Someone to Watch Over Us

SPECIAL INVESTIGATION
PROGRESS REPORT

November 2021

SASKATCHEWAN
advocate
FOR CHILDREN & YOUTH

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Letter of Transmittal

November 8, 2021

The Honourable Randy Weekes
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina, SK S4S 0B3

Dear Mr. Speaker:

In accordance with section 28 of *The Advocate for Children and Youth Act*, it is my duty and privilege to submit to you and members of the Legislative Assembly of Saskatchewan this special report: *Someone to Watch Over Us – Progress Report.*

Respectfully,

Lisa Broda, PhD
Advocate for Children and Youth

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1.0 Saskatchewan Advocate for Children and Youth Office

The Saskatchewan Advocate for Children and Youth is an independent officer of the Legislative Assembly of Saskatchewan. The Advocate has a broad mandate to work on behalf of young people in Saskatchewan under the legislated authority of *The Advocate for Children and Youth Act*. The core areas of the Advocate's work consist of advocacy, investigations, public education, and research. The Advocate may give notice of investigation into any matter concerning children and youth, including services provided by a provincial ministry, delegated agency of the government, or publicly-funded health entity. The key objectives of an investigation by the Advocate's office are to identify any contributing factors leading to a death or harmful event, and to achieve policy or service delivery improvements through recommendations to the provincial government. The United Nations Convention on the Rights of the Child (UNCRC), to which Canada became a signatory in 1991, is foundational to all core areas of the Advocate's office. In 2009 the Government of Saskatchewan developed and adopted Saskatchewan's Children and Youth First Principles, to acknowledge all and highlight key rights under the UNCRC.

2.0 Introduction

On March 3, 2021, Lisa Broda, the Saskatchewan Advocate for Children and Youth (the Advocate), released a special investigation report into the oversight of group homes for children and youth, a service that is typically contracted out by the Ministry of Social Services (the Ministry).

Entitled *Someone to Watch Over Us*, the Report highlighted a serious group home incident in which Elijah, a seven-year-old non-verbal boy with autism, ran away from his group home in the very early morning hours in June 2020. He was located over one kilometre away in a Tim Horton's parking lot, naked, scared, and confused. The Advocate's report assessed the efficacy of group home oversight and concluded that, "Although the Ministry has many staff engaged in the group home system, it does not have a coordinated oversight or properly resourced scheme that proactively monitors well-defined, measurable quality-of-care indicators." The Advocate made three recommendations to the Ministry to improve the group home system with the proper required oversight to ensure the safety and protection of children in this type of out-of-home care.

This Progress Report highlights recent events in relation to group homes and evaluates the Ministry's progress since the release of the March 2021 Report.

3.0 Recent Developments

Since releasing *Someone to Watch Over Us* in March 2021, the Advocate has received further reports about group home incidents so serious that it has prompted this public follow-up Progress Report on group home oversight.

Additionally, we provide an update on the Ministry's recent review of its regulations that relate to residential care services.

3.1 Prince Albert Group Home Incidents

From late June to early August 2021, disturbing allegations were reported to the Advocate involving a group home in Prince Albert, which had opened in March 2021 shortly after the release of our Report. There were six developmental and medically fragile children, ranging in age from five to 11, residing in this specialized "developmental" group home. These children required highly skilled care.

The reported allegations related to insufficiently trained staff, poor supervision, lack of nurturing, medical neglect, harsh treatment toward the children, insufficient nutritious food and medical supplies, inadequate staff vehicles, and operational disorganization and discord that included:

- Poor training in dealing with children with high medical needs. Staff caring for a deaf and blind child with prosthetic eyes were not properly trained in protocols for these medical devices, including how to insert them. Consequently, and contrary to medical standards, they were left out of his eye sockets for eight hours, after which staff were then directed to insert them without proper training;
- Staff being ill-equipped to effectively manage and care for children with psychological and behavioural needs. Against best practices, one child with an acute psychological disorder was locked in their room by a nursing professional staff member, exacerbating behavior issues and further traumatizing the child;
- Staff improperly sharing medical supplies among children in the home. Staff were found to have shared G-tubes, also known as feeding bags, between three of the children who were fed in this way, contrary to medical standards and because of insufficient training and a periodic lack of medical supplies;

- Delays in seeking medical attention for the children. Staff did not immediately seek medical attention for a child whose foot turned blue and who had a urinary tract infection. These were not attended to for days, causing unnecessary medical aggravation.
- A periodic lack of food, especially nutritional food, in the home;
- Staff resorting to using their personal vehicles and paying for their own gas to transport children as the group home vehicles were often without gas;
- Poor operational management with staff turnaround and recruitment difficulties cited as contributing to inconsistent care; and,
- Medications and other medical procedures being missed, including allegations that staff failed to reflect properly or accurately reflect missed procedures in its logbooks, and management of the home dissuaded staff from properly reporting these issues to the Ministry.

Upon learning of these issues, the Ministry immediately began an investigation. It concluded there was sufficient evidence to support all allegations, and that the issues related to: 1) operational organization of the home, 2) staff's ability and training to meet the medical and developmental needs of the children, and 3) supervision. Consequently, all children were moved to another home with the same organization. The Ministry temporarily closed the group home, and eventually the group home operator decided not to seek authorization to re-open.

This company continues to run five other Ministry-contracted group homes throughout the province. The Ministry has assured our office it is closely assessing these homes by regularly meeting with the operator and monitoring the homes and the young residents. The Ministry also reported it is conducting a specialized review, as well as a program-standards review, to assess the services children have received over the previous few years while in the care of this company.

The Ministry further advised our office that it recognized the need for more health-based care plans and that it had engaged the services of a private health organization to complete these for the more vulnerable children. It envisions that care plans developed by health professionals will assist group home operators to provide better care to these children. The Ministry also noted it had started discussions with the Ministry of Health about providing these assessments when children with high medical and developmental needs come into care. Ultimately, the Ministry indicates a desire to have care plans completed for the most vulnerable children prior or at the time of their admission into care.

3.2 Regina Group Home Incidents

In August 2021, a five-year-old child with undiagnosed autism, but who was known to run and be attracted to water, ran away from his group home to a nearby creek. While searching, staff alerted a local resident who also began searching independently and was able to find the missing boy. According to the person who located him, she found the child floating in the water, making a "gurgling" sound. She, with the assistance of another adult bystander, retrieved him from the water. The child was taken to hospital where medical staff cleared his lungs, assessed him, and fortunately he was released the following day without further medical concern.

Although the child had one-on-one supervision at the time of this incident, he was able to flee through an emergency exit without detection for several minutes. At the time of this event there were eight children residing in the group home with six staff working, two of whom were assigned to one-on-one supervision responsibilities with two of the eight children.

Upon learning of this incident, the Ministry immediately intervened and began an investigation as per its usual process. Consequently, the child and his two siblings were moved to another home operated by this same organization. As a result of these events, the group home leadership reviewed its one-on-one policy, addressed concerns about one-on-one care with staff, and restricted the staff member who was assigned to this child from providing one-on-one support. The contracted group home operator committed to providing more staff training and the installation of chimes to detect when doors were opening and closing.

On October 2, 2021, this same child, now six years old, fled his group home again and was undetected for enough time that he was located at a Walmart store more than five kilometres away. The Ministry immediately made inquiries and learned that the child's one-on-one staff had been left in the group home alone with him while the other staff were away from the home with the other resident children. The Ministry reported to the Advocate that the one-on-one staff had been momentarily out of eyesight of the child at which time he was able to run from the home. The staff member immediately contacted police and began searching and asking people in the area if the boy had been seen running away. As part of its response to these events, the group home operator re-committed to emphasizing the responsibilities of one-on-one care with staff and arranged to install alarms on all doors and windows.

The Ministry has assured our office that it continues its investigations into these matters, that it has and continues to meet with the operator and is monitoring the homes closely.

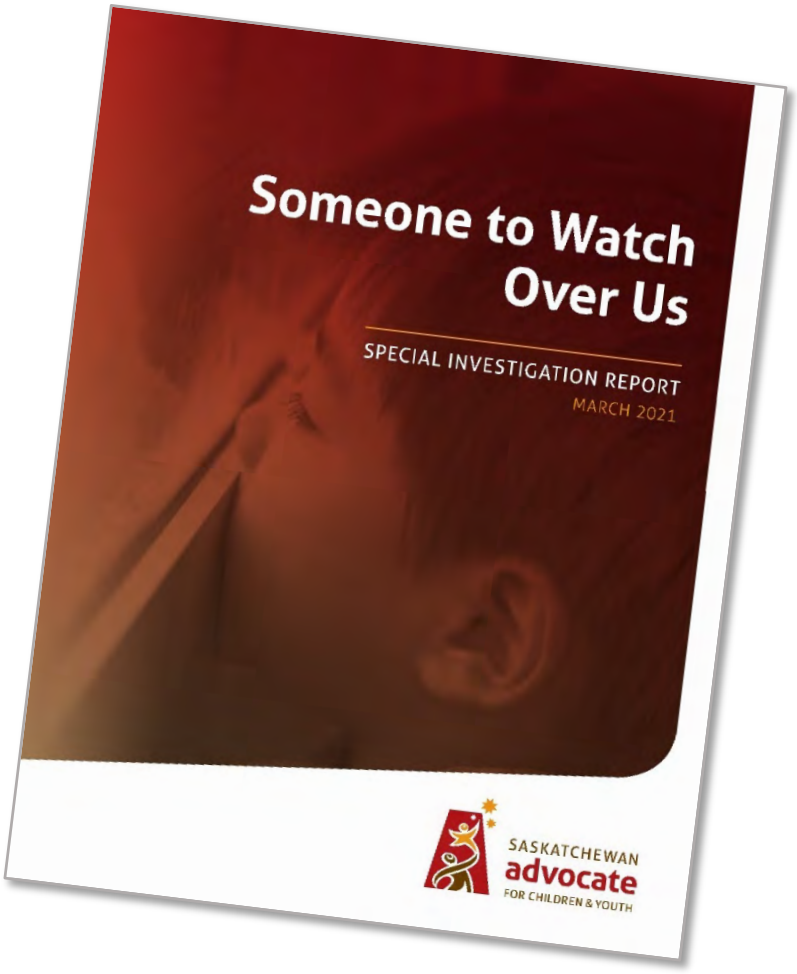
3.3 Advocate's Residential Services Regulations Submission

In September 2021, at the invitation of the Ministry, the Advocate provided input into the development of new regulations relating to residential care services. As highlighted in *Someone to Watch Over Us*, our office provided consultation input to the Ministry in 2017 when it was reviewing *The Residential Services Act*. Unfortunately, our 2017 recommendations were not incorporated into the new Act, entitled *The Residential Services Act, 2018*, which will come into effect when the new regulations are finalized. As with our 2017 submission, our 2021 input focused on strengthening accountability, embedding quality-of-care standards to provide clear expectations to all licensed providers and specifying regular intervals to measure compliance against established physical and quality-of-care standards.

In this submission the Advocate re-stated our position that the guiding statutes, which regulate services for children in group home care, must form the basis for setting clear standards that include expectations beyond physical structural criteria (ie: window size, fire prevention measures, etc.). Further, our office suggested that embedding well-articulated quality-of-care definitions and monitoring requirements into legislation would compel the government to properly and regularly evaluate, resource, and monitor group homes to ensure issues are detected and corrected early, before these fester and negatively impact children.

4.0 Ministry's Progress on *Someone to Watch Over Us* Recommendations

In *Someone to Watch Over Us*, the Advocate made three recommendations regarding group home oversight, all of which the Ministry of Social Services accepted. The Advocate committed to monitoring these recommendations at minimum every six months, to ensure the Ministry achieved the systemic change required to ensure children and youth placed in this type of out-of-home care are safe, protected, and receive appropriate services commensurate to their need.



On March 30, 2021, the Ministry provided the Advocate with a formal response to these recommendations outlining its current processes and its plan to achieve the recommendations. As with our office's monitoring processes, we request periodic updates. In the months since issuing these recommendations, we have gathered information during meetings and email exchanges with Ministry executive staff. Outlined below are the Ministry's responses and actions since it accepted these recommendations.

RECOMMENDATION #1

That the Ministry of Social Services enhance and re-design its group home oversight and accountability structure to:

- incorporate a leadership role that is responsible for the effective oversight of group homes;
- develop comprehensive evidence-based quality-of-care definitions and standards that promote proactive, not reactive, responses to the care of children;
- articulate what evidence is needed to demonstrate that group homes are meeting quality-of-care standards; and,
- include sufficient human and financial resources to enable timely and proactive reviews of group home care.

In its initial response to this recommendation, the Ministry described the overarching structure and mechanisms already in place to ensure children and youth in group homes receive quality care. Generally, these mechanisms are set up to determine whether the services provided by the Ministry adhere to the applicable policies and procedures. Other mechanisms were highlighted such as the Agreement for Services between the Ministry and service providers that receive funding to support the Ministry's clients, as well as the development of contracts with organizations and the oversight involved with the licensing and terms of the contract. The Ministry further acknowledged that more work is needed to "effectively and proactively provide oversight to group homes." A stated commitment was made to review its current processes, structures, and resources to pinpoint areas that require attention.

In September 2021, the Ministry advised that a Value Stream Mapping (VSM) process was initiated to examine what currently exists for group home oversight and identify inefficiencies and ways to improve or streamline processes. The Ministry stated it was at the halfway point on the VSM process, which is being led by its Strategic Management Branch.

RECOMMENDATION #2

That the Ministry of Social Services develop a permanent resource for group home operators, which provides a clear point of contact, support, and resources such as skill development.

In its initial response to this recommendation the Ministry committed to formally articulating the role of the numerous Ministry staff who have responsibility for the care and oversight of children who are placed in community-based resources. To promote effective communication, a position was piloted in its Centre Service Area as the key, single point of contact for community-based resources. The Ministry further stated its intention to implement a Saskatchewan Group Home Support pilot in April 2021 which was to be based on the learnings from a 2020 group home operational support project. The Ministry reported other ways to support community-based resources were to be researched.

In the Ministry's September 2021 update regarding this recommendation, we were advised that the position in the Centre Service Area (under the Child and Family Services Delivery Branch) continues to be dedicated as the main point of contact for community-based resources. Further it confirmed that the Saskatchewan Group Home Support pilot had been implemented and that each of the Ministry's three service areas had identified an organization and discussed the pilot with them.

Additionally, the Ministry announced to our office that it would be developing a new unit to oversee specific group homes. A manager and three staff will comprise this unit – and the job descriptions and classifications either have been or are currently being developed. This unit will operate utilizing existing resources, within its Community Services Branch, and will be used to inform future expansion.

RECOMMENDATION #3

That the Ministry of Social Services enhance its process for approving group home openings to include identifying and verifying the qualifications and training of staff and examining the unique needs of the children who are the intended residents to determine what unique features should be included in the group home.

In its March 2021 response to this recommendation, the Ministry stated that its existing policy manuals outline the minimum requirements and expectations for training group home staff in Saskatchewan. There is an expectation that organizations contracted by the Ministry who provide group home services train their staff and document their credentials on training logs. The Ministry committed to develop a checklist of training required and would continue to monitor training of group home staff through its periodic program standard reviews. The Ministry stated its intention to review training requirements, funding dedicated to training, and methods of delivery for training for all group homes. When developing a new resource for specific children, the Ministry pledged to ensure organizations are assessed through the Request for Proposal process and incorporate the training requirements to meet the needs of the children to be placed in that home.

We learned in September from Ministry officials that its training checklist has now been created and would be used with current and new group homes – to identify the training required based on the type of home and needs of the children, including children with medical and developmental needs. The Advocate learned that staff would need to be trained in CPR, First Aid and Crisis Intervention, and any other training requirements based on the needs of the children in the home. Verification that the training has occurred will be a requirement. Further, the Ministry committed to establishing a team to conduct assessments of all medical and developmental group homes to ensure staff are trained appropriately and have the capacity to serve children with complex medical or behavioral needs.

In addition to the above responses to our three recommendations, Ministry officials advised that staff have continued to work with the group home operator who was the subject of our *Someone to Watch Over Us* Report, to ensure that action items are completed to satisfy the results of its program standards review on the group homes it continues to operate.

5.0 Progress Report – Observations of the Advocate

In *Someone to Watch Over Us*, the Advocate noted that when critical injuries and incidents occur involving children in group home care, the Ministry makes considerable effort to intervene, investigate and attend to the presenting issues, and conduct program standards reviews to identify any other issues with respect to compliance with standards.

However, and as outlined in the Report, our investigation found that the system, in its current form, fails to proactively focus on the infrastructure, resourcing, the identification of clearly defined quality-of-care expectations of service providers, and does not have a robust monitoring system that assesses and detects issues before they become critical. We believe these are the greatest aggravating factors in group care breakdowns within the Ministry's current structure, and despite the Ministry's initial response to the recommendations, immediate action was not evident in the subsequent weeks following the Advocate's recommendations.

The Advocate continues to see the most vulnerable of children neglected as evidenced in the newest critical incidents outlined above. Given these pervasive concerns, and in consideration of the ever-growing reliance on group home care, the Advocate has little confidence at this time in the Ministry's current system in keeping children safe and stresses the urgency of implementing our comprehensive recommendations. The Ministry's over-reliance on the group home model has not been met with the commensurate policies, procedures, and expectations required by the services it contracts to ensure children are safe, protected, and cared for appropriately. The Ministry's response in referencing what it currently has in policy and procedures is insufficient in ensuring a proactive quality-of-care framework when contracting out services for vulnerable children. While identifying critical gaps in service is important, this may do little to address the broader systemic issues – ensuring a structured operational oversight system that encompasses a top-down approach to the service within group home care.

In the Advocate's more recent discussions with the Ministry, resulting particularly from the serious incidents with the homes in Prince Albert and Regina, there now appears to be a more robust commitment toward addressing the systemic issues it acknowledged from our March 2021 Report, some of which are outlined below:

- The Ministry's progress in examining its structure to identify gaps through its Value Stream Mapping process;
- The Ministry's efforts to collaborate with the Ministry of Health to find a path toward working together to assess and develop care plans that will give group homes more information and tools about how best to care for particularly vulnerable children;
- The formation of dedicated work units to offer a consistent point of contact, support, or to provide better oversight for specific group homes; and,
- The Ministry's efforts to identify training based on the unique needs of resident children and youth.

It is not the Advocate's role to prescribe how the Ministry ought to operate. However, there are times when, as with our March 2021 Report, the evidence identifies critical systemic issues and points to potential solutions. Ultimately, to be satisfied with the Ministry's response to recommendations it has accepted, our office must see that it not only takes the Advocate's recommendations seriously, but that it also takes necessary actionable steps to address the issues and meet the intention of the recommendations, whether that be by using the exact path identified within our recommendations, or by taking other avenues. If, in this case, the Ministry departs from the Advocate's proposed path toward meeting our recommendations, then it ought to consider an independent review of its group home system to address how it can provide an oversight framework to ensure the safety of children.

Quality-of-Care oversight, as referenced in *Someone to Watch Over Us*: "The everyday experience of young people in out-of-home care is impacted first and foremost by the quality of care provided in residential services. Such quality of care is a function of a wide range of factors that include the quality of human resources, the relationships among young people and between young people and care givers, the physical infrastructure of residential programs, the appropriateness of program routines, rules, and activities, and also the quality of food, the attention to identity and developmental growth, the levels of physical and emotional safety, and the on-going connections to family, kin, friends and community."[1]

[1] http://www.children.gov.on.ca/htdocs/English/documents/childrensaid/residential-services-review-panel-report-feb2016.pdf

The Advocate continues to be deeply concerned about how the Ministry defines its quality-of-care for children. In *Someone to Watch Over Us* we provided evidence to support the findings of our investigation, described our history with group home concerns, and referenced our attempt to persuade the Ministry to embed quality-of-care definitions and oversight processes (foundational to best practice) within legislation in 2017. Again, in our September 2021 submission to the Ministry on residential services regulations, we urged it to embed quality-of-care definitions and oversight mechanisms within new group home regulations that are currently under consideration. In recent months, and as summarized above, we have seen very serious incidents in group home care that have further heightened our concern. We view these incidents as indicators of a system that is not providing the quality care needed to ensure children are safe, supported, and can thrive.

Ministry definition of Quality-of-Care concerns: actions or acts of omission by the group home staff or program that indicate contravention of out-of-home care standards and have a negative impact on the care of the child but do not rise to the threshold of a child in need of protection pursuant to Section 11 of *The Child and Family Services Act*.[2]

While the Ministry, as per its policies, has identified quality-of-care concerns as actions or acts of omission by group home staff as these may have a negative impact on the child's care, these do not fully encompass the essence of providing and evaluating the quality of care received and experienced by children. As we clearly outlined in *Someone to Watch Over Us*, quality of care is the nurturing and the building blocks of what children and adolescents require to thrive. While such acts and omissions must be assessed and addressed, too much attention on one side is to the detriment of the other, especially for children who are particularly vulnerable, including those with developmental delays and high medical needs. Ultimately, the Ministry acts as the 'parent,' and therefore it is fundamentally incumbent on the Ministry to ensure children are receiving the best possible service while in its care.

The Advocate acknowledges the progress made by the Ministry to date. However, time is of the essence and the Ministry must do what is necessary to secure resources and to act immediately to re-imagine and change its structure – meaning to properly resource the group home system, and to provide support, comprehensive oversight, and accountability. Handing off this responsibility to a contracted service without effective oversight is unacceptable. Anything less will add to the current fault lines that place children in harms way.

[2] Ministry of Social Services – Children's Services Manual and Residential Services Manual

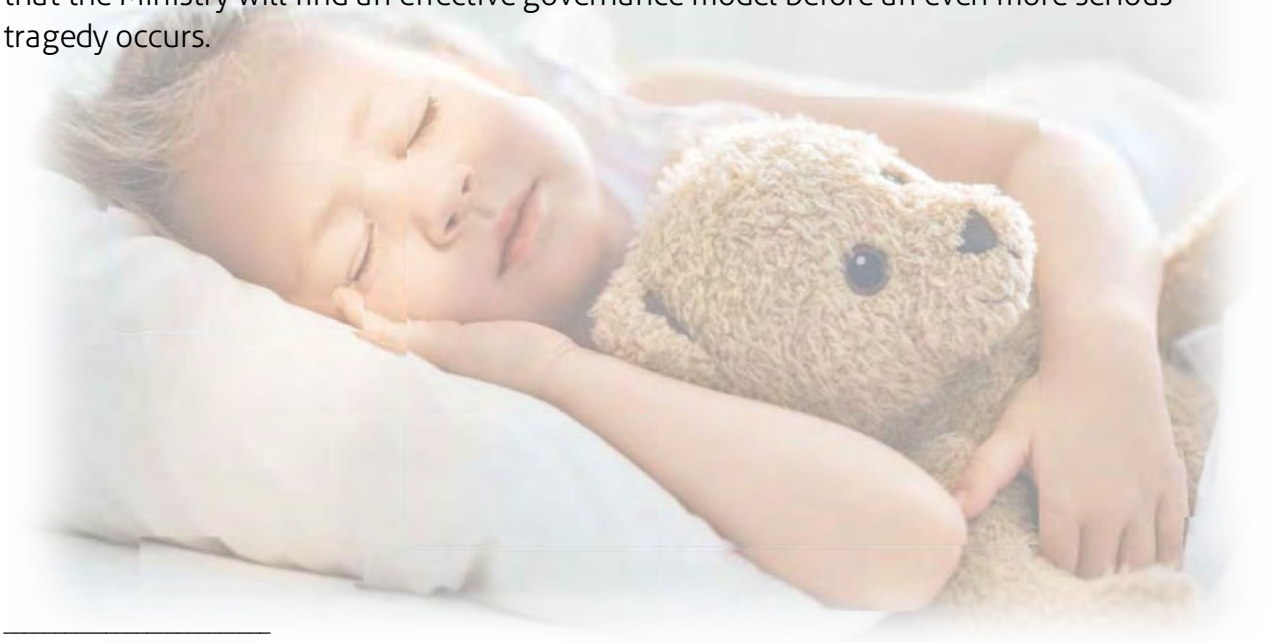
6.0 Conclusion

The title of *Someone to Watch Over Us* was chosen because it imagines a group home environment in which the terms and conditions are such that nurturing caregivers can fully meet parental obligations to vulnerable children, many of whom have exacerbated issues due to serious medical and cognitive impairments. It is incumbent on the Ministry, as the parental figure, to do what is necessary, and ultimately required, to create a system in which its contracted services - such as group home operators – ensure children's rights to be safe, protected, and receive proper care and health services, are fully realized. In the most recent cases, this did not happen.

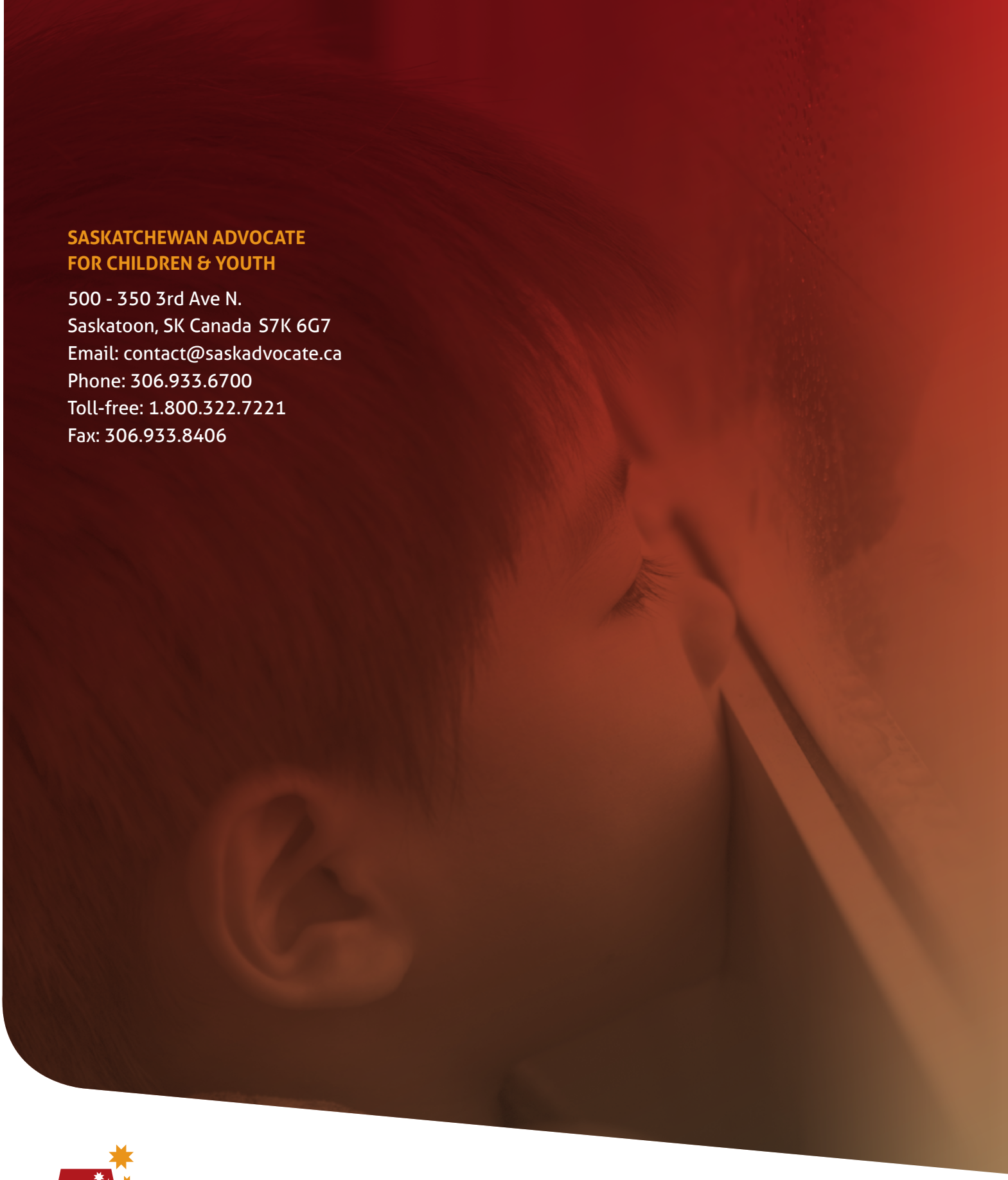
As outlined in our March 2021 Report, the rights contained in the United Nations Convention on the Rights of the Child are foundational to the Advocate's work. In Article 25 and in the UNCRC's corresponding Guidelines for Alternative Care for Children, accountability measures must not only be in place, but must have the efficacy to monitor care, protection, and health; and assess whether quality and conditions are conducive to the child's development.

The Ministry's 2021-22 budget highlights include that it will, "increase funding for residential care spaces by $8.2 million to support children and youth with developmental and complex behavioural needs."[3] This signals a recognition of the pressure on and the need to better support children and youth who are brought into care and receive residential based care.

The Advocate urges the Ministry to accelerate its actions with respect to achieving the intended goals of our recommendations. Ultimately, the Advocate must have confidence that the Ministry will find an effective governance model before an even more serious tragedy occurs.



[3] Ministry of Social Services Plan for 2021-22



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