure that all children are safe, protected, and that they have the supports to develop to their full potential."

The Advocate for Children and Youth is an independent officer of the Legislative Assembly of Saskatchewan. He leads a small team of regional advocates, investigators and other staff who work on behalf of the province's young people. Our vision is that the rights, interests and well-being of children and youth are respected and valued in our communities and in government legislation, policy, programs and practice.

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Backgrounder attached.

For the full report please visit: www.saskadvocate.ca.

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BACKGROUNDER

Embargoed until 11 am, Sept 16, 2014

BACKGROUNDER ON *LOST IN THE SYSTEM: JAKE'S STORY*

This backgrounder consists of the Executive Summary and the Advocate's Recommendations excerpted from the full report, Lost in the System: Jake's Story, which is available at www.saskadvocate.ca.

EXECUTIVE SUMMARY

This report examines the life of a young child we are calling "Jake," who was in care from the age of five months until his death just prior to his second birthday. As per the legislation governing this office, we have not identified him by his real name. This report includes a review of the services Jake and his family received from the Ministry of Social Services (MSS) and Saskatoon Health Region to determine if they received the services to which they were entitled.

Jake was born a healthy baby on December 14, 2007. His parents had previous involvement with MSS with his older brother, due to his mother's alcohol misuse and domestic violence in the home. While at first things seemed to be going well for Jake's family, within several months of his birth MSS received four reports of his mother's suspected alcohol misuse, one of which was substantiated. On May 13, 2008, when Jake was five months old, he and his brother were taken into care following a domestic dispute in which his mother was allegedly injured by his father, after which she was hospitalized and he was taken into custody.

Over the next 10 months, Jake and his brother were moved 11 times, sometimes in short succession. During his time in care, MSS continued to work with Jake's mother, so that she could address her addiction issues and be reunited with her children. While Jake's father was initially involved, later on he refused to participate in case planning and was no longer part of Jake's life.

On March 6, 2009, Jake and his brother were placed in a foster home that was established as an emergency level foster home, meant to care for children for up to two weeks. It had the capacity for 10 emergency placements and two special needs placements, thus considerably exceeding both the maximum number of placements in a foster home (four) and a group home (10).

Jake stayed in this home for the next nine months until his death a few days before his second birthday. On the morning of December 10, 2009, he was found unresponsive when an In-Home Support worker went to wake him up. The day prior, he had appeared to be physically healthy and had been seen by an orthopedic specialist, who confirmed that a fractured femur he had sustained two months prior was healing properly.

The Coroner determined that Jake had died the previous evening, sometime before midnight, although his death was not discovered until the next morning. An autopsy was completed, but neither the cause nor the manner of Jake's death was able to be determined. The Major Crimes division of Saskatoon Police Service investigated Jake's death and found no evidence of foul play.

The purpose of this investigation is to determine whether Jake and his family received the services to which they were entitled, and to make recommendations to improve the capacity of child-serving systems to

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ensure the rights of children are upheld. It is rare in our investigations that we do not know both how and why a child died. However, this investigation did shed light on the circumstances of Jake's short life and his time in care, prompting a number of recommendations.

Key elements of the report include:

- As required by policy, MSS and the Sturgeon Lake Child and Family Services Inc. conducted a joint child death review of Jake's death in June 2011. The Advocate received a detailed report of this review and agreed with its 11 findings and 16 recommendations, 14 of which are considered to be completed, with two still ongoing. In the time since Jake's death, there have been many improvements made. They include discontinuing the practice of opening high-capacity homes that are outside of MSS policy, and the introduction of Structured Decision-Making, a new set of tools to better identify and assess risk to children.

- Our investigation found that Jake was vulnerable in many ways due to his young age, the challenges presented by his parents, his inability to talk along with suspected delays in other areas, and his 11 placements during his 19 months in care. His many moves, some of which were not documented sufficiently, were contrary to MSS policy, which states that reasonable steps must be taken to maintain stability in a child's foster home placement and reduce anxiety for the child. These frequent moves during a critical period of his development were detrimental to Jake, and had an impact on his ability to form the kind of loving, stable relationships with caregivers needed for healthy development.

- MSS did not prioritize Jake's developmental health in the management of his case, as they should have when acting as his parent. As a result, many opportunities to address his suspected developmental delays were missed. Throughout his time in care, concerns about Jake's health and development were raised by Public Health nurses, his family physician, an early childhood psychologist, a pediatrician and one of his foster parents, without sufficient follow-up by MSS. A Public Health nurse indicated that he needed a referral for a developmental assessment at Kinsmen Children's Centre when he was six months old and again when he was 20 months old. When Jake died several months later, he still had not been assessed.

- Jake's fractured femur was not investigated adequately, such that it could not be determined if it was an accidental injury or not. This injury occurred while he was placed in a high-capacity foster home that did not have the standards and procedures required to care for children living there safely and appropriately. Although this home provided some stability for Jake, living in this home was not in his best interests as he was a non-verbal child, cared for by many care providers along with many other children.

The Advocate makes the following recommendations:

- The Advocate recommends that MSS complete a study that includes a review and analysis of the number of moves children and youth experience in out-of-home care and to provide a report to the Advocate. The study should include a random sample of children involved in various types of care in the past two years, the number of moves, rationale for each move and method by which it was

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approved. A study of this sort should provide MSS with the necessary information to thoroughly understand points of intervention to minimize the number of moves that children experience.

- The Advocate recommends that MSS fully implement the software for the "Linkin" Information Database to allow for data collection to monitor the number of placements of children and youth in out-of-home care provincially.

- The Advocate recommends that the Government of Saskatchewan amend *The Child and Family Services Act* (or any legislation replacing this *Act*) or its regulations for the licensing of foster homes, to provide accountability for both MSS and for foster parents, improve public confidence and help ensure that the rights, interests and well-being of children are being respected.

- The Advocate recommends that MSS develop policy for new foster or group home resources that fall outside of the parameters of policy to ensure that Assistant Deputy Minister approval is granted as recommended in the Joint Child Death Review and appropriate operating procedures are developed and implemented prior to the opening of the resource.

- The Advocate recommends that MSS conduct a provincial review of its open foster and group homes as part of the Quality Assurance yearly program review process to ensure that homes are operating as per policy. For those that are operating outside of policy ensure that Assistant Deputy Minister approval is granted, as recommended in the Joint Child Death Review and appropriate operating procedures are developed and implemented.

- The Advocate recommends that MSS amend policy to conduct mandatory investigations of foster home incidents involving highly vulnerable children, including documentation and gathering information from collateral sources such as staff and other children in the home.

- The Advocate recommends that MSS require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies in the Children's Services Manual.

This report is called “Lost in the System” as it appeared in this investigation that while Jake's physical whereabouts were known, his needs and best interests were lost as he moved between caregivers, and the many concerns raised about his developmental delays were lost through inadequate case management, inaccurate documentation and a lack of coordination of services. Jake himself did not have a voice, as he had not yet learned to talk when he passed away four days before his second birthday. This report is intended to restore his voice to the extent possible, so that we can make improvements in child and youth-serving systems for other children.

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ADVOCATE'S RECOMMENDATIONS

The Advocate acknowledges the significant changes that have been made since Jake's death in care. A comprehensive review was conducted and subsequent recommendations have been made and implemented. Many of the deficiencies found in the services MSS provided have been addressed. The following recommendations emerge out of the Advocate's findings and reflect the Advocate's position on what still needs to change to ensure better outcomes for children in care.

Recommendation 1: *That the Ministry of Social Services complete a study that includes a review and analysis of the number of moves children and youth experience in out-of-home care and to provide a report to the Advocate. This study should include:*

- *A random sample of children in emergency receiving homes, regular foster homes, group homes, and alternate care from the past two years;*
- *the number of moves and rationale for each move a child in the sample experienced; and*
- *the method of approval for the moves.*

Multiple moves in foster care is a persistent concern reported to the Advocate and found within many of our investigations. A study of this sort could provide MSS with the necessary information to thoroughly understand points of intervention to minimize the number of moves that children experience. In Jake's case, concerns were raised by the MSS worker and a foster mother related to the number of moves he experienced in a short time. These concerns were not addressed and Jake continued to experience additional moves that may have inhibited his development and well-being.

Recommendation 2: *That the Ministry of Social Services fully implement the software for the "Linkin" Information Database to allow for data collection to monitor the number of placements of children and youth in out-of-home care provincially.*

As indicated earlier, research shows the detrimental effects of multiple moves on a child's development. MSS must be proactive in minimizing the number of moves a child experiences. If the MSS cannot monitor the number of placements of children in care, their situation is difficult or impossible to address.

Recommendation 3: *That the Government of Saskatchewan amend The Child and Family Services Act (or any legislation replacing this Act) or its regulations for the licensing of foster homes.*

The Advocate has raised concerns about the safety of children in foster care for the last two decades, released a major report on overcrowding in foster homes in 2009, and has open recommendations on licensing.[1] Overcrowding in foster homes can overwhelm a caregiver's ability

[1] See page 60 (6.13: It is the Time to Legislate and Regulate) and page 74 (Recommendation 31) in Saskatchewan Children's Advocate Office (former name). *A Breach of Trust: An Investigation into Foster Home Overcrowding in the Saskatoon Service Centre*. February 2009. and pages 25 and 26 (6.3: Licensing and Accreditation of Residential Resources) in Children's Advocate Office (former name). *Change for Children and Youth: A Submission to the Saskatchewan Child Welfare Review*. June 2010. Published as part of the 2010 Annual Report. Both are available at www.saskadvocate.ca under Special Reports and Annual Reports.

to keep children safe and provide the kind of nurturing environment they need to develop optimally. Licensing provides accountability for both the Ministry of Social Services and for foster parents, improves public confidence, and helps ensure that the rights, interests and well-being of children are being respected. Alberta, Manitoba, and Ontario all license foster homes and licenses must be renewed on an annual basis. Saskatchewan already has a good model to follow with *The Child Care Act* and *The Child Care Regulations* for licensing and inspecting child care centres and homes. This legislation includes provisions around meeting children's developmental needs, child to staff ratios, the physical environment, including sleeping areas, health, safety, nutrition, hygiene and procedures for reporting incidents.

Recommendation 4: *That the Ministry of Social Services develop policy for new foster and group home resources that fall outside of the parameters of policy to ensure:*

- *Assistant Deputy Minister approval is granted as recommended in the Joint Child Death Review; and*
- *appropriate operating procedures are developed and implemented prior to the opening of the resource.*

The Advocate does not endorse child welfare services that are not in accordance with MSS policy. However the Advocate acknowledges the need to find unique solutions to the lack of foster home resources. The above requirements are necessary for MSS to achieve an equitable standard for accountability, and the safety and well-being of children.

Recommendation 5: *That the Ministry of Social Services conduct a provincial review of its open foster and group homes to ensure that homes are operating as per policy. For those that are operating outside of policy ensure:*

- *Assistant Deputy Minister approval is granted as recommended in the Joint Child Death Review; and*
- *appropriate operating procedures are implemented.*

In response to Jake's death, a thorough review has already been completed in the Centre Service Area. An assessment of services in the remainder of the province is necessary to determine if the needs and best interests of the children are being met. MSS does conduct reviews on a representative sample of foster and group homes on an annual basis; however, this does not provide a complete picture of all environments where children are placed.

Recommendation 6: *That the Ministry of Social Services amend policy to conduct mandatory investigations of foster home incidents involving highly vulnerable children, including documentation and gathering information from collateral sources such as staff and other children in the home.*

The Advocate understands that the policy on investigations of alleged abuse and neglect allows for significant discretion in whether or not to investigate. The Advocate is concerned that highly

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vulnerable children (children under three, non-verbal, developmentally delayed, severe medical needs, extreme behavioural issues) may not be afforded a high standard of review regarding injuries that occur in out-of-home care. In Jake's case, there were three different explanations of how his fractured femur occurred. It is imperative to interview relevant collateral sources to ensure due diligence in the matters of safety and protection.

Recommendation 7: *That the Ministry of Social Services require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies in the Children's Services Manual.*

The Advocate acknowledges that a child's immediate safety and protection is the priority and children may need emergency placements. However, these children still have a right to safety, security, and protection. Therefore, the number of children in a home must be kept to an acceptable number. While the Lawson Heights home was approved for 10 emergency placements of two weeks, some children stayed for much longer, compromising the level of care, supervision, and nurturing they received. Adhering to these policies would ensure that decision to exceed the recommended number of placements in a home requires a new assessment of the foster parent's capacity and additional resources required, such as In-Home Support staff.

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