SASKATCHEWAN advocate

a Voice for Children and Youth

MEDIA RELEASE

Embargoed until 1:45 pm, May 14, 2014

Advocate for Children and Youth Releases Report into Child Death

REGINA—Bob Pringle, Saskatchewan's Advocate for Children and Youth, released his special report *Two Tragedies: Holding Systems Accountable* today. This report is an investigation into the death of a six-year old child, and the suspected involvement of another child, aged 10.

The death of this child, referred to as "Sam," occurred while he was visiting a rural community with his foster mother. The other boy involved lived in this community. The names of the boys were 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 second boy in the report is referred to as "Derek."

The primary focus of the report is an examination of the services both boys received, or should have received, by child welfare agencies. The report also focuses on the Ministry of Social Services' oversight of its own child welfare services, and those provided under the formal agreements with First Nations Child and Family Service Agencies. Sam was in the care of the Ministry of Social Services at the time of his death. Derek and his family were receiving services from Yorkton Tribal Council Child and Family Services Inc.

"This special investigation report is essentially three investigations in one," said Pringle. "We examined the services Sam and his family received, the services Derek and his family received, and the oversight by the Ministry of Social Services of its own services and the services provided by this particular Agency."

The 44 page report includes 18 recommendations, which are included in full in the attached backgrounder.

Highlights include:

- Sam was provided with outside services such as programming and counselling to address his needs. However, there were gaps in services to his parents. The Advocate identified that improvements need to be made in the timeliness and delivery of the services by both the Ministry of Social Services and the Agency to avoid such incidents from happening again.

- The Advocate found significant gaps in services provided to Derek and his family by the local Agency. Derek has complex needs, was diagnosed with a developmental disorder shortly before Sam's death, and likely should not have been in the community unsupervised on the evening that Sam died. In addition, the Agency had been alerted to Derek's behavioural issues by both the local RCMP detachment and by school officials, yet his needs remained unaddressed.

- These children and their families faced challenges, and would have benefitted from better access to prevention and early intervention services.

- Both the Ministry of Social Services and the Agency need to improve their casework to prevent these types of incidents from recurring. This means greater adherence to procedural guidelines for conducting child welfare casework, as well as greater attention to the workload of social workers to ensure that these policies are consistently implemented. Improved supervision of casework must also be a higher priority of the Ministry and the Agency.

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- The Advocate recommended expansion of the medical supports for families in rural and remote areas, to better serve children with developmental needs. He also recommended an improved joint critical incident review process for the Ministries of Social Services and Health for cases like this.

- The Advocate called on the Ministry of Health to examine their critical incident review policies in cases such as this one.

- The Advocate called on the Ministry of Social Services to improve its oversight of agencies delivering child welfare services. He has asked both the Ministry of Social Services and the Agency to report back to him every three months for the next year on the actions they have taken to address the concerns and recommendations raised in the report.

The Advocate noted that Derek is in the care of the Agency now and is receiving the supports he needs. He will likely require close supervision for many years to come.

"This incident was a very serious one, and one I do not want to see repeated," said Pringle. "No child deserves to have their life ended, as Sam's was. At the same time, no child deserves to have his needs ignored as Derek's were."

"Our commitment to the United Nations *Convention on the Rights of the Child* must be accompanied by a firm resolve by all child-serving agencies to ensure that children are safe when at home and in care."

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
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BACKGROUNDER ON TWO TRAGEDIES: HOLDING SYSTEMS ACCOUNTABLE

This backgrounder consists of the Executive Summary and the Advocate's Recommendations excerpted from the full report, Two Tragedies: Holding Systems Accountable, which is available at www.saskadvocate.ca.

EXECUTIVE SUMMARY

This report examines the lives of two young boys we are calling "Sam" and "Derek", whose paths crossed tragically on August 21, 2013. As per the legislation governing this office, we have not identified the real names of these children. The report includes a review of the services both boys received from the Ministry of Social Services (MSS) and the Yorkton Tribal Council Child and Family Services Inc. (the Agency) leading up to Sam's death. It is also a review of the mechanisms and structures for accountability by those responsible to ensure that quality standards for child protection are being upheld in this province

Sam was six years old at the time of his death. He was in the care of the Ministry of Social Services (MSS) and was living in a foster home. The RCMP determined that Sam was a victim of homicide, and believes that Derek, age ten at the time, was responsible. At the time of the incident, Derek was living with his mother and was receiving services from Yorkton Tribal Council Child and Family Services Inc.(the Agency). In accordance with the *Youth Criminal Justice Act*, Derek was not charged with an offence as he was under the age of 12. Rather, *The Child and Family Services Act* states that a child under 12 who is suspected of committing a criminal offence may be considered to be in need of protection. Derek was determined to be in need of protection and was taken into care by the Agency. He remains in their care.

In conducting this investigation, we are not passing judgment on Derek's guilt or innocence. He will never be charged with an offence in relation to this incident. The purpose of this report is to determine whether these children received the services to which they were entitled and make recommendations to improve the capacity of child-serving systems to ensure the rights of children are upheld. The lessons learned here are critical to guiding future case practice for other children with circumstances similar to those of Sam and Derek. Child-serving systems must provide equal standards of care to all children in Saskatchewan, while promoting the best interests, safety and protection of the children they serve, if tragedies such as this are to be prevented.

Key elements of the report include:

- Sam received many supports from his school and MSS in the two years prior to his death. He was living with his mother when he was apprehended by MSS in June 2013. Sam's mother was experiencing mental health issues and MSS determined that Sam needed to be apprehended for his own safety.

- Our investigation found that some MSS policies and procedures were not followed respecting the services provided to Sam and his family. This resulted in MSS having less than complete information to make timely and accurate decisions for Sam's family and his care.

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- In particular, MSS should have sought more timely assistance for Sam's mother at a crucial period in her life, and when they did apprehend Sam, they should have explored additional options to keep Sam with his family.

- Derek and his family were clients of the Agency and he was living with his mother on a First Nation at the time of Sam's death. He is a vulnerable child with complex needs that were not met. Derek was ten years old when he was diagnosed with Fetal Alcohol Syndrome, which is part of Fetal Alcohol Spectrum Disorder (FASD).

- The RCMP and his school had reported concerns to the Agency about Derek's needs, however these were not adequately followed up by the Agency.

- This investigation found the Agency failed to act when Derek required protection, and failed to provide services to address his complex needs.

- The Advocate recognizes that these children and their families faced challenges, and believes that they would have benefitted from better access to prevention and early intervention services.

- The Advocate recommends that the Government of Saskatchewan invest in well-resourced early childhood development and poverty reduction strategies to advance the goals of its Child and Family Agenda.

- The Advocate recommends a number of improvements to casework practices by child protection staff within MSS and the Agency. These include greater adherence to casework procedures and improved oversight by supervisors.

- MSS has Agreements with First Nations Agencies to provide child and family services to individuals living on First Nations that would otherwise be provided by MSS. MSS continues to be accountable for the safety and protection of all children requiring services under *The Child and Family Services Act*.

- The Advocate recommends that MSS strengthen its oversight of the Agency immediately. The Agency's services must meet provincial standards.

- The Advocate is asking that MSS and the Agency to work collaboratively and to report their progress on the recommendations made in this report to our office.

- The Advocate recommends that the Ministries of Social Services and Health develop a protocol to provide timely services to families and children who are in the child welfare system and experiencing mental health issues.

- The Advocate also recommends the Regina Qu'Appelle Health Region examine whether the criteria for initiating incident reviews of various types need to be adjusted, and that the Ministry of Health and Regional Health Authorities introduce an outreach program for children like Derek in rural and remote areas.

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ADVOCATE'S RECOMMENDATIONS

The multiple reviews and public reports referenced here highlight recurring challenges throughout the child welfare system. The "Baby Andy" Report[1] released ten years ago by MSS and Montreal Lake Child and Family Agency Inc., as well as a review of two child deaths summarized in our office's 2013 Annual Report, identified a number of similar themes and recommendations. Issues related to staffing (including turnover, training and supervision), accountability and compliance with program standards, coordination of services and government support continue to be identified as matters requiring attention to improve the delivery of child welfare services.

The Advocate acknowledges that improvements are being made within both MSS and First Nations Agencies. However, it is clear that more urgency must be placed on the need to move forward on child welfare reform.

The Advocate makes the following recommendations:

Recommendation 1: *That the Government of Saskatchewan develop and implement well-resourced early childhood development and poverty reduction strategies to advance the goals of its Child and Family Agenda.*

Adverse events and conditions early in life cause serious harm to children and youth, and significantly reduce their chances of success as they grow older. Inadequate investment in support for parents and young children has profound social, economic, and personal costs for children, their parents, and society as a whole. Children born with prenatal exposure to alcohol resulting in FASD and the apprehension of children from their parents are two examples of these costs. Government spending on family support and early childhood programs benefits society as a whole—supporting the best interests of children is the right approach. Extensive research shows that this is the most cost-effective way to reduce poverty, encourage economic growth and build strong and supportive communities.[2]

Recommendation 2: *That the Ministry of Social Services and Yorkton Tribal Council Child and Family Services Inc. ensure high quality child protection casework by implementing*:

- a formal process to measure staff competence in the use of SDM® tools;
- a formal process to measure competence in supervision; and
- a standardized supervision tool to assess whether casework policy standards are met.

The SDM® tools alone do not ensure high quality child protection work. SDM®'s effectiveness hinges on staff competence in use of the tools. This not only requires training in the tools, but evaluation of competence in their use. In many complex roles and systems, professionals must demonstrate competency in order to practice (physicians, airline pilots, engineers, and teachers) and child protection should be no different. Strong supervisory skills and oversight are critical to building staff competence. A standardized tool would equip supervisors to transfer their knowledge to frontline workers, promoting better outcomes for children and families.

[1] Saskatchewan Community Resources and Employment/Montreal Lake Child and Family Services Inc. The "Baby Andy" Report: Examination of services provided to Baby Andy and his Family. July 2003.
[2] World Health Organization. Closing the Gap in a Generation: health equity through action on the social determinants of health. Geneva, 2008.

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Recommendation 3: *That the Ministry of Social Services contract with the Children's Research Centre to complete anSDM® workload estimation study that determines standards for caseload size in Saskatchewan. Once the study is completed, implement the recommended standards.*

Supervisors and caseworkers involved with these boys and their families reported to the Advocate that workload demands hindered their ability to comply with policy. The implementation of SDM®, particularly the increased contact standards, has compromised the ability of workers and supervisors to meet the standards set out in policy.

Recommendation 4: *That the Ministry of Social Services amend policy to require a case conference with all key service providers involved with a family within the initial Assessment and Case Plan timeframe (90 days) and thereafter as necessary.*

When a family has an open protection file, MSS must take the lead to ensure services meet identified needs, are coordinated and achieve the intended outcomes. Case conferences are a forum for this integration of planning and services. A policy standard that formalizes this collaboration with other service providers will improve the quality of MSS's work with children and families.

Recommendation 5: *That the Ministry of Social Services strengthen its policy to ensure that scheduled family visits are maintained. The following standards should be embedded in policy*:

- documented supervisory review when a visit is cancelled;
- rescheduling cancelled visits as soon as possible when in the best interest of the child .

Children have a right to family and, when it is safe and in their best interest, this includes the right to regular contact with parents and siblings. For children in out-of-home care whose parents are working to reunify the family, these visits are critical to maintain the parent-child bond and assess the potential for reunification.

Recommendation 6: *That the Ministry of Social Services, in consultation with the Children's Research Centre, amend their Safety and Risk Assessment tools to ensure they support the assessment of each parent's household when parents live apart but there is joint legal custody.*

While *The Child and Family Services Act* and MSS policy speak to preserving and maintaining families whenever possible, the SDM® tools and sections of policy guiding investigation and apprehension do not explicitly guide workers through the process of assessing safety and risk when a child is part of two households. Clarifying policy and embedding consideration of joint custody situations in the assessment tools will ensure that both legal parents are considered before children are placed in out-of-home care.

Recommendation 7: *That the Ministry of Social Services research and implement methods for evaluating the quality of case practice and the outcomes of services for children and families.*

The current quality assurance practices are focused on compliance to policy, not outcomes. MSS needs to equip itself to answer the question: do child and family outcomes improve as a result of their services? To build on the Child Welfare Review recommendations, an improved quality assurance mechanism will be an important factor in the development of an accountability framework.

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Recommendation 8: *That the Ministry of Social Services conduct compliance reviews on First Nations Child and Family Services agencies on a yearly basis, rather than the current practice of every three years.*

Agencies should receive the same level of support and oversight as MSS regional service areas to achieve compliance with policy standards.

Recommendation 9: *That the Ministry of Social Services ensure Child Death and Critical Incident Reviews are comprehensive and include a review of services provided to the child by other service systems. The Ministry of Social Services should consult with these bodies about the development of protocols for information sharing when conducting these reviews.*

These boys were receiving services from multiple systems. Protocols would help the reviewers obtain timely and comprehensive information to assist in development of recommendations aimed at improving the integration of services and continuity of planning.

Recommendation 10: *That Regina Qu'Appelle Health Region examine whether the criteria for initiating incident reviews of various types need to be adjusted, in light of their experience with Derek's case.*

It appears that the current Child and Youth Services review criteria exclude circumstances in which an individual receiving mental health services commits serious harm to someone else, and that no other comprehensive interdisciplinary incident review occurred in a timely way.

Recommendation 11: *That the Ministry of Social Services and the Ministry of Health and their related agencies conduct joint critical incident reviews for children and youth served by both the Ministry of Social Services and the Mental Health and Addictions system within the preceding twelve months.*

Joint reviews would provide an opportunity to identify and address broader systemic issues, including access to and co-ordination of services, in order to determine what could have been done to prevent the critical incident, or to prevent similar incidents in the future.

Recommendation 12: *That the Ministry of Social Services and Yorkton Tribal Council Child and Family Services Inc. develop the protocols identified in their Agreement but not yet in place. Of these, the following protocols should receive immediate priority:*

- staff training, development and support;
- child abuse investigations;
- integrating health, education and family services.

The current Agreement with this Agency is broadly worded and does not provide specific information about the roles and expectations of each party for the delivery of a child welfare program. Protocols would provide this clarity for both parties.

Recommendation 13: *That the Ministry of Social Services increase its knowledge and understanding of Yorkton Tribal Council First Nations Child and Family Services Inc.'s operations to better support their capacity to deliver quality services.*

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Until the recent Critical Incident and Quality Assurance Reviews, MSS did not have detailed information about the operations of the Agency, particularly with respect to its protection and prevention programs. More comprehensive information and open discussions with the Agency about its challenges would have provided the opportunity to work with the Agency to address some of its issues.

Recommendation 14: *That Yorkton Tribal Council First Nations Child and Family Services Inc. fully develop its database system to make all current and historical information accessible to staff that require it.*

Staff did not have access to important information about the Agency's involvement with Derek and his family, therefore risk was not appropriately assessed and services were not provided.

Recommendation 15: *That Yorkton Tribal Council First Nations Child and Family Services Inc. develop policy to create and clarify a working relationship between prevention and protection programming.*

The disconnect between prevention and protection programming impedes the sharing of important information and recognition that a family's level of risk warrants a protection response.

Recommendation 16: *That the Ministry of Social Services and Yorkton Tribal Council First Nations Child and Family Services Inc. provide written progress reports to the Advocate on the applicable recommendations within three months of the release of this report and every three months thereafter for a period of one year.*

The Advocate has the authority to advise government and provide independent oversight of its services. All children have the right to be safe and to live in families. These cases illustrate the urgent need for MSS and the Agency to improve the quality of child and family services. The Advocate's requirement for ongoing reporting reflects this urgency.

Recommendation 17: *That the Ministry of Social Services, Ministry of Health and Regional Health Authorities jointly develop mental health and addiction services to ensure immediate access to mental health and addiction services for high risk families with child protection involvement.*

Complex stressors and multiple risk factors bring families to the attention of the child protection system. Mental health issues and substance misuse are major contributors. These factors impacted both families, neither of whom had timely or reasonable access to treatment, counselling and programs to address their needs. Navigating service systems is challenging and outreach services benefit vulnerable families.

Recommendation 18: *That the Ministry of Social Services, the Ministry of Health, and Regional Health Authorities expand outreach and intervention programs for children with FASD.*

Government support for children with FASD and their families is inadequate in our province, particularly in remote and rural communities. In Derek's case, an assessment was completed, but there were no local resources to assist with intervention. Expanding outreach in these communities will address current unmet needs and the urban-rural disparity. Children living on reserve are entitled to the same standards of health and education services as all other children in the province. Achieving this right will require collaboration with First Nations leaders and the federal government, who funds services for families on reserve.

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