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Advocate for Children and Youth releases investigation of toddler's death in overcrowded foster home

SASKATOON—Bob Pringle, Saskatchewan's Advocate for Children and Youth, released his report *No Time for Mark: The Gap Between Policy and Practice* today. It is an investigation into a toddler in the care of the Minister of Social Services, who passed away in an overcrowded foster home.

This child, referred to as "Mark" in the report, was found face down in the bathtub by his foster father on the evening of June 8, 2010. The Coroner determined that the medical cause of death was drowning, and the manner was accidental. The circumstances of his death were the subject of a court case as the foster mother was charged with criminal negligence causing his death. The matter proceeded to court and she was found not guilty.

Mark'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 Mark 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 report includes reference to past recommendations made in previous reports and nine new recommendations, which are reprinted in full in the attached backgrounder.

Mark entered foster care at the age of seven months, due to concerns regarding mental health and domestic violence in his family. For the majority of his time in care, Mark was cared for by extended family members until they could no longer care for him. At that point, he entered foster care. The Ministry of Social Services was in the process of approving a different extended family member to care for Mark, but this process was not completed before he passed away.

On April 12, 2010, Mark was placed into a foster home which was overcrowded. The foster home had been approved to care for three foster children. When Mark was placed in the home, he was the fifth child under four years of age. The foster home only had one bedroom for foster children and they used a basement bedroom for Mark and another foster child. The foster parents were not provided additional support to assist them to care for the number of children in their care.

"Although I recognize that the Ministry of Social Services has made attempts to address some critical issues in the child welfare system since Mark's death five years ago, both this investigation and our more recent ones into children's deaths in care have made it clear that there are persistent issues in noncompliance with policy," said Advocate Bob Pringle. "This is a systemic problem."

Systemic issues identified in the report include the lack of quality case management and supervision, lack of policy compliance generally, adherence to required contact standards when a child is placed into an out-of-home resource, the quality of investigations, and the continued need to place children in foster homes which are over their recommended capacity.

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Pringle has continued to call for foster homes to be licensed, to improve public confidence that the government is accountable and raise the bar to the highest level in ensuring that the rights, interests, and well-being of children and youth are respected.

"The intent of licensing is so that foster parents can be better supported to care for some of the province's most vulnerable children," said Pringle. "While I agree that the Ministry of Social Services has good policies to provide accountability and oversight of the foster care system, I would like to see these policies embedded in law, to ensure that they are upheld."

"Like 'Jake' before him, whose death we reported on in September 2014, Mark did not get the good start in life to which all children are entitled," Pringle said. "I simply cannot understand why the Ministry of Social Services did not provide the support needed to Mark's foster parents to keep the young children in their care safe. At the time of Mark's death, his parents were waiting for the Ministry of Social Services to move Mark to be cared for by an extended family member, which is tragic."

"Under the United Nations *Convention on the Rights of the Child*, Mark had the right to be safe, to be protected, and to have the supports to reach his full potential, as do all our children and youth. Our investigation found that Mark's rights were violated, and that this was a preventable death," said Pringle.

The Advocate for Children and Youth is an independent officer of the Legislative Assembly of Saskatchewan. He leads a small team of 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 ON *NO TIME FOR MARK; THE GAP BETWEEN POLICY AND PRACTICE*

This backgrounder consists of the Executive Summary and the Advocate's Recommendations excerpted from the full report, No Time for Mark: The Gap Between Policy and Practice, which is available at www.saskadvocate.ca.

EXECUTIVE SUMMARY

This report is an examination of the services provided by the Ministry of Social Services (MSS) to a young child we have called Mark, and to his family. Mark was in the care of MSS from the age of seven months until his death at age twenty two months. As per the legislation governing this office, the report does not identify Mark by his real name.

Mark was born on August 6, 2008 and was being cared for by his mother. MSS had previous involvement with Mark's family due to issues of mental health and domestic violence. After Mark was born, the MSS became involved with Mark's mother when these issues persisted. On March 13, 2009, Mark and his older brother were apprehended by MSS due to reported concerns about Mark's mother's ability to care for them. As a result, the children were placed with extended family members.

MSS was involved with Mark's mother through the use of voluntary agreements until the fall of 2010 when it was determined that Mark's mother was not making the necessary changes to be able to resume care of her children. MSS took the matter to court and Mark was made a temporary ward. At that time, MSS considered whether Mark's father and extended family could be a permanent resource for him.

For the majority of his time in care, Mark remained with extended family until they could no longer care for him. On April 1, 2010 Mark was moved to the Saskatoon Crisis Nursery for 12 days until a foster care placement could be found. MSS was in the process of approving another extended family member as a resource for Mark but it was not completed before he passed away.

On April 12, 2010, Mark was placed into a foster home. The foster home had been approved to care for three foster children. When Mark was placed in the home, he was the fifth child and all of the children were under four years of age. The foster home only had one bedroom for foster children and they used a basement bedroom for Mark and another foster child. The foster parents were not provided any additional support to assist them to care for the number of children in their care.

Mark died on June 8, 2010 and the circumstances of his death were the subject of a court case as the foster mother was charged with criminal negligence causing his death. The matter proceeded to court and she was found not guilty. The Coroner ruled that Mark's death was accidental.

The purpose of this investigation is to determine whether MSS provided Mark and his family services to which they were entitled. It is also to identify whether there were any gaps in service provision or compliance with policy or procedures that may have contributed to or failed to prevent the events that lead

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to Mark's death. Based on the findings of the investigation, the report makes recommendations to improve the delivery of services and ensure that the rights of children are upheld.

Key findings of the report include:

- MSS failed to keep Mark's best interest foremost when they arranged for his placement into an overcrowded foster home without any assessment of the home's capacity to manage five young children placed in their care, contrary to policy. MSS did not act quickly to approve extended family to become a resource for him and the conditions under which he resided were not seen by his caseworker. MSS did not take any steps when alerted to the deficiencies of the home or in Mark's case file. The investigation found that MSS did not act as a prudent parent and violated Mark's rights to a safe and secure environment while in their care. In this regard, the investigation concluded that Mark's death was preventable.

- The investigation found countless occasions when MSS practice did not meet the requirements of policy; and in particular in the absence of required case assessment and child development and assessment plans and child contact standards. The noncompliance with policy affected MSS's ability to ensure that Mark and his family received the services to which they were entitled. • MSS's practices did not follow policy requirements with respect to the approval and oversight of the foster home. Policy was not followed when MSS conducted an investigation of the foster home. MSS did not properly assess the foster home when they decided to place more than three children in their care and allowed the foster home to be in an overcrowded situation without support services.

- Supervisor and senior management oversight were not effective to ensure that policy was followed. There was an absence of critical thinking when Executive Summary matters were reviewed and approvals were provided with insufficient information to make decisions. On a number of occasions, supervisory approval was provided despite noncompliance with policy.

- The issues of overcrowded foster homes and workload remain a concern. Overcrowding continues to impact the ability of MSS to ensure appropriate resources are available for children.

The Advocate recognizes in the five years since Mark's death, MSS has made significant changes toward improving the services provided to children and families. However, systemic issues remain, pertaining to the lack of quality case management and supervision, lack of policy compliance generally, adherence to required contact standards when a child is placed into an out-of-home resource, the quality of investigations, and the continued need to place children in foster homes which are over their recommended capacity.

The recommendations from this investigation include several which are relevant from special investigations released in 2014. Relevant recommendations from *Two Tragedies: Holding Systems Accountable* are: that MSS ensure high quality child protection casework by evaluating the use of the SDM tools; provide certification and clinical oversight in their use; and contract with the Children's Research Centre to conduct a workload estimation study that determines standards for caseload size in Saskatchewan, to then be implemented.

Relevant recommendations from *Lost in the System: Jake's Story* are: that MSS conduct a review and analysis of moves children and youth experience in out-of-home care; that MSS implement the software in

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their database system to track these moves; that the Government of Saskatchewan license foster homes; that MSS conduct mandatory investigations of foster home incidents involving highly vulnerable children; and that MSS require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies.

In Mark's case, the Advocate recommends:

- That MSS conduct a review and amend its policies pertaining to the investigation of foster homes to ensure that investigations are conducted in a thorough and comprehensive manner, and are compliant with the principles of fairness.
- That MSS provide training to staff who are assigned to conduct or supervise foster home investigations related to the principles of fairness and their application to an investigation process.
- That MSS conduct a review of their foster home program, in order to determine those factors that have resulted in a rapid decline in the number of foster homes, and that includes a plan to address this decline. • That MSS amend its policy to require that an In- Home Support contract and required staff are in place prior to the placement of a child, when it is assessed that a foster home requires In-Home Support services.
- That MSS evaluate the recent changes made to the structure of its placement process and provide a report to the Advocate for Children and Youth in six months that outlines the impact of those changes on the ability of staff to match a child to an out-of-home resource. • That MSS include the use of the Structured Decision Making® placement matching tool, or similar tool to guide placement matching decisions.
- That MSS develop internal procedures to ensure that issues requiring immediate attention, as identified through a Quality Assurance Unit review, are addressed in a timely effective manner and the actions are reported back centrally.
- That MSS create and implement procedures in their current policies related to a critical incident or child death around how natural families are notified and provided with support services, and how the First Nations bands or agencies are notified.
- That MSS offer a formal letter of apology to Mark's parents for not acting in Mark's best interests during the time of his last foster home placement.

Mark's story demonstrates how tragic events can occur when there are repeated failures to follow policy, and when oversight mechanisms fail to address matters of persistent noncompliance. I have called this report *No Time for Mark: The Gap Between Policy and Practice* because the repeated evidence of noncompliance cited in this investigation illustrate that MSS staff did not take the time to follow policy and provide Mark and his family with the services to which they were entitled. While it is too late for Mark, it is our hope that with this report, we can close the gap between policy and practice for children who come after him.

ADVOCATE'S RECOMMENDATIONS

It has been five years since Mark's death, and the Advocate recognizes that MSS has made significant changes toward improving the services provided to children and families. Improvements such as implementing the Structured Decision Making® risk assessment tools have arguably made a better system for evaluating risk and improved planning in working with families due to the elements of structured rigorous assessment and increased case management procedures. The new electronic database for documenting

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and sharing information, enhancing case documentation and increasing supervision, along with its ability to track foster homes for available spaces, is noted. MSS policy with respect to building, health and safety requirements has also undergone significant changes. Safe sleeping standards are included in policy and do not permit the use of playpens as beds, except for very limited periods of time, and specify that children under age eight sleep in an area where a capable adult has ready access in case of an emergency.

In spite of these changes, my office observes the continuation of chronic and persistent systemic issues pertaining to the lack of quality case management and supervision, lack of policy compliance generally, adherence to required contact standards when a child is placed into an out-of-home resource, the lack of thoroughness and integrity of investigations, and the continued need to place children in foster homes which are overcrowded or over their recommended capacity. Several themed findings highlighted in this investigation were also found in two of our other reports entitled *Two Tragedies: Holding Systems Accountable* and *Lost in the System: Jake's Story* that we released in 2014. Recommendations made in those reports are relevant to the findings of this investigation, and as such, are restated below. The rationale for restating these recommendations is to highlight the importance of addressing them to improve quality outcomes. In addition, the findings from Mark's case have generated some new recommendations that are required to address deficiencies in practice.

1. Relevant Recommendations from *Two Tragedies: Holding Systems Accountable*

#14-24031

That the Ministry of Social Services ensure high quality child protection casework by implementing:

- ***a method for evaluating the quality of case practice and decision-making (focusing on integrity/fidelity in the use of SDM® tools);***
- ***a formal competency based certification program to develop staff competence in the use of SDM® tools; and***
- ***a method for clinical oversight for effective supervision and monitoring of casework to ensure identified needs are incorporated into the case plan and policy standards and compliance are met.***

Mark's mother was a young person who was transitioning from receiving services from MSS to becoming a parent. The Advocate remains troubled by MSS's commitment to young people who transition to adulthood without adequate support and services. Mark's mother faced considerable challenges in her new role as a parent, and MSS did not adequately assess or provide the services she needed. There also did not appear to be effective clinical oversight when the services that were provided did not seem to be helping her achieve the plan to reunite her with her children. Further, MSS consistently did not consider the role of Mark's father in his life, despite the fact that he remained a key figure in the lives of his children.

The Advocate understands that MSS has accepted this recommendation from the *Two Tragedies* report, and we will continue to monitor the process of its implementation.

#14-24032

That the Ministry of Social Services contract with the Children's Research Centre to complete an SDM® workload estimation study that establishes caseload policy standards for Saskatchewan. Once the study is completed, implement the recommended standards.

Workloads were identified as the reason MSS staff were not able to complete the case planning as required by policy in managing Mark's case. Delays in completing the report of the foster home investigation, in

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conducting required home safety checks and the annual review of the foster home were also attributed to workloads. Further workload and staffing issues were cited as the reasons another MSS region could not assist with completing the home study of the extended family that was willing to be a resource for Mark.

MSS has accepted this recommendation and has reported that they are currently in the initial stages of developing the scope of the study and sites in which to pilot test it. The Advocate is concerned that nearly a year has passed and the study parameters are still in the developmental stages. Workloads continue to be cited as a theme to rationalize noncompliance with policy. It is imperative that MSS prioritize this study to fully understand what is required to ensure that practice is followed. The Advocate will continue to monitor the full implementation of this recommendation.

2. Relevant Recommendations from *Lost in the System: Jake's Story*

In our other recently released public report *Lost in the System: Jake's Story*, recommendations were made that are relevant to the current concerns the Advocate has regarding the number of moves a child experiences, foster home care and licensing of foster homes.

#14-24048

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-ofhome care and provide a report to the Advocate. This study should include:

- *a random sample of children in emergency receiving homes, group homes and alternative 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.*

#14-24049

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.

Data collection is essential to assist MSS in monitoring the number of placements of children in care and in minimizing the number of moves a child experiences. As was the case with Jake, as described in *Lost in the System: Jake's Story*, Mark experienced a number of moves as a result of placement breakdowns with his alternative care provider. Information about the number of moves and rationale for them could provide MSS with information about what types of supports or services might be appropriate to limit moves. Acquiring and acting on this knowledge will assist out-of-home care providers and prevent additional moves for children, thus minimizing the additional trauma children experience every time they are moved.

MSS has indicated that it has completed a report that addresses both of the above recommendations which the Advocate is currently reviewing. These are cited as relevant to Mark's case and, pending our assessment of the report, there may be more information and follow-up required to satisfy this recommendation.

#14-24050

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.

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Over the course of six years, the Advocate has called for licensing foster homes in the *Breach of Trust* report, and *Lost in the System: Jake's Story*. The case of Mark again illustrates the need for licensing as a mechanism to ensure accountability for MSS and for protection of foster parents. Licensing will improve public confidence that the government is accountable and it will raise the bar to the highest level in ensuring that the rights, interests, and well-being of children and youth are respected.

As indicated in my previous reports, Alberta, Manitoba and Ontario all license foster homes and these licenses must be renewed on an annual basis. In the case of Mark, the foster mother had been licensed in Alberta to foster only two children. Their tiered system provides a mechanism in law that ensures capacity is not exceeded unless the foster parents are approved legally for more children. This high level threshold rooted in law is critical in protecting children and the parents who care for them. In this investigation, the Advocate learned that MSS used the other province's home study, which assessed their capacity for only two children, to approve them to foster in Saskatchewan, yet placed five children under the age of five in their care, and at one point asked them about taking a sixth child. The rationale for licensing is the accountability of following law, not simply policy that can change at any given time. Saskatchewan has a good model to follow with its *Child Care Act* and *Child Care Regulations* for licensing child care centres and homes. Entrenching provisions in law will provide the safety net required to ensure the highest standard of care and protection for children in out-of-home care, who are some of our most vulnerable citizens.

MSS has indicated previously that it has not accepted this recommendation to license foster homes, as they are confident that MSS policies are sufficient to provide accountability and oversight of the foster care system.

#14-24053

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.

In Mark's case, early complaints about care provided to an infant in the care of the foster parents were not formally investigated. Amendments to policy would ensure sound decision making and provide clear direction to staff about the need for investigations for highly vulnerable children, such as those under age three, non-verbal children, developmentally delayed children, or those with high medical or behavioural needs, all of whom require the highest level of protection.

#14-24054

That the Ministry of Social Services require strict adherence to the "Maximum Number of Children in a Foster Home" and "Foster Home Review" policies.

As illustrated in Mark's case, there were many times when this foster home was over its recommended number of children for placement. Managerial approval and oversight was not adequate to ensure that policies regarding placing more than four children in a home were followed. The Advocate is also concerned about situations in homes with the maximum number of foster children residing in them that also have other children residing there, as the maximum number of children only considers foster children, not biological or adopted children who may also be living in the home. Situations have come to our attention in which foster parents are overcrowded with foster children, and are caring for other children as well, which has not been considered when placing foster children in the home. We are currently exploring this issue with MSS.

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3. Advocate's Recommendations in Mark's Case

As noted above, the Advocate is making the following recommendations specific to this investigation, in addition to those made in our other reports. Although Mark's death occurred five years ago, issues of noncompliance with policy and practice standards continue to be as deeply troubling today as they were five years ago. The Advocate recognizes MSS's attempts to address some critical issues to work toward improving quality outcomes for children in care. Unfortunately, the themed findings we identify in this death five years ago are the same as those we see today in our investigations, which tells the story of a systemic problem. This can only be solved with a systemic solution that is rooted foundationally in a competency-based mentoring process for practice improvements that focus on improving quality outcomes. The above recommendations speak to this, in addition to these new recommendations that are warranted to improve policy and practices and address gaps in MSS's provision of services.

Recommendation 1: ***That the Ministry of Social Services conduct a review and amend its policies pertaining to the investigation of foster homes to ensure that investigations are conducted in a thorough and comprehensive manner, and are compliant with the principles of fairness. The following elements of the existing policy need to be amended to ensure:***

- independence in assignment of the investigation to ensure that the investigating officer has no relationship with the foster home or any staff associated with the home;
- the inclusion of practice guidelines in the assessment and documentation of evidence;
- the inclusion of a Structured Decision Making® risk assessment tools or similar tools to assist staff in making decisions about if or when children must be removed from a foster home when an investigation is undertaken; and
- an outline of the assessment required to determine the family's ability to provide a safe and nurturing environment for children placed in their care.

Recommendation 2: ***That the Ministry of Social Services provide training to staff who are assigned to conduct or supervise foster home investigations related to the principles of fairness and their application to an investigation process.***

There were numerous shortcomings in the investigation into the complaints about the foster home where existing policy did not appear to provide sufficient direction to staff and managers about what was needed to conduct a comprehensive investigation. Use of a consensus approach compromised the independence and thoroughness of the investigation. It is critical that an independent and objective framework and approach is used to ensure due diligence. Although there have been changes to the policy that clarify the requirements to conduct a thorough investigation, further amendments and staff training are needed to ensure that children in care are protected, and that foster parents are treated fairly when an investigation commences.

Recommendation 3: ***That the Ministry of Social Services conduct a review of their foster home program, in order to determine those factors that have resulted in a rapid decline in the number of foster homes, and that includes a plan to address this decline.***

As indicated above, the Advocate has previously made a similar recommendation in *Lost in the System: Jake's Story* which calls for a provincial review of foster homes. The purpose of this recommendation is to understand the landscape of operational compliance for these homes. The spirit of this recommendation is to understand and strategize how to address the issues which have led to a decrease in the number of foster homes, in order to engage in proper planning to avoid a potential resource crisis.

Recommendation 4: ***That the Ministry of Social Services amend its policy to require that an In-Home Support contract and required staff are in place prior to the placement of a child, when it is assessed that a foster home requires In-Home Support services.***

In-Home Support services were never in place for the foster home where Mark was placed, despite the fact that this home was repeatedly over its assessed capacity. The foster parents were not provided with adequate information about how the program operated, and there was a lack of communication about who was managing the process, which together resulted in a missed opportunity to put needed services in place when Mark was in the foster home. In-Home Support services would have provided the foster home with increased ability to provide a safe and nurturing environment for the children in their care.

Recommendation 5: ***That the Ministry of Social Services evaluate the recent changes made to the structure of its placement process and provide a report to the Advocate for Children and Youth in six months that outlines the impact of those changes on the ability of staff to match a child to an out-of-home resource.***

Recommendation 6*: That the Ministry of Social Services include the use of the Structured Decision Making® placement matching tool, or similar tool to guide placement matching decisions.*

The placement process in Mark's case was not able to ensure that the policy provisions in matching a child to a resource could be met. It is imperative that the new process is reviewed and changes made, so that the best resource can be arranged for a child who requires a foster home placement. Use of an SDM® or similar type of tool would support best practices and ensure that all staff are using the same considerations when making a decision about the rationale for placement of a child into a particular foster home.

Recommendation 7: ***That the Ministry of Social Services develop internal procedures to ensure that issues requiring immediate attention, as identified through a Quality Assurance Unit review, are addressed in a timely effective manner and the actions are reported back centrally.***

The opportunity to review Mark's case was missed when MSS staff did not immediately respond to the findings of the Quality Assurance review. The immediate review of Mark's case may have shed light on the failed home safety check and the reason for delays in the approval of extended family as a resource for Mark. Requiring that actions are reported back to MSS's central Quality Assurance Unit will improve accountability when deficiencies are found.

Recommendation 8: ***That the Ministry of Social Services create and implement procedures in their current policies related to a critical incident or child death that includes*:**

- immediate notification to the natural family by a Ministry of Social Services supervisor or manager that includes all pertinent information available;
- immediate offers of support services and regular follow up with family members to address issues of grieving and loss; and
- immediate notification to the First Nations bands or agency by a Ministry of Social Services manager that includes all pertinent information available.

The manner in which MSS managed notification to Mark's parents when he died failed to deal with their profound loss and the severity of the situation. Immediate notification to the First Nations agency by a senior manager is also required. This issue was raised in the *Breach of Trust* report prior to Mark's death. In their response, MSS's view that the policy was sufficient failed to anticipate the need for very specific guidelines during a time of crisis.

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Recommendation 9:*That the Ministry of Social Services offer an immediate formal letter of apology to Mark's parents for not acting in Mark's best interests during the time of his last foster home placement. The apology must acknowledge that*:

- the Ministry of Social Services did not make a proper assessment at the time Mark was placed into this foster home;
- the Ministry of Social Services did not act quickly in its approval process for another resource for Mark;
- the Ministry of Social Services failed to take opportunities to review Mark's case when notified there were deficiencies; and
- the Ministry of Social Services did not take appropriate steps to immediately notify Mark's parents of his death, prepare them for how he died, or continue to reach out to them after he died. The letter of apology should also include an offer to each parent of any resources that they may still need in dealing with their grief in the loss of their child.

Our office has long advocated for the transformation of the child welfare system towards reconciliation and reparation. The Touchstones of Hope were formally adopted by the Advocate for Children and Youth to speak to the principles of reconciliation in child welfare that holds relationship-building, acknowledging, truth telling and restoring as paramount principles for improving outcomes for children, youth and their families. The Ministry of Social Services has also adopted the Touchstones principles at the encouragement of our office.

The first step towards redress and reconciliation in its very simplest form is that of an apology. Although many years have passed since Mark's death in foster care, an apology provides his parents with an acknowledgement of MSS's failures to act in Mark's best interests. Apologies are the foundation of relationship-building or, as the case may be, re-building, and are an act in the spirit of reconciliation. An apology would pave the way forward for rebuilding relationships and healing the painful loss of Mark for his family and community, whereby MSS acknowledges their accountability for their actions.

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

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