MANITOBA OMBUDSMAN

Follow-up Report on the Process for the Review of Child Welfare and Collateral Services After the Death of a Child

March 2013

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GLOSSARY OF TERMS

Aboriginal Justice Inquiry – Child Welfare Initiative (AJI-CWI) – The AJI-CWI is also referred to as devolution. The beginning of the process intended to restore responsibility to the Aboriginal community for the welfare of its children was recommended in the Aboriginal Justice Inquiry Report by Commissioners Associate Chief Justice A. C. Hamilton and Associate Chief Judge Murray Sinclair in 1991. The transfer process to the new governance structure began in 2003. The majority of the final transfer of 6,700 cases to Aboriginal agencies occurred by May 15, 2005. The AJI-CWI process transferred a significant amount of the responsibility for the governance of the child welfare system to the three Aboriginal Authorities and the General Authority.

Agency – A child and family services (CFS) agency is the service delivery part of the CFS system. CFS Authorities have the power to issue a mandate for a child and family services agency to provide services under provincial legislation, *The Child and Family Services Act*. The majority of an agency's funding for mandated protective services is provided to the Agency from one of the mandating Authorities. See Appendix A on page 25 for a list of all Manitoba CFS Agencies.

Authority – Child and Family Services Authorities are established under *The Child and Family Services Authorities Act* to design and manage the delivery of child and family services throughout the province. The Authorities are entitled to set their own service standards to supplement the existing provincial standards. They have the authority to issue a mandate for a child and family services agency to provide services under *The Child and Family Services Act* and they provide funding to said agencies to deliver services. Presently there are four Authorities:

- First Nations of Northern Manitoba Child and Family Services Authority;
- First Nations of Southern Manitoba Child and Family Services Authority;
- Métis Child and Family Services Authority; and
- General Child and Family Services Authority.

Chief Executive Officer (CEO) – Each of the four Child and Family Service Authorities has a Chief Executive Officer.

Child Protection Branch (CPB) – The Child Protection Branch is the government office that monitors the entire range of child and family services. It provides funding for all the services that are provided by Authorities and agencies (except for services delivered within First Nation reserve communities which are funded by the federal government). The Child Protection Branch also provides other services, including post-adoption services, the adoption registry, and the

Child Abuse Registry. It also licenses residential care facilities for children and licenses adoption agencies.

Child and Family Services Division (the Division) – The Child and Family Services Division is a part of the Manitoba government's Department of Family Services and Labour. The Child and Family Services Division encompasses the Child Protection Branch, the Minister of Family Services and Labour, and the Director of Child Welfare.

Child and Family Services System (CFS) – The CFS system helps to ensure that families and communities provide for the safety and well-being of their children. There are a number of provincial laws that are in place to accomplish this goal, primarily *The Child and Family Services Act*, *The Adoption Act* and *The Child and Family Services Authorities Act*. The CFS system is based on the fundamental guiding principles set out in *The Child and Family Services Act*.

Child and Family Services Information System (CFSIS) – CFSIS is a data management system that supports case tracking and reporting of services provided to children and families as they pass through the Manitoba Child and Family Services (CFS) system. The database provides information on children in care as well as information on families receiving protective services and support services.

***The Child and Family Services Act* or CFS Act** – Laws that the people of Manitoba must follow can be made by the federal parliament, the provincial Legislative Assembly or by city councils which enact by-laws. Manitoba's *Child and Family Services Act* is provincial law designed to ensure the best interests of children are being met, including their safety and well-being.

The Children's Advocate's Enhanced Mandate Act – Proclaimed on September 15, 2008, *The Children's Advocate's Enhanced Mandate Act* officially transferred the responsibilities for conducting "Section 10" reviews of the deaths of children from the Chief Medical Examiner to the Children's Advocate. The reviews are now referred to as child death Special Investigation Reviews (SIRs).

Manitoba Ombudsman –Manitoba Ombudsman is an independent office of the Legislative Assembly which investigates public complaints under the *Ombudsman Act* about administrative acts, decisions, or omissions by departments and agencies of the provincial government and municipal governments, to promote fairness and administrative improvement. Manitoba Ombudsman also has responsibility for monitoring and reporting on the implementation of recommendations resulting from special investigation reviews (SIRs) of child deaths by the Office of the Children's Advocate

Office of the Chief Medical Examiner (OCME) – The Office of the Chief Medical Examiner (OCME) falls within the portfolio of the cabinet minister who serves as Minister of Justice and

Attorney General. The OCME investigates all violent, traumatic, unexplained, unexpected and suspicious deaths in Manitoba, including the deaths of all children and residents of personal care homes and developmental centres, under the authority of *The Fatality Inquiries Act* (FIA). Under the *Act*, only certain types of deaths are investigated by the OCME. These are called "reportable deaths" and they represent about half of the approximately 10,000 deaths which occur annually within the Province of Manitoba.

Office of the Children's Advocate (OCA) – The Office of the Children's Advocate is an independent office of the Legislative Assembly, not part of any provincial government department, agency or municipality. The OCA represents the rights, interests and viewpoints of children and youth throughout Manitoba who are receiving, or should be receiving, services under *The Child and Family Services Act* and *The Adoption Act.* The OCA is also responsible for carrying out a review of services after the death of a young person who was, or had been, receiving services through the child welfare system within the year prior to their death.

Special Investigation Reviews (SIRs) – *The Children's Advocate's Enhanced Mandate Act* was proclaimed on September 15, 2008, officially transferring the responsibilities for conducting "Section 10" reviews of the deaths of children from the Chief Medical Examiner to the Children's Advocate. The reviews are now referred to as child death Special Investigation Reviews (SIRs).

Standing Committee – The Child and Family Services Standing Committee is comprised of the CEOs from the four Authorities and the Director of Child and Family Services for the Province of Manitoba. The Standing Committee is the advisory body with legislated responsibility for promoting cooperation and collaboration across the CFS system and with other systems.

Voluntary Placement Agreement (VPA) – *The Child and Family Services Act* provides for a parent, guardian or other person who has actual care and control of a child, to enter into a voluntary placement agreement with a child and family services (CFS) agency for the placing of a child without transfer of guardianship.

ACTING OMBUDSMAN'S MESSAGE

This is a follow-up report to our December 2011 *Report on the Process for the Review of Child Welfare and Collateral Services After the Death of a Child*, available on our website at www.ombudsman.mb.ca.

Manitoba Ombudsman has a statutory obligation to report annually on the implementation of recommendations made by the Office of the Children's Advocate (OCA), arising from its special investigations into the deaths of children.

In 2011 it became apparent that for various reasons we would not be able to include a report on the implementation of OCA recommendations in our annual report. First, there were a limited number of child death special investigation reports completed and, therefore, few recommendations to report on. Second, the child welfare system was unable to provide our office with consistent information regarding the implementation of said recommendations and therefore we were unable to provide an accurate account of the number of recommendations which had been implemented to date.

In our December 2011 *Report on the Process for the Review of Child Welfare and Collateral Services After the Death of a Child,* we identified a number of challenges impeding the effective operation of the special investigation review process and made recommendations for necessary improvements to allow the process to move forward. At the same time, however, we noted that some of the Authorities appeared to have implemented many of the recommendations directed to them or their agencies, or provided reasonable information regarding actions taken which addressed the recommendations. There was also evidence that all the Authorities had been working with their respective agencies to consider and develop responses to the recommendations directed at them.

Many of the difficulties and challenges within the child death special investigation review process reflected transitional challenges that were not unexpected. Our December 2011 report contained five recommendations to improve the administrative processes surrounding child death reviews. In 2012 there was significant progress in addressing the concerns identified in our report, resulting in an increase in the production of investigative reports by the OCA and an improved process for dealing with recommendations made in those reports.

In this follow-up report we will set out the improvements made by the Office of the Children's Advocate and the child welfare entities to whom the OCA recommendations have been directed. I am also pleased to report that as a result of the significant progress made to the end of 2012, we will be in a position to report publicly, concurrently with our 2012 Annual Report to be released in the spring of 2013, on the implementation of OCA recommendations made up to December 31, 2012.

To provide a foundation for future reports, this report also contains a description of the child welfare system in Manitoba and an explanation of the role and responsibilities of the parties that make up the system, as well as a brief history and background of the special investigation reporting process. We also discuss the approach my office is taking to our role in the process, assessing and reporting publicly on the implementation of recommendations made by the OCA.

Finally, we include a brief description of one development that has the potential for significant positive change throughout the system as a whole, improving the approach taken to risk assessment and case planning.

INTRODUCTION

Manitoba Ombudsman is an independent office of the Legislative Assembly, which investigates public complaints under *The Ombudsman Act* about administrative acts, decisions, or omissions by departments and agencies of the provincial government and municipal governments, to promote fairness and administrative improvement. The Ombudsman has the statutory authority to initiate an investigation on his or her own motion, without a complaint from the public, and to conduct broader systemic investigations on concerns affecting large numbers of people. Manitoba Ombudsman is not part of any provincial government department or agency, or municipal government.

As part of our mandate, Manitoba Ombudsman has responsibility for monitoring and reporting on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA). The OCA is also an independent office of the Legislative Assembly, not part of any provincial government department, agency or municipality. Being outside of government affords both the Ombudsman and the OCA unique perspectives on the child welfare system in Manitoba, a large and complex network of organizations with many objectives, mandates and priorities at play.

From different perspectives, both the Ombudsman and the OCA have the ability to examine and comment upon systemic issues, concerns and challenges that impact the work of the child welfare system, to ensure public accountability and, to help move the system forward with long-term, planned systemic improvements.

The OCA investigates child deaths and makes recommendations to improve services and enhance the safety and well-being of children and prevent deaths in similar circumstances in the future.

Manitoba Ombudsman monitors and reports publicly on the implementation of OCA recommendations. Our role is driven by the need to have an independent body determine what

action has been taken in response to special investigation recommendations, and to report publicly on those actions to ensure accountability.

While there are often valuable lessons to be learned from the tragic death of a child, there are already processes in place within the child welfare system to quickly identify and correct problems that might pose a risk to children.

I share the view of former Ombudsman Irene Hamilton, and many others in the child welfare system, that the identification, monitoring and tracking of larger and systemic issues in the delivery of child welfare services becomes paramount for the continued enhancement and development of improved services for children, youth and their families in the province of Manitoba.

Later in this report, and in future reports, we will comment on the larger areas of concern and patterns arising in the course of the OCA's special investigations and the challenges faced by those who provide services to children. It is our intent to monitor and report upon the implementation of categories of recommendations in future reports 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.

CHILD WELFARE IN MANITOBA

The child welfare system in Manitoba is a complex network of entities that has developed and evolved over time to provide services that supplement, or substitute for, parental care and supervision, and to prevent or help remedy problems that may result in children being abused, neglected, exploited or in trouble with the law.

There are a number of provincial laws that are in place to accomplish these goals, primarily *The Child and Family Services Act*, *The Adoption Act* and *The Child and Family Services Authorities Act*. The CFS system is based on the fundamental guiding principles set out in *The Child and Family Services Act* as follows:

GUIDING PRINCIPLES

The Legislative Assembly of Manitoba declares that the fundamental principles guiding the provision of services to children and families are:

1. The safety, security and well-being of children and their best interests are fundamental responsibilities of society.
2. The family is the basic unit of society and its well-being should be supported and preserved.

3. The family is the basic source of care, nurture and acculturation of children and parents have the primary responsibility to ensure the well-being of their children.
4. Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society.
5. Children have a right to a continuous family environment in which they can flourish.
6. Families and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.
7. Families are entitled to receive preventive and supportive services directed to preserving the family unit.
8. Families are entitled to services which respect their cultural and linguistic heritage.
9. Decisions to place children should be based on the best interests of the child and not on the basis of the family's financial status.
10. Communities have a responsibility to promote the best interests of their children and families and have the right to participate in services to their families and children.
11. Indian bands are entitled to the provision of child and family services in a manner which respects their unique status as aboriginal peoples.

The child welfare system in Manitoba provides many services and supports, both in-home and out-of-home, to strengthen families and provide knowledge, techniques and skills to help parents raise their children. Supports and services include family strengthening programs and services, parenting workshops and courses, life skills programs, support groups, literacy programs, in-home family supports, teen and pre-school programs, counseling, family aides and support workers. Out-of-home care includes foster care, group home care and residential care; adoption services; emergency and after-hours care; and other support services for families who are experiencing difficulties caring for their children.

As of March 31, 2011, the Child Protection Branch reported that of the 19,714 families, unmarried adolescent parents and children receiving support from the child and family services system, 48 percent or 9,432 children, are receiving out-of-home care such as foster care.

THE CHILD AND FAMILY SERVICES GOVERNANCE STRUCTURE

Since its inception in Manitoba, child welfare has undergone many significant changes in its organizational and governance structure. The most significant and important change to the child welfare system in Manitoba has been the Aboriginal Justice Inquiry – Child Welfare Initiative (AJI-CWI), which is sometimes referred to as devolution. The beginning of the process intended to restore responsibility to the Aboriginal community for the welfare of its children was recommended in the Aboriginal Justice Inquiry Report by Commissioners Associate Chief Justice A. C. Hamilton and Associate Chief Judge Murray Sinclair in 1991.

The 1991 AJI recommendations were further reviewed in the Aboriginal Justice Implementation Committee report which outlined the way in which the recommendations of the AJI could be implemented to improve the provision of child and family services for Aboriginal children and families. The government accepted that recommendation and in 2000, the Minister of Family Services and Housing announced his intention to establish partnerships with the leadership of the Aboriginal community to negotiate the transfer of responsibility for child welfare from the department to a new governance structure.

The transfer process began in 2003 and occurred region by region. The majority of the final transfer of 6,700 cases to Aboriginal agencies occurred by May 15, 2005. This transfer is a significant milestone in the delivery of services to the children and families in Manitoba. The Aboriginal community is overrepresented in both the lowest socio-economic strata of our society and in the child welfare system. The AJI-CWI holds the promise of a new system that will provide services and promote the well being of children and families in ways that are appropriate in Aboriginal communities and that promote the use of culturally appropriate standards, practices and protocols.

The AJI-CWI process transferred a significant amount of the responsibility for the governance of the child welfare system to the three Aboriginal Authorities and the General Authority. The most significant change to the governance structures of Aboriginal agencies was their mandate to provide services to the members of their First Nations communities who did not reside on reserve.

Child and Family Services Authorities

By 2006, the majority of the AJI-CWI process and restructuring was accomplished and four new Authorities were created.

- **First Nations of Northern Manitoba Child and Family Services Authority**
- **First Nations of Southern Manitoba Child and Family Services Authority**
- **Métis Child and Family Services Authority**
- **General Child and Family Services Authority**

The four Child and Family Services Authorities are established under *The Child and Family Services Authorities Act*. It is the responsibility of the Authorities to design and manage the delivery of child and family services throughout the province. The Authorities are entitled to set their own service standards to supplement the existing provincial standards. As such, they in turn have the power to issue a mandate for a child and family services agency to provide services under *The Child and Family Services Act*. The Authorities are also responsible to provide funding to the agencies they have mandated to deliver services, and to provide ongoing quality assurance of such services.

The table below shows the number of families and unmarried adolescent parents receiving support and the number of children in care by Authority.

TABLE 1:
CHILD AND FAMILY SERVICES AUTHORITIES — MARCH 31, 2011

As at March 31, 2011 (numbers include both federal and provincial responsibility)

	Number of Children in Care	Number of Families Receiving Services	Number of Unmarried Adolescent Parents	TOTAL
FIRST NATIONS NORTHERN AUTHORITY				
	2,594	2,663	187	5,444
FIRST NATIONS SOUTHERN AUTHORITY				
	4,198	3,059	87	7,344
GENERAL AUTHORITY				
	1,732	3,372	60	5,164
MÉTIS AUTHORITY				
	908	839	15	1,762
TOTAL	9,432	9,933	349	19,714

Source: Manitoba Family Services and Labour 2010/11 Annual Report

Child and Family Services Standing Committee

The Child and Family Services Standing Committee is comprised of the CEOs of the four Authorities and the Director of Child and Family Services for the Province of Manitoba. The Standing Committee is the advisory body with legislated responsibility for promoting cooperation and collaboration across the CFS system and with other systems. As the primary liaison between the agencies and the province, the Standing Committee and the Authorities are directly accountable both to their communities and the Minister. It is the responsibility of the four Authorities to design and manage the delivery of child and family services throughout the province. The Authorities are entitled to set their own service standards to supplement the existing provincial standards. As such, they in turn provide funding to agencies that deliver services.

Because the child welfare system in Manitoba is now decentralized and made up of a complex group of entities reporting to various oversight offices, the Child and Family Services Standing Committee is essential for promoting cooperation and collaboration across the CFS system and

with other systems. With this responsibility as part of its mandate, the Standing Committee is integral to the implementation of multi-level SIR recommendations.

Child Protection Branch

The Child Protection Branch (CPB) is the government office that monitors the entire range of child and family services. It provides funding for all the services that are provided by Authorities and agencies (except for services delivered within First Nation reserve communities which are funded by the federal government). The Child Protection Branch also provides other services, including post-adoption services, the adoption registry, and the Child Abuse Registry. It also licenses residential care facilities for children and licenses adoption agencies.

The Child Protection Branch is represented on Standing Committee and is responsible to work with the four Authorities on multi-level SIR recommendations in addition to implementing SIR recommendations made directly to the CPB.

The CPB also coordinates some of the distribution of the child death special investigation reports by the Office of the Children's Advocate. Upon completion of a SIR, the OCA provides a copy of the report to the Office of the Chief Medical Examiner, the Manitoba Ombudsman and the Minister of Family Services and Labour. The Department then distributes the SIR, or the applicable parts of the SIR, through the Child Protection Branch, to the various Authorities and services providers to whom any findings or recommendations have been made. The CPB also maintains a centralized database of all SIR recommendations.

Set out as Appendix A to this report is a chart demonstrating the current CFS system governance structure.

BACKGROUND

In 2006 Manitoba Ombudsman completed an external review of the child welfare system in Manitoba entitled *Strengthen the Commitment.* This report is available on our website at http://www.ombudsman.mb.ca/uploads/document/files/strengthen-the-commitment-2006-en.pdf and on the website of the Office of the Children's Advocate at http://www.childrensadvocate.mb.ca/resources/special-reports.

In part, the report considered and recommended changes to the process for investigating and reporting upon the deaths of children whose families had received services from the child welfare system. At the time, section 10 of *The Fatality Inquiries Act* required the Office of the Chief Medical Examiner (OCME) to conduct a review when there had been a death of a child who had received child and family services in the previous year.

The reviews conducted by staff at the OCME were thorough, impartial and independent of the child welfare system. However, the findings and recommendations of the OCME were provided only to the department responsible for overseeing the child welfare system. There was no external review of the recommendations to determine whether or not they had been accepted and implemented in a way that might prevent further deaths. The process lacked transparency and public accountability.

In *Strengthen the Commitment*, we recommended that *The Fatality Inquiries Act* be amended to remove the responsibilities of the OCME that were set out in section 10 of that Act, and that *The Child and Family Services Act* be amended to include those duties and responsibilities under the mandate of the Office of the Children's Advocate.

These recommendations were accepted by government and *The Children's Advocate's Enhanced Mandate Act* was proclaimed on September 15, 2008, officially transferring the responsibilities for conducting "Section 10" reviews of the deaths of children from the Chief Medical Examiner to the Children's Advocate. The reviews are now referred to as child death Special Investigation Reviews (SIRs).

The Child and Family Services Act sets out the purpose of the review:

> ***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.*

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 the Manitoba Ombudsman. *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.*

Prior to these legislative changes, if an agency disagreed with a recommendation, the recommendation would often be ignored with little dialogue or problem solving. One of the

purposes of the recommendations we made in 2006 was to have an independent body determine what action had been taken by the child welfare entities in response to special investigation recommendations by the OCA, and to report on those actions. This function is similar to one already performed by Manitoba Ombudsman in respect of recommendations made by provincial judges after inquests arising under *The Fatality Inquiries Act*.

CURRENT CHILD DEATH REVIEW PROCESS

When a child dies in Manitoba, the Office of the Chief Medical Examiner (OCME) determines the manner of death according to an established protocol. Child deaths that meet the criteria for Special Investigation Reviews by the OCA include those cases where the child, or the child's family, had an open file with a child welfare agency or a file that was closed within one year preceding the child's death.

Most child deaths in the province of Manitoba occur naturally – whether a child has received services from a child welfare agency or not. However, that reviewable group of child deaths – cases where the child, or the child's family, had an open file with a child welfare agency or a file that was closed within one year preceding the death – has a lower proportion of accidental or natural deaths and a higher proportion of deaths by suicide and homicide.

The OCA reports in its *2011-2012 Annual Report* that there were 163 child deaths in the province that fiscal year; of those deaths, 61 were eligible for review, and 12 were children who were in the care of a CFS agency. The OCA also reports their previous review of child deaths in Manitoba between 1999 and 2009 revealed that during this timeframe, the annual number of child deaths ranged between 164 and 207 with an average of 179. The majority of child deaths are consistently a result of natural causes.

Historically, many issues and concerns identified in various child welfare reviews and reports resulted from larger systemic issues such as inadequate resources and excessive workloads. Many complex, multi-layered and systemic recommendations, however, require intensive consultation and coordination among the multi-faceted network of organizations within Manitoba's child welfare system. The child death review process enables the OCA and the Ombudsman's office to review, monitor and report publicly on issues that span the province and relate to child welfare as a whole. While there are more immediate processes in place to identify and respond to immediate concerns and risks, resolving the larger systemic issues is essential to ensuring that the child welfare system in Manitoba continues to improve and provide children, families and the communities in the province with better services.

The Child Protection Branch, the Standing Committee, the Authorities and the agencies, and all of the entities to which recommendations have been directed, are responsible for the quality of services provided to children and families in Manitoba. Sustainable change requires attention to the whole system, embedding and sustaining new patterns of working together across

organizations and communities within child welfare throughout the province. Again, the child death review process provides an avenue to examine the larger issues that underpin and impact the child welfare system, and make administrative improvements to help the complex system work together to implement larger systemic, planned changes.

While the process of monitoring and reporting on the implementation of recommendations has been delayed, it has the potential for tremendous benefit. Reporting annually on the implementation of OCA recommendations can provide the legislature, the public, and the child welfare system with a consistent analysis of the issues raised and the actions taken by the system to address them. It is intended to add a layer of transparency to the system in a way that not only identifies the concerns that give rise to OCA recommendations but also discusses the obstacles and barriers to systemic change.

IMPROVEMENTS IN OCA SPECIAL INVESTIGATIONS PROCESSES

In our December 2011 *Report on the Process for the Review of Child Welfare and Collateral Services After the Death of a Child*, we noted that one of the issues identified in both our 2006 and 2011 reviews was a lack of agreement within the child welfare system on the interpretation of the purpose of the child death review process. *The Child and Family Services Act* sets out the purpose of the review:

> ***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.*

Broadly interpreted, a review encompasses standards and quality of care and services provided to a child and his or her family by child welfare entities regardless of the nature of the child's death. 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, a broad review can leave the impression that better services would or could have prevented the death. In addition, while such broad reports are detailed in their examination of the child's life, completing such exhaustive reviews regardless of the cause of the death, is very complex and time-consuming.

Since the transfer of responsibilities to the OCA, broad-based reviews contributed to some administrative difficulties, increasing both the number of reports required and the scope and depth of investigation required for every SIR. This led to backlogs in the investigation system and delayed the completion of reports, causing some of the recommendations to be irrelevant or no longer applicable to a system that had undergone change in the intervening passage of time between the death of a child and the completion of the report. When responsibility for completing child death reviews was transferred to the OCA on September 15, 2008, for example, there were 106 deaths that had not yet been reviewed. By January 1, 2011, the

number of deaths requiring review was 182. As of March 31, 2011, the backlog had grown to 186 deaths requiring review.

Since our 2011 report, however, the OCA has worked diligently to decrease the backlog; the Children's Advocate has stated that while still requiring review, an extensive report will not be completed on every case, in particular those cases where the death resulted from natural causes, deaths related to premature births or birth complications, or deaths of medically fragile children. This approach has had positive results. The OCA no longer has a backlog of child deaths to review and recommendations made in the SIRs are more relevant and timely to the entities to which they are directed.

The OCA has also responded to feedback from recipients of the special investigation reports who noted the potential benefit and efficacy of reports focused on specific areas of concern. Called "aggregate reports," some of the more recent SIRs have grouped together a number of child deaths into one report with a shared focus on similar themes. Grouping together a number of investigations into one report has resulted in shared recommendations that may otherwise have been duplicated in individual reports. The aggregate report format also emphasizes the need for systemic, categorical approaches to many of the recurring issues and challenges in the child welfare system, challenges that require large systemic improvements rather than changes by individual agencies or Authorities.

The OCA has also made other administrative improvements to the process of child death review investigations. Increasing discussions between the OCA and agencies and Authorities in the course of the investigation process has helped to avoid disagreements regarding facts or case events once an investigation is concluded. Also, the OCA has begun to share draft reports with the respondent agencies and Authorities to ensure that there is an opportunity for input prior to any recommendations being issued. This has further helped to improve both the administration of the investigation process and the resulting SIRs, such that the recommendations made are current, relevant, and achievable by those entities to which the recommendations are directed.

There has also been increased communication between the OCA and my office. 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 January 2011, then Ombudsman Irene Hamilton requested that copies of completed responses to Special Investigation Report recommendations directed to agencies and Authorities be sent to the Ombudsman's office directly by the Authorities so we would be informed of their progress towards implementation. The agencies and Authorities have thus provided my office with updates and I have informed them that I am sharing their responses to the recommendations with the OCA to ensure the OCA is aware of developments and progress within the child welfare system. Often the Authorities are directing their responses to both my office and the OCA on their own, ensuring the OCA is aware of the actions taken by the child welfare Authorities and agencies. With feedback on the implementation of recommendations, the OCA's future reports and recommendations will

continue to be more timely, relevant and accurate, and may avoid making recommendations that have already been recently addressed and implemented.

RESPONSES TO THE OMBUDSMAN'S 2011 RECOMMENDATIONS

Our 2011 report focused on the administrative processes that had been implemented to March 31, 2011, the strengths and weaknesses, and areas where improvements had and could be made. In the report, then Ombudsman Irene Hamilton made five recommendations to the various entities involved in child welfare services in Manitoba to move towards administrative improvement and increased success implementing the SIR recommendations.

Our office's first recommendation was directed to the four Authorities in conjunction with the Child Protection Branch through the Child and Family Services Standing Committee **to complete a protocol on the administrative requirements for completing multi-level recommendations as soon as possible, but no later than December 31, 2011**. Standing Committee has confirmed that this protocol is now complete and will further clarify and streamline the processes and respective roles of the Child Protection Branch, the Child and Family Services Division (the Division) and the Authorities following receipt of special investigation reports**.**

Standing Committee established a working group to develop the protocol for sharing and responding to child death recommendations from SIR reports which have implications beyond a single agency or Authority. Their Multiples Working Group (MWG) will consider and address recommendations directed to:

a) The Division and two or more Authorities
b) Two or more Authorities
c) A single agency, Authority or the Division which may have implications or interest for multiple parties in the child welfare system

The Multiples Working Group will share collective responsibility for the development and completion of action plans which respond to and implement the multi-level recommendations. While the MWG will consider recommendations directed to a single agency, Authority or the Division with implications for the larger system, the entity to whom the recommendation was directed remains responsible for developing and completing the formal response to the Ombudsman, the Children's Advocate and the Child Protection Branch.

This new joint protocol on completing multi-level recommendations is significant as it emphasizes the interdependencies of the many varied organizations involved in the delivery of child welfare services and encourages more collaborative dialogue and better outcomes for vulnerable young Manitobans.

Our second recommendation stemmed from the multiple layers of scrutiny and approval involved in completing the implementation of SIR recommendations. We recommended **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.** The confusion arising from the overlapping roles of the Authorities and the Child Protection Branch impeded continuous quality improvement as matters could not reach completion due to internal bottlenecks.

Standing Committee has now implemented this recommendation by addressing unresolved questions with respect to who makes a final determination of whether a recommendation directed by the OCA to an Authority or child and family services agency has been completed or "signed off." It was agreed that Authorities have oversight and sign-off responsibility for recommendations directed to the Authority and its agencies, and the Child Protection Branch assumes responsibility for addressing and signing off on recommendations directed at the Division (through the Assistant Deputy Minister). Multi-party recommendations implemented by the Multiples Working Group will be "signed off" by the Chief Executive Officers of the Authorities and/ or the Assistant Deputy Minister, depending on the entity or entities to whom the recommendation was made. Each organization reports directly to the Ombudsman's office on the status of its respective recommendations. Status reports from the Authorities are to be copied to the Child Protection Branch for entry and tracking in a central database.

In order to ensure transparency and clarity, and to demonstrate the improvements made to the system as a result of the SIRs, our third recommendation was again directed to the Authorities and the Child Protection Branch: **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**.

The Chief Executive Officers of the four Authorities met and reached consensus on the definitions and status terms to be used when describing the progress of completion of child death recommendations. The Child and Family Services Division of the Department of Family Services and Labour adopted these definitions and status terms. This recommendation is now complete and will be reflected in the tables and statistics to be provided in our upcoming report to be released concurrently with our 2012 Annual Report.

Clear definitions to describe the progress towards implementation of recommendations will better demonstrate the work being done and the improvements being made to the system as a result of the SIRs prior to the recommendations being fully implemented. Many complex, multi-layered and systemic recommendations directed to one or all of the Authorities and the Branch or larger system often require intensive consultation and coordination, and determination of successful implementation is not made hastily.

The fourth recommendation made in our 2011 report was **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.** Standing Committee has reported on discussions between the four Authorities' Chief Executive Officers, staff from the Child and Family Services Division, and the OCA, and noted a significant willingness to work towards an agreement on this issue. They intend to finalize an action plan for the completion of a Protocol for coordinating and prioritizing the SIRs in relation to other inquiries. While work on this matter remains in progress, the members of Standing Committee are confident that an agreement and Protocol will be forthcoming shortly.

The fifth and final recommendation made in our 2011 report was directed to the Minister of Family Services and Labour reiterating the recommendation 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.** While the 2008 amendments expanded the scope of the reviews to include "…other publicly funded social services, mental health services, and addiction treatment services," I believe it is important to consider the value of expanding the reviews to include all government services. In response to our 2011 recommendation we were advised that the department "…will continue to consider the intent of Recommendation # 5 as it relates to the broader role of the Office of the Children's Advocate."

COMPLETED SPECIAL INVESTIGATION REPORTS

Since the publication of our December 2011 *Report on the Process for the Review of Child Welfare and Collateral Services After the Death of a Child*, the OCA has provided our office with an additional 66 Special Investigation Reports, 20 with recommendations, to December 31, 2012. In total, since the transfer of responsibilities from the OCME to the OCA in September 2008 to the end of our reporting period, December 31, 2012, the OCA has provided our office with 250 Special Investigation Reports, 75 of which contain recommendations. Within the 75 SIRs that contain recommendations, the OCA has made 347 recommendations to Authorities, agencies, the Child Protection Branch and other entities in Manitoba.

This substantial increase in the number of SIRs and recommendations completed by the OCA since our last report reflects administrative improvements made by the OCA within the child death review process.

Table 2 (next page) illustrates the number of Special Investigation Reports received in our office from the OCA by fiscal year since the enactment of *The Children's Advocate's Enhanced Mandate Act* in 2008, the number of SIRs containing recommendations, and the number of recommendations.

TABLE 2:
SPECIAL INVESTIGATION REPORTS RECEIVED BY THE OMBUDSMAN FROM THE OCA BY FISCAL YEAR — SEPTEMBER 15, 2008 TO DECEMBER 31, 2012

Fiscal Year	Number of Child Deaths Investigated	Number of Special Investigation Reports Received	Number of SIRS Received with Recommendations	Number of Recommendations Received
2008-2009	7	7	7	40
2009-2010	21	21	19	141
2010-2011	27	26	16	63
2011-2012	154	147	15	44
2012-Dec 31, 2012	62	49	18	59
Total	**271***	**250***	**75**	**347**

** Note that the Number of Child Deaths Investigated and the Number of Special Investigation Reports Received are different because some Special Investigation Reports include more than one child death (Aggregate Reports).*

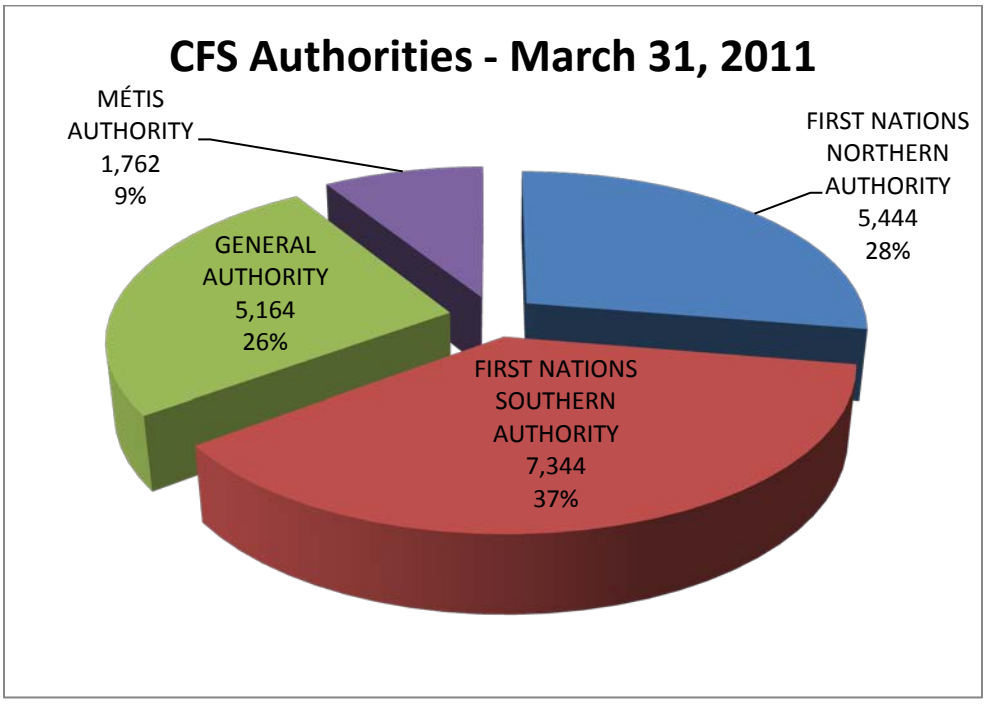
In our upcoming report to be released concurrently with our 2012 Annual Report in the spring of 2013, we will report on the implementation of the recommendations within the Special Investigation Reports to December 31, 2012.

IMPLEMENTATION OF SIR RECOMMENDATIONS

There are many issues that impact the implementation of recommendations made in Special Investigation Reports. Recommendations can range in scope and complexity, and can encompass one entity or many. For example, recommendations may be case-specific and directed to one agency or one Authority, or they may be systemic and directed to one or all of the Authorities, the Child Protection Branch, or the larger system. Issues identified in the special investigation reviews are often the most historically difficult or contentious challenges facing child welfare and are consequently sometimes the most demanding to address. And while the recommendations arise from the review of a tragic loss – the death of a child – the impetus to improve the system, especially large, long-term systemic improvements, is sustained through the SIR process.

Those recommendations that involve multiple levels of the child welfare system also require intensive consultation and coordination. 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 that 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 other committees or working groups across the system.

Also of note is the relative size of each of the four Authorities within Manitoba. Though the number of families and children served by the child welfare system in the province is always in flux, the following pie chart from the *Manitoba Family Services and Labour 2010/11 Annual Report* shows the relative size of each Authority through the number of families and children served on March 31, 2011, also reflected in Table 1 earlier in this report.



Source: Manitoba Family Services and Labour 2010/11 Annual Report

The geographical area of the province that each Authority and its agencies serves also plays a part in the complexity of delivering child welfare services. There are significant and unique challenges faced by northern and remote communities including lack of internet access to connect with the provincial electronic Child and Family Services Information System (CFSIS), lack of cellular telephone networks in some regions, fewer professional and specialist supports such as psychiatrists, and frequently a lack of staff and physical resources.

SPECIAL INVESTIGATION REPORTS: THEMES OF RECOMMENDATIONS

Many of the 347 SIR recommendations made by the OCA relate to ongoing challenges, such as those mentioned above, that continue to be areas of concern today. These challenges are significant, long-standing and difficult. They require in-depth analysis that acknowledges the realities of service delivery in remote areas where resources are scarce and conditions can be harsh. Addressing these concerns requires open dialogue between the parties that make up the child welfare system, a commitment to work collaboratively, and broad public support.

Our role is to examine and report upon the administrative deficiencies identified and the improvements made as a result of OCA recommendations. As previously mentioned, in future reports I will comment on the larger areas of concern and patterns arising in the course of 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 categories of recommendations in future reports 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.

It is my view that the identification, monitoring and tracking of larger and systemic themes in the delivery of child welfare services becomes paramount for the continued enhancement and development of improved services for children, youth and their families in the province of Manitoba. I am aware that the Child Protection Branch and at least one of the four authorities have implemented a process for the tracking and monitoring of common themes and trends arising from the SIR recommendations made by the OCA. The ability of the child welfare system to identify larger areas of concern and patterns encourages a focus towards systemic change with the goal of positively impacting the child welfare system as a whole. The enhancements made to the investigation process by the current Children's Advocate has contributed to the development of more meaningful and achievable recommendations for the child welfare system, while also supporting a more collaborative and transparent communication process between the authorities, agencies and the OCA.

RISK ASSESSMENT

My office has identified that a recurring theme in recommendations made by the OCA continues to be risk assessment as it pertains to the case planning process. Child and Family Services Standard 1.1.2 *Agency Standards: Case Management: Policy: Children in need of protection* states: "Risk assessment is an integral and ongoing part of the case management process that begins at intake when a worker gathers information, identifies issues and conducts a Safety Assessment. It continues in the assessment phase through a more in-depth assessment and in the evaluation process when reviewing cases.

Until recently, Manitoba did not require or use a standardized risk assessment tool to determine the level of risk of maltreatment to children. It was incumbent upon agencies to ensure that staff received the appropriate training either through the provincial core competency-based training program or a recognized equivalent. Unfortunately, it has been demonstrated over time and across Authorities that without a thorough risk assessment, a solid case plan and the development of interventions that are both realistic and workable are much less likely to occur during the life of a case.

According to the Manitoba Child and Family Services Standards, assessment begins at the first contact with a case and is ongoing. It includes information on the strengths, needs and resources of a person or family and could include family and community resources. Assessment becomes the basis for case management. Part of the case management process is planning, which ensures that risk factors identified in the assessment are addressed to keep children safe and strengthen family functioning.

I am pleased to report that a positive development to Manitoba's approach to risk assessment and case planning has been the introduction of the Structured Decision Making (SDM) Model. This integrated model of practice incorporates a series of tools to assess families to determine the safety status of the child and immediacy of response required during initial contact with a family, and also supports ongoing assessment and reassessment for future risk. The availability and use of a standardized assessment tool will provide front line staff and supervisors with additional tools that support consistency in the assessment of child safety. This integrated model of practice is evidence-based and, therefore, provides an approach to working with families that improves outcomes for children, families and communities. My office has been advised that Authorities and their respective agencies have been preparing for the use of the SDM across the child welfare system, and that some agencies are currently working with the tools in the SDM model to assess risk.

My office will continue to work with the OCA, along with the entities responsible for delivering child welfare in Manitoba, to identify themes that suggest a need for systemic improvement.

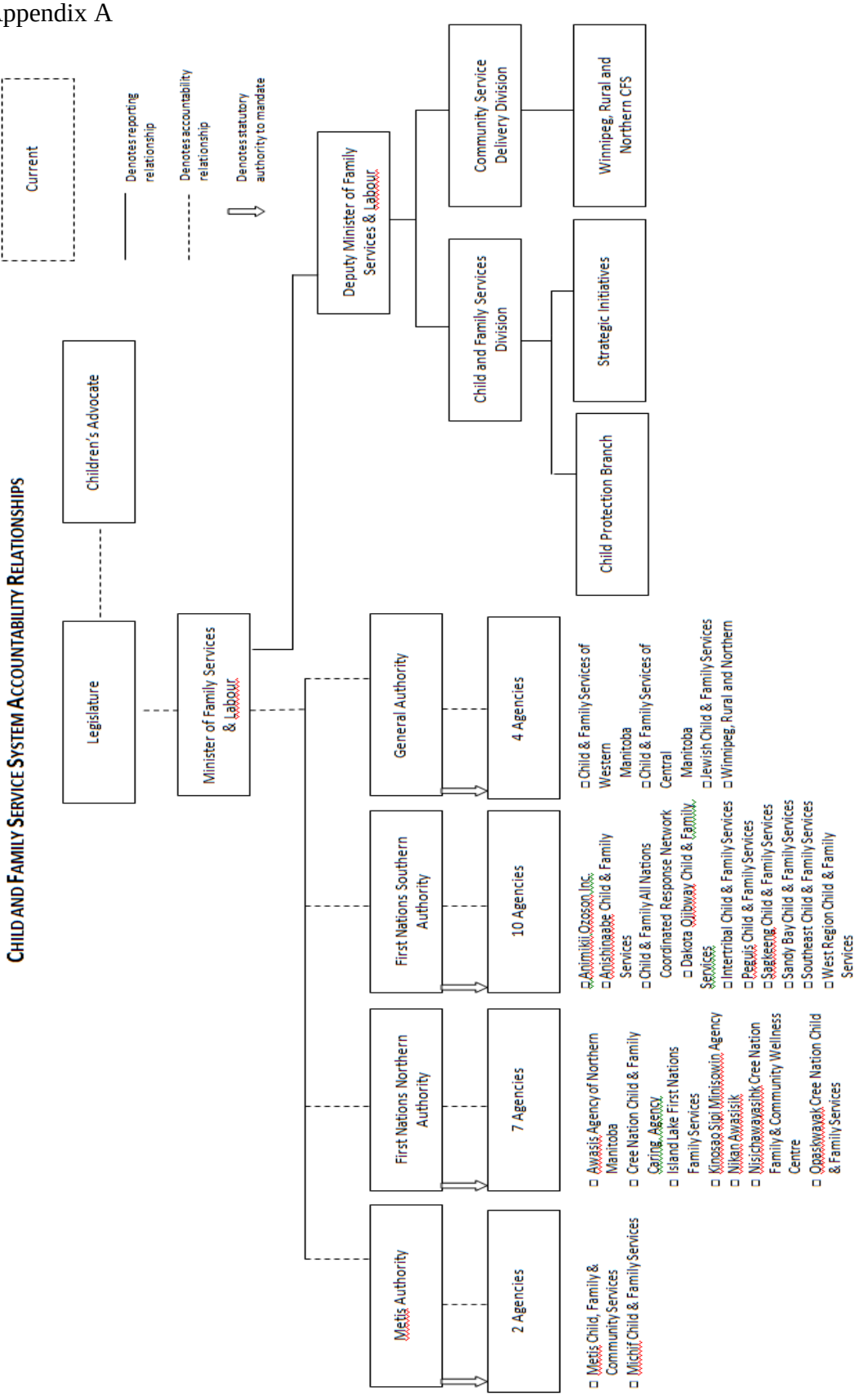
CONCLUSION

In an effort to continue improving the lives of children and families in Manitoba, the child welfare system must be ever-evolving, strengthening the administrative processes that work, and improving identified weaknesses and challenges. The child death review system is tasked with identifying ways in which the programs and services offered by the CFS system and related supports may be improved to enhance the safety and well-being of children and families in the province and to prevent deaths in similar circumstances. Monitoring the implementation of the SIR recommendations and reporting publicly on the actions of the system closes the circle to ensure the improvements and challenges to the system are addressed and progress continues.

With many of the structural challenges now identified and resolved in the child death review process itself, we have received a significant number of responses to recommendations from all of the Authorities, agencies, Child Protection Branch and entities to which SIR recommendations have been made and we are currently in the process of reviewing the material. Once received, responses to recommendations made in Special Investigation Reports require in-depth review and analysis. The analysis includes a review of the responsive material; resolution of questions or issues that remain outstanding; in-depth review of any supporting documentation included with the response; review of the applicable laws, regulations and standards pertaining to the recommendation and response; and consultation with various stakeholders including the Office of the Children's Advocate if required. Once our review, analysis and consultations are complete, we will be issuing a report on the implementation of recommendations concurrently with the release of our 2012 Annual Report in the spring of 2013.

The primary objectives of the system, the protection of children and preservation of families, reflect our core values and beliefs as a society. I wish to express my appreciation to the dedicated professionals who work tirelessly to provide services required to promote the safety and well being of children and families in Manitoba. I would also like to thank the Children's Advocate and her office, the staff and CEOs of the Child and Family Services Authorities, staff of the Child Protection Branch and the Child and Family Services Division of Family Services and Labour for their ongoing commitment to improving the lives of children and families of Manitoba.

Appendix A


CHILD AND FAMILY SERVICE SYSTEM ACCOUNTABILITY RELATIONSHIPS
Current
Denotes reporting relationship
Denotes accountability relationship
Denotes statutory authority to mandate
Legislature
Children's Advocate
Minister of Family Services & Labour
Deputy Minister of Family Services & Labour
Community Service Delivery Division
Winnipeg, Rural and Northern CFS
Child and Family Services Division
Strategic Initiatives
Child Protection Branch
General Authority
4 Agencies
Child & Family Services of Western Manitoba
Child & Family Services of Central Manitoba
Jewish Child & Family Services
Winnipeg, Rural and Northern
First Nations Southern Authority
10 Agencies
Animikii Ozoson Inc.
Anishinaabe Child & Family Services
Child & Family All Nations Coordinated Response Network
Dakota Ojibway Child & Family Services
Intertribal Child & Family Services
Peguis Child & Family Services
Sagkeeng Child & Family Services
Sandy Bay Child & Family Services
Southeast Child & Family Services
West Region Child & Family Services
First Nations Northern Authority
7 Agencies
Awasis Agency of Northern Manitoba
Cree Nation Child & Family Caring Agency
Island Lake First Nations Family Services
Kinosao Sipi Minisowin Agency
Nikan Awasisik
Nisichawayasihk Cree Nation Family & Community Wellness Centre
Opaskwayak Cree Nation Child & Family Services
Metis Authority
2 Agencies
Metis Child, Family & Community Services
Michif Child & Family Services