MANITOBA OMBUDSMAN

REPORT ON THE PROCESS FOR THE REVIEW OF CHILD WELFARE AND COLLATERAL SERVICES AFTER THE DEATH OF CHILD

Report from September 15, 2008 to March 31, 2011

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BACKGROUND

In 2006, we completed an external review of the child welfare system in Manitoba entitled *Strengthen the Commitment.* A portion of that report considered the issues related to child death reviews and resulted in recommended changes to the process for investigating and reporting upon the deaths of children whose families had received services from the system.

These recommendations were accepted by government, and implemented through statutory amendments transferring responsibility for child death investigations from the Office of the Chief Medical Examiner (OCME) to the Office of the Children's Advocate (OCA). Additional resources were allocated to the new process and responsibility for child death reviews formally transferred to the OCA on September 15, 2008.

Child death reviews, previously referred to as "Section 10" reviews under *The Fatality Inquiries Act* and completed by the OCME, became known as "Special Investigations," and are now based on the provisions of *The Child and Family Services Act* which established the Children's Advocate's jurisdiction and powers with respect to the reviews.

At the same time, responsibility for monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the OCA was given to my office, Manitoba Ombudsman.

Many of the processes and procedures necessitated by the amendments were not in place at the time of the transfer of responsibility for child death reviews, and therefore continue to be developed, refined and revised. The limited number of reports completed as of March 31, 2011 reflects transitional challenges that were expected, and as well raises some concerns with the extent to which adequate administrative processes have been developed and implemented to achieve the objectives of the reviews. Because of these limited results, and because of issues identified by a number of decision-makers in the child welfare system, this first report is focused on the administrative processes that have been implemented to date, their strengths and weaknesses, and areas where improvements have been and can be made. Subsequent reports will provide information on recommendations made and their implementation.

LEGISLATIVE AMENDMENTS

To give effect to the recommendations from *Strengthen the Commitment,* amendments were made to *The Fatality Inquiries Act, The Child and Family Services Act,* and *The Ombudsman Act.*

The Office of the Chief Medical Examiner is required to notify the Children's Advocate of the death of a child in accordance with section 10 of *The Fatality Inquiries Act*:

Child's death to be reported to children's advocate

10(1) Upon learning that a child has died in Manitoba, the chief medical examiner must notify the children's advocate under The Child and Family Services Act of that death.

Reports to be given to children's advocate

10(2) If the children's advocate has jurisdiction to conduct a review under section 8.2.3 of The Child and Family Services Act in relation to the death of a child in Manitoba, the chief medical examiner must provide to the children's advocate, upon request,

(a) a copy of the medical examiner's report on the manner and cause of death; and

(b) a copy of the final autopsy report, if one has been ordered by the medical examiner and the children's advocate requires it for the review.

Reports are confidential

10(3) The information provided to the children's advocate under subsection (2) must not be used except for the purpose of a review and report under section 8.2.3 of The Child and Family Services Act, and must not be disclosed in that report except as necessary to support the findings and recommendations made in that report.

Under the statutory framework that came into effect on September 15, 2008, the OCA conducts a review of the death in accordance with section 8.2.3 of *The Child and Family Services Act*, as amended:

Review after death of child

8.2.3(1) After the death of child who was in the care of, or received services from, an agency under this Act within one year before the death, or whose parent or guardian received services from an agency under this Act within one year before the death, the children's advocate

(a) must review the standards and quality of care and services provided under this Act to the child or the child's parent or guardian and any circumstances surrounding the death that relate to the standards or quality of the care and services;

(b) may review the standards and quality of any other publicly funded social services that were provided to the child or, in the opinion of the children's advocate, should have been provided;

(c) may review the standards and quality of any publicly funded mental health or addiction treatment services that were provided to the child or, in the opinion of the children's advocate, should have been provided; and

(d) may recommend changes to the standards, policies or practices relating to the services mentioned in clauses (a) to (c) if, in the children's advocate's opinion, those changes are designed to enhance the safety and well-being of

children and reduce the likelihood of a death occurring in similar circumstances.

Purpose of review

8.2.3(2) The purpose of the review is to identify ways in which the programs and services under review may be improved to enhance the safety and well-being of children and prevent deaths in similar circumstances.

Report

8.2.3(3) Upon completing the review, the children's advocate must prepare a written report of his or her findings and recommendations and provide a copy of it

(a) to the minister;

(b) to the Ombudsman; and

(c) to the chief medical examiner under The Fatality Inquiries Act.

Children's advocate not to determine culpability

8.2.3(4) The report must not express an opinion on, or make a determination with respect to, culpability in such a manner that a person is or could be identified as a culpable party in relation to the death of the child.

Report is confidential

8.2.3(5) The report is confidential and must not be disclosed except as required by subsection (3) or as permitted by subsection (6) or Part VI.

Summary of recommendations in annual report

8.2.3(6) The children's advocate's annual report under clause 8.2(1)(d) for a year may include a summary of the recommendations included in the reports made that year under this section.

"Publicly funded"

8.2.3(7) For the purpose of this section, a program or service is publicly funded if it is operated or provided by the government or by an organization that receives funding from the government for the program or service.

Independent review in case of conflict

8.2.3(8) If services provided by the office of the children's advocate come within the scope of a review under this section, the children's advocate must arrange for that part of the review to be conducted and reported on by an independent person qualified to conduct that review. Subsections (3) to (5) and section 16.1 of The Ombudsman Act apply with necessary changes to that report.

The Ombudsman Act was amended by the addition of the following provisions, to facilitate the monitoring and reporting upon the implementation of recommendations made in special investigation reports:

> ***Monitoring children's advocate's recommendations***
>
> *16.1(1) The Ombudsman must monitor the implementation of recommendations contained in the reports provided to the Ombudsman by the children's advocate under section 8.2.3 of The Child and Family Services Act.*
>
> ***Report to assembly***
>
> *16.1(2) In the annual report to the assembly under section 42, the Ombudsman must report on the implementation of the children's advocate's recommendations.*

COMPLETED SPECIAL INVESTIGATIONS

When responsibility for completing child death reviews was transferred to the OCA on September 15, 2008 there were 106 deaths that had not been reviewed. By January 1, 2011 the number of deaths requiring review was 182.

As of March 31, 2011 the OCA had completed 54 special investigation reports. These reports contained 243 recommendations directed to various levels of the child welfare system, including 19 recommendations to external organizations and departments including social services, mental health and addictions treatment services. As of March 31, 2011, there were 186 deaths requiring review.

The limited number of special investigations completed, and recommendations implemented in response, precludes commenting in a meaningful way on any improvements achieved as a result of the revised child death review process. Although the numbers of completed special investigations are not as high as expected, I wish to acknowledge the ongoing efforts by the child welfare system to refine and improve the process. While there have been challenges, there have also been improvements and we will describe both.

The Statutory Purpose of the Review of the Death of a Child

One of the issues identified in the 2006 review was a lack of agreement or clarity within the child welfare system on the purpose of the child death review process, described at pages 47-48 of *Strengthen the Commitment*.

The resulting recommendation identified the purpose of the inquiry into the circumstances surrounding the death as making recommendations that might prevent deaths in similar circumstances in the future.

> ***We recommend that the necessary amendments be made to the CFS Act, to require the OCA to inquire into the circumstances surrounding the death, and make recommendations to prevent similar deaths in the future. These amendments should ensure that the OCA is***

provided with access to all records held by government that relate to collateral services provided by government, regardless of which department.

On its website, the OCA notes the purpose of the special investigation review "*is to identify ways in which the programs and services under review may be improved to enhance the safety and well-being of children."*

Despite the longstanding confusion we identified in our 2006 review regarding the purpose of the child death reviews under *The Fatality Inquiries Act*, it appears that there continues to be a divide within the child welfare community on the interpretation of these statutory provisions. It is clear that the interpretation of the statute has a direct impact on the focus and scope of the special investigations.

The question is what should a special investigation encompass? When a child who has received services from an agency dies, is the SIR process intended to be a longitudinal review or audit of the standards and quality of care provided by an agency or collateral service provider to the child and his or her family? Alternatively, is the review to be an examination of the services and standards of care provided to the child and his or her family relating to the circumstances of the death of a child, and specifically to identify improvements that would enhance the safety of children and prevent deaths in similar circumstances in future?

In the first instance, although the death of the child causes a special investigation to be conducted, the resulting review may not be relevant to or have any relationship with the circumstances, cause or manner of death. This is particularly evident in relation to the deaths of children resulting from prematurity, birth complications or medical fragility.

If the latter interpretation guides the review, the review considers the standards and quality of care provided to the child and his or her family, but the circumstances surrounding the death are the focus of the investigation. It appears that this interpretation is consistent with the legislation:

> *8.2.3(1) After the death of child who was in the care of, or received services from, an agency under this Act within one year before the death, or whose parent or guardian received services from an agency under this Act within one year before the death, the children's advocate*
>
> > *(a) must review the standards and quality of care and services provided under this Act to the child or the child's parent or guardian and any circumstances surrounding the death that relate to the standards or quality of the care and services;*

While the differences in focus may seem slight, the resulting investigation process, breadth of review, types of findings, recommendations and implications for the system are significant.

Based on our discussions with the OCA in the course of this review and following review of the Special Investigation reports completed up to March 31, 2011, it appeared that the intent had been to conduct comprehensive standards compliance reviews, similar in focus to the former Section 10 reviews, of all the standards and quality of care and services provided to a

child and his or her family, regardless of the nature of a child's death.

We noted the past challenges of these types of reviews in our 2006 report. The difficulty is that while the services and standards of care provided to the family may have had no causal connection to the child's death, the critical review of any or all of the services provided can leave the reader with the impression that better services would have prevented the death. While the reports are detailed in their examination of the child's life, completing such exhaustive reviews on every child who was in care of or received services from an agency within one year of the death, regardless of the cause of the death, is a huge undertaking and would unfortunately seem to have contributed to the following problems noted by the child welfare community.

Timeliness of Completion

The longitudinal review format has been shown to have challenges, all of which are compounded by the number of special investigations yet to be completed. Concern has been expressed that despite increased resources, neither the time-frames nor completion rates have improved since the review process was transferred from the Office of the Chief Medical Examiner (OCME) to the Office of the Children's Advocate (OCA). This concern is borne out by the limited results reported publicly by the OCA for 2009 and 2010. A growing number of deaths to be investigated suggests that ground has been lost rather than gained since the transfer of responsibility.

The purpose of these reviews is to assist agencies and Authorities and the larger system to address issues requiring improvement as soon after a death as possible in order to enhance the safety and well-being of children and prevent deaths in similar circumstances.

With the number of deaths to be investigated, special investigation reports on the services provided may not be completed and distributed to agencies and Authorities until some years after the death of a child. In the interim, internal reviews may have been conducted and some required improvements made. We have been advised by those working in the field that as a result, some of the recommendations made by the OCA in the SIR reports are no longer relevant or have been addressed by the time the report is issued. There appears to be consensus that the usefulness of the special investigation report decreases as the time between the death of a child and the report on that death increases.

Duplication of Reviews

Similar to the special investigations conducted by the OCA, Section 4 reviews carried out by Authorities also critically analyze the services provided to a child and his or her family.

> ***The Child and Family Services Act***
>
> ***Powers of director***
> ***4(2)*** *For the purpose of carrying out the provisions of this Act, the director may*
> *(c) conduct enquiries and carry out investigations with respect to the welfare of any child dealt with under this Act;*

The Child and Family Services Authorities Act
Child and Family Services Authorities Regulation

Investigating welfare of child
25 *Under clause 4(2)(c) of The Child and Family Services Act, an authority has the power of the director to make enquiries and carry out investigations as to the welfare of a child. The director also retains that power.*

Completion of any comprehensive service review involves the participation of agency staff in the investigation process. In some instances special investigations have proceeded after an inquest has been called by the Chief Medical Examiner under *The Fatality Inquiries Act*.

Based on our analysis of this matter and our discussions with those who are subject to review, we recommend that a protocol for coordination and prioritization of the special investigation reviews in relation to these other levels of inquiry be established. We recommend that the OCME, the Child and Family Services Authorities and the Child Protection Branch work with the Children's Advocate to establish that protocol.

Investigative Process, Inclusion and the Formulation of Recommendations

Those who receive and review the SIR reports expressed concerns about the process by which investigations are conducted and recommendations are formulated. It has been suggested that work may have already been done, and improvements to practice made by agencies and Authorities as a result of their own earlier investigations into the death of a child, which may not always be captured in the investigation by the OCA and reflected in the final SIR. It is important that the reviews consider such improvements in practice to avoid unnecessary recommendations being made.

The Authorities raised the importance of their participation in the special investigation process, particularly prior to the drafting of recommendations for improvement. As a trend, all noted the increased efforts of the OCA staff over time to meet with agencies and Authorities to share the findings of the special investigations. We were advised however of the difficulty in discussing case specific details or actions which may be in dispute, or clarifying the services provided without seeing the full case review in a draft of the SIR. Concerns were expressed that without an opportunity to see the entire draft report that there may be occasions when the SIR is perceived as inaccurate, not reflective of improvements made since the time of the death or contain recommendations that are not relevant or meaningful. Discussions with the OCA prior to March 2011 indicated that it was believed that draft reports could not be shared with Authorities or their agencies prior to submission to the Minister.

Scope of Jurisdiction

In our 2006 report we noted the concerns of child welfare workers across the province who advised that child death reviews focused on the standards of care provided to children and families from child welfare agencies, but "collateral" systems that provided services to the child were not held to the same level of accountability or review. Accordingly, we recommended that the legislation be amended and the Children's Advocate's jurisdiction enhanced to allow her to

make recommendations to those collateral service providers and agencies, or non-CFS entities that provided services to children and families.

As noted, section 8.2.3 of *The Child and Family Services Act* was amended to expand the Children's Advocate's jurisdiction in child death reviews to include:

> *(b) may review the standards and quality of* ***any other publicly funded social services*** *that were provided to the child or, in the opinion of the children's advocate, should have been provided;*
>
> *(c) may review the standards and quality of* ***any publicly funded mental health or addiction treatment services*** *that were provided to the child or, in the opinion of the children's advocate, should have been provided; (emphasis added)*

Discussions with the OCA, the Department and the Child Protection Branch noted that while the legislation directed the Children's Advocate to provide copies of her reports to the Minister, the Chief Medical Examiner and the Ombudsman, there is no statutory provision that allows the disclosure of special investigation reports, which contain information protected under *The Child and Family Services Act*, to entities outside the child welfare system that provided services to the child. By late 2010, recommendations made to these collateral social services and government departments had not been provided to them.

We raised this issue with the Department and in February 2011, the Deputy Minister of Family Services and Consumer Affairs advised that the following resolution to the reporting issue had been devised and agreements on the plan for monitoring the implementation of the external recommendations confirmed:

> *The Manitoba government is committed to working with the OCA and the Ombudsman to find a collaborative solution to this problem. To ensure service agencies to which recommendations are made receive the recommendations with sufficient background, a number of issues are being considered.*
>
> *First, the issue of sharing confidential information is being addressed. The special investigation reports cannot be released directly to external organizations without breaching section 76(3) of the Act. However, as you know, representatives from your office, the Department, and the OCA have discussed this problem and agreed that, going forward, the OCA would write recommendations involving non-CFS organizations to ensure confidentiality in accordance with the Act. The OCA will also review and revise past recommendations for non-CFS organizations to ensure confidentiality as per the Act.*
>
> *The second issue regarding the sharing of special investigation reports with non-CFS organizations involves tracking the implementation of the recommendations. The Child Protection Branch (CPB) of the Department will follow up with organizations that are funded by FSCA. in accordance with the terms of our Service Purchase Agreements with these organizations.*
>
> *With respect to recommendations directed at non-CFS organizations that are not funded by FSCA, the CPB going forward will provide non-CFS organizations with the*

excerpted recommendations section of the special investigations report. The Ombudsman's office will then follow-up with the non-CFS organizations to monitor, assess and track the implementation of the recommendations in accordance with the authority granted under The Ombudsman Act.

With the disclosure issue resolved, the subsequent distribution of some of the recommendations to non-CFS organizations raised some additional issues. We note that of the 19 recommendations made to date to collateral services, 4 have been made to levels of government that cannot be described as publicly funded social services, mental health or addictions treatment services, even though they may have had some contact or history of involvement with the child who died, or their decisions had a significant impact on services to children.

As there is no statutory provision in *The Child and Family Services Act* which extends the jurisdiction of the OCA's authority for child death reviews across all government departments, there does not appear to be jurisdiction for such recommendations to be made to entities other than those specifically described in the statute.

This is disappointing in view of our comments in the 2006 report, where I noted the concern from the child welfare system that the former section 10 reviews were restricted to examining the services provided by child welfare agencies. We were advised that services provided by other agencies, or the absence of those services, may well have affected the quality or standard of care provided by the child welfare agency. Accordingly, in 2006 we recommended that the OCA be provided with access to all records held by government that relate to collateral services provided by government, regardless of which department, to allow the Children's Advocate to consider such services in her investigations. I reiterate that recommendation.

Without a further legislative amendment to expand her jurisdiction, I have advised the Children's Advocate that where a special investigation into the death of a child has noted questions, concerns or areas for improved services for children and families from a government department or agency that falls outside of the services described under clauses 8.2.3 (1) (b) and (c) of the Act, she may refer her comments on those entities to my office for further consideration in view of my jurisdiction under section 15 of *The Ombudsman Act*:

Investigations

15 *The Ombudsman may, on a written complaint or on his own initiative, investigate*

(a) any decision or recommendation made, including any recommendation made to a minister, or any act done or omitted, relating to a matter of administration in or by any department or agency of the government, or by any officer, employee or member thereof, whereby any person is or may be aggrieved; or

(b) any decision or recommendation made, including any recommendation made to a council, or any act done or omitted, relating to a matter of administration in or by any municipality or by any officer or employee of a municipality, whereby any person is or may be aggrieved.

COMMENTS ON IMPROVEMENTS IN SPECIAL INVESTIGATIONS

As part of our review process, we met with the staff of the OCA to relay the observations of those we spoke to in the child welfare system (agencies, Authorities, Child Protection Branch). A new Children's Advocate was appointed on April 11, 2011 and shortly thereafter, a number of the issues raised by the system had been addressed by her. Highlights of enhancements the Children's Advocate has made to the child death review process are as follows:

On the issue of inclusion, the Children's Advocate has advised that there will be increased discussion between her office, and agencies and Authorities in the course of the investigation process to avoid disagreements regarding facts or case events once an investigation is concluded. More importantly, the Children's Advocate has determined that prior to issuing recommendations, draft reports will be shared with the respondent agencies and Authorities so that there is an opportunity for input prior to the recommendation being issued. While maintaining the independent scrutiny of the office and the findings of her reviews, the Children's Advocate has indicated the intent to focus her recommendations on changes that are achievable by those to whom the recommendations are directed.

With regard to the timeliness of special investigation reports, the Children's Advocate has advised that the number of incomplete investigations is being reduced. Indeed, from March 31, 2011 to August 31, 2011, 79 SIRs have been issued, a significantly higher rate of completion than in the initial years since transfer of responsibility. The Children's Advocate advises she has directed her investigators to prioritize more recent deaths of children for investigation to ensure that special investigation reports are more timely and will therefore contain recommendations or comments which continue to be relevant.

The Children's Advocate has stated that extensive reports will not be completed on every case, in particular in cases where the death resulted from natural causes, deaths related to premature births or birth complications, or deaths of medically fragile children.

THE ROLE AND FUNCTION OF THE CHILD PROTECTION BRANCH OF FAMILY SERVICES AND CONSUMER AFFAIRS FOLLOWING A SPECIAL INVESTIGATION

In our discussions across the system in preparation for this report, we were advised repeatedly of the confusion over the role of the Branch and its Director in the SIR process.

With respect to the responses to the recommendations, the Branch has provided this information regarding the approval process:

> *Once the response to the recommendations are complete, a Status Report is completed by the Authority Relations Quality Assurance Specialist. The CEO of the Authority signs off the status report to indicate that the action plan has been carried out by the Agencies. It then goes to the Executive Director of the Child Protection Branch who signs off the status report confirming that the Authorities have carried out their responsibility to ensure that agencies are providing the standard of services and following established procedures and practices.*

Based on the information we received, it is this overlapping level of responsibility between the Director and the Authority which appears problematic.

The conflict appears to arise from the statutory powers and duties of the Director under *The Child and Family Services Act* vis-à-vis the express provisions of sections 17 and 19 of *The Child and Family Services Authorities Act* and Regulations, which devolve specific responsibilities to the Authorities and removes those powers from the Director. With regard to the area of quality assurance and ensuring compliance with standards, while the language may differ, both statutes establish similar requirements for the Director and the Authority.

At least three child welfare authorities have expressed a view that is different than the Branch on the critical question of who has final responsibility for determining that recommendations to agencies have been completed. While theoretically the roles of the Authorities and the Director as described above differ, this distinction blurs at a practical level when the agency and its staff, the Authority staff and the various levels of the Child Protection Branch are all considering whether the agency and Authority's response to a single recommendation is complete.

To date there has been neither an agreed upon protocol between the Branch and the Authorities on how to deal with SIR recommendations, nor a protocol on critical issues such as who has the responsibility to determine that implementation of a recommendation is complete. There is a question about the extent of the power of the Branch to monitor the performance of Authorities in fulfilling their statutory mandate and whether this extends to monitoring the implementation of the SIR recommendations made to agencies.

Beyond the disputed question of the extent of the role of the Branch in monitoring and sign-off, there is also a question about the contribution of the Branch to achieving the goals of the statutory mandate underlying the process - to identify ways to make children safer and to prevent deaths in the future. Does the Branch's quality assurance function, or the monitoring of the actions of the Authorities in overseeing their agencies, detract from a larger mandate to address systemic areas of concern which arise out of the special investigations such as the availability of staff in the system and the historical and pervasive difficulty across the system in meeting the provincial standards as they exist?

Questions have also been raised about the timeliness of the Branch's quality assurance function in determining that recommendations have been completed, with one Authority reporting that a final response from the Branch can take up to two years after an Authority response is provided, because of multiple layers of approval built into the Branch's internal processes.

COMMENTS ON IMPROVEMENT: THE CHILD PROTECTION BRANCH

While some concerns with the administrative processes and the role of the Child Protection Branch have been noted, it is important to acknowledge that almost all the Authorities' specialists spoke of the support and assistance received from the Quality Assurance/Authority Relations (QA/AR) Unit of the Branch. This is an achievement given the existing confusion regarding roles described above. In our review of this matter, we heard about the assistance provided by the QA/AR Unit with interpretation of the recommendations, identification of issues and areas of

concern, making available the Branch's Access database and providing suggestions for organizing and tracking the recommendations.

COMPLETION OF RESPONSES TO RECOMMENDATIONS AND THE REPORT TO THE OMBUDSMAN

In its written response of April 2011, the Branch advised that it would be providing status reports to the Ombudsman once the responses to the special investigation recommendations are deemed complete in cases of recommendations directed to agencies, Authorities, the Branch, Division, or Department:

> *Progress on the action plan is documented and once the recommendations are complete, a status report is generated by the AR/QA (Authority Relations/Quality Assurance) team. The CEO of the Authority signs off the status report to indicate that the action plan has been carried out. The Child Protection Branch signs off that the plan provided in the status report addresses the recommendation. A copy of the signed report is then provided to the Ombudsman.*
>
> *If there are recommendations to the Department, Division, Minister, Director or Branch, the report is sent to the Authority Relations/ Quality Assurance (AR/QA) team. The AR/QA team reviews all recommendations, develops themes, and assigns leads within the Department. The AR/QA team meets monthly with the leads to obtain information on progress. All responses are documented into the Recommendations Database which is maintained by the Strategic Initiatives and Program Support Branch. Upon completion of the implementation of the recommendations, a Status Report is generated by the AR/QA team. The Assistant Deputy Minister signs off the Status Report to indicate that the action plan has been implemented. A copy of the signed Status Report is then provided to the Ombudsman. Once all of the recommendations are signed off, the file is closed.*

Earlier, in January 2011, I requested that copies of completed responses to recommendations directed to agencies or Authorities be sent to me directly by the Authorities so I would be informed earlier of their progress towards implementation. I asked that the responses be sent to me upon their completion, at the same time they are forwarded to the Child Protection Branch for tracking and insertion in the database. I also advised that this would allow my office to track the length of the questioning phase, if any, that may occur after an Authority has provided information to the Branch, as well as providing the full response from the Authority for my review.

As of August 31, 2011 my office had received status reports from the Branch that responded to twelve recommendations from five special investigations. Based on our discussions with and information received from the OCA, the Authorities, the Branch and Child and Family Services Division, there appear to be a number of reasons for the difficulties in providing my office with completed responses:

- **Complexity of the recommendations**
  Recommendations can range in scope from the case-specific directed to one agency or one Authority, to systemic recommendations which are directed to one or all of the

Authorities, the Branch or the larger system. Issues identified in the special investigations are often the most historically difficult or contentious challenges facing child welfare and are consequently sometimes the most demanding to address. Recommendations which involve multiple levels of the child welfare system also require intensive consultation and coordination. We are also advised by the recipients of the recommendations that there may be different interpretations of the intent of the OCA's recommendations and that this adds to their complexity. However we expect that where this arises in the future, the opportunity to review draft reports will also provide an opportunity to seek clarification on recommendations as needed.

- **The number of people who review and consider the response**

  Within each Authority and each agency, there are a number of staff who consider, develop and approve a response prior to the submission to the Child Protection Branch for input into the database. We were informed that given the seriousness and the impact of the recommendations on the system, considerations regarding their implementation are paramount and not made hastily.

  Consultations and discussions regarding the service areas which are the subject of the recommendations may require participation across Authorities and the Branch involving the Child and Family Services Standing Committee, or any number of committees or working groups across the system.

- **Lack of agreement as to who has the final authority to determine if a recommendation is complete**

  It appears that the more significant or complex the recommendation, and whether it touches on areas for which operational responsibilities have devolved to the Authorities but where the Director continues to have some foundational role, the more cumbersome and protracted achieving completion is. The following recommendation is an example of one that was made to the Child Protection Branch, but also involves several agencies, and each of the Authorities:

  > *The Children's Advocate recommends that the Child Protection Branch ensure that standard risk assessment be consistently completed at intake by Designated Intake Agencies in order to make an accurate determination about the need for ongoing child welfare service based on future potential of maltreatment.*

- **The definitions ascribed to the status leading up to and including "complete"**

  In order to have a consistent level of understanding of the progress made by the recipients of the recommendations, the Branch established status indicators relating to the progress towards implementation. These descriptors are as follows:
  - pending (recommendation received but no action has occurred);
  - in progress;
  - significant progress (response is mostly complete);
  - complete pending approval or complete pending sign off (some additional level of approval is required but the work has been done);

- complete alternative solution (an alternative resolve to the recommendation);
- complete and ongoing (implementation will be an ongoing process or plan);
- complete.

As indicated, there are some variations in the "complete" category. We have observed that while "complete pending approval" may confirm that significant and positive work has occurred, further questions or concerns about the appropriateness of the response from the ultimate decision-makers to a recommendation can then re-start the process and a matter is not, in fact, complete.

- **Discrepancies between the information provided to us from the Child and Family Services Division, the Child Protection Branch and the Authorities.**

  As noted we have received information on the status of implementation in a variety of formats: an annual report to the Ombudsman on the progress towards implementation of the recommendations from FSCA, Child and Family Services Division; individual signed status reports from the Child Protection Branch representatives and the CEO of the Authority or in the case of recommendations to the Branch, Division, Department or Minister from the Assistant Deputy Minister of FSCA ; informal liaison with the QA/AR team of the CPB, and most recently from the Authorities. (As previously stated, information on the progress of implementation of recommendations to collateral agencies is provided directly to my office.)

  The issue with all of these sources of information is that there is inconsistency regarding the status of completion and in many cases there are differences of opinion between the Branches of the Department, or between the Branch and the Authority regarding the status of completion.

For all of these reasons, as the child welfare system is unable to provide me with consistent information, I am unable to provide an accurate account of the number of recommendations which have been implemented to date.

From all the information provided, I can indicate that some of the Authorities appear to have implemented many of the recommendations directed to them or their agencies, or provided reasonable information regarding actions taken which address the recommendations. Based on information from the Child Protection Branch and each of the Authorities, there is evidence that all the Authorities have been working with their respective agencies to consider and develop responses to the recommendations directed to them and all have provided frequent updates to the Branch when additional information or clarification has been requested.

I have notified all the Authorities that my next annual report will focus on the implementation of all the recommendations, collectively and by Authority, and that I will therefore require information from all of the Authorities on their progress.

ROLE OF THE OMBUDSMAN

Part of the intent of the recommendations we made in 2006 with respect to the child death review process, and the subsequent legislative amendments, was to have an independent body determine what action had been taken in response to special investigation recommendations, and to report publicly on those actions.

Our statutory role is to monitor and report upon the implementation of the recommendations. Our approach to monitoring and reporting on the implementation of OCA recommendations is driven, in part, by a concern identified in the 2006 review of the child welfare system.

The 2006 review (at page 42) noted that in 2000 the OCME had reported upon significant issues identified through the child death reviews. As part of the 2006 review our office examined the subsequent special investigations conducted by the OCME between 2001and 2005, and noted that the issues identified in both periods were similar, and remained issues of concern to the people interviewed during the 2006 review, as noted at page 45:

> *The issues and concerns identified in both periods of time are consistent with the issues that were raised with us in the course of the review. These issues and concerns result from larger systemic issues such as inadequate resources and excessive workloads. Inadequate resources for staff training or excessive workloads may result in inadequate assessments and an inability to meet the provincial standards. Concerns about inadequate file documentation are related to workload but are also directly related to the problems with the automated information systems described elsewhere in this report.*
>
> *Addressing these concerns promptly can help reduce the risk to children in the system. Resolving the larger systemic issues is essential to creating the solid foundation necessary to prevent the deterioration of the system feared by people working in the field throughout the province.*

These issues continued to be raised as concerns, despite the fact they had been repeatedly identified in the Section 10 reports of the OCME and their implementation had been monitored by the Child Protection Branch.

In the course of seeking the comments of the OCA, the Child Protection Branch and the Authorities with regard to the child death review process, we noted the concern by some that the Ombudsman, an office other than the OCA who conducts the special investigations, would be monitoring the responses to those same recommendations.

The concern about adding yet another layer of oversight to a child death review mechanism which is already complex is a legitimate one. To ensure that the requirement of my mandate to comment on the implementation does not add an extra burden to the system, I have been committed to working closely with the OCA to ensure that the responses to the recommendations are shared with the OCA to close the "feedback loop.

In the past, as noted with the Section 10 reviews, if an agency disagreed with a recommendation, it would often be ignored with little dialogue or problem solving. Reporting publicly will serve to ensure that the value of that work will not be lost, as it appears to have been in the past, and

will enhance public trust and accountability in the child welfare system. Reporting publicly is also a means by which the Legislature and the public can be alerted if progress appears to be inadequate.

As noted earlier in this report, the agencies, Authorities, the Child Protection Branch and all of those entities to which recommendations have been directed, are responsible for the quality of services provided to children and families in Manitoba. We have seen that for every recommendation made there are a number of staff from every level of the system working to address that recommendation, to improve some facet of child welfare service delivery and above all to prevent the death of a child from occurring in similar circumstances.

I am required to comment annually on the implementation of the recommendations to ensure public accountability. In future annual reports, I will comment on the larger areas of concern and issues emerging from the OCA's special investigations, and the challenges faced by those who provide services to children. It is my intent to monitor and report upon the implementation of recommendations on a system-wide basis, with a view to ensuring that necessary improvements are identified for implementation in a way that meets the purposes of section 8.2.3 (2) of *The Child and Family Services Act* and results in improved services for children and families.

RECOMMENDATIONS

I wish to express my appreciation to the Children's Advocate and her office, the staff and CEOs of the Child and Family Services Authorities, staff of the Child Protection and Strategic Initiatives Branches and the Child and Family Services Division of Family Services and Consumer Affairs for their detailed replies to our inquiries on the child death review process and for their ongoing commitment to improving the lives of children and families of Manitoba. Based on the information gathered from all of these stakeholders and in consideration of the statutory provisions which guide the review of child deaths, I am making the following recommendations:

As of the writing of this report, I am advised that the four Authorities in conjunction with the Child Protection Branch through the Office of the Child and Family Services Standing Committee are in the process of completing a protocol on the administrative requirements for completing multi-level recommendations. Both the OCA and my office have indicated an interest in seeing this protocol once complete. It is hoped that this further clarifies and streamlines the processes and respective roles of the Child Protection Branch, the Child and Family Services Division and the Authorities following receipt of special investigation reports**. I recommend that this protocol be completed as soon as possible, but no later than December 31, 2011**.

It is more than apparent that the multiple layers of scrutiny and approval, with respect to the responses to special investigation recommendations have impeded continuous quality improvement as matters cannot reach completion due to internal bottlenecks. To date there has been neither an agreed upon protocol between the Branch and the Authorities on how to deal with SIR recommendations, nor a protocol on critical issues such as who has the responsibility to determine that implementation of a recommendation is complete. There is a question about the

extent of the power of the Branch to monitor the performance of Authorities in fulfilling their statutory mandate and whether this extends to monitoring the implementation of the SIR recommendations made to agencies. **I recommend that the confusion arising from the overlapping roles of the Authorities and the Child Protection Branch be resolved and a protocol as described above be developed and adopted by the Authorities and the Branch.**

In order to ensure transparency and clarity, and to demonstrate the improvements made to the system as a result of the SIRs, **I recommend that clear definitions be agreed to and adopted by the Authorities and the Branch to clarify progress towards implementation of the recommendations and to allow me to fully and accurately report on these improvements in subsequent annual reports.**

Most of the Authorities also spoke about their work on establishing outcome indicators for children by which agencies and Authorities can measure and assess their achievements other than solely by determining whether the child and family service standards were met. As the Children's Advocate continues to refine the focus and formulation of recommendations for improvement to enhance the safety and well-being of children and prevent deaths from occurring in future, the Authorities' work on outcomes may be of great benefit. Both the Children's Advocate and my office would appreciate receiving information on the Authorities' work in this area.

The recipients of the special investigation reports have all noted the potential benefit and efficacy of reports focused on specific areas of concern which may have greater impact and scope for improvement; I am advised by the Children's Advocate that such reports are currently being considered.

I have described the significant administrative improvements made by the new Children's Advocate to the special investigation process on page 11. While these improvements are noteworthy, resolution of the differing interpretations of subsections 8.2.3(1) and 8.2.3(2) of *The Child and Family Services Act* should occur. Any larger forum for discussion of this issue should also include the OCME.

Based on our analysis and our discussions with those who are subject to reviews, **I recommend that a protocol for coordination and prioritization of the special investigation reviews in relation to other inquiries be established. I recommend that the OCME, the Child and Family Services Authorities and the Child Protection Branch work with the Children's Advocate to establish that protocol.**

Further I reiterate the recommendation I made in 2006 that the scope of the investigations within the mandate of the Children's Advocate include all services that have or should have been provided by government to a child and his or her family.

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