DUTY TO **PROTECT**

SPECIAL INVESTIGATION REPORT | OCTOBER 2016

SASKATCHEWAN
advocate
a Voice for Children and Youth

Letter of **Transmittal**

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October 13, 2016

The Honourable Corey Tochor
Speaker of the Legislative Assembly
Legislative Building
2405 Legislative Drive
Regina SK S4S 0B3

Dear Mr. Speaker:

In accordance with Section 29 of *The Advocate for Children and Youth Act,* it is my duty and privilege to submit to you and the members of the Legislative Assembly of Saskatchewan this special investigation report: *Duty to Protect*

Respectfully,

Bob Pringle
Advocate for Children and Youth
Province of Saskatchewan

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Executive Summary

This report is an examination of the events surrounding the death of a two-and-a-half month old infant we are calling Aiden, whose short life ended October 25, 2015. As per our legislation, we are not using Aiden's real name. In conducting this investigation, the goal is not to determine blame for Aiden's death, but to examine the services provided to Aiden, and his family, and to make recommendations to ensure that all children in Saskatchewan have equal access to the services to which they are entitled.

Aiden and his twin sister were born prematurely in August 2015. He remained in hospital for one month after his birth in the Neo-natal Intensive Care Unit. He was released with no medical concerns, apart from vulnerabilities related to being a premature newborn. He passed away in late October from Bronchopneumonia, secondary to a bacterial infection known as Haemophilus influenzae.

Aiden and his sister were the youngest of nine children in a family that had various involvements with the Saskatoon Tribal Council Health and Family Services Inc. (the Agency) prior to his death for issues related to domestic violence, substance misuse, lack of child supervision, and the use of inappropriate caregivers. Because of this involvement with the Agency, the Advocate for Children and Youth was notified of Aiden's death and an investigation was undertaken to examine the services received by the family. During the course of our investigation, interviews were conducted with senior officials from the Agency and the Ministry of Social Services, child protection workers, physicians, community support staff, and other healthcare workers.

Our investigation revealed that on numerous occasions, concerns were raised about the care Aiden was receiving, his living conditions, and the level of supervision in the home. The Saskatoon Tribal Council Health and Family Services Inc. has indicated that it did receive calls and made inquiries related to the safety of Aiden and his siblings, but stated that no action was required other than forwarding the file to support programs in the community. In assessing whether this was the proper course of action, we discovered intake and investigation processes that lacked rigour and an inadequate operational framework for the provision of ongoing protection services when children remain in parental care.

As a result of the findings of this investigation, the Advocate has made a number of recommendations to both the Ministry of Social Services and the Saskatoon Tribal Council Health and Family Services Inc. These are:

Recommendation 1: The Saskatoon Tribal Council Health and Family Services Inc., with the support of the Ministry of Social Services, ensure that, any time risk to children is identified, the following provincial policy and procedures are adhered to:

- proper assessment of risk using an objective risk tool and to assess risk before any course of action is taken;
- proper documentation of the assessment of risk;
- clear documentation of risk rating with commensurate case planning in cases where risk is substantiated; and,
- establishment of a structured and ongoing monitoring procedure for reassessment of risk to ensure consistent safety, protection and well-being of children.

Recommendation 2: The Saskatoon Tribal Council Health and Family Services Inc., with the support of the Ministry of Social Services, develop and implement training that incorporates:

- the use of the Risk Assessment tool with commensurate structured mentoring to assist staff in application of the tool;
- critical thinking skills and their application when assessing risk;
- examination of the totality of the circumstances related to risk; and,
- proper file documentation.

Recommendation 3: The Ministry of Social Services work with the Saskatoon Tribal Council Health and Family Services Inc. and with Indigenous and Northern Affairs Canada to ensure clarity between these three bodies as it pertains to understanding prevention services in the context of the mandate under *The Child and Family Services Act.*

Recommendation 4: The Saskatoon Tribal Council Health and Family Services Inc., with the support of the Ministry of Social Services, operationalize its definition and process of family service delivery to meet the intent of Sections 5 and 14 of *The Child and Family Services Act.*

Recommendation 5: Under the current framework of *The Child and Family Services Act,* the Ministry of Social Services increase its knowledge and understanding of the manner in which all First Nations child and family services agencies operationalize their prevention and protection services.

It cannot be determined with absolute certainty that Aiden's death was preventable, as the illness that took his life is unpredictable. As mentioned, our goal was not to lay blame for Aiden's death, but to look at the policy and processes that surrounded his care. As stated in the United Nations *Convention on the Rights of the Child,* the rights and interests of the child must be paramount, with their needs at the centre of all planning. We believe the recommendations put forth in our report will allow the Saskatoon Tribal Council Child and Family Services Inc. and the Ministry of Social Services to better meet this mandate.

1.0 Introduction

1.1 Circumstances of incident

Aiden was a fraternal twin born prematurely in August 2015. He and his sister were the youngest of nine children in the family home. Aiden remained in the Neo-natal Intensive Care Unit (NICU) for approximately one month after his birth. He was discharged to his parents in early September 2015 with no outstanding medical concerns apart from the vulnerabilities related to being a premature newborn. On October 25, 2015, at just under three months of age, Aiden passed away at home from Acute Bronchopneumonia secondary to Haemophilus influenzae (see text box). Aiden's family had been struggling with a number of challenges and had various involvements with the Saskatoon Tribal Council Health and Family Services Inc. (the Agency) in the weeks, months and years leading up to his passing. It was due to this involvement that the Advocate for Children and Youth received notification of Aiden's death.

Haemophilus influenzae and Bronchopneumonia

Haemophilus influenzae is a type of bacteria that typically causes illness in infants and young children. These illnesses can be mild, such as ear infections, sinus infections or lung infections (including bronchopneumonia). On rare occasions, it can lead to more severe conditions, like meningitis. It is spread from person to person through mucus and saliva. Despite its name, this bacteria does not cause the flu. There are six identifiable types of Haemophilus infuenzae (categorized from A to F) and others that are considered "non-typeable". A vaccine exists for only one strain of this bacteria – Haemophilus influenzae B (or Hib) (Public Health Agency of Canada. (2014). *Haemophilus influenzae disease.* Retrieved from http://www.phac-aspc.gc.ca/im/vpd-mev/hib-eng.php). This vaccine is typically given to children in Saskatchewan at two, four and six months old (Government of Canada. (2015). *Immunization Schedule Tool.* Retrieved from http://healthycanadians.gc.ca/apps/schedule-calendrier/index-eng.php). Aiden was found to have a non-typeable strain, for which there is no vaccine.

Bronchopneumonia is an infection causing inflammation of both the lungs and bronchi. Symptoms can develop gradually or suddenly and can include fever, cough with mucus, rapid breathing, sweating and chills. Bacterial bronchopneumonia is treated with antibiotics. The best prevention for an infant Aiden's age would be to maintain proper hygiene and avoid contact with sick individuals (Martell, J. (2015, October 6) Bronchopneumonia. Retrieved from: http://www.healthline.com/health/bronchopneumonia#Prevention7).

1.2 Mandate of the Advocate

The Advocate for Children and Youth (the Advocate) is an independent officer of the Legislative Assembly of Saskatchewan with a broad mandate to work on behalf of children and youth in Saskatchewan pursuant to *The Advocate for Children and Youth Act.* The core areas of work consist of advocacy, public education, research and investigations.

The Advocate's work is grounded in the United Nations *Convention on the Rights of the Child*, [1] an international human rights treaty that was ratified by Canada in 1991 and distilled into the *Saskatchewan Children and Youth First Principles.* [2] These principles were adopted by the provincial government in 2009. These Principles state that:

- Services to children must be provided equitably across the province, with the highest standard of health and education being available to them to help reach their full potential;
- Children should be free from all forms of physical, emotional and sexual harm; and
- The rights and interests of the child must be paramount, with their needs at the centre of all planning about their care.

The Advocate also follows the *Touchstones of Hope for Indigenous Children, Youth and Families* [3] that ensure services provided to First Nations and Métis children recognize the child is shaped by his or her traditions, spirituality, and social customs, and serve as a guide for reconciliation in Indigenous child welfare.

The Advocate is notified of all deaths and serious injuries of children who are receiving services, or have received services within the previous 12 months, under *The Child and Family Services Act.* The authority to investigate is derived from *The Advocate for Children and Youth Act.* This allows the Advocate to investigate any matter concerning services provided to children and youth by any provincial ministry, direct or delegated agency (including First Nations child and family services agencies), or publicly-funded health entity. The purpose of an investigation is to identify outstanding issues regarding those services that may require legislative, policy or practice changes to improve the quality of child-serving systems and to prevent deaths or injuries in the future.

1. UNICEF. UNICEF Convention on the Rights of the Child. http://www.unicef.org/crc/. Accessed September 20, 2016.

2. Saskatchewan Advocate for Children and Youth. Children and Youth First Principles. Available at: http://www.saskadvocate.ca/children-youth-first/children-youth-first-principles.

3. Blackstock, C., Cross, T., George, J., Brown, I., & Formsma, J. (2006). *Reconciliation in child welfare: Touchstones of Hope for Indigenous children, youth, and families.* Ottawa, ON, Canada: First Nations Child & Family Caring Society of Canada / Portland, OR: National Indian Child Welfare Association. More information on the Saskatchewan Advocate for Children and Youth's adoption of these principles is available at: http://www.saskadvocate.ca/children-youth-first/touchstones-of-hope.

The Child and Family Services Act

The Ministry of Social Services' Child and Family Services Division administers *The Child and Family Services Act (CFSA)*. The purpose of the *CFSA* is to promote the well-being of children in need of protection by offering services designed to support and preserve the family in the least disruptive manner. The *CFSA* provides the mandate to investigate reports of child abuse or neglect, and encourages that services to families be provided in such a way so that children can remain safely in their homes wherever possible. Where necessary, children may be removed from the family home when their parents are not able to meet their needs. The *CFSA* informs the policies followed by Ministry of Social Services and First Nations child and family services agencies.

First Nations Child and Family Services Agencies

Currently, child welfare is a provincial and territorial responsibility. First Nations child and family services agencies have been created as a mechanism for First Nations to exercise what is viewed as their pre-existing and continuous authority and responsibility to protect the rights and well-being of their people. Pursuant to *The Child and Family Services Act,* the Minister of Social Services has entered into agreements with First Nations agencies in Saskatchewan delegating to them the authority to deliver child protection services on reserve. These agencies are funded by the federal government and, as a condition of this funding in Saskatchewan, must apply the same legislative framework to child welfare as the Province. The Minister of Social Services remains ultimately accountable for all child welfare activities in Saskatchewan and requires periodic reports from the First Nations agencies. First Nations see this arrangement as an interim measure only, until such a time as they achieve full self-determination of their own affairs.

During the course of our investigation, the Ministry of Social Services (the Ministry) embarked on a process to revoke the Agency's delegated authority to provide child welfare services on reserve due to a dispute over reporting and the signing of an updated delegation agreement. The Agency challenged the Province's jurisdictional authority to take this step. In June 2016, the Court of Queen's Bench granted a temporary injunction prohibiting the Agency from exercising any powers under *The Child and Family Services* Act and requiring the Agency to provide the Ministry with access to its child welfare files. This interim measure was meant to allow the parties an opportunity to resolve their dispute. In the event that resolution is not reached, the matter would go back before the court to determine the larger questions of jurisdiction and the legality of the Ministry's termination of its agreement. At the time of writing, this process was ongoing. The above context is noted, as this process is separate from, and outside of, the legislated role and mandate of the Advocate's office.

1.3 Scope and method

Information related to Aiden's death was brought to the attention of our office in October 2015. However, the Advocate had not received official notification. Upon request by our office for information related to his death, the Agency initially denied having involvement with Aiden and his family. Once we determined the Agency had been involved with the family, the Ministry officially notified the Advocate. The Advocate's typical process upon notification of a child death or critical injury is to assess all available information from the service providers involved. We then determine whether there are outstanding questions or noticeable gaps in service provision that require further exploration through a full investigation.

At the outset of our assessment process, the Agency stated to the Advocate that its activities on reserve did not fall under the authority of provincial entities and that the Advocate had no powers to investigate. While recognizing the aspirations of Indigenous peoples towards full self-determination and control of child welfare systems in their communities, the Advocate has a legislated mandate to ensure the rights of children and youth are respected and adhered to through service provision by public authorities – no matter where in the province they are located. Our office has long advocated for Indigenous Peoples to have their own systems of child welfare, which may include independent oversight bodies. However, at the moment, the Advocate for Children and Youth is the *only* entity with a legal mandate to provide this oversight with respect to services to children and youth in Saskatchewan – both on and off reserve. Therefore, once a concern comes to the attention of the Advocate, it cannot be ignored.

In time, the Agency agreed to work with the Advocate out of the spirit of cooperation without prejudice as to their position on jurisdiction. However, limited information from the Agency was then provided to our office on the child welfare services offered to Aiden and his family. The Agency disclosed receiving four child protection reports involving Aiden's family. Evidence from other sources led the Advocate to believe this was not the full extent of the Agency's involvement. What we understand to be the complete documented record of service was eventually provided to our office. This documentation revealed significant involvement by the Agency over a number of years, with the last documented protection report occurring 11 days prior to Aiden's death. Further review revealed that Aiden's family also had various involvements with the Ministry of Social Services.

We understand that the Agency adheres to the *Indian Child Welfare and Family Support Act* created by the then Federation of Saskatchewan Indian Nations (FSIN), [4] in addition to *The Child and Family Services Act.* [5] The Advocate is advised by the Ministry that First Nations agencies are able to develop and implement their own local policies and procedures, as long as they satisfy the intent of *The Child and Family Services Act* and meet, or exceed, the provincial standards of service provision. The Saskatoon Tribal Council Health and Family Services Inc. has not yet taken this step, and confirmed to the Advocate that

it follows provincial policy. Therefore, all policy standards referred to in this report are assessed against the provincial guidelines that were in place at the time.

Due, in part, to the need for transparency and accountability in child welfare services, the Advocate determined that an investigation was necessary to establish whether Aiden's rights had been respected throughout service provision by the Agency and the Ministry. The Minister of Social Services is ultimately responsible for all child protection services in the province. Thus, the scope of our investigation also includes the Ministry in this regard.

Our scope also included an examination of the provincial health services provided to Aiden due to the inherent vulnerabilities resulting from his premature birth and the nature of the condition which led to his death. Our office obtained all available documentation from the Agency and Ministry, as well as all relevant file information from the two Health Regions that had contact with Aiden in his short life.

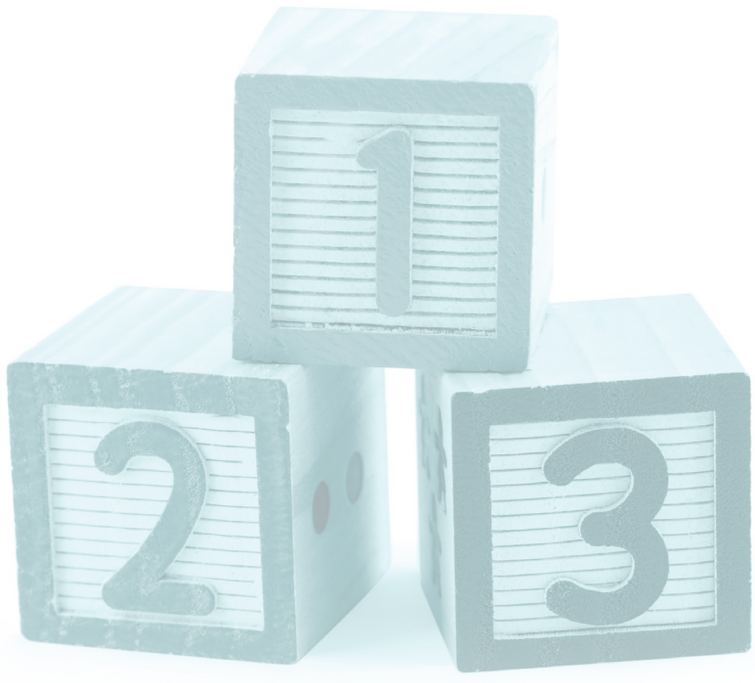
The Advocate for Children and Youth Act also gives us the authority to gather relevant information held by entities not specifically captured by our legislation. Accordingly, we reviewed all accessible information regarding social and health services provided to Aiden and his family by community programs in his home First Nation, and relevant information held by the RCMP.

Interviews were conducted with various service providers involved with Aiden and his family. These included child protection workers, community program staff, physicians and other health care workers. Discussions were also held with Agency management and senior Ministry officials with portfolios related to oversight of the Agency's activities. We are thankful for the cooperation of those involved in providing evidence to inform our investigation.

The Advocate notes, however, that we encountered many challenges from the Agency throughout our investigation with respect to gathering information, and interviewing leadership and staff. Our office found their cooperation to be reluctant and selective. While these barriers arose further to the Agency's position on jurisdiction, this situation is regrettable, as all children in Saskatchewan have a right to independent oversight of the child welfare services they are entitled to receive.

4. In May 2016, the FSIN changed its name from "Federation of Saskatchewan Indian Nations" to "Federation of Sovereign Indigenous Nations".

5. The FSIN *Indian Child Welfare and Family Support Act* has not been passed by the Saskatchewan Legislature, but has been recognized by the Ministry of Social Services as being consistent with the framework of *The Child and Family Services Act* and "equivalent to ministerial policies, practices and standards" (Letter from Minister Pat Atkinson to Vice Chief Tom Iron, 1993). It does not, however, contain clinical standards directing child protection workers in their day-to-day work.



2.0 Chronology of Events

2.1 Aiden's family history with the child welfare system

Aiden's family has a long history of involvement with the child welfare system. Both his parents were involved in the system as children, growing up in families where concerns of abuse and neglect were present. As adults, they had a tumultuous relationship and periods of separation. Aiden's parents primarily resided in their First Nations community, while also experiencing some transiency. They had their first child together in 2003 and became involved with the child protection system as parents shortly thereafter. Their children were placed in care under voluntary Section 9 agreements (see text box) a number of times from 2003 to 2013 due to concerns of domestic violence, substance misuse, home hygiene, use of inappropriate caregivers and a lack of supervision of the children.

Section 9 Agreements

Under Section 9 of *The Child and Family Services Act* parents can voluntarily place their child(ren) in the care of an Agency (or the Ministry) by signing an Agreement for Residential Services (commonly referred to as a Section 9 Agreement). These Agreements can be initiated at the request of parents who feel they are unable to meet a child's needs, or – as in this case – by an Agency when they feel a child is not safe in the care of their parents, even with the provision of supports. In the latter circumstances, if parents are not willing to sign such an Agreement, the Agency must apprehend the child and apply to the courts to make the child a temporary ward of the Minister.

By 2013, the family had five children in care with the Agency and a sixth on the way. Apart from incomplete case plans for two children, there was no documented planning for, or contact with, the children during their time in care under the Agency. In 2013, the Agency signed separate Parental Services Agreements (see text box) with the parents.

By signing these Agreements, Aiden's parents committed to seek programming for mental health and addictions, improve their parenting skills and secure housing appropriate for their children. As a result of the Agreement signed by the mother, their sixth child was discharged into her care at birth. The parents voluntarily agreed to keep their other children in care until these issues could be addressed.

Parental Services Agreements

A Parental Services Agreement is a voluntary agreement signed between a child's parents and a First Nations child and family services agency (or the Ministry) reflecting their desire to work together in the best interests of the child. The Agreement outlines the reason for child and family services involvement and identifies the tasks and outcomes to be achieved by the parents and Agency staff. These Agreements are typically 120 days in length and can be renewed or amended as necessary. If Agency staff believe a child requires protection, but could safely remain in the home with supports, either or both parents will be asked to sign a Parental Services Agreement. If parents are unwilling to sign an Agreement, the Agency is required to make an application to court for a protection hearing, where a judge will determine whether the child is in need of protection. [6]

The other children were returned to the parents in August 2013, once appropriate housing was secured. However, there is no indication that risk to the children had been objectively assessed prior to

their return or that any of the other steps outlined in the Parental Services Agreements had been taken to mitigate identified risk factors. Policy requires an objective Risk Assessment be completed at two points in case management – at the conclusion of an investigation and prior to the return of children from care. [7] These Assessments examine a number of factors that could negatively impact children. The Risk Assessment Tool used by the Agency assigns a risk level of zero, low, moderate or high. [8] Ratings of moderate or high risk indicate that a child is in need of protection and require ongoing intervention by child protection agencies until the risk factors are addressed.

The Agency continued to have concerns in relation to domestic violence, substance abuse and low parenting skills upon the return of the children. To deal with these issues, the family was referred to their First Nation's community Prevention Program. Prevention is a program that is separate from the Agency. However, both the Agency and the community understand it to be a support for families to help them keep their children out of care. The Prevention worker met with the family on a few occasions in October 2013, but there is no evidence to suggest that services were provided to address the issues identified above. According to file documentation, the Agency did not continue to monitor the family after the referral to the Prevention program. No further concerns were reported to the Agency over the next eight months.

In April and May 2014, there were three contacts with the Agency. The first was an allegation that the children, then aged one to nine, had been left home alone a few days earlier. The Agency responded within appropriate timelines and followed up with the parent, who denied leaving the children home alone. On this occasion, the worker counselled the parents to ensure the children were not left at home alone.

The other two reports were related to domestic discord between the parents during a process of separation and requests for assistance in mediating disputes over housing, provision of supplies for the children, and access to visits. The Agency attended on these occasions to provide assistance, but did not consider these issues to be child protection concerns. Accordingly, no additional action was taken. Aiden's parents separated and his mother moved from the First Nation to an urban centre with the children shortly thereafter.

2.2 Ministry involvement with the family

Moving from the community to the city brought Aiden's mother and children into the jurisdiction of the Ministry of Social Services. A concern was reported to the Ministry in June 2014 that a nine-year-old child was at a mall unsupervised and the mall was closing. The matter was assigned for investigation and a Ministry worker spoke to the mother and determined that she was appropriate in her response to the child's absence. There were no protection concerns identified and the investigation was closed.

Aiden's mother gave birth to her seventh child with Aiden's father in late August 2014. It appears the parents had reconciled by this time and, while in the hospital, left the other children with an extended family member in their First Nations community who was unable to meet their needs. This resulted in a report to the Agency. Agency staff intervened by locating the parents and making arrangements with other extended family members to care for the children.

At the same time, the hospital made a report to the Ministry concerning prenatal substance abuse. The Ministry conducted an immediate investigation, including having the mother submit to a drug and alcohol screen and contacting the Agency to gather more information. Although the Ministry completed the required investigation documentation, this did not occur within policy timelines. The Ministry concluded that the family was at high risk, but used its discretion to reduce the risk level due to its understanding that they were residing with the maternal grandmother, who acted as a support.

It appears there was not clarity within the Ministry or the Agency with respect to the actual residence of the children, as they seemed to be moving back and forth from the First Nation to the city. There is no documentation on the Ministry or Agency files to indicate the Agency was informed of the high risk rating found by the

Ministry. The Ministry continued to follow up and closed its file in October 2014, as the mother's drug and alcohol screen was negative and the family continued to live with the grandmother for support.

In November 2014, Aiden's mother and siblings moved back to their First Nations community. They were connected with the community's Focus on Families home visitor (see text box) for reasons of transiency, domestic violence and addictions. These issues were outside the role of this service provider. However, there is no documentation these concerns were reported to the Agency at this time or that the Agency had any knowledge the family had returned to their First Nations community.

6. Saskatchewan Ministry of Social Services. *Family-Centred Services Manual.* Ch. 5, Sec. 2. Saskatchewan: Ministry of Social Services.

7. Saskatchewan Ministry of Social Services. *Family-Centred Services Manual.* Ch. 2, Sec. 5. Saskatchewan: Ministry of Social Services.

8. In 2012, the Ministry implemented The Structured Decision-Making © System for Child Protective Services (SDM). This procedural model requires the use of different assessment tools related to safety and risk at key points in a child welfare case. It also contains service standards for re-assessment, contact with children and families and planning around their strengths and needs. Saskatoon Tribal Council Health and Family Services Inc. has not adopted the SDM model. Therefore, the Ministry continues to audit the Agency's activities against the former policy standards.

Focus on Families Home Visitor

The Focus on Families home visitor is a voluntary community-based service described to the Advocate as focusing on children aged 0 – 5 to provide early childhood education, assist parents in understanding the stages of child development, and encourage parent/child bonding.

2.3 Agency involvement in the year before Aiden's death

2.3.1 First child protection report in the twelve months prior to Aiden's death

There were no further reported concerns documented by the Agency until January 23, 2015, when it was alleged that the children were home alone. The Agency determined that an investigation was required and immediately attended the home. The father was present and indicated he had been home all day. The Agency's response was recorded on its Intake Report (see text box) and the matter was then closed with no further investigation. This met provincial policy standards for instances when allegations are proven to be false (i.e. rather than "unsubstantiated") and no other child protection concerns exist. [9]

However, contrary to provincial policy, the Agency had a general practice of documenting responses to allegations, and conclusions reached, on its Intake Reports rather than carrying out full investigations. If the specific allegation was not verified based on these preliminary responses, the Agency considered the matter to be an "unsubstantiated intake". Provincial policy states that, in most instances, contact with a family constitutes an investigation requiring additional assessment and documentation.

More than three months passed before the family had further involvement with the Agency. However, the family was visited often throughout January to March 2015 by the community's Focus on Families home visitor. Over this period, the family was moving between residences in the First Nations community and continued to struggle with domestic discord and substance use. The father appeared to be taking primary responsibility for the children. Both parents were encouraged by the Focus on Family home visitor to meet with the community addictions worker, but were reluctant to do so.

Intake and Investigation

Under provincial policy, the "intake" function is to receive reported concerns and gather as much information as possible from the reporter to determine whether an investigation is required. This information is then recorded in a form called an Intake Report. These documents are meant to describe the nature of the allegation, identify the parties involved, list past child protection involvement with a family, record supervisor direction and document the decision whether or not to investigate. Any personal contact with a family to determine the safety of the children is considered to be part of an "investigation" and requires corresponding investigation documentation. Provincial investigation policy applicable to the Agency at the time included a Risk Assessment to determine the likelihood of future harm to the children, and an Investigation Record to document all steps taken during an investigation and the rationale for conclusions reached.

2.3.2 Second report

A second concern was reported to the Agency on May 11, 2015. This report described a domestic dispute and concerns the children were left unsupervised. Agency staff attended the home to find two children, aged eight and four, alone. [10] The Agency also noted concerns about the hygiene of both the children and the home. The children were taken to the home of an extended family member who already had the two youngest children in her care, and returned to the parents shortly thereafter.

Although there is no legally defined age in Saskatchewan at which a child can be left home alone, Agency documentation stated that the children were removed on this occasion *"for their safety"*, indicating that immediate child protection concerns existed. The Intake Report completed on this occasion indicated that an investigation was required. The home visit and removal of the children was later added to the Intake Report, along with direction that referrals be made to both the Prevention and Focus on Families programs. There was no Risk Assessment or Investigation Record found in Agency files specific to this report. There was a notation in the file that the mother was pregnant (with Aiden and his twin sister) and was believed to be using substances. The worker indicated that a birth alert should be issued advising nearby hospitals of these concerns. However, there is no indication in the files of the Agency or the two closest Health Regions that this was done.

2.3.3 Third report

On May 16, 2015, the RCMP reported to the Agency that the eldest child, who was 12 years old at the time, had run away from home and did not want to return. Agency staff attended the residence where the child was located and transported her to the home of a family member. The mother was also present and was actively encouraging the child to return. The child disclosed to Agency staff that she did not want to go home because of her parents' substance use and the other children often being left in her care.

Although the Agency's Intake Report did not indicate whether the matter required investigation, a Risk Assessment was completed within policy timelines. However, this Assessment did not meet policy standards as it was specific to the child involved in this report and assessed only the risk posed by the mother. Risk Assessments are required to include an assessment of each child living in the household and every adult who may impact risk to the children. [11] This Assessment identified risks related to parenting skills, substance abuse, cooperation, family violence, condition of the home, and "other stressors" as high. It also identified that the child was often required to care for her siblings. Overall risk was found to be moderate. This was the only Risk Assessment found in the Agency's files. According to applicable policy standards, a moderate risk rating required intervention and monitoring by the child protection agency. [12] However, the Agency instead made another referral to the community Focus on Families program.

9. Saskatchewan Ministry of Social Services. (2012). Family-Centred Services Manual. Ch. 3, Sec. 11A. Saskatchewan: Ministry of Social Services.

10. In Saskatchewan, there is no legally defined age at which a child can be left alone. It is typically a matter of parental discretion. However, any child under the age of 16 could be found to be "in need of protection" under Section 11 of *The Child and Family Services Act* "if there is no adult person able or willing to provide care for the child's needs and physical or emotional harm to the child has occurred or is likely to occur". A determination in this regard is dependent upon the circumstances (age, development, maturity, safety of the neighbourhood, number of other children, etc.). Under Section 218 of *the Criminal Code*, it is an offence to "abandon" a child under age 10 if it will likely endanger his/her life or health.

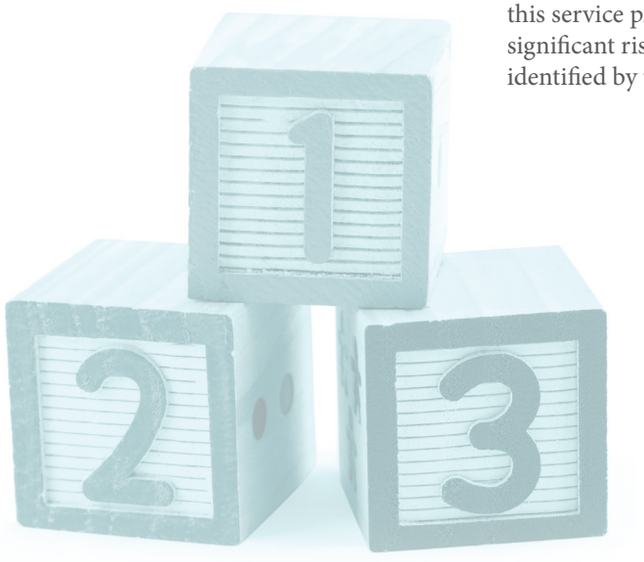
11. Saskatchewan Ministry of Social Services. (2015). Family-Centred Services Manual. Ch. 2, Sec. 5. Saskatchewan: Ministry of Social Services.

12. Saskatchewan Ministry of Social Services. (2015). Family-Centred Services Manual. Ch. 2, Sec. 5. Saskatchewan: Ministry of Social Services.

The reasons for this referral were identified as domestic violence, improper supervision of the children, lack of parenting skills, substance abuse and concerns with the cleanliness of the home. A summary of involvement with Aiden's mother was completed by the Agency, apparently to inform this referral. This summary described limited cooperation by the parents with community supports. It called for *"urgent intervention"* to support Aiden's mother with her addictions, as well as various supports for the other issues identified in the referral. There was no documented discussion of the level of involvement of the father at this time. Finally, this report stated that a further Risk Assessment should be completed including all the children.

Risk Assessments are the responsibility of Agency staff, rather than community service providers, such as the Focus on Families program. There is no evidence in the file that a further Risk Assessment was completed. The issues identified in the Agency's summary and the moderate risk rating indicate that the children should have been determined to be "in need of protection" at this time. This would have necessitated ongoing involvement by the Agency, further to its duty to provide family services under Section 14 of *The Child and Family Services Act* (see text box). However, there was no further monitoring by the Agency following the referral to the Focus on Families program.

While this program is an asset to the community and was a useful resource to this family, it was not the role of this service provider to deal with the significant risk factors of the parents identified by the Agency.



The Child and Family Services Act – Duty to Offer Family Services

14 **(1)** Where, on investigation, an officer concludes that a child is in need of protection, the officer shall:

(a) notify the parent in writing of the officer's conclusion; and

(b) offer family services to the parent.

(2) Where a parent acknowledges the need for family services and agrees to the provision of those services, a director may enter into an agreement with the parent for the provision of family services.

(3) Section 9 applies, with any necessary modification, to an agreement for residential services made pursuant to this section.

(4) Where the parent and the director do not enter into an agreement pursuant to subsection (2) and an officer believes that the child is in need of protection, the officer shall, within 30 days of giving notice to the parent pursuant to clause **(1)(a)**:

(a) apply to the court for a protection hearing; or

(b) submit the officer's reasons for that belief to a mediator pursuant to section 15.

(5) An application pursuant to clause **(4)(a)** may be made by telephone in accordance with the regulations.

The Focus on Families home visitor met with the family an average of once a week from the end of May 2015 to Aiden's death at the end of October 2015. Activities focused on assisting the family with cleanliness of the home and providing instruction on parenting skills such as hygiene and feeding. Neither the Agency, nor Focus on Families, made formal referrals for addictions treatment, anger management or domestic violence programming. The Focus on Families home visitor attempted to help the parents

build trust in the other community services providers. However, these services were considered voluntary and it was stated to the Advocate that the parents did not seek them out due, in part, to concerns of confidentiality.

Meanwhile, it was reported to the Agency in August 2015 that Aiden's mother continued to use substances during her pregnancy with him and his sister and had not participated in prenatal care. The Agency did not document this contact in an Intake Report, but made an immediate referral to the Focus on Families home visitor for follow-up. The visitor attended the home, but found that the family was already in the city for the birth.

2.4 Aiden's short life

Aiden and his twin sister were born prematurely in early August 2015, both weighing approximately 3.6 pounds. Although the First Nation's community Health Centre offered support during this pregnancy in the form of reminders to attend appointments and assistance with transportation, Aiden's mother received very limited prenatal care and was unaware that she was carrying twins. Aiden and his sister became the youngest of nine children in the care of their parents, the eldest of whom was 12 years old.

Aiden remained in the Neo-natal Intensive Care Unit (NICU) of the hospital for four weeks after his birth. His stay in the NICU was unremarkable and his medical file indicated he had no apparent cerebral, cardiovascular or respiratory complications from his prematurity. Aiden gained weight while in the NICU and was 4.7 pounds at the time of his discharge. However, he remained vulnerable due to his size and prematurity. He required a special diet of high calorie formula, follow-up with a dietician, and to be assessed and weighed on a weekly basis to observe growth and development. He was also required to have contact with specialists, including the NICU follow-up clinic and an audiologist, in addition to regular monitoring by a general physician, a course of multivitamins and routine immunizations beginning at two months of age.

The Agency was informed of the twins' premature birth and that they would remain in the hospital for some time. The Focus on Families home visitor continued to attend the home and assisted the family with required clean-up and repairs. Aiden was discharged from the hospital on September 5, 2015. The hospital social worker had been consulted by the NICU prior to his discharge. On the basis of one meeting with the parents, the social worker had no immediate concerns.

2.4.1 Fourth child protection report in the twelve months prior to Aiden's death

On September 18, 2015, another concern was reported to the Agency. While Aiden attended his required weigh-in the week following his discharge, he missed both a medical appointment and his scheduled weigh-in the following week. In addition, his dietary recommendations were not being complied with and his nurses were concerned that he was not gaining adequate weight. They also believed Aiden had thrush, a common yeast infection that occurs in a baby's mouth, but were not able to examine him. As a result, referrals were made to both the Agency for child protection services, as well as the community Prevention program. The Prevention worker assisted the parents in attending to have Aiden weighed on this occasion. There was no documented response by the Agency.

2.4.2 Fifth report

Aiden missed his next scheduled medical appointment/weigh-in on September 21, 2015, and this was reported to the Agency. On this day, a case conference was held including Agency staff, the Prevention worker, the Focus on Families home visitor and the community Health Nurse. The Agency was advised that the parents were not meeting the medical needs of the twins and were not cooperating with these community supports.

An Agency staff member attended the home later that day and found six of the children, including the then one-and-a-half-month-old twins, home alone. The oldest child present was ten years old. This was the second time in four months that this worker had witnessed young children home alone. Significant concerns

were also noted at this time about the cleanliness of the residence. The Agency staff member contacted the parents, who then returned. Agency staff arranged for the twins to be seen at a hospital that evening. An Agency staff member attended with the family to ensure the babies' medical needs were met.

During this examination, Aiden was found to have an eye infection, oral thrush and mild diaper rash – symptoms common to infants his age. At this time, there were no signs of other illness. However, the doctor stated that, due to the vulnerability of the twins, medical appointments and weekly weigh-ins must be honoured, the home must be kept clean, the children must be bathed daily, and their diapers must be changed regularly in order to avoid infection. The physician documented concerns about there being no hot water in the home and the impact this would have on the hygiene of the twins.

The physician communicated his instructions to Aiden's father, the community Health Centre and the Agency. The doctor stated that it was important for the twins and the mother to maintain their bond. However, he advised all parties that if the parents did not follow his recommendations, he felt there would be grounds to apprehend the babies. The physician requested the Agency follow up on whether the hot water was repaired and whether there was an improvement in parenting skills.

An Intake Report was created as a result of this situation and stated that *"Further child protection concerns would be discussed with the supervisor and addressed with the parents."* This form was missing the section indicating whether an investigation is required. However, the supervisor's direction on the form was that *"All parties need to monitor the twin's [sic]. Case conference with all involved, plus family."*

Despite the fact that this was the second report to the Agency of a missed medical appointment for these vulnerable infants, a formal investigation was not conducted and risk was not objectively assessed. Rather, the day after this appointment, the Agency referred the family back to the community Prevention worker, citing concerns related to substance abuse, hygiene of the twins, and the need to honour medical appointments. Again, as "child protection concerns" were identified at this time, the children should have been determined to be "in need of protection" by the Agency.

The Prevention worker is documented to have made two home visits following this referral. The Prevention file indicated that the father was willing to work with this service provider and that the Band Council was to fix the water heater. However, there were no documented referrals to addictions programming and no structured plan to ensure the family met the twins' medical needs.

2.4.3 Sixth report

On September 23, 2015, a second case conference took place to discuss the physician's orders, including Agency staff, the community Health Nurse, the Prevention worker and the Focus on Families home visitor. The family was not involved. Agency file documentation did not describe the conclusions reached, but our office was informed that the Health Nurses agreed to check in with the family weekly to weigh the twins and assess the home. In addition, the Prevention worker and Focus on Families home visitor would meet with the family at the beginning and end of each week. The Agency did not assume an ongoing role, but reportedly instructed that it be notified of any problems in this regard. The next day, a concern was reported to the Agency that the parents were not cooperating with these community supports. This was the third report regarding the failure to cooperate with medical supports for the twins, and the sixth concern received by the Agency in the previous year. Yet, the Agency did not record this referral in an Intake Report and there was no documented Agency follow-up.

Aiden's parents did have him assessed by a second doctor on October 3, 2015 for an unrelated medical condition. The twins also attended their scheduled weigh-in and received their two-month immunizations on October 7, 2015. No other health concerns were noted by medical professionals at this time. In fact, Aiden appeared to be gaining weight and his dietician recommended his formula concentration be decreased. This was the last time Aiden was weighed prior to his death two-and-a-half weeks later.

2.4.4 Seventh report

The next documented involvement of the Agency occurred on October 10, 2015. On this occasion, the RCMP reported it had received an allegation that seven children – including the then two-month-old twins – were left alone, with the eldest child present being ten years of age. A staff member was not immediately available to travel to the area. As a result, RCMP members attended the home approximately one hour after the matter was reported and found the mother to be home with the children. However, the RCMP told the Agency it still had serious concerns about the family due to the number of reports it had received and because officers had attended the home on past occasions when the children had been left alone.

An Intake Report was created stating that a response was required within one week, as per policy standards. The Agency met this timeline when the supervisor spoke with collaterals and met with the mother three days later on October 14, 2015. The mother denied leaving the children home alone, but nonetheless was counselled that one parent had to be at home at all times, or there needed to be an appropriate babysitter. There was no indication in the file that the twins or the other children were seen on this occasion. The twins' weekly weigh-in was scheduled on this day, but there is no indication that the supervisor discussed this with the mother during this visit.

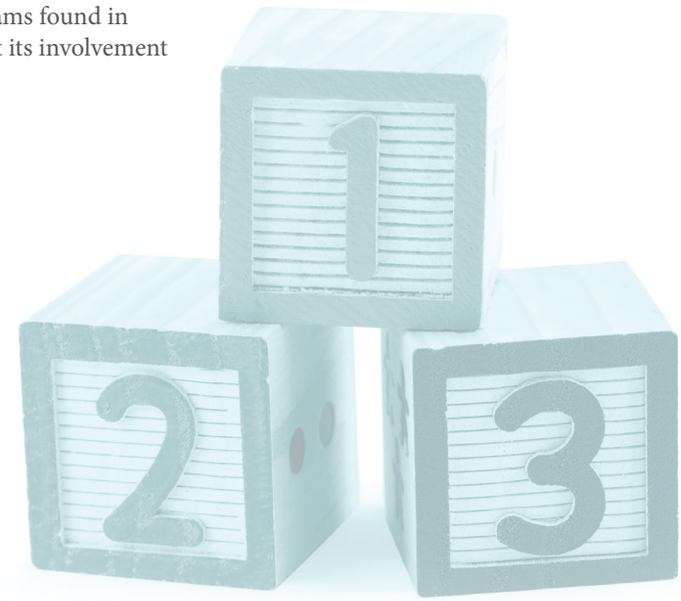
2.4.5 Eighth report

Later in the day of October 14, 2015, it was reported to the Agency supervisor that the twins had not been brought in to be weighed. The supervisor followed up with the Focus on Families home visitor, who indicated the parents could not attend as scheduled due to issues with transportation, and were instructed by the home visitor not to attend the next day as the Health Centre staff were not available. There was no other documented follow up with the family by the Agency between this time and Aiden's death 11 days later. Again, risk was not assessed. Had this been done, due to Aiden's vulnerabilities, the doctor's orders and the support needed by the family to meet his medical needs, he would have been found to be in need of protection.

The Advocate was informed that Aiden and his sister also missed their next weekly weigh-in, which was scheduled to take place four days before Aiden passed away. A report was not made to the Agency on this occasion, nor did the Agency document any steps to verify whether or not the twins attended. Aiden's audiology follow-up was scheduled for two days before his death, but he also did not attend this appointment. Again, the Agency was not made aware of these particular circumstances.

2.5 Aiden's death

Aiden passed away at home on October 25, 2015 from Acute Bronchopneumonia secondary to non-typeable Haemophilus influenzae, at just under three months of age. The Advocate received information that he had been exhibiting signs of illness at least three days before his death, the degree to which is unknown. In the days following his death, his twin sister was also briefly hospitalized for a respiratory illness. The forensic pathologist who examined Aiden after his death reported no concerns with his weight or physical development. The Agency supported the family following his passing and eventually apprehended his siblings for reasons of escalating parental substance use resulting from their grief, lack of supervision of the children, low parenting skills and historical concerns of domestic violence. The parents were then referred to programming, including addictions and mental health counselling, to address these issues. These were the first formal referrals to those programs found in Agency files throughout its involvement with the family.



3.0 Internal Review of the Agency

An internal review of the Agency's service provision leading up to Aiden's death, entitled *Root Cause Analysis,* was provided to the Advocate's office, as well as posted on the Saskatoon Tribal Council's (STC) website and made available to community members. The stated purpose of this document was to: 1) fulfill STC's commitment to providing exceptional service delivery by utilizing the recommendations as a guide for change; 2) acknowledge responsibility to examine and question the circumstances around Aiden's death; and 3) publish and circulate the findings as a mechanism of accountability to the STC's membership.

The review examined only four concerns reported to the Agency. These included the January 23 and October 10, 2015 reports that the children were left alone, the May 16, 2015 report involving the eldest child not wanting to return home, and the report advising the Agency of Aiden's death. Further to its analysis of these reports, the review concluded that the Agency had no mandate to be involved with the family. The review stated, *"that no mandatory services had been provided by STC Child and Family Services Inc., though the family was in receipt of and supported by voluntary community services."* The review did not refer to the various other contacts, Intake Reports or referrals for protection services received by the Agency that are discussed above. Notably, it did not indicate that the Agency had found a moderate risk rating in May 2015, or that it had been made aware Aiden had missed required medical appointments on at least three occasions.

On the basis of the four reports assessed, the review concluded that the Agency had met its legislated obligations and that no amount of services could have prevented Aiden's death. In spite of this finding, the review suggested that a larger assessment of the delivery and intersection of community services provided to Aiden's family had been conducted. Although the details of these services were not discussed in this document, the review identified *"several overarching organizational risks which require immediate remedy"* as part of the quality assurance and improvement processes. It found the need for a comprehensive structural review of the Child and Family Services Program to ensure that client-centred services were being provided and legislated obligations were being maintained. It stated that a mechanism of oversight needed to be implemented as part of this process. It also identified a need for immediate action to define processes and procedures of collaboration across all programs to ensure compliance and consistency in service delivery.

The review identified several corrective actions to meet these goals. These included:

- creating new positions to place a renewed focus on documentation, training, and oversight;
- increasing cooperation between Agency Child Protection supervisors and clinical supervisors of community programs to improve collaboration and service consistency;
- provide more education on the Duty to Report child protection concerns;
- ensure all staff are in compliance with STC policies and procedures, especially where confidentiality is concerned;
- clearly define roles and responsibilities and lines of authority when multiple programs are involved with one family; and
- obtain a centralized case management system with the ability to reflect all services to assist in the oversight and administration of complex files with numerous service providers.

The review indicated that these actions were expected to ensure the better integration and education of all STC programs and services coordinating with the Agency related to both mandated and voluntary services.

The Advocate is encouraged by these recommendations and resulting action plan, as they have the potential to address many of the issues identified in our

investigation. However, it is unclear how only the four child protection reports discussed in the review were determined to constitute "mandatory services" when there were numerous other concerns reported to the Agency that, in accordance with provincial standards, required its intervention.

4.0 Advocates Findings and Recommendations

Our investigation found several gaps in service provision by the Agency in relation to its investigation and assessment of risk, and the assumption of responsibility for case management of ongoing family services. It was also determined that the Ministry of Social Services lacked clarity in regards to the Agency's approach to "family services" under *The Child and Family Services Act,* and how it distinguishes between prevention and protection services.

As discussed above, the Ministry had temporarily assumed responsibility for child welfare services previously provided by the Agency. At the time of writing, the Ministry and the Agency were working to resolve the issue, and the matter was before the courts. It is not known to the Advocate how this process will conclude. In the event the Agency resumes its services, we hope the following findings and recommendations pertaining to its activities will help guide future service provision. We also expect the Ministry will take heed of the recommendations regarding its processes of oversight and their application, not just to STC Health and Family Services Inc., but to all First Nations agencies with whom it works.

4.1 Intake and investigation

Finding 1: Documentation maintained by the Agency did not meet policy standards and negatively impacted service provision to Aiden and his family.

A "family services" file under the names of the parents was never opened. This is in spite of the fact that the Agency had signed Parental Services Agreements with them while the children were in care and circumstances have been identified by this investigation where the children should have been found to be in need of protection. Rather, the Advocate was provided only with "Child in Care" files for each of Aiden's eight siblings, which included duplicates of documents and contact notes.

It is unclear to the Advocate how the Agency would have kept track of progress made by the parents with their case plans while the children were in care. In fact, there was no indication in these files that steps were made by the Agency to monitor progress in this regard. Files attached to parents' names would allow for more consistency and efficacy in case planning.

Furthermore, there was no documentation of contact with the children while in care and insufficient documentation of case planning for them during these periods. Although this issue is far removed from Aiden's death, this absence is particularly concerning as children separated from their parents have a right to special care and protection by the public authorities responsible. [13] It is difficult to conclude how this care was being provided when there was no documented contact with, or planning for, these children.

While the Agency did document numerous contacts, some important communications with the family or other service providers were not found in its files. For instance, an Agency worker is reported to have attended the home in March 2015 along with the RCMP related to conflict between the parents. Additionally, a community service provider reported having expressed various concerns to the Agency related to the safety of the children. These contacts are not recorded in Agency files.

13. United Nations General Assembly. (1989). Article 20 of Convention on the Rights of the Child. Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

Intake Reports were often not created when the Agency received a written referral from a community program. As a result, there was no mechanism to record supervisor direction, past involvement with a family, or decisions related to the need for an investigation, all of which affected practice and decision making. When Intake Reports were completed by the Agency, the section meant to record past involvement was not utilized. These practices could result in lost opportunities to make decisions on the need for investigation based on a full and objective review of family history. Required investigation documentation was also not found in the files. While this is discussed below in relation to risk assessment, it bears mentioning here as it is indicative of a lack of policy compliance with respect to documentation in general.

In the internal review, recommended actions were put forward to place an increased focus on documentation and compliance oversight. Additionally, the Agency's intention to implement a centralized information tracking system may have the potential to improve access to historical information at the intake stage. The Advocate would welcome a discussion on how these actions will address the specific issues identified here.

Finding 2: In the month before Aiden's death, two child protection reports related to his medical care were received for which there was either no response or an insufficient response documented in Agency files.

There were instances where the Agency's immediate response to reported concerns was appropriate. For instance, when it was alleged the children were home alone, Agency staff promptly attended to verify the safety of the children. In addition, when Aiden missed his second medical appointment on September 21, 2015, the Agency intervened and made sure he and his sister were seen by a physician, going as far as having an Agency staff member attend with the family. Whether additional investigation or intervention was required following an initial response is discussed further in subsequent findings. In other cases, referrals were appropriately made to other services when allegations did not clearly meet the threshold for child protection services.

These included a reported lack of prenatal care and, possibly, the first instance in which Aiden did not attend a scheduled medical appointment.

However, there were occasions on which a concern was reported specific to Aiden and documented response by the Agency was lacking. In a case conference on September 23, 2015, community service providers agreed to report back to the Agency regarding any problem with the parents following up on the twins' medical needs. In spite of this arrangement, two concerns were reported in this regard where documented follow-up did not occur or was insufficient.

In light of the vulnerabilities of the twins and the previous instruction from a physician on the necessity of honouring their medical appointments, these circumstances met the criteria for potential neglect on the basis of inadequate medical care. Policy required a response from the Agency, including further investigation into the well-being of, or risk to, Aiden and his sister.

The twins then missed their weigh-in scheduled four days before Aiden's death. Although Aiden was to be weighed and assessed on a weekly basis, he was not seen by a medical professional for nearly three weeks before he died. Aiden was exhibiting signs of illness at least three days before his death. This last instance was not reported to the Agency, and it is unknown whether his symptoms would have been visible to medical professionals at this time. However, had the Agency become involved as a result of previous reports it would have been in a position to support his family in his attending this specific appointment.

Including visits with a general physician and an audiologist, as well as weekly weigh-ins and assessments, Aiden missed six scheduled medical appointments in the approximately six weeks since his release from the hospital – four of which were made known to the Agency. He did eventually attend on two of these occasions with the assistance of either the Prevention Worker or Agency staff. It is clear that his family required significant support to meet the medical needs of the twins.

It must be noted that the medical care referred to in these instances was unrelated to the condition which led to

Aiden's death. Regardless, this discussion is important as the United Nations *Convention on the Rights of the Child* guarantees to children and youth the right to life, survival, and development to the maximum extent possible.[14] This is tied to their right to the highest possible standard of health. [15] When parents face challenges in ensuring children's access to necessary and available health care, the State has an obligation to investigate these circumstances and assist parents in their discharge of these responsibilities. [16]

Finding 3: The Agency's approach to investigation processes did not meet provincial policy standards and lacked the rigour those standards require.

Child protection agencies in Saskatchewan have a legal duty under Section 13 of *The Child and Family Services Act* to investigate all reports in which there are allegations, and reasonable grounds to believe, that a child may be in need of protection. The purpose of child protection investigations is to determine the validity of allegations, assess the likelihood of future harm and build cooperation with a family in the event that ongoing services will be required. [17]

As mentioned above, the Agency considers initial responses to substantiate a report to be part of the intake process. This approach lacks the objectivity and rigour required by policy when a matter is considered to be under investigation.

Provincial investigation policy requires personal contact with the child and parents, and documentation of any contact with other children including observations about their well-being. In addition to the reported incident, the investigator must assess the existence of other types of abuse or neglect in the family, consider the family's history with the child welfare system and gather collateral information, when appropriate, with consideration of the family's right to privacy and confidentiality. [18] Risk Assessment Tools and Investigation Records are mandatory documents to be completed during an investigation unless the allegations are confirmed to be false and there are no other child protection concerns. [19] Although the Agency did respond to some degree to the majority of concerns received, many of these steps were not taken.

The file material indicated that only one of the children was interviewed on one occasion throughout the history of involvement with the family, despite the fact that many of the children would have been old enough to provide information on their experiences. On that occasion, this child disclosed parental substance abuse and lack of supervision. However, these statements did not appear to be taken seriously, as the internal review described this incident as *"not involving the family home or any other family members"*.

There was an insufficient use of collateral sources when gathering information relevant to reported concerns. The Executive Director stated to our office that there was never any evidence to verify domestic violence or the impact it may be having on the children. However, substantial information in this regard could have been collected from the RCMP, the Ministry of Justice - Corrections and Policing and the Focus on Families program without violating the family's right to confidentiality. Although concerns with substance abuse were persistent in the year before Aiden's death, the Agency did not request the parents undergo alcohol or drug screening. Further, there was no documented contact with the children's school to determine whether their behaviour was being impacted by any of the circumstances within the home. It seems the Agency was viewing each report in isolation, rather than considering the totality of challenges the family faced and assessing whether other forms of risk or negative patterns existed. Risk Assessments and Investigation Records were not found on file on occasions where they were warranted.

Had the above steps been taken, the Agency would have had a much clearer picture of any potential risks to the children. This information would have better-informed case management decisions.

14. United Nations General Assembly. (1989). Article 6 of Convention on the Rights of the Child.

15. United Nations General Assembly. (1989). Article 24 of Convention on the Rights of the Child.

16. United Nations General Assembly. (1989). Articles 18 & 19 of Convention on the Rights of the Child.

17. Saskatchewan Ministry of Social Services. (2015). Family-Centred Services Manual. Ch. 3, Sec. 1. Saskatchewan: Ministry of Social Services.

18. Saskatchewan Ministry of Social Services. (2015). Family-Centred Services Manual. Ch. 3, Sec. 11. Saskatchewan: Ministry of Social Services.

19. Saskatchewan Ministry of Social Services. (2015). Family-Centred Services Manual. Ch. 3, Sec. 11A. Saskatchewan: Ministry of Social Services.

Finding 4: The Agency did not use Risk Assessments as required by provincial policy.

File documentation revealed only one Risk Assessment had been completed, despite the children having been in care and numerous reported concerns with the family from September 2010 to October 2015. The one Risk Assessment completed in May 2015 was appropriate due to the nature of the circumstances. However, this document was incomplete and did not follow policy standards, as it assessed only one of seven children living in the home and did not assess both parents.

Our investigation determined that Risk Assessments were likely required on at least three other occasions in the year before Aiden's death alone. Two of those occurred in the one-and-a-half months between his discharge from the NICU and his death and were related to reports of missed medical appointments.

Because the Agency considered its response to reported concerns to have resulted in "unsubstantiated intakes", rather than to have been investigations requiring systematic evaluation and documentation of risk, the door was left open for subjective assessments. Risk Assessments prompt child protection workers to take a comprehensive look at all factors potentially impacting children in a negative way, rather than assessing the particulars of each allegation in isolation.

Both the Child Protection worker assigned to Aiden's community and the Executive Director of the Agency stated to the Advocate that they conducted Risk Assessments if they felt risk was present after attending a home. This notion negates the purpose of the Risk Assessment Tool as being the objective standard against which risk is determined. To not use it unless risk is perceived, is to wholly substitute one's subjective assessment of the circumstances in contravention of policy.

In the absence of objective assessments of risk, it is not clear how the Agency determined that referrals to community programs – without ongoing support from the Agency – were sufficient to ensure the children's safety. Our office has limited information regarding the degree to which the challenges faced by Aiden's parents impacted their ability to parent. Information such as this would typically be collected through the process of completing a Risk Assessment and a thorough investigation. However, we do know that both the Ministry and the Agency found risk levels high enough in late 2014 and early 2015 to require ongoing child protection services.

In the case of the Ministry's assessment, risk was only mitigated by the fact that the family had the support of the maternal grandmother. This protective factor was lost shortly thereafter when Aiden's mother and the children moved back to the First Nations community in or about November 2014. Considering that no steps had been taken to address parental issues, it can be expected that risk levels would have remained the same, if not increased with the unexpected arrival of premature twins to an already large and struggling family.

Recommendation 1:

The Saskatoon Tribal Council Health and Family Services Inc., with the support of the Ministry of Social Services, ensure that, any time risk to children is identified, the following provincial policy and procedures are adhered to:

- proper assessment of risk using an objective risk tool and to assess risk before any course of action is taken;
- proper documentation of the assessment of risk;
- clear documentation of risk rating with commensurate case planning in cases where risk is substantiated; and,
- establishment of a structured and ongoing monitoring procedures for reassessment of risk to ensure consistent well-being and safety of children.

Recommendation 2:

The Saskatoon Tribal Council Health and Family Services Inc., with the support of the Ministry of Social Services, develop and implement training that incorporates:

- the use of the Risk Assessment tool with commensurate structured mentoring to assist staff in application of the tool;
- critical thinking skills and their application when assessing risk;
- examination of the totality of the circumstances related to risk; and,
- proper file documentation.

4.2 Boundaries between prevention and protection

Finding 5: The Agency did not provide ongoing family services when required and, instead, continually referred Aiden's family to community programs without a legislated mandate to address, monitor, and assess the risks identified as impacting the children.

The Child and Family Services Act defines "family services"' as *"services designed to strengthen, enhance and maintain the family unit"*. Child welfare agencies have a duty under *The Child and Family Services Act* to offer family services when a child is in need of protection, but could safely remain in the home if risks can be mitigated through supports to the family. [20] Case management in these circumstances remains the responsibility of Agency staff as delegated "officers" under *The Child and Family Services Act*.

This concept is also contemplated by the FSIN *Indian Child Welfare and Family Support Act*, which contains an identical definition under the term "family support services", and identifies First Nations parents as having a right to these services *"in the case of family crisis which has led or may lead to a child being in need of protection"*. Family support services are identified in this document as being separate from "preventative services" which are to be provided in cases where children are not considered to be in need of protection. [21] The definition of "a child in need of protection" is also comparable between these two documents.

The Agency did not consider itself to have provided "family services/family support services," as is evidenced by the statement in its *Root Cause Analysis* that *"no mandatory services had been provided by STC Child and Family Services Inc.; though the family was in receipt of and supported by voluntary community services"*.

As indicated above, there were points in time when – had risk been objectively and comprehensively assessed – Aiden and his sibling(s) would have been found to be in need of protection. Further, on the one occasion that a Risk Assessment was completed, a moderate risk level was found which, according to applicable provincial standards, required ongoing family services by the Agency. Yet, this did not occur. At the very least, these circumstances would have necessitated the Agency enter into an agreement with the family (i.e. Parental Services Agreement), create a case plan to address the identified risks, make any necessary referrals to assist the parents in this regard, and monitor progress with that plan. These agreements also carry ramifications for non-compliance with the case plan, in contrast to the voluntary approach taken following a referral to the Focus on Families or Prevention programs.

20. *The Child and Family Services Act,* Statutes of Saskatchewan. (1990, c. C-7.2, Sec. 14).

21. Federation of Saskatchewan Indian Nations. (2011). *Indian Child Welfare and Family Support Act,* Article VI.

The parents were reluctant to engage in any services, which was a barrier for community programs to move forward. No formal referrals were made to services that could support the parents with addiction or domestic discord in the year before Aiden's death. Thus, a more rigorous approach was required. Our investigation found no evidence that the Agency provides family services in Aiden's community despite having a mandate to do so under both *The Child and Family Services Act* and FSIN *Indian Child Welfare and Family Support Act*. It seems the Agency sees its role as investigating child protection reports and taking children into care when the risks are too great for them to safely remain at home. Any services meant to support the family while the children are in parental care are left to community service providers, with no structured oversight or assessment by the Agency. Agency leadership stated to the Advocate that the Child Protection worker will stay informed as to whether a family is continuing to work with community services. However, it was stated that, *"the protection worker just steps away from there when prevention takes over"*. The Agency indicated that this approach is necessitated by the historical experiences of their communities with the child welfare system. The Agency works with families *"where they are"* and looks to see who a family would accept ongoing services from. The Agency also indicated that it would not be in a child's best interest to have a Child Protection worker remain involved if it meant the family would not cooperate with services. However, the Advocate notes that community service providers are not delegated officers under *The Child and Family Services Act* and do not have the authority to provide the same level of service as is received by children elsewhere in the province. In effect, the Agency abdicated its responsibility for the provision of family services under both *The Child and Family Services Act* and the FSIN *Indian Child Welfare and Family Support Act.*

There was a common understanding among service providers in the community that – if a family was not cooperating with the Focus on Families home visitor, the Prevention worker or the Health Nurses within a week of referral to those services – the matter would be referred back to the Agency to take more intensive action. While this is a useful process, under the authority of *The Child and Family Services Act*, it should have been implemented in conjunction with regular oversight and case management by the Agency of the family's participation and progress in services, as per provincial policy.

According to the internal review of the Agency, Child Protection supervisors are now working closely with clinical supervisors of community programs, and the Agency is working to clarify roles and responsibilities between service providers. The Agency expects these activities to improve communication between its child protection services and the community's prevention services. This plan is encouraging. However, the Agency will first have to ensure it is taking responsibility for case management when children in parental care are found to be at risk.

Finding 6: The Ministry of Social Services lacks a comprehensive understanding of the Agency's operational structure, and its methods of discharging its responsibility for family services under *The Child and Family Services Act.*

In the current context, the Ministry of Social Services remains accountable for all child welfare services in the province, both on and off reserve. To discharge its responsibility in this regard, the Ministry requires First Nations child and family services agencies to regularly report on their operations and casework. The Ministry stated the delegation agreements between the agencies and the Province define these reporting requirements. The Ministry also indicated that these agreements do not require reporting on activities funded as "prevention" services under the current funding formula. Those remain the responsibility of the federal government. There are 17 First Nations child and family services agencies in Saskatchewan. The Advocate has found over the years that prevention services are often conceptualized and operationalized differently among the different agencies.

Ministry officials stated to our office that some agencies are blurring the lines between protection and prevention services. The Ministry further indicated it has been trying to work on this through the implementation of new assessment tools. However, the Ministry also reported that it needs to clarify its own understanding of the definition of, and parameters around, prevention services as defined in the federal funding arrangement and are working with the federal government in this regard.

In this case, circumstances that met the threshold for mandatory child protection services (i.e. family services) were referred to community programs by the Agency. Due to the Agency's categorization of these activities as prevention services, the Ministry has not had previous access to any files which would include what would otherwise be considered "family services" under *The Child and Family Services Act.* This has resulted in the Ministry's inability to complete joint audits and ensure compliance with casework standards in these cases. The Ministry reported to the Advocate that this is, in part, why it has embarked upon the process of rescinding the Agency's delegated authority, and why both parties are now working to resolve these issues.

The Advocate acknowledges the efforts of both the Ministry and Agency in this regard. However, the current funding formula has been in place in Saskatchewan for eight years. We are discouraged the Ministry has not taken more significant steps to clarify the parameters and expectations placed on prevention funding, and how it interfaces with protection services, before now. The Advocate's 2014 special investigation report *Two Tragedies: Holding Systems Accountable* found a similar lack of clarity by the Ministry related to the operations of another First Nations child and family services agency – particularly with respect to its prevention and protection programs. In *Two Tragedies,* we recommended the Ministry rectify this knowledge gap in order to better support that Agency's capacity to deliver quality services.

In accordance with the particularities of the Agency's agreement with the Province, Saskatoon Tribal Council Health and Family Services Inc. has asserted that it is not required to report to the Ministry, but is accountable to Saskatoon Tribal Council's member communities and its accrediting body. We acknowledge these circumstances have created significant barriers for the Ministry in gathering information.

Considering the need for increased clarity pertaining to the above, we urge the Ministry to continue to clarify with the federal government (as they have indicated they are) and all First Nations agencies the nature of prevention services as operationalized in practice, and the distinction between these activities and child protection services mandated by *The Child and Family Services Act.* We also urge both the Agency and the Ministry to ensure all mandated child protection services are being delivered by the appropriate delegated officers under *The Child and Family Services Act.*

Recommendation 3:

The Ministry of Social Services work with the Saskatoon Tribal Council Health and Family Services Inc. and with Indigenous and Northern Affairs Canada to ensure clarity between these three bodies as it pertains to understanding prevention services in the context of the mandate under *The Child and Family Services Act.*

Recommendation 4:

The Saskatoon Tribal Council Health and Family Services Inc., with the support of the Ministry of Social Services, operationalize its definition and process of family services delivery to meet the intent of Sections 5 and 14 of *The Child and Family Services Act.*

Recommendation 5:

Under the current framework of *The Child and Family Services Act,* the Ministry of Social Services increase its knowledge and understanding of the manner in which all First Nations child and family services agencies operationalize their prevention and protection services.

5.0 Conclusion

The Advocate cannot determine with absolute certainty that any additional services could have prevented Aiden's death, as the illness that ultimately claimed his life is unpredictable and can arise suddenly in an infant his age.

What we can say, is that it is clear the family required significant support to recognize Aiden's unique vulnerabilities and meet his particular medical needs. Aiden's birth brought the stress of the unexpected arrival of premature twins to a family who was already struggling in many ways. These circumstances made Aiden inherently vulnerable. His social challenges were further compounded by the physical vulnerabilities resulting from his prematurity.

During the one-and-a-half months after Aiden was discharged from the NICU, the Agency received four reports that his parents were struggling to comply with medical care that was necessary to ensure his well-being. According to the information available to the Advocate, the last two of these reports went unaddressed. All of this occurred in a context where the Agency was aware of other significant challenges placing Aiden and his siblings at risk, yet did not sufficiently intervene. Instead, responsibility for case management was left to community programs without a mandate to systematically assess risk and ensure the safety of the children in light of the child protection concerns identified.

Pursuant to its legislated obligations, had the Agency entered into an agreement for family services when risks were identified, the necessity of abiding by the recommendations for Aiden's medical care – and the implications for not doing so – may have been more clearly understood by his parents. Additionally, a structured plan could have been put in place to assist them with any challenges they faced in this regard. If additional support had been provided for Aiden to attend the last scheduled weigh-in only days before his passing, it is possible that health care professionals could have detected the illness that took his life.

Our office acknowledges the historical context of child welfare practices applied to Indigenous children in this province, and the resulting reluctance there may be for First Nations child and family services agencies to intervene in families and risk removing children from their communities, cultures, and identities. We share deep concerns about the persistent over-representation of Indigenous children in the child welfare system and take every opportunity to call for systemic transformation and reconciliation to address these past harms.

Accordingly, the Advocate supports the ability of First Nations child and family services agencies to create their own, culturally-appropriate models of service provision, providing that Indigenous children's right to an equal standard of care and protection is fulfilled. The desire to keep Indigenous children in their communities must be balanced with objective assessments of risk and structured practices that put their safety and well-being first.

Family preservation, where possible, is also the primary goal of the current provincial child welfare framework. Provincial policies have therefore been developed with this goal in mind. Meeting provincial policy standards with respect to investigation and the delivery of family services would not necessarily have resulted in the removal of Aiden and his siblings. Rather, it would have meant another layer of support provided to the family to help meet the needs of, and reduce risk to, the children by a body with a *legal mandate* to do so. In Aiden's case, the Agency does not appear to have exercised the required critical thinking, or utilized the assessment tools available, to ensure that the totality of circumstances impacting his safety was taken into consideration. Additionally, when referrals to community programs were made, the Agency stepped away from its responsibility to oversee and evaluate progress with those services.

The *Convention on the Rights of the Child* guarantees to children that the State will take all appropriate measures to protect them from abuse and neglect. [22] It further

promises that this will be done without discrimination as to who they are or where they live. [23] The promise of equality of service has been restated both by the provincial government in its adoption of the *Saskatchewan Children and Youth First Principles* as outlined earlier in this report, and by the Indigenous community through the FSIN *Indian Child Welfare and Family Support Act*.[24] The Advocate found that the Province and the Agency approach the responsibility for the protection of children who remain in parental care differently. This means that children in Saskatchewan, depending on their geographic location, may be receiving different levels of child welfare services. The Advocate calls on the Ministry and the Agency to work together to clarify and rectify these disparities in a way that ensures children are at the centre of all planning, their rights to equal care, protection and services are upheld and their best interests are prioritized.

22. United Nations General Assembly. (1989). *Article 19 of Convention on the Rights of the Child.*

23. United Nations General Assembly. (1989). *Article 2 of Convention on the Rights of the Child.*

24. Federation of Saskatchewan Indian Nations. (2011). *Indian Child Welfare and Family Support Act, Article X(1)(e).*

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