The 2019-20 Child Death Review Roll-Up

A Summary of Findings from the 71 Child Death Reviews Completed in the 2019-20 Fiscal Year

A special report released in accordance with

The Advocate for Children and Youth Act

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About Our Office

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 reviewing public service delivery after the death of a child, and by conducting child-centered research regarding the effectiveness of public services in Manitoba. The Manitoba Advocate is empowered by legislation to make recommendations to improve the effectiveness and responsiveness of services provided to children, youth, and young adults and further, to track compliance with the implementation of recommendations made under the Advocate's legal mandate. We are mandated through *The Advocate for Children and Youth Act* and guided by the *United Nations Convention on the Rights of the Child* (UNCRC) and we act according to the best interests of children and youth.

Our Commitment to Reconciliation

The mandate of the Manitoba Advocate for Children and Youth extends throughout the province of Manitoba and we therefore travel and work on a number of treaty areas, including areas 1, 2, 3, 4, 5, 6 and 10. Specifically, our offices in Southern Manitoba are on Treaty 1 land and our Northern office is located on Treaty 5. The services we provide to children, youth, young adults and their families extend throughout the traditional territories of Anishnaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, and the beautiful homeland of the Metis nation.

The Manitoba Advocate is committed to the principles of decolonization and reconciliation and strives to contribute in meaningful ways to improve the lives of all children, youth, and young adults, but especially the lives of First Nations, Metis, and Inuit young people, who continue to be disproportionately impacted by systemic inequalities and other barriers in our communities. This is particularly true in this summary report that examines child deaths, where First Nations and Metis children and youth With a commitment to social justice and through a rights-based lens, we integrate the *United Nations Convention on the Rights of the Child*, the *United Nations Declaration on the Rights of Indigenous Peoples* and the national Truth and Reconciliation Commission's *Calls to Action* into our practice.

An Important Note: Confidentiality

For the purposes of this document, all identifying information with respect to individuals and places has been removed to protect their confidentiality and privacy.

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About This Report

In November 2019, the Manitoba Advocate released The 2018-2019 Child Death Review Roll-up, the first of its kind from our office, as a companion document to the 2018-2019 Annual Report. It is our intent to continue to release these reports as a way to help the public understand the circumstances and trends we are observing in the delivery of reviewable services during the child death review process and to further provide context and information about the issues young people and families in our province are facing. These roll-up reports allow the Manitoba Advocate to provide thorough information to Manitobans about the many child death reviews completed at the office each year that do not result in a public special report. This report is being released under Section 31 of The Advocate for Children and Youth Act (ACYA) as a "special report."

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

This document profiles the work completed by the Manitoba Advocate for Child and Youth's Investigations and Child Death Review program between April 1, 2019, and March 31, 2020. In that time, our office completed 71 reviews and 26 investigations, one of which was released as special public report[1], into the designated services delivered to children, youth, and young adults who died in our province. This document will provide a summary of the information including:

- Observations of gaps in child welfare service delivery organized by four main categories: assessment, planning, service provision, and evaluation;
- The number of child death notifications received and an analysis of child death review data including: involvement by child welfare authority, commonly observed gaps in service delivery by child welfare authority, age, and manner of death;
- 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.

As was noted last year, the data presented in this document reflects only what was found in the 71 child death reviews completed in the 2019-2020 year. For further information about the Manitoba Advocate for Children and Youth's (MACY's) child death data, trend data, and additional year-over-year comparisons, see our annual reports: https://manitobaadvocate.ca/resources/annual-reports/

[1] To read *The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness* (Manitoba Advocate, 2020a), please see: https://manitobaadvocate.ca/adult/reports-publications/public-reports/

The 2018-2019 child death review roll-up released last year detailed the 57 child death reviews completed in the 2018-2019 fiscal year. Those deaths had occurred between the years 2014 to 2018. The Manitoba Advocate continues to make progress toward ensuring that reviews and investigations are being completed within one year of the death of the child, youth, or young adult. Eighty nine percent of the child death reviews completed in the 2019-2020 fiscal year included deaths that occurred from 2018 onward. These steps forward are particularly important as they ensure that information about service gaps and inefficiencies are identified and shared back to the system in a timely manner so there is a higher likelihood of preventing future deaths in similar circumstances. However, in some cases this is not possible, such as when there is an open criminal investigation, or during subsequent criminal court proceedings, such as appeals and convictions. While these restrictions prohibit further investigation, they do not inhibit the completion of a child death review.

INTRODUCTION

Child Death Reviews – Our Mandate

The Manitoba Advocate for Children and Youth (MACY) has been responsible for conducting child death reviews and investigations since 2008, when the legislated responsibility transferred from the Office of the Chief Medical Examiner (OCME) to MACY (then known as the Office of the Children's Advocate). More recently in 2018, another shift occurred with the proclamation of *The Advocate for Children and Youth Act* (ACYA). The Manitoba Advocate's mandate expanded under this new legislation and the ACYA broadened the scope of our work in many ways. One critical addition was the inclusion of young adults to our legal scope. Our office now receives child death notifications from the Office of the Chief Medical Examiner (OCME) of all children, youth, and young adults up to age 21.

The ACYA empowers the Manitoba Advocate to conduct a review of services following a child, youth, or young adult's death if certain provisions are met. When the Advocate receives notification of a death, we conduct an assessment to determine 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 we determine that a reviewable service was involved with the family in the year before the death, the Manitoba Advocate may conduct a review or investigation into the services that were provided to the child, youth, young adult, or their family.

REVIEWS OF SERIOUS INJURIES AND DEATHS
Jurisdiction to review- death of a 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 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.

The term "reviewable service" was a new addition to the ACYA and 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. (s.1, *Definitions*, ACYA, 2018)

However, as was discussed in the 2018-2019 Child Death Review Roll-up, and other reports released by our office, a decision was made at the time of proclamation to roll out the ACYA in phases. While Phase 1 is currently in force, Phase 2 and Phase 3 have been held back by the government. Phase 2 has particular relevance to child death reviews. At present, the Advocate's ability to launch a review of

services following the death of a child is limited to those circumstances where the child, or the child's family, had any form of child and family services (CFS) involvement in the 12 months before the date of death of the child (see s.20(3), above). When Phase 2 comes into force, it will expand the circumstances when the Manitoba Advocate may review services following the death of a young person. More specifically, it will allow the Advocate to conduct a child death review if the child that died, or their family, received any form of mental health, addictions, or youth justice services, regardless of whether CFS was involved.

Despite the two years that have passed since the ACYA was proclaimed and several public commitments to bringing in the full scope of the legislation,[2] the Government of Manitoba has yet to set a coming into force date for Phase 2. This delay continues to interfere with our office's ability to review deaths of many children, youth, and young adults in Manitoba and limits opportunities for public systems to learn and change, as recurring circumstances, trends, and gaps in service delivery in other provincial public services may be missed.

Child Death Reviews - Our Process

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 scope of the legal mandate. The process begins when the Office of the Chief Medical Examiner (OCME) notifies the Manitoba Advocate of the death of a child, youth, or young adult up to the age of 21. Typically, within a day, our office assesses whether the death falls under our legislation, or is "in scope," using the parameters outlined in legislation. If the death is determined to be in scope, the death is assigned to a child death investigator and our office contacts the CFS agency involved, or that was previously involved, with the family and arranges for the agency to provide their file information for the purposes of conducting the child death review. The investigator also 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. During the child death review phase, MACY initially requests only CFS file documentation but additional information may also be requested to obtain a complete and true picture of the services delivered. A thorough child death review can take a few weeks and up to 60 days for an investigator to complete, depending of the complexity of service delivery in the life of the young person or their family.

[2] To view some of the public commitments made by the Government of Manitoba, and the Manitoba Advocate speak about the importance of implementing outstanding phases of the legislation, please follow the article links below:
https://www.cbc.ca/news/canada/manitoba/manitoba-childrens-advocate-committee-meeting-1.4981086
https://www.winnipegfreepress.com/local/these-kids-need-action-today-504455362.html

Our focus during the review process is to determine if the services that were delivered matched the needs of the child or their family. 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 and their family. Investigators note recurring circumstances and trends, including any gaps in services that could have improved a child, youth, or young adult's life, or may have prevented their death.

When a child death review is complete, the Manitoba Advocate will determine whether the case will close following the review, if more information is required, or the case warrants further attention. If the Manitoba Advocate's questions and concerns regarding the services which were delivered are sufficiently answered at the review phase, the Advocate may decide no further investigation is needed and may notify the relevant agencies, organizations, and government departments that provided a reviewable service of the 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. However, even after the child's file has closed, circumstances and trends observed in their story may still inform future reports by MACY's Research Hub or the Investigations and Child Death Review programs.

> **INVESTIGATIONS OF SERIOUS INJURIES AND DEATHS**
>
> **23(1)** The Advocate may investigate a serious injury or death of a child or young adult if, after completing a review under section 20, the Advocate determines that
>
> (a) A reviewable service, or related policies or practices might have contributed to the serious injury or death; and
> (b) the serious injury or death,
> i. In the case of a child, was or may have been due to one or more of the circumstances set out in section 17 of The Child and Family Services Act (child in need of protection),
> ii. Occurred in unusual or suspicious circumstances, or
> iii. Was, or may have been, self-inflicted or inflicted by another

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. A more comprehensive investigation may be conducted in situations where we have significant concerns or questions about the services that were delivered, or which should have been delivered, to the child, youth, or young adult, or their family. An investigation may also be summarized and released to the public in the form of a special report. MACY's investigations and special reports may include formal recommendations to the government or to service providers for changes to standards, policies, regulations, and practices, relating to the delivery of provincial public services. Our 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.

A SUMMARY OF THE 2019-2020 YEAR

The following is a breakdown of the total number of Manitoba child death notifications the Manitoba Advocate received, the number of child death reviews and investigations that were completed, and the number of files that were carried forward to the 2020-21 reporting year.

We received 198 Manitoba Child Death Notifications

170 Notifications were children and youth ages birth-17

28 Notifications were for young adults ages 18-20

13 Notifications were for a Child in Care of CFS

Of the 198 notifications that went through the Assessment phase:

62 of the deaths were assessed to be in scope for the Advocate's review under the ACYA

Child Death Reviews Completed

71 Reviews were completed in the 2019-20 year. Following our formal review:

38 files were closed following the Review phase

33 files remained open and advanced to the Investigation phase

Child Death Investigations Completed

26 comprehensive investigations were completed in the 2019-20 year:

3 individual investigations were completed with final reports as outlined under Part 4 of the ACYA

1 individual investigation informed a public special report involving one youth, as outlined under Parts 4 and 5 of the ACYA

22 individual investigations informed a public special report which involved multiple youth, as outlined under Parts 4 and 5 of the ACYA but the report's release was delayed until the 2020-21 fiscal year due to COVID-19

Carry-Over into the 2020-21 Year

68 child deaths were carried over to the new reporting year on April 1, 2020:

43 open child deaths were moved into the 2020-2021 review phase

25 open child deaths moved into the 2020-2021 investigation phase

THEMES

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

As presented in *The 2018-2019 Child Death Review Roll-up* (Manitoba Advocate, 2019), the current report will also provide a summary of the concerns and gaps noted in the services provided by CFS during the child death review process. These concerns are organized into the four categories below and were observed the following number of times in the 71 total child death reviews completed in the 2019-2020 year. Numbers from the 2018-2019 year are also included for comparison. These theme categories continue to be based on case management standards set out in the *Child and Family Services Standards Manual*.

SERVICE CONCERN:	INCLUDING:	OBSERVATIONS 2018-2019:	OBSERVATIONS 2019-2020:
ASSESSMENT	• Family Assessment • Child assessment • Child protection investigation	52/57 or 91%	66/71 or 93%
PLANNING	• Safety planning • Ongoing family planning • Child in care planning	53/57 or 93%	59/71 or 83%
SERVICE PROVISION	• Frequency of contact with families and caregivers • Services are provided as outlined in plans • Families and children are engaged • Services are updated to reflect the changing needs of a child or family	52/57 or 91%	62/71 or 86%
EVALUATION	• Monitoring • Review	49/57 or 86%	58/71 or 82%

Table 1. *Prominent service delivery issues noted during the child death review process in the 2019-2020 and 2018-2019 fiscal years.*

Note: *For a more detailed explanation of what each theme area entails, see Appendix B of this document.*

While concerns related to case planning were the most prominent in 2018-2019, concerns related to assessment were the most prominent in 2019-2020. Nonetheless, concerns observed remain high in all areas. These numbers display year-over-year that the services delivered by CFS agencies continue to fall short when compared to the minimum services standards outlined by the Province of Manitoba. The Child and Family Services Standards Manual continues to be one evaluation tool utilized by investigators of the Manitoba Advocate when determining whether case management standards 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.

The numbers presented above are, in some situations, influenced by complex systemic issues CFS agencies face across Manitoba. Previous reports by our office have noted that agencies are under-resourced and the resources that are available are stretched much too thin when attempting to meet the needs of the children and families they serve. When agencies look to the landscape of external prevention and supportive resources in the community, they too are under resourced. As a result, families face long wait lists and must meet rigorous entrance criteria to access support. These barriers to service are further complicated by other systemic concerns prevalent in Manitoba, such as poverty, limited access to safe housing, the rising use of substances, particularly methamphetamine, and increasing criminal activity (Illicit Drug Task Force, 2019). While CFS service delivery is certainly a challenge in some areas of the province, the minimum CFS provincial service standards are unquestionably important as they ensure CFS agencies are accountable to provide a minimum standard of service to children, youth, young adults, and their families. Systemic barriers do not absolve agencies of their legal responsibility to provide a minimum standard of service but MACY has observed through copious reviews and investigations how some barriers complicate service delivery.

The following table provides further detail with respect to the most commonly observed issues in the areas of assessment, planning, service provision, and evaluation. Investigators continue to note concerns in more than one category, if more than a single issue is prevalent.

Table 2. *Commonly observed issues in each theme area*

ISSUES NOTED IN THE ASSESSMENT PROCESS: OBSERVED IN 93% OF REVIEWS (66/71)	
Family Assessments	• 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 completed incorrectly (i.e. were scored incorrectly or were completed with incorrect information) • 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 Assessments	• Assessments did not comply with standard time frames and were not ongoing • Assessments of children's strengths and needs were absent or incomplete • Assessments were completed incorrectly (i.e. were scored incorrectly or were completed with incorrect information) • 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	• Absent or incomplete critical child protection assessments and investigation when abuse was suspected or reported, including when children made disclosures
ISSUES NOTED IN THE PLANNING PROCESS: OBSERVED IN 83% OF REVIEWS (59/71)	
Safety Planning	• Safety plans were not completed in a timely manner when there were concerns about the immediate safety of children or youth • Safety plans were insufficient to address the complexity and/or seriousness of the presenting concerns
Ongoing Family Planning	• 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, especially at periods when risk was increasing • The family plan focused on the needs of the parent(s), not the children • Consultation with the family as a whole, or certain members of the family, was missing when creating the family plan
Child in Care Planning	• 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 child in care plan was not revised or updated to adapt to the needs of the child or youth, especially at periods when risk was increasing • The child in care plan did not include concepts such as reunification and permanency • Age appropriate consultation with the child was missing when creating the child in care plan
ISSUES NOTED IN THE SERVICE PROVISION PROCESS: OBSERVED IN 87% OF REVIEWS (62/71)	
Service Provision to the Child and their Family	• No evidence of service provision by the responsible agency • Services provided were inadequate to address the presenting concerns, were incomplete, or ill-coordinated • The provision of service was delayed or inconsistent • CFS agencies did not collaborate with collaterals as required • The services provided were not updated to meet the changing needs of the child, youth, young adult, or their family • Frequency of contact standards were not met by the CFS agency involved

	• Services were provided to the family but not the children
ISSUES WITH THE <u>EVALUATION</u> PROCESS: OBSERVED IN 82% OF REVIEWS (58/71)	
Ongoing Monitoring of Service Effectiveness	• Progress reviews were absent, inconsistent, or feedback from monitoring reviews was not used to alter plans and the provision of service as required • Progress reviews were not ongoing and were reactionary during times of crisis; therefore, valuable information about when the child/family was doing well was missed • There was no evidence of review prior to file closure
Appropriate Supervisory Review	• Evidence of ongoing supervisor oversight and review could not be found

Table 3. *Additional issues observed in child death reviews*

Examples of Additional Issues Observed in Reviews	
Parental and youth/young adult substance misuse	Parental and child, youth, or young adult mental health challenges
Youth missing from their homes or placements	Sexual exploitation
Absent or missing agency documentation on CFSIS or in the physical file	Child abuse and/or neglect
Violent manners of death	Children with complex needs did not receive the support they required, including specialized placements
Family visitation was inconsistent or absent	Multiple placements
Intimate partner violence	Lack of or poor transitional planning
Bullying	Poor school attendance
A lack of access to safe housing	A lack of available resources to support children, youth, young adults, and their families
Unsafe persons having access to children	

PROVINCIAL CFS SERVICE INVOLVEMENT

In Manitoba, families can select to receive CFS services from their preferred child welfare authority. This process is known as the Authority Determination Protocol (ADP) and allows a family to select one of the four child welfare authorities in Manitoba that oversee the delivery of provincial child welfare services. This protocol was developed to promote delivery of child welfare services that are culturally informed. However, families may choose to receive services from any of the four authorities: First Nations of Northern Manitoba Child and Family Services Authority (Northern Authority), Southern First Nations Network of Care (Southern Authority), Metis Child and Family Services Authority (Metis Authority) and the General Child and Family Services Authority (General Authority).

Involvement by Child Welfare Authority

Of the 71 child death reviews completed in the 2019-2020 year:

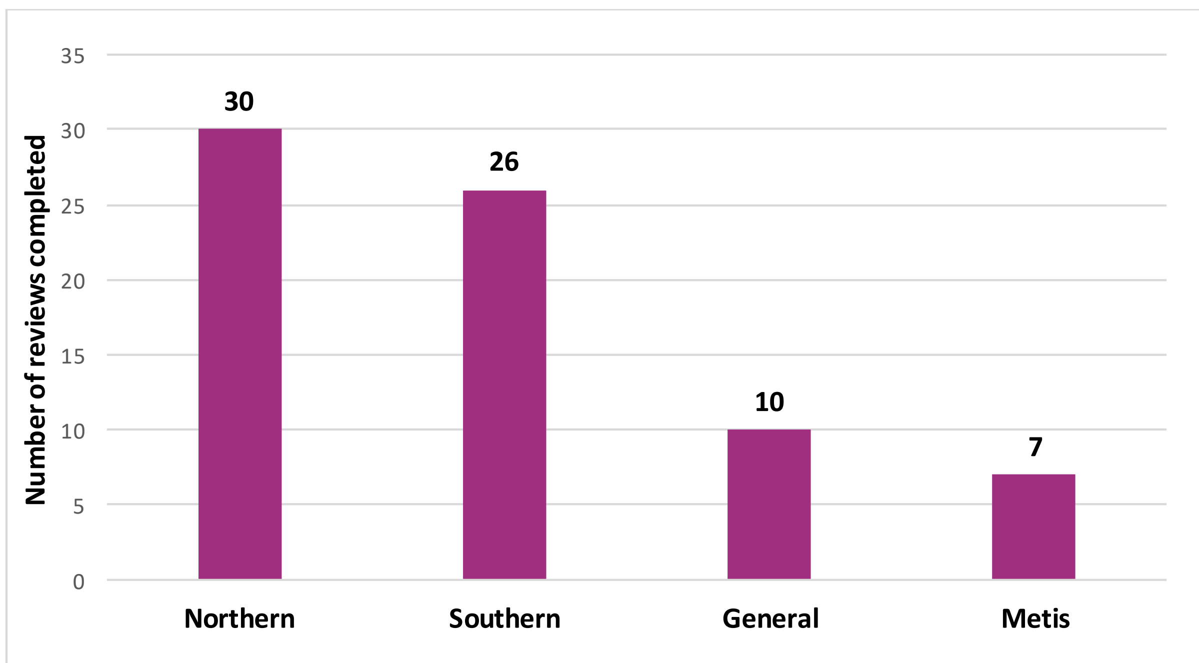


Figure 2. *71 child death reviews involvement by child welfare authority*

*Note: Two children were receiving service from two different authorities at the time of their death; therefore, the values in Figure 2 equal 73, for 71 child deaths.

Involvement per Authority at Time of Death

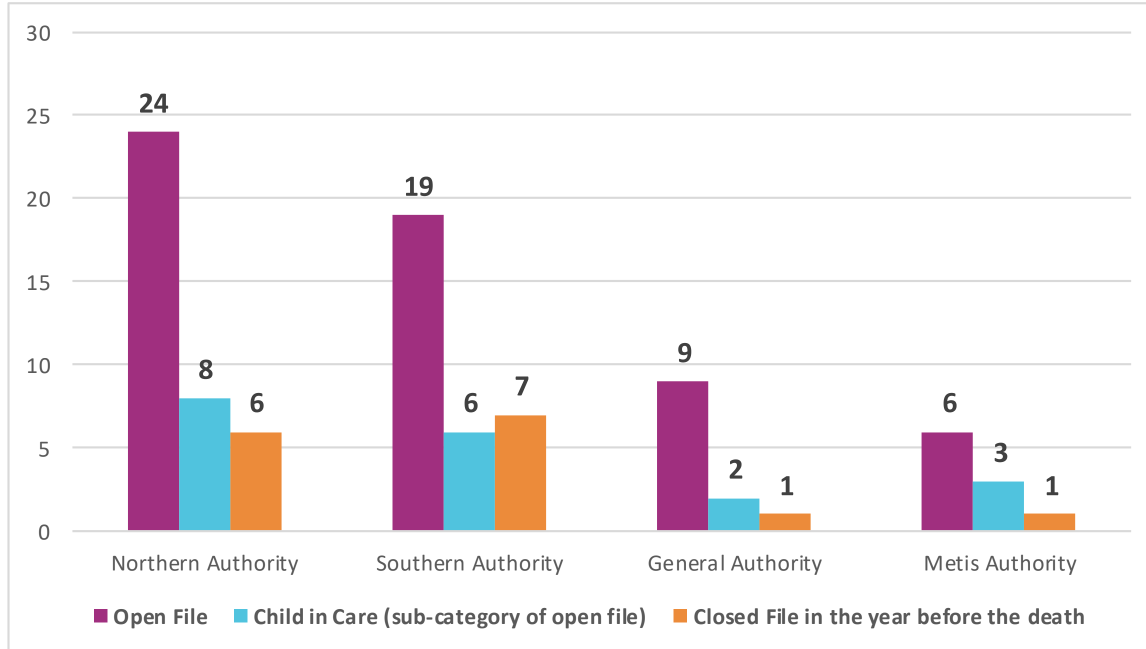


Figure 3. *71 child death reviews, involvement by authority at time of death*

First Nations of Northern Manitoba Child and Family Services Authority

The Northern Authority oversees seven agencies that are legislated to deliver services to 26 northern First Nations and their members, or persons who are identified with those Northern First Nations throughout Manitoba, and those that choose to receive services from the Northern Authority (*Child and Family Services Authorities Act*, 2015). The Department of Families reported that on March 31, 2019, Northern Authority agencies were responsible for 5,697 open files, including those of 2,928 children in care. Of the 71 child death reviews completed in the 2019-2020 year, **30** of the children or youth that died, or their families, were receiving services from agencies overseen by the Northern Authority.

Involvement at Time of Death – Northern Authority

Total Number of Reviews	Number of reviews involving Open Files at the time of the child's death		Number of reviews involving Closed Files that had been closed in the year preceding the child's death
30	24	8 of whom were children in care at the time of their death	6

Table 4. *Child death reviews, involvement with the Northern Authority at time of death*

Commonly Observed Themes – Northern Authority

The following chart presents examples of issues noted in each of the four theme areas when the 30 child death reviews were completed for those children, and their families, who were receiving services from an agency overseen by the Northern Authority.

Table 5. *Examples of observed issues, MACY child death reviews involving the **Northern Authority***

Theme Area	Number of Observations	Examples of Observed Issues in each Theme Area
Assessment	29/30	• Family and child assessments did not comply with standard time frames and were not ongoing • Assessments were missing or incomplete when there was a risk to a child's safety reported to a CFS agency • 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 • Absent or incomplete critical child protection assessments and investigation when abuse was suspected or reported, including when children made disclosures
Planning	28/30	• Safety plans were not completed in a timely manner when there were concerns about the immediate safety of children or youth • A family plan was absent or was inadequate to address the complexity and seriousness of the presenting concerns • 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
Service Provision	29/30	• No evidence of service provision by the responsible agency • Services provided were inadequate to address the presenting concerns, incomplete, or ill-coordinated • The provision of service was delayed or inconsistent • Frequency of contact standards were not met by the CFS agency involved
Evaluation	27/30	• Progress reviews were absent, inconsistent, or feedback from monitoring reviews was not used to alter plans and the provision of service as required • Evidence of ongoing supervisor oversight and review could not be found

Southern First Nations Network of Care ("Southern Authority")

The Southern Authority oversees ten agencies that are legislated to deliver services to 36 Southern First Nations communities and their members, or persons who are identified with those Southern First Nations throughout Manitoba, and those that choose to receive services from the Southern Authority (*Child and Family Services Authorities Act*, 2015). The Southern Authority also services Ontario First Nations community members residing in Winnipeg and oversees the designated intake agency for Winnipeg (Southern First Nations Network of Care, 2020). The Department of Families reported that on

March 31, 2019, the Southern Authority agencies were responsible for 7,945 open files, including those of 4,897 children in care. Of the 71 child death reviews completed in the 2019-2020 year, **26** of the children or youth that died, or their families, were receiving services from agencies overseen by the Southern Authority.

Involvement at Time of Death – Southern Authority

Total Number of Reviews	Number of reviews involving Open Files at the time of the child's death		Number of reviews involving Closed Files that had been closed in the year preceding the child's death
26	19	6 of whom were children in care at the time of their death	7

Table 6. *Child death reviews involvement with the Southern Authority at time of death*

Commonly Observed Themes – Southern Authority

The following chart presents examples of issues noted in each of the four theme areas when the 26 child death reviews were completed for those children, and their families, who were receiving services from an agency overseen by the Southern Authority.

Table 7. *Examples of observed issues, MACY child death reviews involving the* ***Southern Authority***

Theme Area	Number of Observations	Examples of Observed Issues in each Theme Area
Assessment	21/26	• Assessments were missing or incomplete when there was a risk to a child's safety reported to a CFS agency • Assessments of child's strengths and needs were absent or incomplete • Family and child assessments were completed incorrectly (i.e. were scored incorrectly or were completed with incorrect information)
Planning	18/26	• Safety plans were insufficient to address the complexity and/or seriousness of the presenting concerns • A family plan was absent or was inadequate to address the complexity and seriousness of the presenting concerns • 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, especially at periods when risk was increasing
Service Provision	20/26	• Services provided were inadequate to address the presenting concerns, incomplete, or ill-coordinated • The provision of service was delayed or inconsistent

		• The services provided were not updated to meet the changing needs of the child, youth, young adult, or their family • Frequency of contact standards were not met by the CFS agency involved
Evaluation	19/26	• Progress reviews were absent, inconsistent, or feedback from monitoring reviews was not used to alter plans and the provision of service as required • Progress reviews were not ongoing and were reactionary during times of crisis; therefore, valuable information about when the child/family was doing well was missed

General Child and Family Services Authority

The General Authority oversees eight agencies that are legislated to deliver services across Manitoba to those that choose to receive services from the General Authority and who are not receiving services from another authority (*Child and Family Services Authorities Act*, 2015). The Department of Families reported that on March 31, 2019, General Authority agencies oversee 4,243 open files, including those of 1,359 children in care. Of the 71 child death reviews completed in the 2019-2020 year, **10** of the children or youth that died, or their families, were receiving services from agencies overseen by the General Authority.

Involvement at Time of Death – General Authority

Total Number of Reviews	Number of reviews involving Open Files at the time of the child's death		Number of reviews involving Closed Files that had been closed in the year preceding the child's death
10	9	2 of whom were children in care at the time of their death	1

Table 8. *Child death reviews involvement with the General Authority at time of death*

Commonly Observed Themes – General Authority

The following chart presents examples of issues noted in each of the four theme areas when the 10 child death reviews were completed for those children, and their families, who were receiving services from an agency overseen by the General Authority.

Table 9. *Examples of observed issues, MACY child death reviews involving the* ***General Authority***

Theme Area	Number of Observations	Examples of Observed Issues in each Theme Area
Assessment	10/10	• Assessments of family's and child's strengths and needs were absent or incomplete • Assessments were missing or incomplete when there was a risk to a child's safety reported to a CFS agency

Planning	8/10	• Safety plans were insufficient to address the complexity and/or seriousness of the presenting concerns • A family plan or child in care plan was absent or was inadequate to address the complexity and seriousness of the presenting concerns • Consultation with the family as a whole, or certain members of the family, was missing when creating the family plan
Service Provision	7/10	• Services provided were inadequate to address the presenting concerns, incomplete, or ill-coordinated • Frequency of contact standards were not met by the CFS agency involved • Services were provided to the family but not the children
Evaluation	7/10	• Progress reviews were absent, inconsistent, or feedback from monitoring reviews was not used to alter plans and the provision of service as required • Progress reviews were not ongoing and were reactionary during times of crisis; therefore, valuable information about when the child/family was doing well was missed

Metis Child and Family Services Authority

The Metis Authority oversees two agencies that are legislated to deliver services to Metis and Inuit persons, or those who identify as Metis or Inuit persons throughout Manitoba, and those that choose to receive services from the Metis Authority (*Child and Family Services Authorities Act*, 2015). The Department of Families reported that on March 31, 2019, Metis Authority agencies were responsible for 2,039 open files, including those of 1,144 children in care. Of the 71 child death reviews completed in the 2019-2020 year, **7** of the children or youth that died, or their families, were receiving services from agencies overseen by the Metis Authority.

Involvement at Time of Death – Metis Authority

Total Number of Reviews	Number of reviews involving Open Files at the time of the child's death		Number of reviews involving Closed Files that had been closed in the year preceding the child's death
7	6	3 of whom were children in care at the time of their death	1

Table 10. *Child death reviews involvement with the Metis Authority at time of death*

Commonly Observed Themes – Metis Authority

The following chart presents examples of issues noted in each of the four theme areas when the child death reviews were completed for those children, and their families, who were receiving services from an agency overseen by the Metis Authority.

Table 11. *Examples of observed issues, MACY child death reviews involving the* ***Metis Authority***

Theme Area	Number of Observations	Examples of Observed Issues in each Theme Area
Assessment	6/7	• Assessments of family's and child's strengths and needs were absent or incomplete • Assessments were missing or incomplete when there was a risk to a child's safety reported to a CFS agency
Planning	5/7	• A family plan or child in care plan was absent or was inadequate to address the complexity and seriousness of the presenting concerns
Service Provision	6/7	• No evidence of service provision by the responsible agency • Services provided were inadequate to address the presenting concerns, incomplete, or ill-coordinated • Frequency of contact standards were not met by the CFS agency involved
Evaluation	5/7	• Progress reviews were absent, inconsistent, or feedback from monitoring reviews was not used to alter plans and the provision of service as required • Progress reviews were not ongoing and were reactionary during times of crisis; therefore, valuable information about when the child/family was doing well was missed

A CLOSER LOOK AT CHILD DEATH REVIEWS

Of the 71 child death reviews completed in the 2019-2020 year:

By Age

25, or 35%, were children from birth to age 2

5, or 7%, were children ages 3 to 5

10, or 14%, were children ages 6 to 12

29, or 41%, were children ages 13 to 17

2, or 3%, were young adults ages 18 to 20

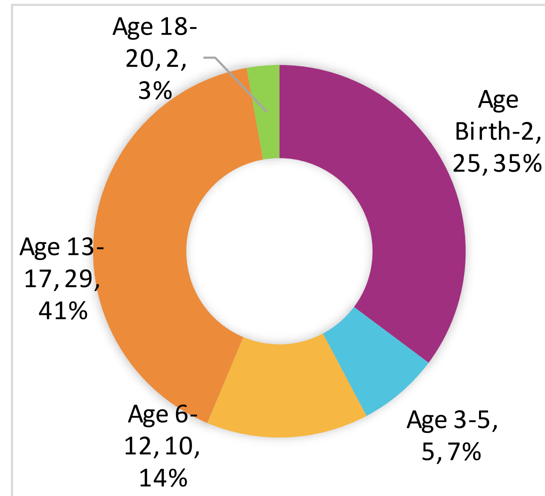


Figure 4. *Percentages of children, youth, and young adults who died by age group in the 71 child death reviews*

Notes

- As in 2018-2019, the highest number of deaths were in the birth to age 2 and 13 to 17 age groups, at 35% and 41% respectively.
- The 3 to 5, 6 to 10, and 18-20 age groups had comparatively smaller percentages at 7%, 14%, and 3% respectively.

By Manner of Death

When a child, youth, or young adult has died, the Manitoba Advocate receives a child death notification from the Office of the Chief Medical Examiner. In that notification, there are **preliminary causes of death**. The information is preliminary because a full autopsy has not been completed. The chief medical examiner classifies deaths 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 OCME cannot conclusively determine how the death occurred, even if the physical cause may be known

Of the 71 child death reviews completed:

- 4 (6%) were victims of homicide
- 25 (35%) died by suicide
- 8 (11%) died from natural causes
- 13 (18%) died accidentally
- 18 (25%) died an undetermined manner of death
  3 (4%) the manner of death is unknown due to pending autopsy

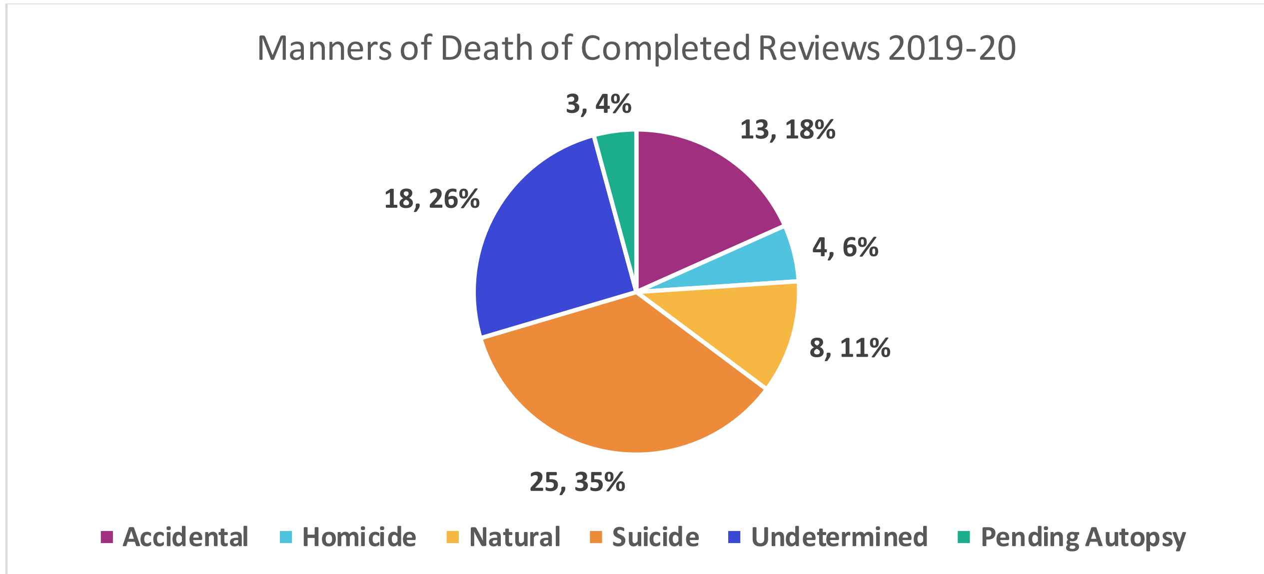


Figure 5. *71 child death reviews, by manner of death*

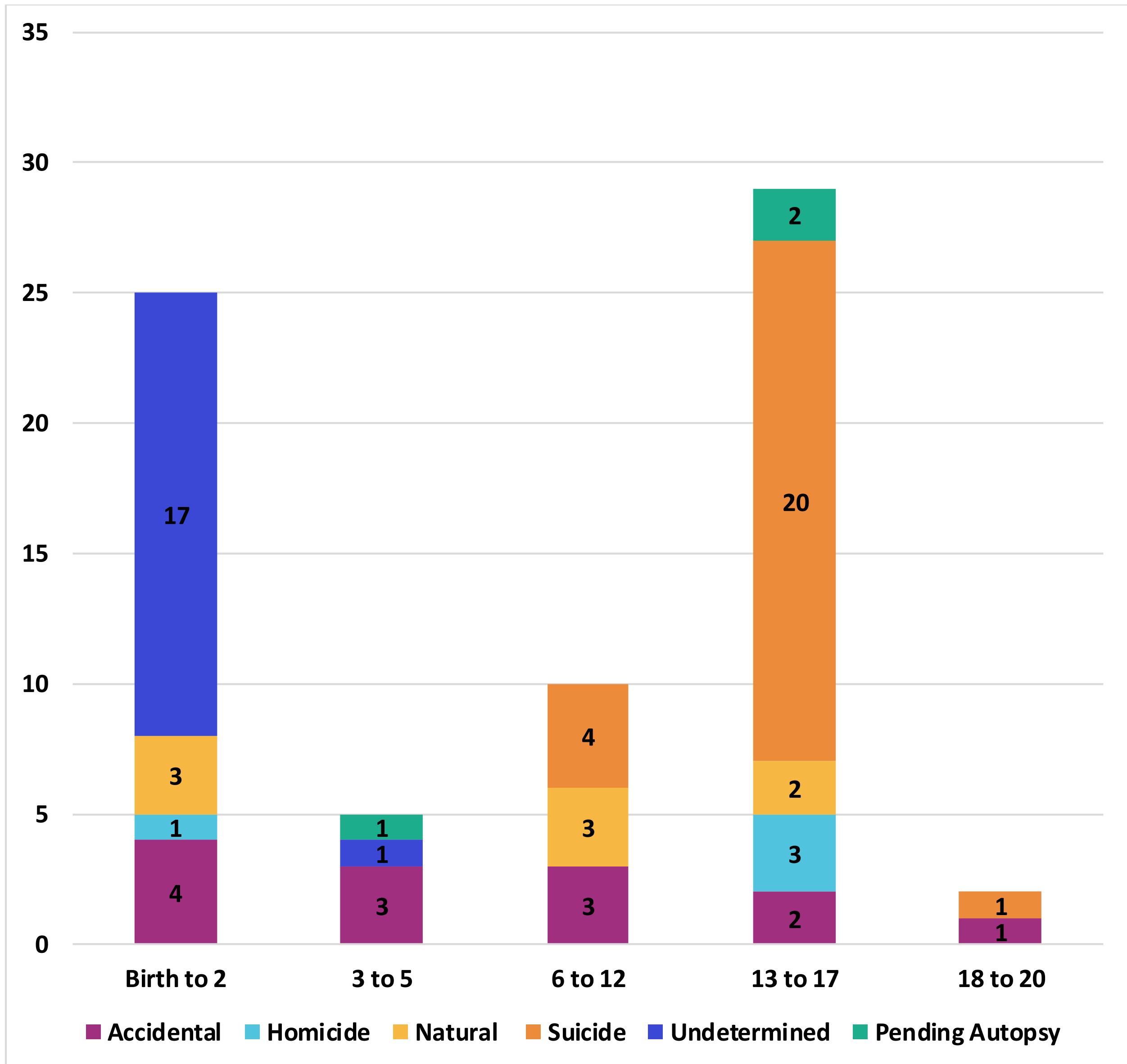
Notes

- Importantly, the chart above is not reflective of the breakdown of manners of death in a typical year because of the low numbers in the above chart of deaths deemed to have been Natural. This is because as part of our internal process, Natural deaths, when received, 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 and therefore, Natural deaths assessed by the QA department are not being included here.
- Of the deaths in scope and reviewed, the most prominent manner of death was suicide (35%), followed closely by undetermined (26%), accidental (18%), natural (11%* see note above), and homicide (6%).

71 Child Death Reviews: Manners of Death, by Age Grouping

	Accidental	Homicide	Natural	Suicide	Undetermined	Pending Autopsy	
Ages							
Birth to 2	4	1	3	-	17	-	25
3 to 5	3	-	-	-	1	1	5
6 to 12	3	-	3	4	-	-	10
13 to 17	2	3	2	20	-	2	29
18 to 20	1	-	-	1	-	-	2
Total	**13**	**4**	**8**	**25**	**18**	**3**	**71**

Figure 6. *71 child death reviews, by age and manner of death*



Notes

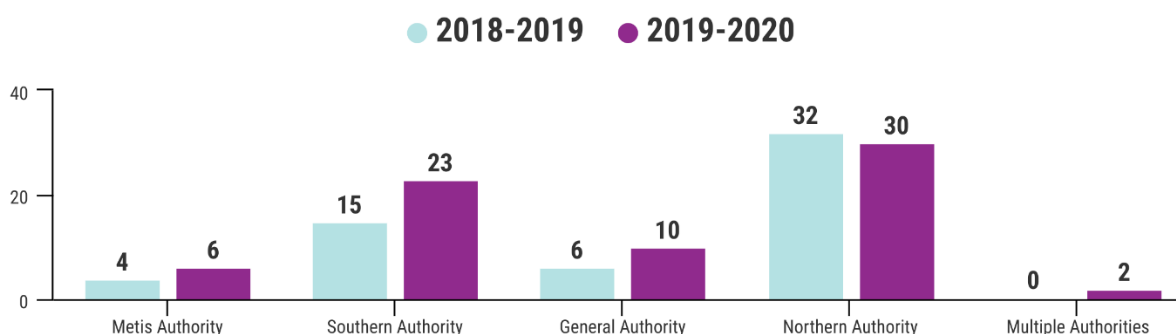
- For the 25 children who died between their birth and age 2, the number of undetermined deaths is particularly high because that category includes unsafe sleep related deaths and those deaths were associated with Sudden Unexplained Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS).
- The reviews completed in the 2019-2020 year included three 11-year-olds who died by suicide.

Child Death Review Summary 2019-20

The Manitoba Advocate for Children and Youth is notified of all deaths of Manitoba children and youth until age 21. The Advocate assesses each death, determines whether it requires further review, and later, whether it requires a more comprehensive investigation. Some investigations are publicly released as special reports.

During the reporting year, the Advocate completed 71 individual child death reviews for children who died between 2013 and 2020.

Child's Involvement, by CFS Authority



Age at Death, by CFS Authority

Age Group	Metis Authority	Southern Authority	General Authority	Northern Authority	Multiple Authorities	Total
Birth-2	2	11	4	8	-	25
3-5	1	1	1	2	-	5
6-12	-	1	3	6	-	10
13-17	3	8	2	14	2	29
18-20	-	2	-	-	-	2
Totals	6	23	10	30	2	71

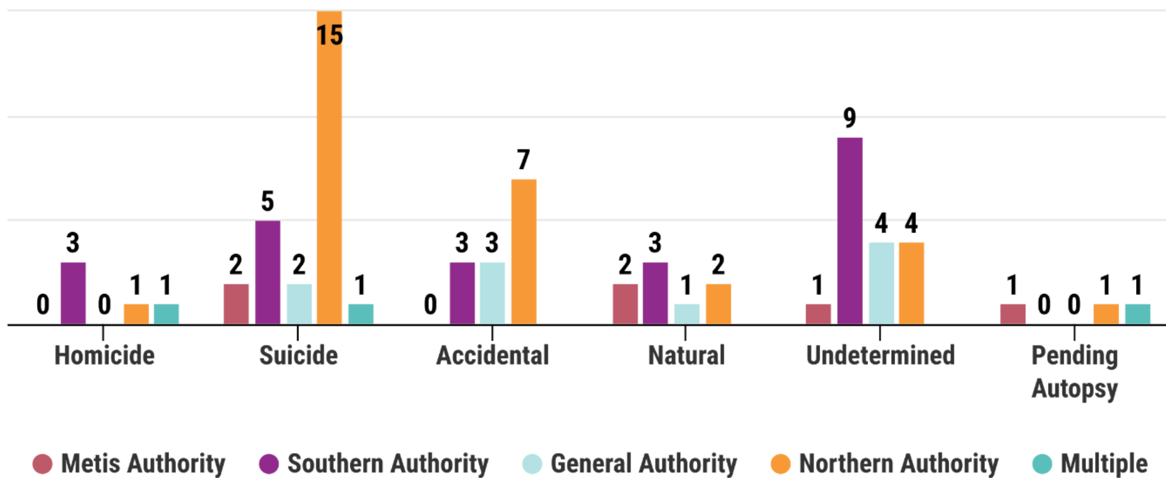
Source: Data from the Manitoba Advocate for Children and Youth

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**:

*Undetermined is the label the chief medical examiner gives when they cannot conclusively determine how the death occurred, even if the physical cause may be known. This category includes sudden unexplained infant death (SUID) and sudden infant death syndrome (SIDS).

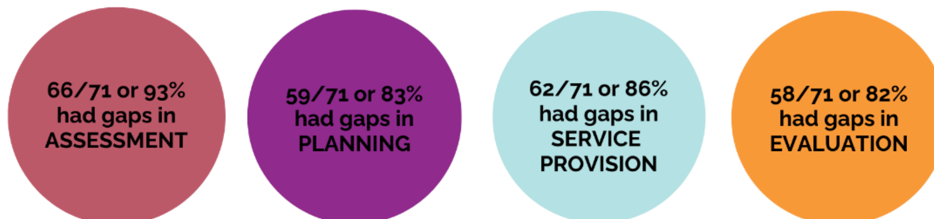
Manners of death for the 71 reviews completed this year
(deaths occurred between 2013 and 2020):



Source: Data from the Manitoba Advocate for Children and Youth

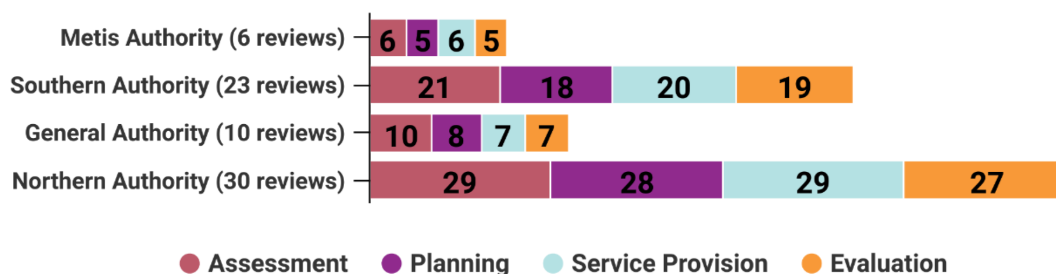
Where the Service Gaps Were

When our investigators are reviewing the death of a child, we use the provincial minimum CFS service standards manual as one source to compare what services were provided to a family to what services ought to have been provided. The standards can broadly be organized into four categories: assessment, planning, service provision, and the evaluation of those services.



The chart below reflects the number of times our office observed gaps in services, based on the evidence analyzed for the child death review.

Number of Gaps Found in Services, by Authority



After a Child Death Review...What Happens Next?

After a child death review is completed, the Manitoba Advocate determines if our involvement will end or if a more comprehensive investigation is warranted. The Advocate may open an investigation if a reviewable service might have contributed to the death, and if the death was related to a child protection issue, if the death occurred in unusual or suspicious circumstances, or if the death was self-inflicted or inflicted by another person.

Source: Data from the Manitoba Advocate for Children and Youth

DISCUSSION

Exposure to Intimate Partner Violence Impacts Children, Youth, and Young Adults of all Ages

Children who have experienced neglect, abuse, exploitation, torture or who are victims of war must receive special support to help them recover their health, dignity, self-respect and social life (UNCRC, Article 39).

Year over year, investigators at MACY note children's and youth's exposures to intimate partner violence (IPV) when completing child death reviews. In 71 child death reviews completed from April 1, 2019 to March 31, 2020, children were exposed to intimate partner violence in 39 reviews, or 55% of cases we examined.

IPV includes physical violence, sexual violence, stalking, and/or physical aggression by a current or former partner toward a current or former partner. IPV can range in severity and in the length of time over which it occurs (Centers for Disease Control and Prevention, 2019). IPV is a widespread public health issue, with 30% of women in Canada reporting they experience IPV in their lifetime (Government of Canada, 2015). A study released by Conroy, Burczycka, and Savage (2019) reported that Manitoba has the second highest rate of police reported intimate partner violence of all Canadian provinces. Also particularly important to our Manitoba context, Indigenous women are twice as likely to experience IPV as non-Indigenous women (Government of Canada, 2015). Sadly, as IPV is often underreported, these statistics are likely much higher.

Exposure to IPV during childhood can have a host of negative effects on a child or youth's physical, behavioural, psychological and cognitive development (The National Child Traumatic Stress Network, 2020). Some of these effects will continue to impact children and youth as they age and may follow them across their lifespan. Every child's or youth's exposure to IPV may look different, for example it may mean the child or youth hears IPV, sees IPV, or is aware of the effects of IPV but may not witness it directly. Children or youth may also be physically injured during incidents of IPV. Similarly, how every child or youth reacts or responds to this exposure may look different. Exposure to IPV is a form of child maltreatment and warrants intervention by public systems.

Given its prevalence, and the profound negative impact exposure to IPV can have for children and youth, the Manitoba Advocate's Research Hub has undertaken a report that aims to shed further light on this issue in Manitoba. The upcoming report will examine the extent to which children and youth are exposed in our province and how systems and services can best respond and intervene to ensure that children and youth are safe and supported in their environments.

Youth Suicide and Homicide in Manitoba from a Gendered Perspective

Every child has the right to life. Governments must do all they can
to ensure that children survive and develop to their full potential (UNCRC, Article 6).

Suicide is a complex issue that impacts the lives of many children and families across Manitoba. Youth suicide has long been an area of focus for MACY, as the office endeavors to understand what is happening for an individual who contemplates or attempts suicide, and what supports and intervention may work to prevent suicide. Since September 2008, when the Manitoba Advocate received the legal mandate to conduct child death reviews and investigations, our office has received 199 notifications for children, youth, and young adults where the preliminary manner of death was reported as suicide, although only 116 of those deaths have fallen into scope for review by the Manitoba Advocate for Children and Youth.

The Manitoba Advocate has reviewed and investigated the stories of several of these children and youth. Those reviews and investigations have led to the release of multiple individual, aggregated, and systemic reports examining youth suicide in Manitoba, with the goals of educating service providers and the general public, challenging outdated beliefs, and establishing a body of work that is a comprehensive and valuable resource for all peoples to better understand youth suicide in our province.

Suicide has become the leading manner of death for young people aged 10-17 in Manitoba, highlighting the importance of these reports at this time. From 2014 to 2019, the Manitoba Advocate received preliminary notification that 79 children and youth ages 11 to 17 died by suicide. Similarly, the 71 child death reviews completed in the 2019-2020 fiscal year included several suicide deaths and youth dying by suicide at younger ages, including 26 deaths by suicide, with three of who were just 11 years old.

Suicide impacts both females and males in Manitoba. As the Advocate's investigators have worked through child death reviews over the years, it became clear that, while there may be some similar experiences and risk factors for suicide, there were some marked differences in the experiences of females and males who have died by suicide. What emerged was a decision to embark on two distinct aggregated investigations: one examining the experiences of 22 girls who died by suicide (Manitoba Advocate, 2020b), and one looking specifically at the experiences of boys (upcoming release).

In examining preventable deaths of young people in Manitoba, investigators determined an additional issue that seemed disproportionately to affect boys in Manitoba. As investigations into the homicide deaths of boys has not been previously publicly reported by the Manitoba Advocate, a coming report

will examine both suicide and homicide deaths of Manitoba boys and the lessons their stories can teach us.

Both the female suicide aggregate report released earlier this year (Manitoba Advocate, 2020b) and the male suicide and homicide report (to be released in 2021) explore the lives and challenges of young people in Manitoba, including an examination of the issues or factors that may place young people at increased risk of dying by suicide or homicide, which are both preventable if interventions and services are provided early. Additionally, these reports review how public systems in Manitoba respond to and interact with children and families, what supports are available or should be available to keep young people safe in Manitoba, so that these deaths may be prevented in the future.

Maltreatment of Children Ages 5 and Under

Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them (UNCRC, Article 19).

Of the 71 reviews completed between April 1, 2019, and March 31, 2020, five children under the age of five who died were maltreated by their caregivers. This maltreatment has been, or is currently, being investigated by law enforcement to determine the role it played in these children's deaths. For this reason, not all of these deaths have been deemed a homicide in the section above.

In 2005, the death of five-year-old Phoenix Sinclair, who experienced horrific abuse and who ultimately died at the hands of her caregivers, set the Province of Manitoba on a course to further examine child maltreatment. In 2011, an Inquiry into the circumstances that surrounded Phoenix's death was ordered by the Attorney General. The resultant report by the Honourable Ted Hughes, *The Legacy of Phoenix Sinclair: Achieving the Best for All Our Children* was released in 2014 and included 62 recommendations to the Government of Manitoba.

The final report of the Phoenix Sinclair Inquiry, a seminal document for child welfare transformation in our province, will act as the foundation to an upcoming report by MACY. The upcoming report will highlight maltreatment of children age five and under since the death of Phoenix Sinclair, and look to ways to prevent the maltreatment and deaths of children in similar circumstances. Best practice service delivery tools will be highlighted that promote the well-being and safety for children aged five and under.

Case Status after Review

Of the 71 reviews concluded by the Manitoba Advocate between April 1, 2019, and March 31, 2020, **33** were moved to a more comprehensive investigation, **20** were moved forward to inform individual or aggregate investigations or systemic research reports, and **18** did not require further investigation and were closed by the Advocate following the review phase.

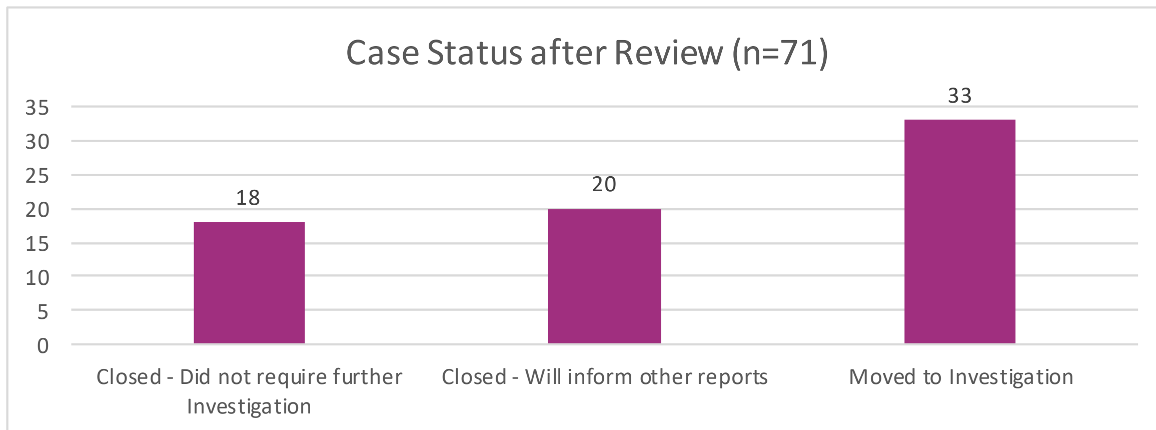


Figure 7. *Case status following completion of 71 child death reviews*

Investigations and Special Reports

If the Manitoba Advocate determines after the review stage a death requires more information or warrants further attention, it may move on to the next phase of our process – the investigation phase. After an investigation is completed it may be summarized and released to the public in the form of a public special report. This is particularly important when there were significant gaps in the services provided by public systems. If this was the case, the Manitoba Advocate is empowered to make formal recommendations in both investigations and special reports to service providers or to the government that would improve the effectiveness and responsiveness of the services and systems that support children, youth, young adults, and their families across the province. After a recommendation is made to an organization or department, progress toward meeting that recommendation is then tracked by the Manitoba Advocate per the ACYA. The Manitoba Advocate is empowered to report to the public on the progress of recommendations as well as the compliance with recommendations demonstrated by public serving systems and organizations. This information is published and updated on an ongoing basis on our website. The recommendation tracking database can be accessed through the following link. This information is also be summarized in the annual report of the Manitoba Advocate.

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

A YEAR IN REVIEW

As in the 2018-2019 child death review roll-up, our office continues to note concerning circumstances and trends in the areas of CFS assessment, planning, service provision, and evaluation. In the 71 child death reviews completed between April 1, 2019, and March 31, 2020, issues were noted in the vast majority of reviews and across all four child welfare authorities. When investigators note issues in the theme areas shared in this report, these often foreshadow serious and negative effects for families involved with CFS agencies. Too often, service issues in the areas of assessment, planning, service provision, and evaluation translate to a child, youth, young adult, of family's needs not being met. When CFS service does not meet a minimum standard, and is combined with many of the complicated systemic issues that are discussed in this report, this can have serious life-altering impacts, including decreasing children, youth, and young adult's opportunities for positive connection and wellbeing. Staff employed at all levels across CFS agencies and authorities do the work they do because they genuinely care about children and this can be seen through the positive work MACY staff encounter and read about daily. However, effective outcomes rely on more than good intentions. What we also see is that staff in CFS agencies and authorities are too often hindered by high caseloads, a lack of training, a scarcity of resources, and a lack of quality assurance processes to ensure minimum service standards are met.

In the previous year, the landscape of child welfare in Manitoba and Canada has drastically changed, and many more changes will follow. In June 2019, a landmark piece of legislation, *An Act respecting First Nations, Inuit and Metis children, youth, and families* became law in Canada. This legislation came into force on January 1, 2020, and comes at a time when the current system is experiencing a crisis. Indigenous children are overrepresented in child welfare systems across Canada, yet only make up a small percentage of the overall population. We know that when children are removed from their family and culture, this can have catastrophic effects on a child, youth, or young adult's development across their lifespan and even for the generations to follow them. The federal legislation aims to empower Indigenous peoples to deliver CFS services to their nations and families. *An Act respecting First Nations, Inuit and Metis children, youth, and families* allows for individual nations or groups to create their own legislation and enter into agreements with the federal government to deliver child and family services. At this time of transition, and with many outstanding questions about the federal law, the future of provincial child welfare in Manitoba is unclear. What does remain certain however, is that strong and well-coordinated and resourced systems are needed to ensure the safety of children and youth and all levels of government have critical responsibilities to ensure the needs of children and youth are at the forefront of all decisions.

As our landscape drastically changes, it has become even more critical that the Government of Manitoba set coming into force dates for Phase 2 and Phase 3 of the ACYA. The legislation was designed to amplify the voices of children, youth, and young adults, ensure children, youth, and young adult's rights are fulfilled, and increase accountability and transparency with respect to the way provincial services are delivered in Manitoba. Through these pathways, the Manitoba Advocate acts in the best interests of children to improve the effectiveness and responsiveness of provincial services. When the remaining sections of the ACYA are finally brought into force, the Manitoba Advocate will be positioned to better serve children, youth, young adults, and their families in Manitoba. In all things, the Manitoba Advocate seeks to amplify and represent the voices of children, youth, and young adults across this province and empower them to raise their own voices and share their stories to champion positive change for all Manitobans.

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 – Theme Definitions

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.

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.

Service Provision: The service provision 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.

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.

Appendix C – References

Botelho-Urbanski, J. (2019, January 16). 'These kids need action today' Child advocate pushes province for increased services as mandate expands. *Winnipeg Free Press.* https://www.winnipegfreepress.com/local/these-kids-need-action-today-504455362.html#long-story

Centers for Disease Control and Prevention. (2019). *Preventing intimate partner violence.* https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html

Conroy, S., Burczycka, M., & Savage, L. (2019, December 12). *Family violence in Canada: A statistical profile, 2018.* Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/85-002-/2019001/article/00018-eng.pdf?st=mlW_JV--

Government of Canada. (2019). *An Act respecting First Nations, Inuit and Metis children, youth and families.* (S.C., 2019 c.24). https://laws-lois.justice.gc.ca/eng/acts/F-11.73/FullText.html

Government of Canada. (2015). *Snapshot of family violence in Canada – Infographic.* https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/snapshot-family-violence-canada-infographic.html

Government of Manitoba. (2015). *Child and Family Services Authorities Act.* (S.M. 2015, c.90). https://web2.gov.mb.ca/bills/37-3/b035e.php

Government of Manitoba. (2017). *The Advocate for Children and Youth Act*. (S.M. 2017, c.8). http://web2.gov.mb.ca/laws/statutes/2017/pdf/c00817.pdf

Government of Manitoba. (2019). *Manitoba Families Annual Report 2018-2019.* *https://gov.mb.ca/fs/about/pubs/fsar_2018-2019.pdf*

Hoye, B. (2019, January 16). Gap in addictions, mental health services placing kids in care at risk: Manitoba Children's Advocate. *CBC.* https://www.cbc.ca/news/canada/manitoba/manitoba-childrens-advocate-committee-meeting-1.4981086

Hughes, T. (2014). *The legacy of Phoenix Sinclair: Achieving the best for all our children, Vol 2.* *http://phoenixsinclairinquiry.ca/rulings/ps_volume2.pdf*

Illicit Drug Task Force. (2019). *Recommendations to reduce the use and effects of illicit drugs within Manitoba Communities.* https://winnipeg.ca/cao/pdfs/2019-Illicit-Drug-Task-Force-Report.pdf

Manitoba Advocate for Children and Youth (2019). The 2018-2019 child death review roll-up. Online: https://manitobaadvocate.ca/wp-content/uploads/2018-2019-Child-Death-Review-Roll-Up.pdf

Manitoba Advocate for Children and Youth. (2020a). *The slow disappearance of Matthew a family's fight for youth mental health care in the wake of bullying and mental illness.* https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-The-Slow-Disappearance-of-Matthew-Feb2020.pdf

Manitoba Advocate for Children and Youth. (2020b). *"Stop giving me a number and start giving me a person": How 22 girls illuminate the cracks in the Manitoba youth mental health and addictions*

system. *https://manitobaadvocate.ca/wp-content/uploads/MACY-Special-Report-Suicide-Aggregate-2020.pdf*

National Child Traumatic Stress Network. (2020). *Intimate partner violence: Effects.* *https://www.nctsn.org/what-is-child-trauma/trauma-types/intimate-partner-violence/effects*

Southern First Nations Network of Care. (2020). *Our member agencies.* https://www.southernnetwork.org/site/member-agencies-child-family-services-manitoba-ontario