

**COMPANION DOCUMENT
TO THE 2018-2019 ANNUAL REPORT**

Manitoba Advocate

STAND UP for children & youth

**The 2018-2019
Child Death Review
Roll-Up**

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

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Printed in Canada.

ISBN- 978-1-9995410-3-3

Suggested Citation

Manitoba Advocate for Children and Youth. (2019). *The 2018-2019 child death review roll-up*. Winnipeg, MB: Manitoba Advocate for Children and Youth.

Who We Are

The Manitoba Advocate for Children and Youth is an independent, non-partisan office of the Manitoba Legislative Assembly. We represent the rights, interests, and viewpoints of children, youth, and young adults throughout Manitoba who are receiving, or should be receiving, provincial public services. We do this by providing direct advocacy support to young people and their families, by engaging directly with youth to amplify their voices, by reviewing public service delivery after the death of a child, and by conducting child-centred research regarding the effectiveness of public services in Manitoba. The Manitoba Advocate is empowered by provincial legislation to make recommendations to improve the effectiveness and responsiveness of services provided to children, youth, and young adults. We are guided by the *United Nations Convention on the Rights of the Child* (UNCRC), the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), and we act according to the best interests of children and youth.

For the purposes of this document, all identifying information with respect to individuals and places has been removed or modified to protect the confidentiality of children, youth, and young adults and their rights to privacy.

Acknowledgements

The mandate of our office extends throughout the province of Manitoba and we therefore travel and work on a number of treaty areas. Our offices in Southern Manitoba are on Treaty 1 land, which is the traditional territory of Anishnaabeg, Cree, Oji-Cree, Dakota, Ojibwe and Dene peoples, and the beautiful homeland of the Metis nation. Our new Northern office is on Treaty 5 land, and the services we provide to children, youth, young adults, and their families extend throughout the province and throughout Treaty areas 1, 2, 3, 4, 5, 6, and 10. As an organization, we are committed to the principles of decolonization and reconciliation and strive to integrate the TRC Calls to Action into our practice.

TABLE OF CONTENTS

About This Report	4
INTRODUCTION	6
What is the Manitoba Advocate for Children and Youth?	6
What is the Purpose of a Child Death Review?	6
What is The Advocate for Children and Youth Act?	7
What Happens During a Child Death Review?	8
A SUMMARY OF THE 2018-2019 YEAR	10
THEMES	11
Prominent Service Delivery Issues for Children, Youth, and Young Adults	11
Examples of Additional Issues Observed in Reviews	14
KIRRA’S STORY: THE IMPORTANCE OF EARLY, CONSISTENT SUPPORTS	15
A CLOSER LOOK AT CHILD DEATH REVIEWS	16
Manners of Death	17
57 Completed Reviews: Manners of Death, by Age Grouping	18
Comparing Child/Youth Deaths to Deaths of Young Adults	18
JACK’S STORY: THE LEGACY OF INTIMATE PARTNER VIOLENCE	19
PROVINCIAL SERVICE INVOLVEMENT	20
Involvement by Child Welfare Authority	20
RAIN’S STORY: CHILDREN IN NEED OF PROTECTION	21
Case Status After Review	22
Recommendations	22
A YEAR IN REVIEW	23
APPENDICES	24
Appendix A – Enabling legislation of the Manitoba Advocate for Children and Youth	24
Appendix B – References	24

About This Report

This report is being released as a companion document to the Manitoba Advocate's 2018-2019 annual report. *The Advocate for Children and Youth Act (ACYA)* allows the Manitoba Advocate to share this summary of the 57 child death reviews completed this year. Section 31 of *The Advocate for Children and Youth Act (ACYA)*, allows the Manitoba Advocate to release public reports about the work of the office.

SPECIAL REPORTS

Special reports

31(1) In order to improve the effectiveness and responsiveness of designated services, the Advocate may publish special reports.

In releasing this Section 31 special report of the work completed over the span of a single year, it is also the Manitoba Advocate's intent to provide a profile of the Investigations and Child Death Review program at MACY. Between April 1, 2018 and March 31, 2019, our office completed 57 child death reviews and four investigations into designated services delivered to children, youth, and young adults who died in Manitoba. This report also highlights the stories of three children who died. Their experiences provide opportunities for learning for service providers, policy makers, and government departments in the areas of assessment, planning, service delivery, and evaluation.¹

As a companion document to the annual report and a program profile, this document highlights:

- Observations of gaps in provincial public service delivery organized by four main categories: assessment, planning, service delivery, and evaluation;
- Child death review data including: age, manner of death, and provincial public service involvement by child welfare authority; and
- The outcome of each review: the decision made by the Manitoba Advocate to close the case following the review, to launch a more comprehensive investigation of public services, or to look to the story of the child to help inform a future aggregate or systemic report.

It should be noted that the data presented in this document are representative of only the 57 reviews completed in the 2018-2019 year by the Manitoba Advocate. This report is a summary of what we saw in our work over the span of a year. For further information about child death data, trend data, and additional year-over-year comparisons, see our annual reports, found on our website at:

<https://manitobaadvocate.ca/resources/annual-reports/>

The 57 child death reviews completed by the Manitoba Advocate in the 2018-2019 year were of deaths that occurred between 2014 and 2018.

Also of note, the 57 child death reviews completed in the 2018-2019 year consisted of child and youth deaths that occurred between 2014 and 2018. As of April 1, 2018, the goal of the Manitoba Advocate was to ensure that reviews and investigations were being completed within one year of the death of the child, youth, or young adult. This ensures that critical information about service gaps and inefficiencies are

identified, analyzed, and shared back to the system so there is a greater likelihood of preventing future

¹As the 57 reviews highlighted in this report have not been released publicly, identifying information has been removed to protect the confidentiality and privacy of the deceased children, youth, young adults, and their families.

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

deaths in similar circumstances. However, in some cases this is not possible. For example, the ACYA does not allow the Manitoba Advocate to conduct an investigation of a child's death while the death is under criminal investigation, or during any subsequent criminal court proceedings, such as appeals on convictions, unless the Attorney General gives the Manitoba Advocate written permission to proceed with an investigation.

When a death is under criminal investigation or before a criminal court, our office does not undertake any actions that might inadvertently create evidence or otherwise interfere with the criminal proceedings. Specifically, this means we do not conduct interviews of service providers or family members, and we wait to travel to communities where the child lived. It also means that certain file information, such as autopsies and reports of the medical examiner, which we routinely receive and review, may not be available to us while the death is under criminal investigation. In these situations, we remain in contact with crown attorneys and other officials to receive progress updates so that we know when criminal proceedings and appeal windows have concluded, at which point the Manitoba Advocate may initiate investigative proceedings. However, these restrictions do not typically inhibit the completion of a child death review, which is focused on recorded file information.

INTRODUCTION

What is the Manitoba Advocate for Children and Youth?

The Manitoba Advocate for Children and Youth (MACY) is an independent, non-partisan office of the Manitoba Legislative Assembly. The office is separate and apart from the government, and receives its mandate from *The Advocate for Children and Youth Act (ACYA)*, proclaimed in 2018.

As an independent office, we represent the rights, interests, and viewpoints of children, youth, and young adults throughout Manitoba who are receiving, or should be receiving, “designated services.” Designated services are defined in the ACYA as including: child and family services, adoption, disabilities, mental health, addictions, education, victim supports, domestic violence, sexual exploitation, and youth justice. We fulfill our mandate by:

- providing direct advocacy support to young people and their families,
- reviewing public service delivery after the deaths of children,
- conducting child-centred research regarding the effectiveness of public services in Manitoba,
- monitoring formal recommendations made to service providers,
- reporting on the levels of systemic compliance with recommended changes, and
- reaching out and engaging communities, especially children, youth, and young adults.

As noted, the Manitoba Advocate is empowered by legislation to make formal recommendations to service providers and the government to improve the effectiveness, responsiveness, and accessibility of services provided to children, youth, and young adults. We are guided by the voices of children and youth, the advice of our Elder’s Council, the *United Nations Convention on the Rights of the Child (UNCRC)*, and the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*. MACY has the legislated responsibilities to support, assist, inform, and advise children, youth, young adults, and their families about designated services. Our office also amplifies the voices of children, youth, and young adults to promote their safety, security, and wellbeing.

What is the Purpose of a Child Death Review?

Child death reviews are a unique form of advocacy undertaken by the Manitoba Advocate when a child, youth, or young adult dies and their death falls into the scope of our legislated mandate. When conducting child death reviews, our office is empowered to gather evidence from many sources. As part of our analysis, investigators note recurring circumstances and trends, including those gaps in services that could have improved a child, youth, or young adult’s life, or may have prevented their death. If the case meets certain legislated criteria, the Manitoba Advocate may then determine that a more comprehensive investigation is required. This includes situations where we have significant concerns or questions about the services that were delivered, or which ought to have been delivered, to the child, youth, young adult, or their family.

Investigations and special reports are designed to improve the effectiveness and responsiveness of public services, enhance the safety and wellbeing of children, youth, and young adults, and reduce the likelihood of a death occurring in similar circumstances in the future.

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

The Manitoba Advocate is also empowered by the ACYA to release special reports to the public, which can be summaries of child death investigations, or information about any other issue the Manitoba Advocate considers necessary about any matter for which the Advocate has responsibility under the ACYA. MACY's investigations and special reports may also include formal recommendations to the government or to service providers for changes to standards, policies, regulations, and practices, relating to the delivery of designated services. Our investigations and special reports are designed to improve the effectiveness and responsiveness of designated services, enhance the safety and wellbeing of children, youth, and young adults, and reduce the likelihood of a death occurring in similar circumstances in the future.

What is *The Advocate for Children and Youth Act*?

The Advocate for Children and Youth Act (ACYA, 2018), describes the Manitoba Advocate's responsibilities and jurisdiction to review the deaths of children, youth, and young adults when certain criteria under the ACYA are met. *Section 20(3)* states:

After receiving notice of the death of a child or young adult from the chief medical examiner under *The Fatality Inquires Act*, the Advocate may review

- (a) a child's death, if the child or his or her family was receiving a reviewable service at the time of the death or in the year before the death; and
- (b) a young adult's death, if the young adult was receiving services under subsection 50(2) of *The Child and Family Services Act* at the time of the death or in the year before the death.

In simpler terms, the Manitoba Advocate is notified by the chief medical examiner of Manitoba of all deaths of all people under the age of 21. Our office assesses every notification received and determines if the child who died, or a member of their family, received any "reviewable service" in the 12 months before the death of that child. If so, the Manitoba Advocate may review and investigate the reviewable and designated services that were being provided, or the services which should have been provided to the child, youth, young adult, or to their family.

Under Part 1 of the ACYA (2018), a "reviewable service" is defined as:

- (a) services and programs for children and their families provided under *The Child and Family Services Act* or *The Adoption Act*;
- (b) mental health services for children and youth provided by or on behalf of a public body or a health care facility;
- (c) addiction services for children provided by or on behalf of a public body or a health care facility;
- (d) youth justice services;
- (e) services for young adults provided under subsection 50(2) of *The Child and Family Services Act* to assist former permanent wards in their transition to independence;
- (f) additional designated services that are set out in the regulations.

However, when the ACYA came into force in March 2018, the government opted to roll it out in phases. Phase 1 was proclaimed in March 2018, broadening and expanding many areas of the Manitoba Advocate's mandate. With respect to our capacity for child death reviews, the key expansion of our mandate in child deaths has been held back to Phase 2, which at the time of this writing in November

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

2019, is not yet in force. What this means is that while the Manitoba Advocate is notified of all deaths of all young people under age 21 who die in Manitoba, our office is only empowered to review and possibly investigate those deaths where the child, or the child’s family, has received any form of child and family services (CFS) in the 12 months before the date of death of the child. When Phase 2 of the ACYA comes into force, the Manitoba Advocate will also be able to review and investigate deaths where the child, or the child’s family had received any reviewable service from mental health, addictions, or youth justice services in the 12 months before the date of death of the child, in addition to our ongoing jurisdiction in cases involving CFS.²

As our child death mandate remains tethered to CFS cases, the reviews described in this report all involve children where one of the following was true:

1. There was an open CFS file regarding the child or child’s family at the time of the child’s death (“Open file”), or
2. A CFS file regarding the child or the child’s family had been closed within one year of the child’s death (“Closed file”), or
3. The child was in care of CFS at the time of their death (“Child in care”).

This presents as a limitation of the report and restricts the scope of the child death reviews presented in this document. This also means that, until Phase 2 of the ACYA is proclaimed, valuable opportunities for learning and change may be missed concerning recurring circumstances, trends, and gaps in service delivery in other provincial public services.

What Happens During a Child Death Review?

The Manitoba Advocate receives an official notification of every death of children, youth, and young adults under age 21 in Manitoba.

The Manitoba Advocate receives an official notification from the Office of the Chief Medical Examiner (OCME) upon the death of every child, youth, or young adult between birth and age 21. Our team then assesses whether the death is in scope of our mandate, as outlined above. If we determine the death is in scope, our office contacts the CFS agency involved with the family and arranges for the agency to provide their file information for the purposes of conducting the child death review. In addition, our office reviews electronic file information contained in the Child and Family Services Information System (CFSIS), an electronic database CFS agencies in Manitoba are required to use to record open and closed CFS files, demographic information, assessments, documentation, and more. At this time during the review phase, MACY requests only CFS file documentation; however, additional information may be requested to obtain a complete and true picture of the services delivered during the child, youth, or young adult’s life. A thorough child death review may take up to 60 days for an investigator to complete, depending on the complexity of service delivery in the life of the young person or their family.

Within our child death reviews, investigations, and reports, we strive to listen to the voices and experiences of young people, and we search for the lessons their stories can teach us. The voices and

²In January 2019, the provincial government announced its intent to proclaim Phase 2 of the ACYA (expanded child death reviews) in May 2019 and Phase 3 of the ACYA (serious injury reporting) in fall 2019. To date, the Manitoba Advocate continues to wait on the government to provide an updated timeline for the remainder of the current legislation.

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

experiences of young people are an essential element we use in writing reports and in carefully designing any formal recommendations that may be issued as part of our reporting. This is one of the many forms of child-centred advocacy we practice at MACY.

Our focus during the review process is to determine if the services delivered matched the needs of the child or family. In addition, we review whether the services met organizational policies, provincial standards and legislation, and practice regulations, and if those services delivered reflected the best interests of that child, youth, young adult, and their family. We look to identify where there were opportunities for intervention and whether there were gaps or concerns with the types of services or how the supports were being delivered.

When a child death review is complete, the Manitoba Advocate determines whether the case will close at the review stage, if more information is required, or the case warrants further attention. If our questions and concerns regarding the services which were delivered are sufficiently answered at the review phase, the Manitoba Advocate may decide no further investigation is needed and may notify the relevant agencies, organizations, and government departments that provided a reviewable service of our intention to close our file. If we have identified any service delivery issues and concerns, we share these with the stakeholders involved for their attention and follow-up action.

If the Manitoba Advocate determines a case warrants further attention, and the death meets the legislated thresholds, an investigation or special report may be undertaken. The investigation may focus on an individual child or systemic issues related to a group of children, youth, or young adults in Manitoba. If a full investigation is opened, our office will request and gather all service files we deem relevant to our investigation. Our legislation ensures we have access to the information we need to understand the child's life and the ways in which public services were active in the family. Sections 17, 25, and 26 of the ACYA describe these powers of the Manitoba Advocate:

RIGHT TO INFORMATION

Right to information

17(1) The Advocate may require a public body or other person to provide any information in its custody or under its control – including personal information and personal health information – necessary to enable the Advocate to carry out responsibilities or exercise powers under this Act.

Duty to provide information and assistance

17(2) Despite any other enactment, the public body or other person must provide the Advocate with the information and assistance that the Advocate requires.

INVESTIGATIVE POWERS

Right to enter and inspect

25 For the purpose of an investigation under this Part, the Manitoba Advocate may at any reasonable time enter and inspect any place where a reviewable service being investigated is or was provided.

Power to compel persons to answer questions and order disclosure

26(1) For the purpose of an investigation under this Part and subject to subsection 17(3) (privileged information), the Advocate may make one or both of the following orders:

- (a) an order requiring a person to attend, personally or by electronic means, before the Advocate to answer questions on oath or affirmation, or in any other manner;

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

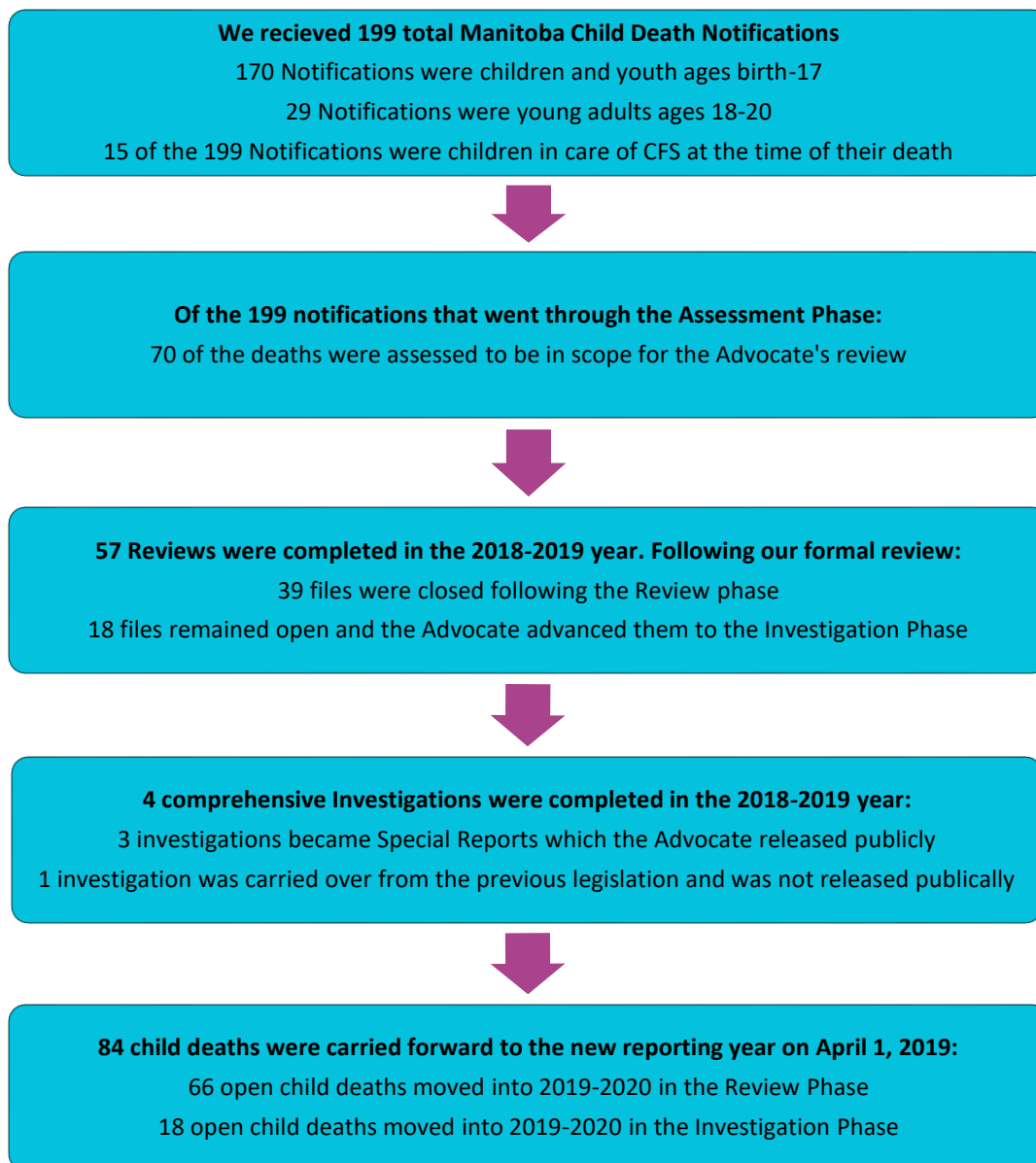
- (b) an order requiring a public body or other person to produce for the Advocate a record or other thing in the person's custody or under his or her control.

Order to comply

26(2) The Advocate may apply to the Court of Queen's Bench for an order directing a public body or person to comply with an order made under subsection (1).

A SUMMARY OF THE 2018-2019 YEAR

The following schematic is a breakdown of the total Manitoba child death notifications our office received, the number of child death reviews and investigations that were completed, and the number of files that were carried forward to the 2019-2020 reporting year.



THEMES

Prominent Service Delivery Issues for Children, Youth, and Young Adults

When concerns or gaps in provincial public service delivery are noted during the child death review process, they are themed and analyzed by the Advocate, as follows:

SERVICE CONCERN:	INCLUDING:
ASSESSMENT	<ul style="list-style-type: none"> • Safety assessments • Risk assessments • Child assessment • Child protection investigation
PLANNING	<ul style="list-style-type: none"> • Safety planning • Ongoing family planning • Child in care planning
SERVICE DELIVERY	<ul style="list-style-type: none"> • Service delivery to child or family • Quality of service • Service reflecting the changing needs of a child or family
EVALUATION	<ul style="list-style-type: none"> • Ongoing monitoring of the effectiveness of services by the service provider • Appropriate supervisory review

The table below includes the definitions of each theme category and indicates the number of times concerns in each category were noted by MACY investigators when reviewing the provincial public services delivered to the 57 children, youth, young adults, and their families. In the 2018-2019 year, Planning was the most prominently observed theme and concerns were noted in this area in 53 of 57 child death reviews. **During the review process, investigators may note concerns in more than one category, if more than a single issue is prevalent.**

The Child and Family Services Standards Manual is one evaluation tool utilized by investigators of the Manitoba Advocate when determining whether standards of service delivery were met by CFS. This document sets out the minimum service requirements in Manitoba that must be met by all workers and supervisors in each agency that delivers child and family services to children and families. For more information, the Child and Family Services Standards Manual can be found online at: <https://www.gov.mb.ca/fs/cfsmanual/index.html>.

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

THEME	DEFINITION	OBSERVATIONS
ASSESSMENT	Assessment is the process of gathering information from a variety of sources to determine the strengths and needs of a child and their family. Assessment is a powerful tool that provides the basis for meaningful intervention designed to improve functioning and wellbeing. Without a full and accurate assessment, future plans and services may not be relevant or appropriate to meet the needs of the child and their family. The assessment is an ongoing process that should include the child(ren), their immediate and extended family, informal supports (i.e. friends, neighbours, community members), and relevant provincial public service providers.	52 in 57 cases
PLANNING	Planning follows a thorough assessment and relates the needs of a child and their family to supports and services that may be implemented to address those needs. Plans should also incorporate the strengths of a child and their family to heighten the likelihood of the plan's success. Like assessments, planning is a continuous process and case plans should evolve to meet ever-changing needs. The absence of an ongoing plan, places the service provider, child and family at a disadvantage as plans are often crisis oriented and are reactive as opposed to proactive.	53 in 57 cases
SERVICE DELIVERY	The service delivery phase is the implementation of the plan by the child, their family, their supports, and the service providers. The services provided to a family are often broad and multifaceted; therefore, systemic cooperation and coordination are required to ensure services, or a combination of services, success in improving the safety and wellbeing of the child and their family.	52 in 57 cases
EVALUATION	Evaluation is an essential part of the above process, as it assists those engaged in the plan to determine if the plan, and services provided, were successful in meeting the assessed needs of the child and their family. Without feedback, mechanisms to evaluate whether the plan was successful, risk to the child may not be appropriately addressed.	49 in 57 cases

As has been previously examined in Special Reports produced by the Manitoba Advocate, the minimum requirements for service delivery set out in the Child and Family Services Standards Manual may be unachievable in some situations within the current system. While these minimum standards are inherently important, as they ensure that CFS agencies in Manitoba are accountable to ensure all children, youth, young adults, and their families, receive a minimum standard of service, myriad challenges to meeting these standards exist. Issues such as a lack of CFS staff training, internal agency resources, and access to risk prevention services across Manitoba present as barriers to achieving standards for service delivery. The numbers presented in the above table highlight this concern. Providing further detail, the following table notes the most commonly observed issues in the areas of

Manitoba Advocate for Children and Youth – November 2019
The 2018-2019 Child Death Review Roll-Up

assessment, planning, service delivery, and evaluation in the 57 child death reviews completed in the 2018-2019 year.

ISSUES NOTED IN THE ASSESSMENT PROCESS: OBSERVED IN 52 OF 57 REVIEWS	
Family Assessment	<ul style="list-style-type: none"> ○ Assessments did not comply with standard time frames and were not ongoing ○ Assessments of family’s strengths and needs were absent or incomplete ○ Assessments were missing at key points such as when a CFS file opened or closed ○ Assessments were missing or incomplete when there was a risk to a child’s safety reported to a CFS agency
Child Assessment	<ul style="list-style-type: none"> ○ Assessments did not comply with standard time frames and were not ongoing ○ Assessments of children’s strengths and needs were absent or incomplete ○ Assessments of a child’s needs were missing at key points such as when a child entered into care or was being reunified with their family
Child Protection Investigation	<ul style="list-style-type: none"> ○ Assessment did not comply with standard time frames ○ Absent or incomplete critical child protection assessment and investigation when abuse was suspected or reported
ISSUES NOTED IN THE PLANNING PROCESS: OBSERVED IN 53 OF 57 REVIEWS	
Safety Planning	<ul style="list-style-type: none"> ○ Safety plans were not completed in a timely manner when there were concerns about the immediate safety of children or youth ○ Safety plans were inadequate to address the complexity and seriousness of the presenting concerns
Ongoing Family Planning	<ul style="list-style-type: none"> ○ The creation of a family plan did not comply with standard time frames ○ A family plan was absent or was inadequate to address the complexity and seriousness of the presenting concerns ○ The family plan was not revised or updated to adapt to the changing needs of the family
Ongoing Child in Care Planning	<ul style="list-style-type: none"> ○ The creation of a child in care plan did not comply with standard time frames ○ A child in care plan was absent or was inadequate to address the complexity and seriousness of the presenting concerns and/or did not foster cultural, spiritual, emotional, and physical wellbeing ○ The plan was not revised or updated to adapt to the needs of the child or youth ○ The child in care plan did not include concepts such as reunification and permanency
ISSUES NOTED IN THE SERVICE DELIVERY PROCESS: OBSERVED IN 52 OF 57 REVIEWS	
Service Delivery to Child and their Family	<ul style="list-style-type: none"> ○ No evidence of service delivery by the responsible agency ○ Services provided were inadequate, incomplete, or ill-coordinated ○ The provision of service was delayed or inconsistent ○ CFS agencies did not have contact with collaterals as required ○ The services provided were not updated to meet the ever changing needs of the child, youth, young adult, or their family ○ Frequency of contact standards were not met by the CFS agency involved
ISSUES WITH THE EVALUATION PROCESS: OBSERVED IN 49 OF 57 REVIEWS	
Monitoring	<ul style="list-style-type: none"> ○ Progress reviews were absent, inconsistent, or feedback from monitoring reviews was not used to alter plans and the provision of service as required
Review	<ul style="list-style-type: none"> ○ Evidence of supervisor oversight and review could not be found

Examples of Additional Issues Observed in Reviews

- A lack of access to safe housing
- Absent or delayed transitional planning
- Absent or missing agency documentation on CFSIS or in the physical file
- Agencies lack resources to support children, youth, young adults, and their families
- Child in care plans did not ensure a child, youth, or young adult's wellbeing
- Child neglect and abuse
- Conflict of interest issues
- Incomplete or conflictual documentation
- Intimate partner violence
- Lack of access to prevention resources, mental health and addictions resources, and placements for children and youth with complex needs
- Lack of training and resources for placement staff and caregivers
- Minimal/inconsistent access between children, their immediate family, and extended family
- Missing/ill coordinated service delivery internally between CFS agencies or between CFS agencies and collaterals
- Multiple placements
- Parental and child, youth, or young adult mental health concerns
- Parental and youth/young adult substance misuse
- Parental capacity concerns
- Sexual exploitation
- Unsafe persons having access to children
- Unsafe sleep environments for infants
- Youth missing from their homes or placements

KIRRA'S STORY: THE IMPORTANCE OF EARLY, CONSISTENT SUPPORTS

Kirra* died from accidental drowning when she was a teenager. The Manitoba Advocate received the death notification from the Office of the Chief Medical Examiner shortly after Kirra's death. We determined that Kirra's parents had a CFS protection file that had been closed by CFS for less than 12 months at the time of Kirra's death; therefore, Kirra's death was deemed reviewable under the Manitoba Advocate's legislation.

An investigator from the Manitoba Advocate for Children and Youth (MACY) completed Kirra's child death review with information contained in the CFS protection file, which had been provided to MACY by the agency involved, and electronic documentation from historical files that described previous CFS services. The investigator discovered that Kirra's family had extensive CFS involvement, which stemmed from concerns about risk to the children due to the parents' misuse of drugs and alcohol, one parent's criminal activity and incarceration, concerns about child neglect, excessive discipline, transience, and the use of inappropriate caregivers for the children. Kirra's parents were separated and resided in different households. The agency had assessed that Kirra's parents were not always safe caregivers for their children, resulting in the apprehension of Kirra's siblings on two occasions. There was no documentation of planning with Kirra's family or regular assessment of her siblings' safety by the agency. For the first 13 years of her life, Kirra lived with alternate caregivers, not her immediate family.

The first time Kirra had contact with CFS was in 2014, when she was 13 years old, and living with her mother. The agency learned that Kirra had been in the care of a family member, but that individual could no longer care for her. The agency investigated allegations of physical abuse toward Kirra by her former caregivers and the allegations were deemed "inappropriate discipline." Shortly thereafter, the agency became aware that Kirra was using drugs and alcohol and had expressed suicidal ideation. An agency worker met with Kirra one time and Kirra told them she did not know if she was safe at her home and asked about entering into agency care. Kirra's mother was directed to contact the agency, but when the agency was unable to successfully engage Kirra's mother, the agency did not meet with Kirra again. Documentation indicated that the agency attempted to contact the family; however, the agency worker did not document the dates and details of those attempts. The agency did not complete an assessment of Kirra's safety in her mother's care, Kirra's drug and alcohol use, or her risk for suicide. Further, they did not implement a plan with Kirra and her family, or provide services to address the risk factors that impacted Kirra's safety. Without addressing the needs of Kirra or her family, the agency closed its file; Kirra died less than one year later.

The Manitoba Advocate determined that this file would not progress to a more comprehensive investigation, and would close following our review of the CFS file. A significant factor in that decision was that the CFS agency completed a process known as an Internal Agency Review (IAR) following Kirra's death. An IAR is a process that may be undertaken by a CFS agency whereby the agency completes an analysis of the services they provided to a family to determine if they met policies, standards, and regulations. In Kirra's case, the agency involved recognized the gaps in the services they provided and put into place protocols to improve their service delivery and to help avoid a death happening in similar circumstances. Based on this response, we concluded our involvement following the review phase.

**Name and other details changed to protect the privacy of the family.*

A CLOSER LOOK AT CHILD DEATH REVIEWS

Of the 57 child death reviews completed in the 2018-2019 year:

By Age

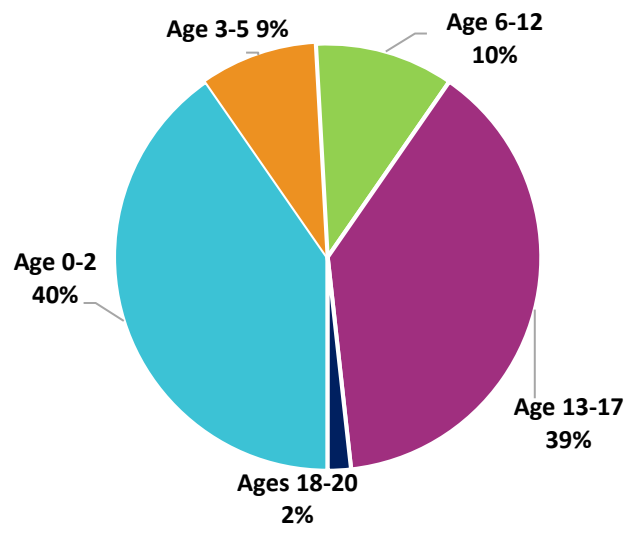
23, or 40%, were children aged birth-2

5, or 9%, were children aged 3-5

6, or 10%, were children aged 6-12

22, or 39%, were youth aged 13-17

1, or 2%, were young adults aged 18-20



Notes

- Of the cases reviewed, the highest number of deaths were in the birth-2 and 13-17 age groups, at 40% and 39% respectively
- The 3-5, 6-12, and 18-20 age groups had comparatively smaller numbers of death at 9%, 10%, and 2% respectively

Missed Opportunities

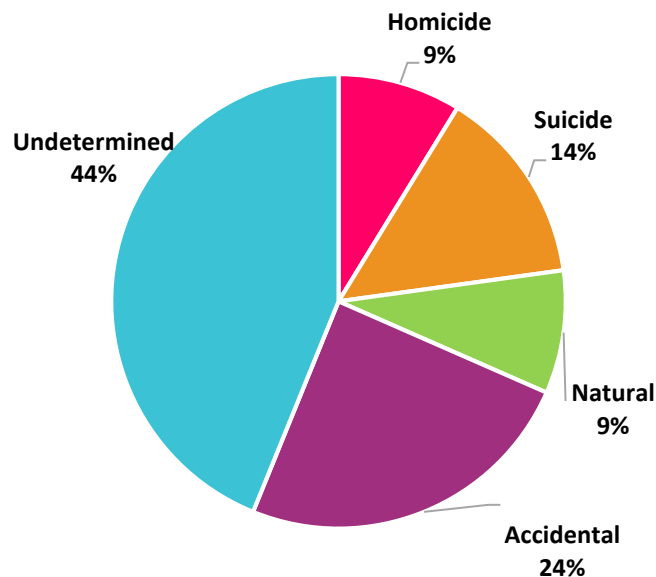
As mentioned above, a limitation of the current legislation is that it remains the case that a child or their family must have had some manner of CFS involvement in the year before the child's death in order for the Manitoba Advocate to be able to conduct a review of "designated services." This restricts the scope of the child death reviews that are completed, limiting opportunities for learning and system change.

One area where a significant gap has been noted by the Manitoba Advocate is the services provided to young adults, ages 18 to 20. While a young adult may have received CFS services prior to the age of 18, their death will not fall in scope if the young person is not receiving supports beyond termination of guardianship, also commonly known as an "extension of care." This gap is highlighted in the figure above, as the death of only one young adult fell in scope to review in the 2018-2019 year. Yet, we know young adults face significant changes as they make the transition from youth to young adults at age 18. Indeed, this is one of the more common reasons older youth contact our Advocacy Services program – to request help navigating transition-to-adulthood challenges. Our analysis indicates that risk also increases for young people as they enter adulthood. The stark differences in the manners of death between the age groups of birth-17 and 18-20 are alarming, which can be observed in the charts on page 19.

Manners of Death

When a child, youth, or young adult has died, the chief medical examiner classifies their manner of death into one of five categories:

1. **Homicide** – death was inflicted by another person
2. **Suicide** – death was self-inflicted
3. **Natural** – death was of natural causes, or illness
4. **Accidental** – death was caused by an accident
5. **Undetermined** – the chief medical examiner cannot conclusively determine the manner of the death, even if the physical cause may be known (includes unsafe sleep-related deaths of infants)



Of the 57 reviews we completed:

- 5 (9%) were victims of homicide
- 8 (14%) died by suicide
- 5 (9%) died from natural causes
- 14 (24%) died from accidental causes
- 25 (44%) died from an undetermined manner

Notes

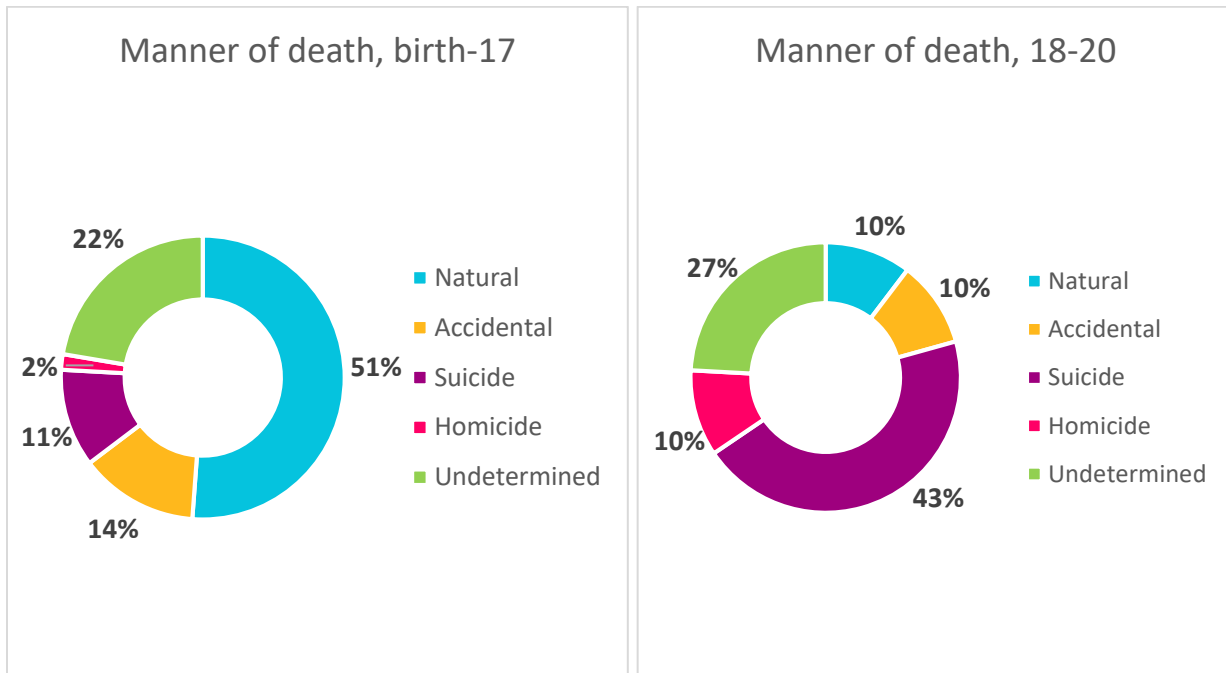
- The chart above is not reflective of typical annual statistics because as part of our internal process, deaths which are deemed Natural are assigned to the Manitoba Advocate's Quality Assurance program for data-tracking purposes. These deaths, which are often expected deaths (e.g. children diagnosed with terminal illnesses, or who have congenital complications), are often closed after an initial assessment, unless service delivery concerns are identified in the assessment. This report focuses on the child deaths reviewed by the Investigations and Child Death Review Program over the span of the year.
 - Of the cases reviewed, the most prominent manner of death was undetermined (44%), followed by accidental (24%), suicide (14%), natural (9%), and homicide (9%)
 - The undetermined category includes unsafe sleep-related deaths and those deaths attributed to Sudden Unexplained Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS)
-

57 Completed Reviews: Manners of Death, by Age Grouping

Age Group	Accidental	Natural	Suicide	Homicide	Undetermined	TOTAL
0-2 years	0	4	0	3	16	23
3-5 years	2	0	0	0	3	5
6-12 years	2	1	0	0	3	6
13-17 years	9	0	8	2	3	22
18-20 years	1	0	0	0	0	1

Comparing Child/Youth Deaths to Deaths of Young Adults

Child death data tracked by the Manitoba Advocate indicate that 63% of deaths between the ages of 18 to 20 last year were due to accidents, suicides, or homicides. Comparatively, accidents, suicides, and homicides made up 27% of the deaths between birth and 17 years old. Year over year data show that the majority of deaths from birth to age 17 are due to natural causes, primarily before a child reaches age two. The figure below displays this striking comparison between the two age categories using the most recent province-wide data between April 1, 2018, and March 31, 2019.



JACK'S STORY: THE LEGACY OF INTIMATE PARTNER VIOLENCE

When Jack* died in his teenage years, one of Jack's parents had an open CFS protection file; therefore, his death fell in scope of MACY's legislation. The MACY investigator assigned to Jack's case completed the child death review with information contained in physical files from the agency and electronic documentation found on CFSIS.

Five child welfare agencies provided services to Jack's family throughout his life. The agencies noted issues including parental addiction, intimate partner violence between the adults in Jack's life, drug trafficking from the home, poor school attendance for Jack and his siblings, and issues of child neglect. Some of the child protection concerns noted above, such as child neglect, required immediate intervention to ensure the safety of the children. One such incident resulted in Jack being apprehended by CFS when he was 8 years old. For some of the other concerns, safety plans and case plans were created by the agencies involved to mitigate the risk to Jack and his siblings while they remained in their mother's care. Over the years, Jack's family's case plans included his mother engaging in counselling and programming focused on intimate partner violence, parenting, addictions treatment and recovery support, grief and loss, and anger management. In addition, case plans included Jack's mother ending her relationships with perpetrators of intimate partner violence, including Jack's father, and the agencies safety planned with Jack's mother to support her in protecting the children from further violence. As they became older, CFS engaged Jack and his siblings in programming to address trauma, improve coping skills, and build capacity.

The risk to Jack and his siblings was assessed as low when his mother engaged in programming, maintained sobriety, and worked hard to provide adequate care and supervision for her children. When this occurred, CFS would close their file. However, the issues resurfaced and agency documentation reflected the elevated risk to Jack and his siblings when intimate partner violence resurfaced, with the children witnessing volatile arguments and physical violence, or coming to harm themselves in altercations between adults. When the children were physically harmed, abuse investigations were not initiated by the agency involved and few assessments were completed when they were required to be, as set out by the Child and Family Services Standards Manual.

As Jack grew older, he began displaying aggressive behavior and rarely attended school. The agency involved helped connect Jack's mother to a program that assisted children with school attendance; however, Jack was not eligible for the program due to his age. He was described by his mother as "closed off," quick to anger and eventually received a mental health diagnosis. Verbal conflict in his own relationship was documented, and shortly thereafter, Jack assaulted his girlfriend. Three months after the assault, Jack's family's file was transferred for ongoing service at a new CFS agency. That agency planned with Jack's family to connect them to therapy and support Jack and his siblings to attend school; however, Jack died one month later.

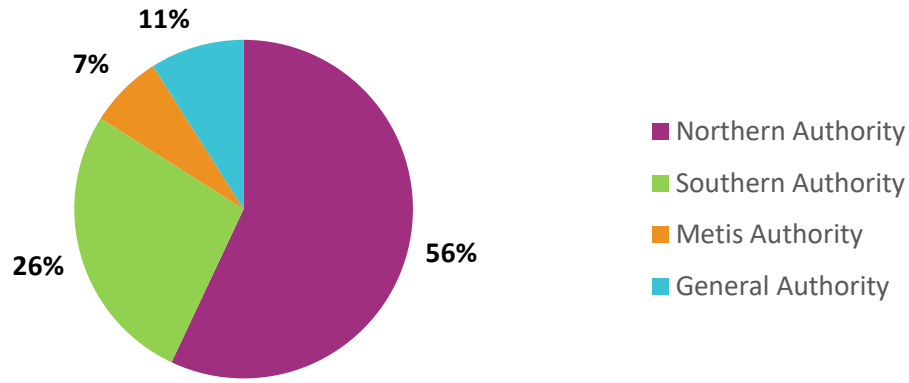
The Manitoba Advocate's review revealed issues that our team is also seeing in other cases. Some of Jack's experiences mirror those of other youth in our communities. As such, while Jack's death will not lead to a child-specific investigation, his story will inform a pending MACY aggregate special report that explores systemic issues and barriers encountered by older male youth receiving public services who died by suicide or homicide.

**Name and other details changed to protect privacy of family.*

PROVINCIAL SERVICE INVOLVEMENT

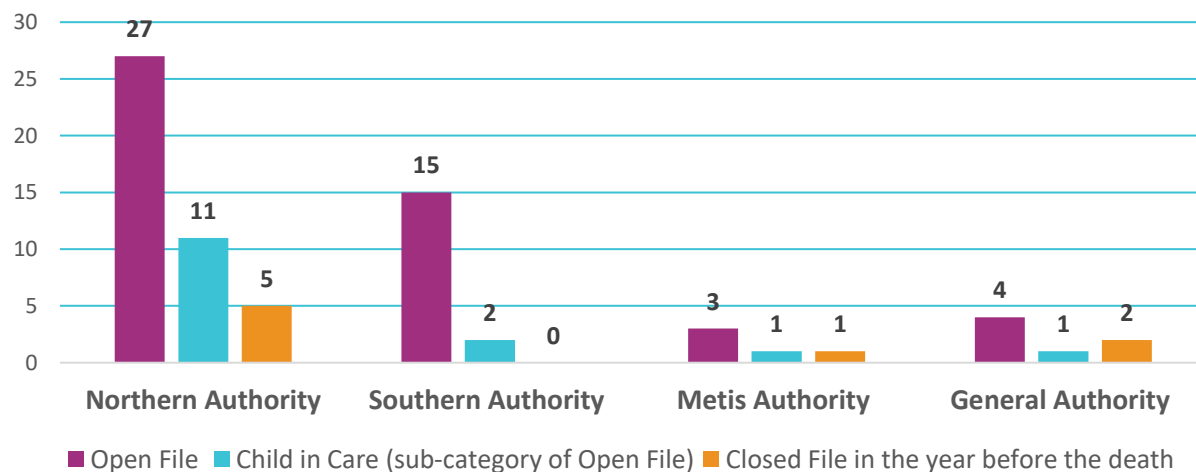
Of the 57 child death reviews completed in the 2018-2019 year:

Involvement by Child Welfare Authority



- 32 (56%), of the children or youth, or their families, were receiving, or had been receiving services from the **First Nations of Northern Manitoba Child and Family Services Authority (Northern Authority)**
- 15 (26%), were receiving, or had been receiving services from the **Southern First Nations Network of Care (Southern Authority)**
- 4 (7%), were receiving, or had been receiving services from the **Metis Child and Family Services Authority (Metis Authority)**
- 6 (11%), were receiving, or had been receiving services from the **General Child and Family Services Authority (General Authority)**

Involvement at the Time of Death



Note: Child in care files are a sub-category of open files.

RAIN'S STORY: CHILDREN IN NEED OF PROTECTION

Rain* (age 11 months) died of an undetermined manner in an unsafe sleep environment (i.e. bed sharing). At the time of Rain's death, her mother had an open protection file with a CFS agency; therefore, her death fell in scope for review by the Manitoba Advocate. An investigator completed Rain's child death review with information in the physical CFS protection file and using electronic documentation on CFSIS. Rain's family had received services from a child welfare agency for 11 years prior to Rain's birth in 2017, as she had three older siblings. Child welfare involvement had initially been because Rain's mother had been a minor child when she became pregnant with her first child. Over the course of the agency's involvement, they also received reports of sexualized behavior between children, criminal activity involving the children, intimate partner violence, suicidal ideation of one of Rain's siblings, and allegations of physical abuse by one of Rain's parents.

Concerns were reported to the CFS agency involved in 2006, 2014, 2016, and 2018; however, there was minimal documented follow up by the agency or assessment of the safety of the children after the agency became aware of the concerns. The agency documented that they attended Rain's home on one occasion in 2014; however, observed only one of Rain's siblings and did not investigate the child protection concerns further. The agency started a safety assessment in 2016, but the process was not completed.

Amidst the reported child protection concerns, Rain's family was under a great deal of stress due to the death of one of her parents. The agency documented in its files that they knew the family was "struggling to cope," yet there was no evidence of services or intervention provided to respond to this concern or to support the family. There was no documentation of ongoing casework or regular family, child, or safety assessments completed by the agency, nor were allegations of abuse investigated. The agency took no meaningful action to assess safety or intervene even though it had knowledge that the family needed support and the children might be in need of protection.

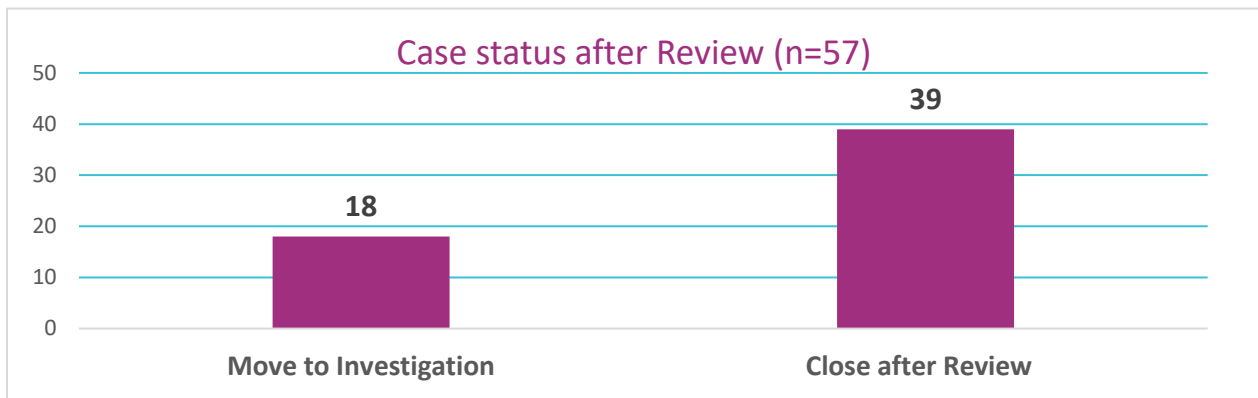
In 2018, Rain (age 11 months) was found unresponsive in the bed she was sharing with two other people. There were prolonged attempts at resuscitation, which were not successful, and Rain was later pronounced deceased.

The Manitoba Advocate determined that while Rain's case will not be part of a child-specific Investigation, Rain's experience will inform a pending aggregate special report focusing on unsafe sleep risks and infant death in Manitoba, a prominent concern our office has noted year after year.

**Name and other details changed to protect privacy of family.*

Case Status After Review

Of the 57 reviews concluded by the Manitoba Advocate between April 1, 2018 and March 31, 2019, 18 were moved forward to inform individual or aggregate investigations, and 39 did not require further investigation by the Investigations and Child Death Review program and were concluded by the Advocate following the review phase. However, the Manitoba Advocate’s Research Hub is informed by issues and trends observed across the scope of the Advocate’s mandate and as such, a number of closed reviews may be aggregated to inform systemic research and future special reports.



Recommendations

Upon completion of an investigation or special report, the Manitoba Advocate is empowered by the ACYA to issue formal recommendations to service providers or to government towards changes of their practices, policies, standards, or legislation. Recommendations are designed to respond to a gap in services for children. When implemented, they hold the likelihood of improving safety, making public services more effective, and ultimately, improving the lives and outcomes for Manitoba’s young people and their families. When an organization or department is named in a recommendation by the Manitoba Advocate, they also become part of a process that is initiated at the close of the investigation or special report in which the formal recommendation appears. Under the ACYA, the Manitoba Advocate is responsible for tracking progress on recommendations, and can report on the levels of compliance the organization or department demonstrates in enacting the recommended changes. **The Manitoba Advocate will be sharing information with the public on a regular and ongoing basis on the status and progress of recommendations made in our reports. This information will be published on our website and will also be summarized in the annual report of the Manitoba Advocate.**

The Manitoba Advocate publishes ongoing updates on recommendations made to government, as well as analysis on the levels of compliance with the implementation of those recommendations. Updated information throughout the year may be found at:

<https://manitobaadvocate.ca/recommendation-tracking/>

A YEAR IN REVIEW

The 57 child death reviews completed in the 2018-2019 year served to highlight concerning circumstances and trends in four main areas: assessment, planning, service delivery, and evaluation. There were gaps in each of those areas, and when these gaps were observed, the casework by the agencies often did not meet the minimum required activities or timeframes as set out in the Child and Family Services Standards Manual. Deficiencies in casework when families require support can have a significant impact on the wellbeing of children, youth, young adults, and families, and may increase their risk of harm. When case-specific issues are coupled with larger systemic concerns, such as ongoing changes within the CFS system, staff training, income disparity and poverty across Manitoba, and a lack of access to necessary resources, then children, youth, young adults, and families are placed at a further disadvantage. When services are ill-coordinated, agencies are over-stressed, and families are needing specialized supports, these factors can come together resulting in services which are reactionary and crisis oriented, only meeting the most critical of needs. Instead, when families need help, they ought to be able to access public systems that strive to intervene early, aim to keep the family intact, and offer services that are preventative and which are delivered through a holistic lens that promotes the wellbeing and best interests of all. It should not be overlooked that we also noted instances of positive support and services provided to Manitoba families by CFS agencies in the province, and situations where the services provided appropriately matched the needs of the family. Typically, those cases will close following the review phase, because our more comprehensive investigations focus on stories where the Manitoba Advocate has observed significant or long-standing deficiencies and where a more comprehensive examination of services is warranted.

The 57 reviews at the core of this report each represent a child, youth, or young adult that has died. The responsibility we feel, as advocates for children and youth, to hold their stories with reverence and care guides us as we analyze the services which were active in their lives. Each child represents an important story that we are honoured and humbled in striving to tell. In each story, our team examines and analyzes the public services **through the eyes of the child** who has died. We seek to understand what the needs of the child and their family were and which services were active, or which services ought to have been active to support the young person and those who loved and surrounded them. Each story of a child who has died creates critical opportunities to learn and enhance service delivery to improve the lives of all children, youth, and young adults in Manitoba. A number of these 57 reviews will go on to inform pending special reports on systemic issues, and the Manitoba Advocate has moved a number of the stories into comprehensive investigations.

As we look forward, our office is hopeful the government will move to proclaim the outstanding sections of *The Advocate for Children and Youth Act*, as this legislation was designed cohesively to promote and champion the rights and voices of children and youth and to help improve the outcomes of young people in our province. We know that good policies are built on good evidence and we look forward to our continued work in all areas of our mandate as we respond to the needs and experiences of young people through our advocacy, youth engagement, investigations, research, and system accountability responsibilities. As our work continues now and once our full mandate is proclaimed, we hope to lend our data and our expertise to help improve the effectiveness and responsiveness of services and better meet the best interests of children, youth, and young adults in Manitoba.

APPENDICES

Appendix A – Enabling legislation of the Manitoba Advocate for Children and Youth

Reviews:

Jurisdiction to review — death of child or young adult

20(3) After receiving notice of the death of a child or young adult from the chief medical examiner under *The Fatality Inquiries Act*, the Advocate may review

- (a) a child's death, if the child or his or her family was receiving a reviewable service at the time of the death or in the year before the death; and
- (b) a young adult's death, if the young adult was receiving services under subsection 50(2) of *The Child and Family Services Act* at the time of the death or in the year before the death.

Purpose of review

20(4) A review under this section may be conducted for the following purposes:

- (a) to determine whether to investigate the serious injury or death under section 23;
- (b) to identify and analyse recurring circumstances or trends
 - (i) to improve the effectiveness and responsiveness of reviewable services, or
 - (ii) to inform improvements to public policies relating to designated services.

Disclosure of results of the review

22 If, after completing a review under section 20, the Advocate decides not to investigate under section 23, the Advocate may disclose the results of the review to

- (a) the government department or regional health authority responsible for the provision of the reviewable service that is the subject of the review;
- (b) the public body or other person who provided the reviewable service; and
- (c) any other person or entity that the Advocate considers appropriate to notify in the circumstances.

Appendix B – References

Manitoba Families. (n.d.). *Child and family services standards manual*. Retrieved from <https://gov.mb.ca/fs/cfsmanual/index.html>

The Advocate for Children and Youth Act. (S.M. 2017, C.8) Retrieved from <http://web2.gov.mb.ca/laws/statutes/2017/pdf/c00817.pdf>

