Still Waiting

Investigating Child Maltreatment after the Phoenix Sinclair Inquiry

A SPECIAL REPORT BY THE MANITOBA ADVOCATE FOR CHILDREN AND YOUTH, 2021

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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-centred 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. We are mandated through *The Advocate for Children and Youth Act* (ACYA), guided by the *United Nations Convention on the Rights of the Child* (UNCRC), and we act in accordance with the best interests of children and youth.

Our Vision: A safe and healthy society that hears, includes, values, and protects all children, youth, and young adults.
Our Mission: We amplify the voices and champion the rights of children, youth, and young adults.
Our Values: Child-Centredness; Equity; Respect; Accountability; Independence

CONTENT WARNING

This special report includes discussion of violence, abuse, and child maltreatment. In telling the stories of the children in this special report, we have carefully considered each detail included in this final version. Be advised, however, that some information in this special report may not be appropriate for all readers.

In Manitoba, it is everyone's legal obligation to report suspected child maltreatment. Call the province-wide emergency toll free line: 1-866-345-9241.

An aggregate special report of 19 child deaths conducted in accordance with Part 4 and Part 5 of *The Advocate for Children and Youth Act*.

Presented throughout this special report are children's stories. In accordance with *The Advocate for Children and Youth Act*, only the names of Phoenix Sinclair, Kierra Williams, and Jaylene Sanderson-Redhead are used in this special report, as these names have been previously and lawfully been made public (see s.32(2)(b), ACYA). All other names and identifying information have been changed in order to protect the privacy of children and their families.

Our Commitment to Reconciliation

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 and our northern office is on Treaty 5 land. 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, which are the traditional territories of the Anishnaabeg, Cree, Oji-Cree, Dakota, and Dene peoples, and the beautiful homeland of the Metis nation.

As an organization, we are committed to the principles of decolonization and reconciliation. We strive to contribute in meaningful ways to improve the lives of all children, youth, and young adults, but especially to 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.

With a commitment to social justice and through a rights-based lens, as an office 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. Our hope is that the scope of our work on behalf of children, youth, young adults, and their families contributes to amplifying their voices and results in tangible improvements to their lives and outcomes.

Dedication and Acknowledgements

This special report and its recommendations are dedicated to those who have been harmed or lost their lives as a result of maltreatment. In particular, we pause to remember and honour Phoenix Sinclair, Kierra Williams, Jaylene Sanderson-Redhead, and all children whose stories are included in this special report. We remember you and we strive to honour your memories every day. Your lives were taken too soon.

We also remember the legacy of the Honourable Ted Hughes, who died in 2020, and the foundational impact his life has had on children and youth across our country, including here in Manitoba. His presiding over the public inquiry into the life and death of Phoenix Sinclair resulted in a report that included 62 recommendations. It was through his work, and in the spirit of better care for all young people in our province, that we are privileged to serve Manitoba's children, youth, and young adults through *The Advocate for Children and Youth Act*.

Thanks to the members of the Manitoba Advocate's Youth Ambassador Advisory Squad! (YAAS!) who shared their thoughts and ideas on preventing child maltreatment. Your insight and wisdom were invaluable for this special report. Your voices are essential in the work that we do. The Manitoba Advocate also wishes to thank the following organizations for their cooperation with this special report: the Manitoba Child and Family Services Agencies, the Child and Family Services Authorities, the Child Protection Centre, and the Canadian Families and Corrections Network.

Table of Contents

Ainsley Krone
A/Manitoba Advocate for Children and Youth

Message from the Advocate

Phoenix Sinclair would have turned 21 years old this year. Fifteen years after her death and seven years after the release of the public inquiry into her death, major changes have occurred in the child welfare system. Yet, we are still waiting for the system to consistently support families to keep children safe.

Some of the changes include the continued devolution of the child welfare system in Manitoba, new child welfare agencies established, and, more recently, federal legislation aimed at ensuring children can be looked after in their home communities, with sovereign systems for First Nations, Inuit, and Metis peoples. As advocates for young people and their families, our role is to examine these structural changes for their impacts on children, specifically, whether their lives are improved, if these changes are prioritizing the needs of children and youth, and if changes and investments are making families and communities safer.

Phoenix was five years old when she died after being severely beaten and abused after being reunified with her mother and step-father. Though she died in June 2005, her remains were not discovered until eight months later, when she was found in a shallow grave near a garbage dump. The suffering Phoenix endured was appalling and rightly shook our province to its core.

What you will read in this special report is that while large-scale change has occurred and continues to unfold, the needs of children and youth are not always prioritized and consistent and equitable services remain out-of-reach for too many families. Despite the massive public inquiry into Phoenix Sinclair's death and the 62 recommendations that were made based on that evidence, children are still dying of maltreatment similar to what Phoenix experienced. For example, between 2008 and 2020, there were 19 Manitoba children under the age of five who were maltreated and died. Their lives inspired this special report.

The 19 children we are including in this aggregate special report were very young. Twelve of the 19 children were under the age of two when they were injured and died from those injuries. Two of the 19 children did not die immediately following the injuries they sustained. For those two children, they survived the event, but their injuries were life-altering and they required significant care afterwards. One of them died before they turned five and one lived for a few years longer before dying as a result of complications associated with their injuries.

Police were involved in each of the 19 deaths. As a result, 15 people faced criminal charges related to the death of a child. Of those 15 individuals, nine were convicted, two cases did not result in conviction, and four of the cases are pending trial. In those 4 cases, our office has only conducted preliminary reviews to date as a full investigation is required to wait until the conclusion of all criminal proceedings. Those four children's stories are included in the report for data purposes only.

This report focuses on the provincial CFS system. Recent reports from our office have examined services beyond CFS, but due to the young ages of these children and the circumstances of their lives, for many of them, CFS was the only system delivering services in the time leading up to their deaths.

Almost a decade after Phoenix's death, Kierra Williams died from severe intra-abdominal injuries after being maltreated and suffering ongoing abuse and chronic malnutrition. She had not yet reached her second birthday.

You may be familiar with the names of Phoenix and Kierra, as their stories garnered significant media attention. Jaylene Sanderson-Redhead was another child who was maltreated and died. Jaylene was brought into care at the time of her birth due to significant safety concerns. She began visits with her parent shortly after coming into care and was then reunified and returned home when she was 14 months old. Six months later, Jaylene sustained fatal injuries and died. She was one and a half years old at the time of her death. She had suffered multiple inflicted injuries all over her body. Her death was the subject of a public inquest (Allen, 2014).

This special report includes the tragic stories of many more infants and young children who never got the same public attention as Phoenix, Kierra, or Jaylene. Yet, all of the children were at risk for maltreatment and their families did not receive the child welfare services to which they were entitled. Each one of these deaths was preventable.

When a child dies in Manitoba, it is the responsibility of the Manitoba Advocate to shed light on what happened and to provide analysis, findings, and evidence-informed recommendations that can reduce the likelihood of children dying in similar circumstances in the future. The recommendations laid out in these special reports and other correspondence with government describe solutions to system cracks our office discovers and evidence-informed changes that would improve service delivery to children, youth, young adults, and their families.

Phoenix's death rightfully jolted Manitobans awake to the many fixes required of the province's child and family services system. Her death opened many eyes to the realities of child abuse and maltreatment that often lurk away from public view.

In December 2013, the provincial government was provided with a roadmap to fix child welfare services, written by Commissioner Ted Hughes after he conducted the public inquiry into the life and death of Phoenix Sinclair. Hughes released 62 recommendations stemming from the more than $14-million public inquiry.

In 2016, our office provided the public with a status report on Hughes' recommendations, which found 50 per cent were in progress, 21 per cent were pending, and 29 per cent were complete or ongoing. At that time, the Advocate's office called on the provincial government to regularly update Manitobans on its progress of implementing the 62 recommendations Hughes made.

Seven years after the conclusion of the public inquiry, the provincial government has yet to proactively release a complete status report on the Phoenix Sinclair Inquiry's recommendations. Therefore, as part of this special report I am releasing today, I asked the government once again for an update on its progress on the Phoenix Sinclair Inquiry recommendations. Following our analysis of the work the government has undertaken in response to the 62 recommendations, I am releasing detailed analysis of the government's progress on the Phoenix Sinclair Inquiry recommendations.

The 19 children profiled in this special report experienced maltreatment by the adults who were responsible to keep them safe. And while minimum service standards and quality assurance processes are critical to child safety and protection from maltreatment, so too are housing equity, food security, poverty reduction, family violence prevention, and addictions care, which play equally critical roles in the safe care of young children. The ecological model, which we discuss at length in this special report, is not new, but based on traditional parenting practices. It remains a key framework to achieve child safety, protect human rights, and prevent further deaths.

Manitoba must become a leader in changing the ways in which services are offered to families who require them. Apprehension models and others where children are separated from their families and then returned without the supports needed to change the safety and care environment in a family, will continue to result in cases of maltreatment, serious injuries, and deaths. Systems must aim to set families up to build their capacities and succeed, and interventions must always result in tangible improvements in the lives of those families.

This special report is a heartbreaking collection of stories of children who died far too soon. Their lives underscore the tragedies that can occur when children need protection and when their environments are not safe. While child and family services is a system of last resort, some families do require rapid and sustained interventions, including the use of apprehensions, in order to protect children from harm because not all adults are safe caregivers at all times. When a child's safety is compromised, child and family services has a legal obligation to ensure safety. As part of the development of this special report, our office met with a mother who is currently in custody for her role in the death of her child. The reflections and insight her experience provides are an important and sobering context for child maltreatment and what more can be done.

Based on the stories you will read, several others we have reviewed but not included, as well as the evidence gathered and analyzed during the development of this special report, I am issuing six recommendations.

First, in honour of the life and legacy of Phoenix Sinclair, I am calling on the government to finish implementing the outstanding recommendations from the public inquiry that was held in Phoenix's name. The provincial government was given the inquiry's report seven years ago and progress remains slow.

My second recommendation recognizes that parents and other caregivers need improved access to parenting resources. Our work with families tells us that too often, parents worry about asking for help because they fear the power held by service providers. We need to make sure that if parents need help, they know support is available because this makes homes safer for all family members, especially young children.

As such, today I am calling on the provincial government to work with First Nations and Metis governments, and community organizations to improve access to parenting resources, with a particular focus on access for families who live in rural and remote communities.

There is also much work that can be done at the organizational level to address service delivery and so, my third recommendation calls for the implementation or enhancing of culturally-safe reunification policies to be used by child and family services agencies, as developed by their mandating authorities. Recommendation four looks at the practice level and calls for agencies across the province to conduct case reviews for all children in care under the age of five where a reunification is planned. As you will read in this report, a lack of proper reunification planning and post-reunification monitoring and support can significantly increase the risk to young children.

Finally, what became clear to us as we completed the child death reviews, investigations, and this special report, is that understanding by service providers is inconsistent of the dynamics and signs of child maltreatment. This gap in system-wide knowledge may best be addressed through training. Recommendation five, therefore, is for mandatory training on two key issues identified in this special report: child maltreatment and reunification.

Fifteen years ago, our province shared in the grief upon learning of the circumstances of how one five-year-old child died due to maltreatment. Phoenix's death uncovered serious concerns in the child welfare system. Many lessons emerged from the process of the public inquiry, but we are still waiting for changes. Children need all of us to help create safe environments for them. While important and significant systemic changes are underway, we must remember that the needs of the youngest and most vulnerable must always be prioritized. Children need us to get it right.

Ainsley Krone
A/Manitoba Advocate for Children and Youth

Recommendations Summary

Implement all Phoenix Sinclair Inquiry Recommendations

Fund parenting programs and resources in Manitoba communities

Improve reunification practices and supports

Audit reunification plans regularly to ensure families are supported

Train social workers on child maltreatment and reunification best practices

Introduction

Children are born dependent and in need of special care and protection. They are unable to fend for themselves and rely on caregivers for their survival. Infants and toddlers do not have the ability to use words to have their needs met and communicate through their behaviour. Many caregivers can find it challenging to provide care when they do not understand what their child needs. The younger the child, the more dependent they are on their caregiver, and the greater the risk for maltreatment.

Protecting children from harm and ensuring that children thrive is a duty of all members of a community. The Government of Canada acknowledged the special place of children in society and assumed responsibility for the fulfillment of children's rights by ratifying the *United Nations Convention on the Rights of the Child* (UNCRC). The UNCRC is an agreement between nearly every country in the world that recognizes and honours children and the support they need to help them experience happy, healthy, and safe childhoods. This special report focuses on the following commitments in the UNCRC made by Canada and shared by the Province of Manitoba:

- To ensure children are protected from being hurt or badly treated (Article 19)
- To diminish infant and child mortality (Article 24)
- To ensure all segments of society – including caregivers – have access to education and are supported in the use of basic knowledge of child health (Article 24)
- To ensure caregivers have the financial and physical resources they need to support the health and well-being of children (Article 27)
- To ensure children are helped if they are hurt, neglected, or badly treated (Article 39)

In addition to children's rights, the Manitoba Advocate is committed to reconciliation between Indigenous and non-Indigenous communities. This special report is aligned with the principles of the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP) and the *Calls to Action* of the Truth and Reconciliation Commission of Canada. In particular, this special report reinforces Article 7 of UNDRIP, which asserts Indigenous individuals' right to life, physical and mental integrity, liberty, and security of person. This report also reinforces *Call to Action* 1.ii which calls on provincial governments to provide adequate resources to enable Indigenous communities to keep families together where it is safe to do so.

Rationale and Purpose

Fifteen years ago, the death of Phoenix Sinclair jolted many Manitobans awake to the realities of what can happen when children are left in need of protection. Phoenix was five years old when she died after being severely maltreated following a reunification with her mother and step-father. Though she died in 2005, her remains were not discovered until eight months later, when she was found in a makeshift shallow grave.

Phoenix's death sparked a public inquiry, which commenced in March 2011, and resulted in a report delivered to the Manitoba government in December 2013. The report was released to the public in early 2014, and contained 62 recommendations for changes to provincial systems and services.

The purpose of this special report is to understand what has changed since the death of Phoenix Sinclair. This special report identifies the extent and nature of maltreatment-related deaths of children involved in the child welfare system in Manitoba and whether the Government of Manitoba complied with recommendations made in the Phoenix Sinclair Inquiry. Child maltreatment deaths are preventable. The ultimate goal of this report is to reduce the number of maltreatment-related deaths in children under the age of five in Manitoba by increasing the effectiveness and responsiveness of services for children and their families (s.31(1),ACYA).

In addition to informing Manitobans of the experiences of the children whose stories are contained herein, we respectfully offer this special report to those Nations and communities preparing to establish their own processes and systems for caring for families and keeping children safe. It is in that spirit of community building and reconciliation that the Manitoba Advocate releases this special report, its findings, recommendations, and lessons.

Background

What is maltreatment?

The Government of Canada (2012) defines child maltreatment as:

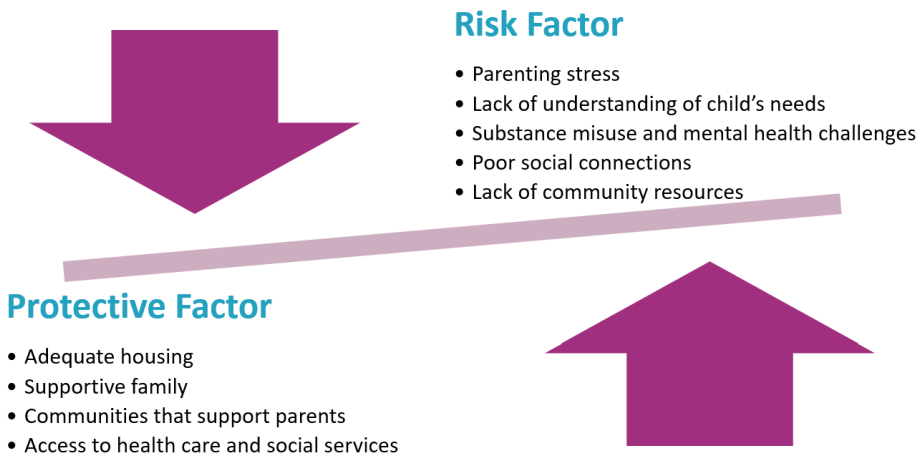
"…the harm, or risk of harm, that a child or youth may experience while in the care of a person they trust or depend on, including a parent, sibling, other relative, teacher, caregiver, or guardian. Harm may occur through direct actions by the person (known as acts of commission) or through the person's neglect to provide a component of care necessary for healthy child growth and development (known as acts of omission)" (para. 3).

There are five types of child maltreatment including: physical abuse, sexual abuse, neglect, emotional harm, and exposure to family violence (Government of Canada, 2012). Child maltreatment can lead to death. Maltreatment fatalities include deaths where the injury from abuse or neglect was the cause of deaths, or where the abuse and/or neglect was a contributing factor in the death of a child (Levine et al., 1994).

What are the risks and protective factors for maltreatment?

The Child Information Gateway (2020) defines risk factors as "conditions, events, or circumstances that increase a family's chances for poor outcomes, including child abuse and neglect" (p. 2). It is important to understand that while risk factors are not causes of child maltreatment, the interaction of risk factors with minimal protective factors may increase the likelihood of child maltreatment (Figure 1). For a complete list of risk and protective factors, see Appendix A.

Figure 1. Risk and Protective Factors of Child Maltreatment



According to the Australian Institute of Family Studies (2017), "Understanding the risk and protective factors for child abuse and neglect is useful when developing effective prevention and early intervention strategies, and identifying families who are most likely to benefit from additional support" (n.p.).

Understanding risk and protective factors allows service providers to have a more accurate view of the family experience, and ultimately this could ensure the development of effective and successful planning with the family, and assist the family in identifying additional services and supports that would meet their needs. Further, knowledge of the risk and protective factors may help the caregivers of young children recognize their parenting strengths and limitations, understand child development, and recognize when they need support.

Maltreatment in Manitoba

Child maltreatment is a serious concern in Manitoba. The Child Protection Centre (CPC) at the Children's Hospital functions as a multidisciplinary team that provides medical and psychosocial assessment and consultative services to support children who have experienced abuse, and their families. As documented in the Child Protection Centre's (CPC) annual report, in the six months from October 7, 2019, to March 31, 2020, CPC received 505 new requests for service. Fifty-eight per cent of the requests for services came from child and family services (Child Protection Centre, 2020). We know, however, that many more incidents of maltreatment are occurring, which are not reported or counted in provincial statistics.

Responsibility to Report

In Manitoba, **everyone is legally obligated to report suspected child abuse, including maltreatment** (see s.17 and s.18 of *The Child and Family Services Act*). If you believe that a child may not be safe, you are legally required to report it. According to the Provincial Advisory Committee on Child Abuse's factsheet, Report of Child Protection and Child Abuse (2013):

- You do not have to prove or be sure that the abuse is occurring.
- The obligation to report also applies to allegations of past abuse.
- Even if you think someone else is reporting the situation, you must still report it.
- All reports will be followed up by a Child and Family Services (CFS) agency.
- The CFS agency response will vary [and may include providing] community supports, protective services, supports in the home, or removal of the child(ren).
- Where applicable, follow your workplace guidelines or procedures for reporting suspected child abuse.
- Your individual obligation to report abuse supersedes all internal organizational policies and procedures.
- Reporting does not require staff consensus or the approval of your supervisor.
- No retaliatory action can be taken against a person who, in good faith, reports information about suspected child abuse.
- You cannot be dismissed, suspended, demoted, disciplined, harassed, or disadvantaged.
- Your identity is protected and kept confidential, except as required in the course of judicial proceedings or with your written consent (n.p).

What children need to feel safe

According to our Youth Ambassador Advisory Squad (YAAS!):

- Continuity of care, stability, and routine
- Clean home, food, and nutrition
- Attention and nurturing
- Attachment and encouragement
- Parental stress management through respite
- Education and support
- Caregiver knowledge of child development
- Connections for parents
- Parental self-care

Methods

The Manitoba Advocate has the responsibility of reviewing and investigating the deaths of children in Manitoba if that child or their family had received any reviewable services within a year preceding the death of the child (s.20(3), ACYA). To this end, the Manitoba Advocate receives notifications of all child deaths up to age 21 in Manitoba from the Office of the Chief Medical Examiner in accordance with *The Fatality Inquiries Act* (FIA) s.10(1).

Between September 15, 2008, and March 31, 2020, the Manitoba Advocate was notified of 1,383 deaths of Manitoba children between birth and five years of age. To identify children who specifically died maltreatment-related deaths, all reviewable deaths of children under five years old between the aforementioned time period, and where the manner of death was deemed accidental, homicide, or undetermined, were re-examined (n=273). Criteria for inclusion:

- Children whose cause of death was a result of maltreatment;
- Children who survived serious inflicted injuries but lived with profound impacts and died later; and/or,
- Children where the Medical Examiner's report and autopsy noted multiple inflicted injuries.

A total of 19 children were identified for inclusion in this special report. Child welfare files were reviewed for all 19 children and, when applicable, supplemental files, including Child and Family Services Information System (CFSIS) documentation, law enforcement information, health records, and the autopsy report and medical examiner reports were reviewed. In cases where there were ongoing criminal investigations and criminal court proceedings, in accordance with s.24(a) of the ACYA, these children were included for statistical purposes only and their circumstances were not investigated.

Presented throughout this special report are four case studies. In accordance with s.32(2)(b) of the ACYA, only the names of Phoenix Sinclair, Kierra Williams, and Jaylene Sanderson-Redhead are used in this special report, as these names have been previously disclosed to the public. All other names and identifying information have been changed to protect the privacy of the children and their families.

When reviewing records from those services noted above, particular attention was paid to the documented risk factors and protective factors for child maltreatment, and the delivery of child and family services through an **ecological approach**. An ecological approach positions the child within their environment, acknowledges the various components of the child's and family's life, and recognizes and challenges the impacts of systemic oppression. An ecological approach to the child-specific analysis focuses on how these different environmental factors interact. Missed opportunities for interventions or gaps in the services provided to the 19 children and their families were identified and are discussed in this special report.

Consultation and Engagement

In acknowledgement of their inherent right to self-determination over child and family services, the Manitoba Advocate extended invitations to the Assembly of Manitoba Chiefs, Manitoba Keewatinowi Okimakanak, Southern Chiefs Organization Inc., and Manitoba Metis Federation to discuss this special report and its findings. These consultations were held virtually due to the ongoing COVID-19 public health restrictions. Support during these meetings was provided by the Knowledge Keeper at the Manitoba Advocate for Children and Youth (MACY).

Additionally, the Manitoba Advocate hosted a virtual presentation of findings attended by First Nations, Metis, and non-Indigenous agencies, authorities, and government departments to discuss the report and its findings. The purpose of these meetings was two-fold: to verify the accuracy of our draft report and for the Manitoba Advocate to receive and consider any service or policy updates or feedback on the special report.

We also met with members of the Elder's Council at our office, who provided insight and guidance during the development of the special report, and who helped us bridge this current report to historical and community context. A subsequent meeting with the Elder's Council was held just prior to the report's release to continue the discussion. Elders worked with the Manitoba Advocate, office leadership, and the MACY Knowledge Keeper to hold ceremony in honour of the children whose stories inspired this special report.

Importantly, we also consulted our youth advisory council, the Youth Ambassador Advisory Squad (YAAS!) to gain a deeper understanding on how government services could be improved. The importance of including the voices of youth in a report discussing challenges that have impacted their lives cannot be understated. Their input, advice, and feedback are integrated throughout this report.

Limitations

This special report examines the information from 19 reviews and investigations, which are based on case records and interviews. The accuracy of our information relies on the completeness and accuracy of administrative records and on the abilities of service providers to recall or confirm details of cases.

It is also important to highlight that the children and their families featured in this special report are not representative of all children under the age of five in Manitoba who have been maltreated or who have died as a result of maltreatment. First, we do not know the full extent of these cases due to child maltreatment incidents not consistently being acknowledged, reported, or investigated. Second, the Manitoba Advocate's mandate for child death reviews remains restricted to children involved with the child welfare system within 12 months of their deaths. All other children continue to fall outside of the Manitoba Advocate's legal scope for review. The Manitoba Advocate has been outspoken about the importance of bringing into force the remaining two sections of the ACYA, which would expand the scope of reviews, and continues to urge the government to do so. A more detailed summary of methods can be found in Appendix B.

The 19 Children: Statistical Summary

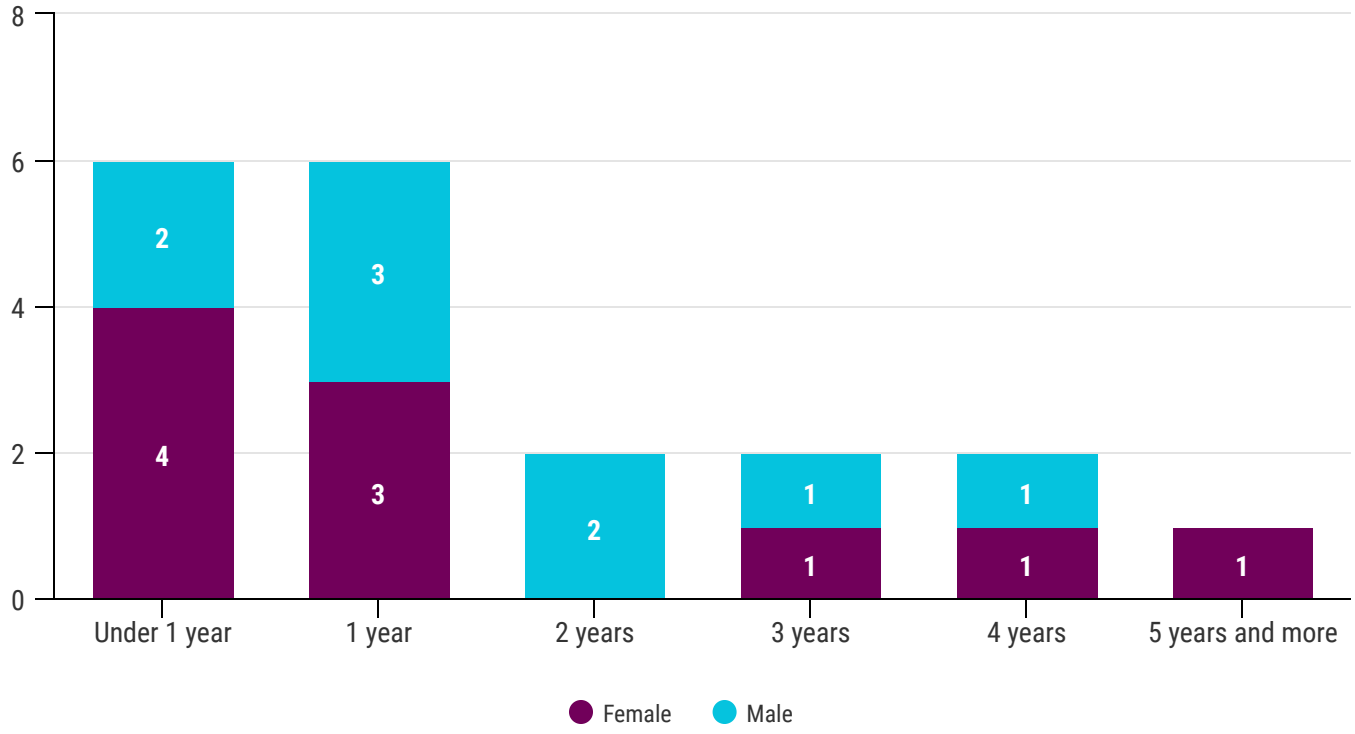
Key Findings

- 12 of the 19 children (63%) were under the age of two when they died or were seriously injured.
- 8 of the 19 children (42%) were First Nations and 2 of the 19 children (11%) were Metis.
- 14 of the 19 families (74%) were receiving ongoing child and family services support at the time of the child's death.
- 14 of the 19 children (74%) were living in their family home when they died or were seriously injured.
- All four child welfare authorities were represented in this special report.

Age and Sex at Time of Death

Of the 19 children who died, 12 were under the age of two when their death occurred (Figure 2). Children at this age are particularly vulnerable due to being fully dependent on their caregivers. These early years lay the foundation also for emotional attachment to their primary caregiver and for developing basic trust in others. Of the 19 children in this review, 10 were female (53%).

Figure 2. The 19 Children by Sex and Age



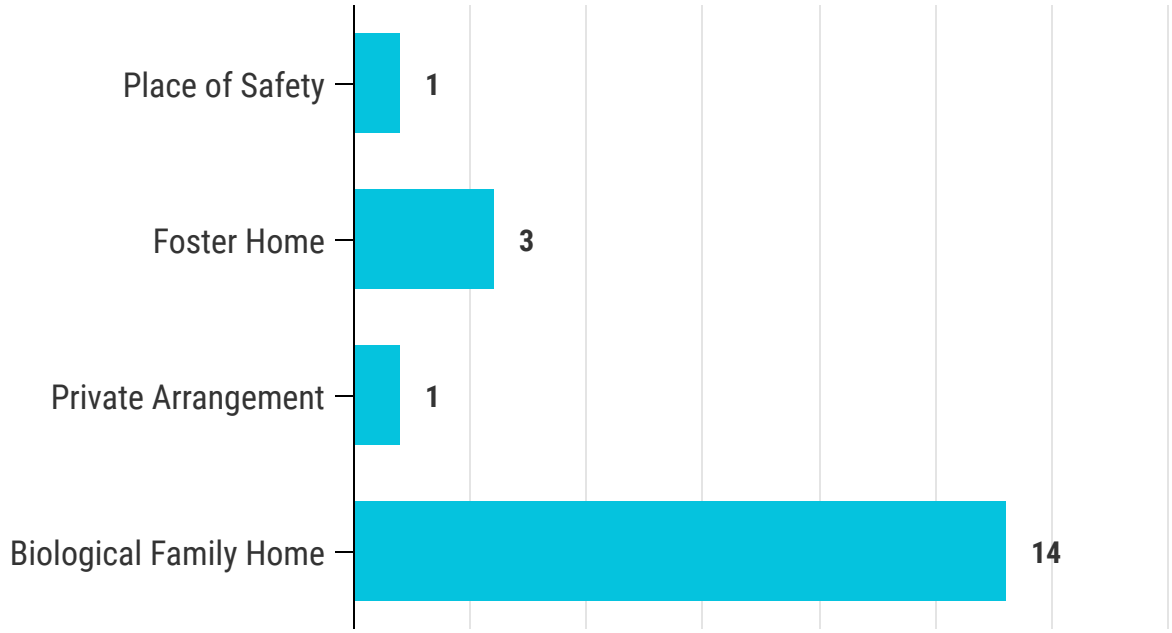
Location and Residence at Time of Death

Manitoba is divided geographically into five regional health authorities. Ten of the 19 children featured in this special report lived in Winnipeg, and their deaths occurred within the geographical boundaries of the Winnipeg Regional Health Authority (Table 1). Of the 19 children featured in this special report, 74% were living with their biological parent(s) in their family home at the time they suffered the serious injury (N=2) or death (N=12) (Figure 3).

Table 1. Maltreatment Deaths by Regional Health Authority

Regional Health Authority	N	%
Interlake-Eastern	1	5%
Northern	3	16%
Prairie Mountain	2	11%
Southern	3	16%
Winnipeg	10	53%

Figure 3. Residence at Time of Death



Indigenous Ancestry: First Nations and Metis Children

To determine the Indigenous ancestry of the 19 children, we relied on information from the 'Culture of Origin' section of the Child and Family Services application. Of the 19 children, we were able to confirm that eight were First Nations (42%), two were Metis (11%), and four were non-Indigenous (21%). Importantly, based on available records, we were unable to confirm ancestry for five of the children (Table 2).

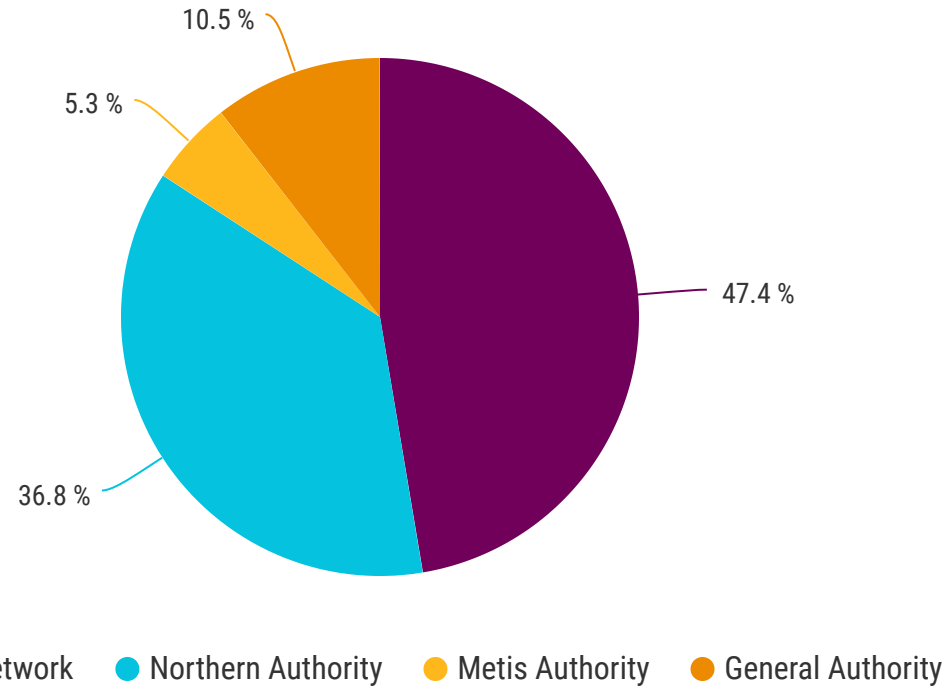
Table 2. Maltreatment Deaths by CFSIS Indigenous Ancestry

CFSIS Indigenous Ancestry	N	%
First Nations	8	42%
Metis	2	11%
Non-Indigenous	4	21%
Unknown	5	26%

Child Welfare Involvement

Each of the four child and family services authorities were represented in this special report and oversaw child and family services agencies which were responsible for providing child welfare services to the 19 children and their families (Figure 4).

Figure 4. Maltreatment Deaths by Child Welfare Authority



Examining Child Welfare Through an Ecological Approach

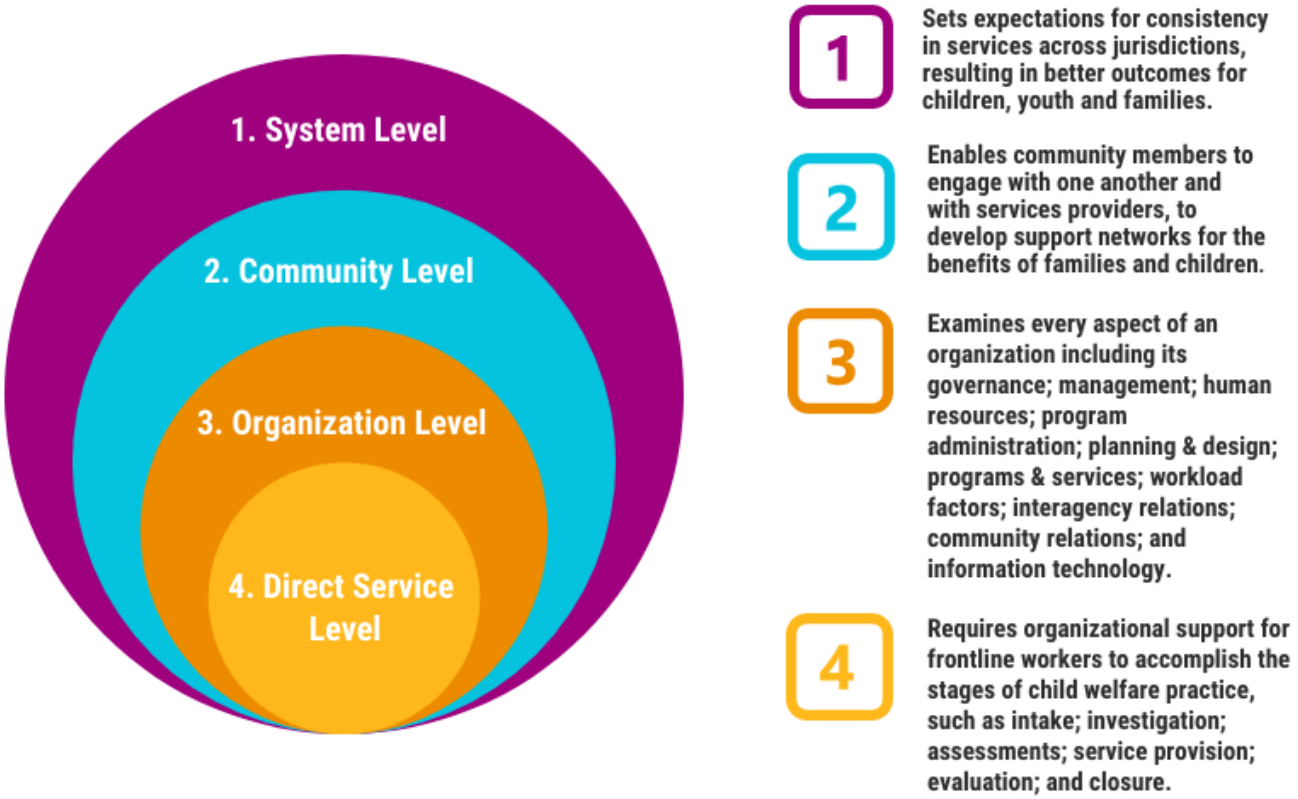
The Ecological Approach

In the final report from the public inquiry, *The Legacy of Phoenix Sinclair: Achieving the Best for All Our Children,* Commissioner Hughes' findings and recommendations were informed, in part, by the evidence provided from Dr. Alexandra Wright regarding best practices in child welfare. Wright asserts that applying an ecological approach to child welfare practice as a framework is useful when examining child welfare service planning and provision.

The focus of child welfare practice from an ecological standpoint positions the child within their environment and recognizes the various components of the child's and family's life, and the challenges the impacts of systemic oppression that families face. Dr. Wright states, "an ecological approach to working in child welfare integrates individual, familial, community, environmental, and cultural factors as important contributors to, as well as solutions to, child maltreatment" (2013, p. 6). These child deaths remind us of the importance of utilizing an ecological approach in order to keep young children safe and prevent child maltreatment. Importantly, the ecological model is not new, it is a concept that is tied to and reflects traditional parenting approaches from cultures across the globe. The ecological model includes four interconnected levels: System, Community, Organization, and Direct Practice (Figure 5).

These levels are not exclusive of one another but overlap and interact to impact the lives of families. To achieve best practice, it is important that child welfare organizations acknowledge and understand these levels within the child's and family's life when delivering services using an ecological approach.

Figure 5. An Ecological Approach to Child Welfare



The System Level – Colonization and Child Welfare

At the system level, it is important to explore and understand the negative effects of systemic issues such as racism, poverty, sexism, and the impacts of colonization, residential and day schools, and the Sixties Scoop on First Nations and Metis communities. Stemming from structural inequalities and systemic racism, there is a disproportionate number of First Nations and Metis children in care of the Manitoba child welfare system. Manitoba has the highest number of Indigenous children and youth that are removed from their homes and placed in care compared to the rest of Canada. According to the Manitoba Families 2019-20 annual report, as of March 31, 2020, there were 9,849 children in care, 90 per cent of whom are Indigenous (Government of Manitoba, 2020).

Sinha et al. (2011) offer an informative context on the history of child welfare in Canada in *Kiskisik Awasisak: Remember the Children. Understanding the Overrepresentation of First Nations Children in the Child Welfare System*. The authors note:

> **Prior to colonization, First Nations families and communities cared for their children in accordance with their cultural practices, spiritual beliefs, laws and traditions. The arrival of non-Aboriginal settlers, and subsequent extension of colonial policies into First Nations territories, disrupted traditional systems of child rearing and imposed practices which resulted in the removal of tens of thousands of First Nations children from their homes and communities. The mass removal of First Nations children began with the residential school system and was continued by the child welfare system under the policies of the "Sixties Scoop". (p.5)**

Over the years, the child welfare system in Manitoba has undergone significant changes in its governance structure. One such change has been the Aboriginal Justice Inquiry – Child Welfare Initiative (AJI-CWI), sometimes referred to in Manitoba as the **devolution** of the CFS system. To address the inequities and inadequacies of the child welfare system in Manitoba, child welfare services were restructured to include off-reserve authority for First Nations and the establishment of a province-wide Metis mandate to provide culturally-appropriate services.

On November 24, 2003, legislation was proclaimed by the Government of Manitoba that established four culturally-appropriate child and family service authorities responsible for overseeing and coordinating the delivery of child welfare services throughout the province.[1] Even though devolution was based on decolonization, there still remained limitations for First Nations and Metis agencies to provide culturally-appropriate services. Sinha et al. (2011) attest that "the abilities of all child welfare agencies to help First Nations children are restricted by funding and jurisdictional frameworks," and this discriminatory approach "…can affect the balance factors which protect a child or place him/her at risk for harm"(p. 19).

[1] Further details of the AJI-CWI, can be found at https://manitobaadvocate.ca/wp-content/uploads/Strengthen-the-Commitment-September-29-2006-1.pdf

This system of devolution remained rooted in a legislative structure for child welfare services that is governed by the laws, regulations, and program standards set by the Manitoba government and which did not consider the diverse relational worldviews and teachings of First Nations, Metis, and Inuit families and communities. Policies and procedures were thus established province-wide, which limited the ways First Nations and Metis agencies could practice child welfare.

"Our professionals and Elders saw similarities between residential schools and the child apprehension system, with long-term effects such as loss of culture, depression and addiction. The *Removal of the Parent Program* is a community-based approach grounded in traditional Cree teachings, and aims to break the cycle of family trauma."

-Nisichawayasihk Cree Nation Family and Community Wellness Centre Inc., 2018, p.15

Within the last two decades, many changes have been made within the Manitoba child welfare system. Agencies and authorities have worked to develop and implement culturally-appropriate programs and services that focus on early intervention, prevention, and child welfare practices which reflect the unique traditions and values of each community.

One unique and First Nations-led example of a community approach to reduce the trauma of child apprehension is the *Intervention and Removal of Parent Program* developed by Nisichawayasihk Cree Nation (NCN) Family and Community Wellness Centre Inc. (2018), implemented in the community known as Nelson House, Manitoba. Instead of removing a child or children from their home when they were in need of protection, the parents are temporarily removed, and supported by the community to undergo counselling, treatment, and healing programs. This holistic approach minimizes disruption and trauma to children, ensures they feel safe in their community, and aims at strengthening families.

According to Gaspard (2018), due to the *Intervention and Removal of Parent Program* and a community-based approach to family care, NCN reunified families 85 per cent of the time (p. 3). This creative approach to addressing protection concerns in child welfare speaks to the need for effective and equitable reform within the system that protects and improves outcomes for First Nations, Metis, and Inuit children.

In 2014, the Assembly of Manitoba Chiefs (AMC) hosted a forum exploring the child welfare system in Manitoba in response to the Phoenix Sinclair Inquiry Report. The June 2014 report titled, *Bringing Our Children Home Report and Recommendations*, included 10 recommendations addressing "the devastating impact that the policies and practices of the current child welfare system are having on the First Nations children and families in Manitoba" (p. 2). In response to one of the recommendations, on June 1, 2015, AMC officially opened the Manitoba First Nations Family Advocate Office (FNFAO), which supports and advocates for First Nations families involved with the child and family services system.[2]

In 2016, the Canadian Human Rights Tribunal (CHRT) finalized a decision on a human rights complaint made by the First Nations Child & Family Caring Society of Canada (FNCFCS) and the Assembly of First Nations (AFN). In its decision, the CHRT found the Government of Canada discriminates against First Nations children and their families by failing to provide equitable child welfare funding in First Nations communities and by failing to properly implement Jordan's Principle.[3,4]

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[2] Further details of the First Nations Family Advocate Office can be found at https://firstnationsfamilyadvocate.com/.
[3] Further details of the Canadian Human Rights Tribunal decisions can be found at www.fnwitness.ca
[4] Further details of Jordan's Principle can be found at https://manitobachiefs.com/wp-content/uploads/13131-KeewaywinJordansPrincipleEngagementReport_web.pdf

Despite the CHRT's decision on the Government of Canada's discriminatory practices, Canada has been issued 15 non-compliance rulings to date. Child welfare services in First Nation communities remain inequitable compared to services provided off-reserve.

> **"This [the Canadian Human Rights Tribunal Decision] is an important win, but we will continue to seek further clarification on the decision. Canada must compensate those First Nations families who have experienced a child welfare system that hurt our most vulnerable. Our children are our most precious resource. They have been given to us by the Creator and it is our sacred duty to ensure their health and safety.**
>
> **-Manitoba Regional Chief Kevin Hart (Quoted in Assembly of First Nations, 2020)**

In January 2020, the Government of Canada proclaimed *An Act Respecting First Nations, Inuit and Metis Children, Youth and Families* ("the federal Act"). The federal Act affirms the inherent rights of Indigenous self-government, including jurisdiction in relation to child and family services.[5] The federal Act was designed to enable First Nations, Metis, and Inuit groups and communities, once they have existing legislation, to transition towards exercising partial or full jurisdiction over child and family services at a pace they choose.

Though the federal Act envisions substantial and positive changes to First Nations, Metis, and Inuit child and family services, there are limitations. The Yellowhead Institute, a First Nations-led research centre at Ryerson University, believes the legislation should address five key areas in order to make meaningful changes in the lives of Indigenous children and families: national standards, jurisdiction, funding, accountability, and data collection (Metallic et al., 2019a). Collaborating with legal scholars to examine and analyze the final version of the federal Act, the Yellowhead Institute concluded that if these limitations are left unaddressed, the present circumstances of Indigenous child welfare will continue to replicate the current situation (Metallic et al., 2019b).

Among other Manitoba communities, Opaskwayak Cree Nation (OCN) in northern Manitoba has officially begun the process of creating a law that will give full authority for its child welfare services to their First Nation (Hobson, 2020). Through community consultations, a Cree child welfare law, called Wahkohtowin, will be developed. OCN plans to have the law drafted by October 2021 and have it come into force a year later.

The child welfare system, despite changes, remains rooted in the colonial structures that ensure the continuation of structural inequities and systemic racism. To understand the systemic risk factors involved in maltreatment deaths, MACY met with Charlene (not her real name), the mother of Alex (not their real name) who died by homicide when they were a toddler.

"Our children will remain with their families, our parents and families will receive the supports they need, and Opaskwayak will continue to thrive as we return to our own Ininewak ways."

-Chief Christian Sinclair, Opaskwayak Cree Nation (quoted in Frew, 2020)

[5] A full copy of this Act can be found at, https://laws.justice.gc.ca/PDF/F-11.73.pdf, and a comprehensive summary from the Government of Canada can be found at https://www.sac-isc.gc.ca/eng/1541187352297/1541187392851wbdisable=true

A summary of our conversation with Charlene provides some insight on the factors that can influence a family's inner turmoil, sometimes with tragic consequences. Charlene's own experiences with childhood trauma, loss of culture, intimate partner violence, poverty, and few natural supports illustrate how cultural genocide, separation of mothers from their children, and a lack of reunification support can all place the lives and wellbeing of children at risk.

These factors do not absolve Charlene of individual responsibility in Alex's death, but they are essential to understand the context of her actions, and to identify the supports and systemic changes needed to prevent maltreatment and child deaths and to transform the child welfare system in Manitoba and beyond.

Reflections from a Mother in Custody

When Charlene was a child, she experienced trauma and separation from her family and community. Charlene discussed her upbringing at residential day school and shared that much of her family went to residential schools where they experienced sexual, verbal, and physical abuse. She described her language and identity as being taken away from her while at school. Her father, a spiritual man with ties to traditional language and knowledge, died by homicide in her youth. Charlene said she learned "a little" about her culture from her father, but lost this knowledge during her time at day school.

Charlene was a teenager when she became a mother for the first time. She was the victim of violence and abuse in her relationships. Her youngest, Alex, was born premature. Charlene said she spent lots of time at the hospital with Alex, singing to her baby, who she knew was having a tough start in life. Alex was apprehended by child and family services (CFS) from the hospital, and placed in a foster home. In the first two months of life, apart from the early days in the hospital and a subsequent visit, Charlene said she did not have contact with Alex. Charlene told us she believed her baby would come home. Alex remained in care.

Charlene and her partner were homeless for some time before moving to a relative's property. Charlene said she attended numerous programs required by CFS, including parenting, addictions, and anger management meetings, but she did not understand how or when her children would be returned. Visits occurred in various places, including the agency office, restaurants, and a hotel. Charlene expressed that she wished visits could have been in a home-like setting. During these visits, Charlene said Alex cried frequently. Charlene stated that she could not comfort Alex and became frustrated when her child would not stop crying.

Charlene's youngest kids, including Alex, were returned home all at once. Charlene was grateful, but described parenting several small children on her own as very difficult. Alex was still an infant and Charlene was lacking resources and help, including from her partner who, according to Charlene, provided little parenting support. She felt that CFS workers rarely came to visit to see if the family required help. Meanwhile, Charlene's own ongoing health issues worsened.

Charlene described having flu-like symptoms and one morning, she went to the hospital and she said a doctor gave her ibuprofen, alleging her pain was all in her head. Charlene remembered coughing, having chest pains, and not being able to sleep at night. In the months after her family's reunification, Charlene suffered a heart attack and was hospitalized.

Upon her return home, Charlene was given "some temporary help." Still, Alex was often upset and crying around Charlene. When Charlene told a CFS worker about her difficulties building a bond and calming Alex, she shared with our office being told that if she could not parent Alex, then CFS would take all of her children away again. This made her fearful of asking for further help.

About a year after the reunification, Alex died. Alex's death was ruled a homicide by the Chief Medical Examiner and there was evidence of severe maltreatment. Charlene was convicted in the death.

Now in custody, Charlene is receiving peer supports, reconnecting with her culture, and deepening bonds with family and community liaisons. Charlene described a need for more parental supports from CFS, especially for single parents and those experiencing intimate partner violence. She also wished her children could have been placed with her relatives, rather than in foster homes.

The death of Alex was a preventable tragedy. To break the cycles of violence and trauma resulting from colonialism, parents must be adequately resourced to be healthy and well. Charlene's testimony teaches us that, to the largest extent possible, children must be kept within families or kinship networks and contact should be familial and in home-like settings. In cases of reunification, vigilance and care must be given to the restoration of the attachment between parents and children and that supports should aim for success in this area. Improving child safety means ensuring that parents experience no shame or danger of losing custody if they ask for extra help when they know they need it to safely parent their children.

The Community Level – Social Determinants of Health

Seeing a child's needs and strengths within the context of the family and community is important. When viewed within this context, a focus on building on the capacity of the community can empower its members to engage with one another and with service providers to seek culturally-respectful and appropriate services that benefit children, families, and, ultimately, the health and strength of the community. The social determinants of health:

> **"…refer to a specific group of social and economic factors within the broader determinants of health. These relate to an individual's place in society, such as income, education or employment. Experiences of discrimination, racism and historical trauma are important social determinants of health for certain groups such as Indigenous Peoples, LGBTQ and Black Canadians.**
>
> **-Government of Canada website, 2020**

Greenwood (2017) emphasizes that First Nations, Inuit, and Metis peoples in Canada continue to suffer greater inequities in a number of factors that impact their lives, such as access to safe drinking water, poverty, food insecurity, chronic health conditions (such as diabetes), and alcohol and drug misuse.[7] Consequently, "they bear a greater burden of ill health compared to other Canadians. Furthermore, these inequities are rooted in systemic issues such as racism, colonialism, health care and education practices" (p. 3).

The Canadian Institute of Child Health (n.d.) utilizes Greenwood's *Determinants of Health Model*. The model "…presents a way of thinking about the complexity of individual and collective health and well-being. It is meant to provide a more holistic way of understanding children and their health within their collective and broader society" (para. 1). Addressing these features is key to supporting and building healthy communities and families, which ultimately, will affect an individual's health and well-being.

Greenwood's model (as cited in Canadian Institute of Child Health, n.d.) provides definitions for the enablers and indicators of the determinants of health. These include: **structural enablers of well-being, systemic enablers of well-being, indicators of community well-being**, and **indicators of family well-being**. The definitions are provided below (see blue text boxes), along with examples from a Manitoba context.

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[7] Detailed descriptions on social determinants of First Nations, Inuit, and Metis health can be viewed at https://www.nccih.ca/34/publications.aspx?sortcode=2.8.10&type=7

Structural enablers of well-being include high level legislation, policies, or agreements that either enable or hinder the development of healthy, positive environments for children, youth, and families. Health service delivery agreements, governance, and land treaties are examples of structural enablers that can either support or hinder well-being.

For example, in 2019, the provincial government announced a new child and family service funding model for Manitoba, called "single envelope" or block funding.[8] Previously, funding for child welfare services was based on the number of children in care, and, as a result, child welfare agencies had limited means to provide prevention and family support services. In a Government of Manitoba news release (2019), the provincial Families Minister stated, "Block funding will fund authorities and agencies up front to improve outcomes for children and families, not by the size of their caseloads or the length of a child's stay in care" (para. 2).

Although on its surface, this new policy appears to support the movement towards autonomy within child welfare practices, First Nations and Metis governments, child welfare agencies, and CFS authorities have criticized the model for creating a funding deficit. In a 2019 NationTalk article, Manitoba Metis Federation President David Chartrand stated:

> **"The block funding structure might be new, but the numbers are based on the old formula. It does not matter what you call it, the funding rewards removals [apprehensions]… There is no room in this block funding for prevention, no support to keep our families together.**
>
> **-Manitoba Metis Federation President David Chartrand, para. 3**

Without appropriate funding, child welfare services will remain inadequate and unable to meet the needs of all children, youth, and families in Manitoba.

Systemic enablers of well-being relate to systems (e.g., education, health, child and family services, justice) that provide needed services. Schools, hospitals, mental health programs, well-baby clinics and Head Start programs are examples of system components that support and enable well-being. Strong, community-focused, accessible systems that support families and individuals are instrumental to the development of healthy environments for First Nations, Metis, and Inuit children and youth.

There are a total of 23 child welfare agencies that provide services to children and families throughout Manitoba. Manitoba is home to 63 First Nations, as well as many rural municipalities. Providing equitable and effective services is a challenge due to factors such as limited road access, geographical isolation, inadequate infrastructure, and minimal service funding. These barriers impact the social, emotional, and physical health and well-being of communities.

[8] Further details of the benefits of Block Funding can be found at https://news.gov.mb.ca/asset_library/en/newslinks/2019/02/BKG-Block_Funding-FAM.pdf

The Assembly of Manitoba Chiefs stated in the final report of *Keewaywin Engagement: Manitoba First Nations Child and Family Services Reform* (2017):

> **"Federal funding dollars for First Nations is inadequate. Education quality, health services quality and availability, recreation, cultural and social program quality and availability and community infrastructure suffer as a result. This amounts to discrimination, the outcome of which is higher rates of poverty and increased child apprehension rates. -p. 30**

Child welfare agencies and their authorities have often expressed that the resources in their communities are unable to meet the needs of the children and families they support. As a result, there is increased pressure on child welfare agencies to address issues relating to mental health, justice matters, and poverty. For example, in previous MACY child death investigations, CFS agencies have conveyed that children and their families will frequent their offices seeking basic needs, such as food and shelter. Often, agencies will provide support at funerals and wakes and this assistance has become a community expectation. Due to inadequate resources, child and family service agencies are often called upon to provide these supports that are beyond the reasonable scope of CFS agencies to address on their own. A multi-disciplinary community approach is needed to ensure the safety and well-being of children.

Indicators of community well-being include feeling safe, supported, and engaged. Opportunities for land-based learning, participation in cultural ceremonies and events, language learning activities, and recreation/sport initiatives provided at the community level can greatly contribute to family and individual health and well-being.

It is common for child welfare agencies in Manitoba to provide services to multiple communities. At times, agencies also collaborate with out-of-province counterparts to provide services to children and families. Promoting ongoing community contact and connections for children is vital for cultural connectedness and creating a sense of belonging.

The Metis Child & Family Services Authority (n.d.) highlights a program that connects or reconnects children to family, extended family, and community. Created in 2018 at the Metis Child, Family and Community Services agency (MCFCS), *Metis Connect* engages children to feel a sense of belonging within their community. According to the Metis Authority's website, *Metis Connect* is an initiative that:

> **"…is unique to our Manitoba Metis CFS System. *Metis Connect* workers teach workers specialized techniques for locating extended family and trusted community members so they can become part of a network for the child and engage with the agency in planning and decision making…it helps to ensure children in care know their identity, and have a sense of belonging through their connection to family, community and culture.**

Another example of promoting community well-being is the creation of a community-based child welfare agency. More than two decades ago, Norway House Cree Nation (n.d.) Chief and Council recognized the value of developing a community-based child and family service agency and in 1999, Kinosao Sipi Minisowin Agency (KSMA), was incorporated, with their primary vision:

> **…to assist in the development and delivery of program and services directed at promoting the best interest of the community and preserving family unity…KSMA has taken a proactive approach to service delivery developing new departments, projects and programs that reflect the tradition, culture and values of Norway House Cree Nation.**
>
> **-para. 2**

The value of providing culturally-appropriate services to its members of Norway House Cree Nation, both on- and off-reserve, was understood and valued in the context of supporting and maintaining the well-being of their community and, ultimately, having a positive impact on the children, youth, and their families.

What communities need to keep their children safe

According to our Youth Ambassador Advisory Squad (YAAS!):

- Partnerships
- Daycare
- Safe and welcoming resource centres
- Safe spaces
- Support groups
- Mentorship opportunities
- Prenatal and child development teachings

Indicators of family well-being in the Greenwood model (Canadian Institute of Child Health, n.d.) help build strong, healthy families. Parental age, employment, education levels, and health, as well as parental lifestyle behaviours that impact children such as smoking, folic acid use, and breastfeeding initiation, are important contributors to overall family well-being. The home environment has an enormous impact on children, especially young children. Supporting parents and caregivers to make healthy choices for themselves and their children is essential.

As an organization serving Manitoba's children and youth, the Manitoba Advocate for Children and Youth recognizes and seeks to understand the ongoing impacts of intergenerational trauma. Rooted in injustices and oppression by the Canadian government and reinforced by general society, the impacts of intergenerational trauma for Indigenous peoples are deeply felt. Aguir and Halseth (2015) summarize a previous explanation of the effects of historical trauma stating "the effects of trauma can reverberate through individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations" (p.7).

Moreover, Aguiar and Halseth (2015) note "this chronic exposure to trauma has manifested in individual symptoms such as anxiety, depression, grief, addictions, and self-destructive behaviours within generations of Aboriginal people" (p. 7). Child death investigations completed by the Manitoba Advocate commonly encounter parents who had themselves experienced childhood trauma, did not receive opportunities for healing, and as a result, saw their children experience persistent instability and trauma. Evidence suggests that perpetrators of child maltreatment have often experienced maltreatment themselves (Berlin et al., 2011).

The effects of intergenerational trauma and violence on children and the connection to child maltreatment are clearly present in the story of Kierra (see below). Kierra's mother was the victim of intimate partner violence and was hospitalized with severe injuries. The family environment of Kierra and siblings was marked by trauma and violence.

It is important to support and provide opportunities for parents and caregivers in meaningful ways that encourage a healthy home environment for each family member. Best Start Resource Centre (2010) runs an Indigenous-led program that provides supportive strategies, called Wheels of Support, for each family member at various stages of the life cycle in a First Nations context.[9] As Hughes (2014) declared in the final report of the Phoenix Sinclair Inquiry:

> **"…a collaborative approach, working with parents and harnessing the collective resources of child welfare and other provincial government departments, other levels of government, and the province's many community-based organizations, can make a difference for vulnerable families… We all must play our part.**
>
> **-page 28**

When using an ecological approach to child welfare, at the community level, young children are impacted by the environments in which they grow up. In order for children to thrive, it is imperative that all families and every community have access to healthy food, cultural and recreational activities, quality education, health care, and positive community programs that promote healing. These are the protective factors that will minimize child maltreatment and help reduce child deaths.

Indicators of individual children's well-being are at the heart of the Greenwood model because, ultimately, all other layers of the circle impact the health and well-being of the individual. When looking at individual well-being, it is important to examine social, emotional, cognitive, physical, and spiritual aspects to ensure a holistic approach is understood. Ensuring enablers are in place to support all aspects of health and well-being is essential and needs to be the goal of every other layer of the model.

Kierra's Story

Kierra had not yet reached her second birthday when, on July 17, 2014, she died from severe intra-abdominal injuries after being maltreated. At the time of her death, Kierra had bruises and abrasions, healing fractures, loss of multiple teeth, and brain injuries resulting from the ongoing abuse. Kierra had also suffered from chronic malnutrition.

Kierra's death occurred nine years after Phoenix died, seven months after the Manitoba government received the final report of the inquiry into Phoenix Sinclair's death, and two months after the final report of the inquest into Jaylene Sanderson-Redhead's death.

Kierra's parents' relationship was marked by intimate partner violence and substance misuse, which affected their abilities to provide safe care for their children. In 2012, Kierra's siblings were apprehended and placed in foster care after an incident of intimate partner violence in which their mother was hospitalized with severe injuries. Shortly afterwards, Kierra was born. She was apprehended and placed in a licensed foster home.

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[9] For detailed information see, https://resources.beststart.org/wp-content/uploads/2019/01/K12-A-child-becomes-strong-2020.pdf

The agency's case plan was for Kierra's parents to attend culturally-based programs related to anger management, family violence, healing, and parenting skills. They were expected to attend counselling, drug testing, and participate in a parenting capacity assessment. Within a few months, Kierra's parents completed the required programs.

During her time in care, Kierra attended visits with her parents and siblings, but these did not always go well as there were limited opportunities for the family members to develop familiarity and comfort with each other.

Kierra was nine months old when she and her siblings returned to her parents' care. The agency did not conduct an individual child assessment prior to Kierra being reunified.

For the first six months after Kierra was reunified, the worker saw the family regularly. Kierra was observed to be happy and smiling, and her mother was able to comfort her when she was upset. The agency last documented seeing Kierra seven months before her death. Like Phoenix, the injuries Kierra sustained in the months before her death were extensive and also witnessed by her siblings. The agency involved with Kierra initiated an Internal Agency Review (IAR), and made nine recommendations relating to direct service (use of assessment tools, records management practices, service completion, evaluation), organization (quality assurance file review, staff training, agency organization), and community (mandatory reporting).

The Organization Level – Service Reviews

The quality of service delivered by agency staff to children and their families is directly connected to the level of support they receive from the organization and the organization's capacity and functioning. This support includes a vast array of factors, including: staff education and training, staff recruitment and retention, workload, supervision, community relations, information technology, programs, and service delivery. Each of these elements contributes to the strength of an agency, keeping staff supported, and engaging and empowering children and families. Best practice requires ongoing evaluation and quality assurance, which are essential in identifying areas for service improvement and better outcomes for children.

During testimony at the Phoenix Sinclair Inquiry, Wright (2013) stated, "A key concept of Best Practices is not that mistakes are not made, but rather that child welfare practice should be informed and thought about, to learn from mistakes and implement the knowledge to improve services" (p. 5). There are a number of ways child welfare agency practices are reviewed when service concerns are identified such as Section 4 reviews, inquests, inquiries, and Internal Agency Reviews (IAR). These are in addition to the independent reviews undertaken under *The Advocate for Children and Youth Act.*

- Under s.4(2)(c) of *The Child and Family Services Act* (CFSA), a **Section 4 review** can be initiated to conduct enquiries and carry out investigations with respect to the welfare of any child dealt with under the CFSA. The provincial director of child protection may authorize a person or an agency to perform any of the director's duties or any of the director's powers. Similarly, a review can also be mandated under s.25 of *The Child and Family Services Authorities Regulation*.
- According to s.19(1) of *The Fatality Inquiries Act*, the chief medical examiner may call an **inquest** if the general public would benefit from the information being made public during such a hearing. This was the authority that called for the inquest into the death of Jaylene Sanderson-Redhead.[10]
- The authority to conduct an **inquiry** comes from *The Manitoba Evidence Act*. This Act gives the Lieutenant Governor in Council the power to order an inquiry into any matter within the jurisdiction of the provincial legislature that is of sufficient public importance to justify an inquiry. This was the authority that called for the inquiry into the death of Phoenix Sinclair.[11]

[10] Further information regarding inquests can be found at https://www.gov.mb.ca/justice/crown/cme.html.

[11] Further information regarding inquiries can be found at https://web2.gov.mb.ca/laws/statutes/ccsm/_pdf.php?cap=e150

- According to Section 1.7.4 of the provincial Child and Family Services Standards Manual ("provincial minimum standards"), an **Internal Agency Review** (IAR), is initiated after a critical incident, such as the death of a child, to examine the circumstances of the child's death, assess the quality of service delivery, identify areas for improvement, and make recommendations for change. Section 1.7.4 of the provincial minimum standards indicates that an IAR will obtain the following detailed information on the circumstances leading to the critical incident:
    - Identify applicable agency programs and services;
    - Determine whether applicable programs and services were involved;
    - Assess the actions and decisions of any workers or supervisors involved in providing services to the child or the child's family;
    - Determine whether staff followed applicable policies and procedures including provincial minimum standards;
    - Reassign case management responsibilities when indicated;
    - Determine if additional staff training is required; and
    - Take appropriate disciplinary action when indicated.

The IAR also provides information on the context in which services were provided, such as: caseload numbers, workload expectations, staff training, challenges in recruiting and retaining staff, staff vacancies, and working conditions for staff in rural communities including isolation, physical safety, standard of living, community expectations, and community relationships. For example, weather and transportation may not be considerations for urban centres but they can significantly impact service delivery in rural communities. These factors provide an important context for the organization and the processes necessary to address gaps in service.

IARs also address the impact of the death of a child on staff at a CFS agency. When a child dies as a result of maltreatment, the emotional toll on staff can be heavy, especially in small and remote communities. In one case, three staff resigned following the death of a child.

Of the 19 children whose stories are highlighted in this special report, IARs were completed on only six of the children, Section 4 reviews were completed for two children, and an inquest was completed for one child. The completed IARs were, for the most part, thorough and thoughtful, and contained recommendations related to case management, as well as organizational and community-related aspects of service.

68% **of the 19 children** did **NOT** have an IAR completed

Not only is an IAR a powerful tool that provides an opportunity for active reflection on, and evaluation of, the quality of services provided to children and families, it is also an opportunity for agencies and authorities to examine and address their organizational practices. Evaluation of services provided by the agency and enacting recommendations for improvements are protective factors benefitting children, families, the organization, and community. The child death reviews and investigations conducted by the Manitoba Advocate are an example of the quality assurance processes needed to identify areas of improvement.

After Terry's death (see next page), an IAR was conducted by the child and family services agency, and several recommendations were made with regards to assessment training for staff. When reviewing the services Terry and their family received from the agency, gaps were evident. For example, there were no assessments completed for the family or for Terry. An assessment would have been important in understanding the family members' individual functioning, as well as the relationships within the family and the functioning of the family unit as a whole.

Terry's Story

"Terry" (not their real name) died from multi-organ failure as a result of inflicted trauma. Terry was a First Nations child living in a rural area.

Child and family services became involved with Terry when they were born because their mother was unable to provide safe care for them and their siblings. The child welfare agency and the family developed a plan for Terry and their mother to live together with additional supports. This arrangement lasted several weeks after which Terry and their mother moved out on their own. Terry's mother was unable to provide the care that Terry required and Terry was apprehended and placed in an agency facility. Their caregivers described Terry as a happy child, easy to care for, who loved to be with people. Terry had regular visits with their mother and people supervising the visits noted Terry's mother was attentive and affectionate towards Terry.

Terry was returned to their mother's care and their child welfare file was closed. A few months later, Terry's mother arranged for Terry to live with friends.

Child and family services reopened their file with Terry's mother due to concerns that Terry's mother was unable to provide appropriate care for Terry and their siblings. In the time that the children were in agency care, Terry's mother completed programs as required by the agency. Several months later, Terry's siblings were reunified with their mother and her partner. The agency provided a support worker who met with the family regularly to monitor the progress of the reunification. The support worker noted the family was stable and no concerns were raised. Three months later, Terry was also reunified.

When Terry was reunified, the agency did not arrange a support worker to assist with the reunification process. Part of the plan when Terry returned home was for Terry to attend daycare; however, their attendance became sporadic and eventually their mother stopped taking Terry to daycare.

Over the next year, the agency conducted monthly home visits. Throughout this time, Terry's mother reported that Terry's behaviour was challenging. It was recommended to the agency that they provide Terry's mother with respite, therapy, and that Terry resume daycare. The agency did not follow up with these recommendations.

Six months after Terry returned home, the child suffered multiple injuries and died. It was determined that Terry's injuries were inflicted.

A child assessment would have captured information about Terry's experiences, their needs, and their place in the family. There was no assessment of Terry's mother's ability to meet their needs. An assessment that considered the needs of the family was essential to examine and consider the information available, identify risk and protective factors, and inform the services for the family.

The Direct Service Level – Case Management

The direct service level refers to child welfare service provision. Manitoba's child and family services standards manual identifies six areas of the case management process: intake, assessment, planning, service provision, evaluation, and service completion. [12]

Child and family service agencies in Manitoba are responsible to deliver services that identify, assess, and address the needs of children, youth, and families, in accordance with *The Child and Family Services Act*.

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[12] The Manitoba Child and Family Services Standards Manual can be viewed at https://www.gov.mb.ca/fs/cfsmanual/index.html

The public inquiry into the death of Phoenix Sinclair identified gaps in CFS case management practices related to assessment, planning, service provision, and evaluation. These gaps were also noted in reviewing the deaths of the children featured in this report. Importantly, the Manitoba Advocate continues to identify gaps in these same areas of service delivery when reviewing deaths of children under the age of five.

These concerns are illustrated in the brief summary of Lee's story. Lee was taken into care as an infant due to protection concerns at home. Lee was placed in a foster home without the foster parents being provided any information about Lee by the CFS agency. After being placed in the home, there was no contact from the agency to check on how Lee was settling in, or if the foster parents had any questions or needed any support.

Lee's Story

"Lee" (not their real name) died after suffering head injuries and multiple bone fractures. Lee's family became involved with child welfare after concerns were reported that their parents could not provide safe care. On the day that Lee was apprehended, they were placed in a home where the agency did not provide information about Lee's personality, development, or routines, and, ultimately, the agency did not observe how Lee's new caregivers responded to Lee's needs.

After Lee's placement, there was no further contact by the agency to see how Lee or their caregivers were adjusting to their new situation. There was no identification of Lee's needs or their caregivers' needs and no resources were offered to them.

Shortly after being placed in care, Lee died from maltreatment.

Table 3. Service Delivery Issues in Child Death Reviews, 2018-19 and 2019-20 Fiscal Years

AREA OF CFS CASE MANAGEMENT SERVICE	SERVICE REQUIREMENTS	CONCERNS NOTED IN FILES (2018-19)	CONCERNS NOTED IN FILES (2019-20)
ASSESSMENT	• Family assessments • Child assessments • Child protection investigations	**52 out of 57 reviews, or 91%**	**66 out of 71 reviews, or 93%**
PLANNING	• Safety planning • Ongoing family planning • Child in care planning	**53 out of 57 reviews, or 93%**	**59 out of 71 reviews, or 83%**
SERVICE PROVISION	• Frequency of contact with family/caregivers • Services provided as outlined in plans • Families and children are engaged • Services updated to reflect the changing needs of a child or family	**52 out of 57 reviews, or 91%**	**62 out of 71 reviews, or 86%**
EVALUATION	• Monitoring for changing needs • Review of effectiveness	**49 out of 57 reviews, or 86%**	**58 out of 71 reviews, or 82%**

In November 2020, The Manitoba Advocate published *The 2019-2020 Child Death Review Roll-Up*, which summarized findings from all 71 child death reviews completed by the Manitoba Advocate in the 2019-20 year (2020a). Themes were identified in the areas of assessment, planning, service delivery, and evaluation (Table 3). In the table above, numbers from the 2018-19 year are also included for comparison. Even though these numbers include children ages birth to 21, out of the 71 child deaths reviewed, 30 (42%) of those child deaths were ages birth to five.

Similar to the review roll-up (Table 3), the table below highlights the service concerns that were identified in the areas of assessment, planning, service delivery, and evaluation in the maltreatment-related child deaths included in this special report (Table 4). Four of the 19 children featured in this special report had no child welfare services prior to maltreatment. As such, those children are not included in the analysis shown in Table 4. These numbers highlight the importance of thorough case management practices. When working with children, youth, and families, comprehensive assessments, plans, service delivery, and evaluation are essential to identify risk and protective factors that may prevent the maltreatment of children.

Table 4. Prominent Service Delivery Issues Identified for 15 Children Featured in this Special Report

AREA OF CFS CASE MANAGEMENT SERVICE	SERVICE REQUIREMENTS	CONCERNS NOTED IN PHOENIX SINCLAIR FILES	CONCERNS NOTED IN CHILDREN FILES (N=15)
ASSESSMENT	• Family assessments • Child assessments • Child protection investigations	YES	**14 out of 15 reviews, or 93%**
PLANNING	• Safety planning • Ongoing family planning • Child in care planning	YES	**11 out of 15 reviews, or 73%**
SERVICE PROVISION	• Frequency of contact with family/caregivers • Services provided as outlined in plans • Families and children are engaged • Services updated to reflect the changing needs of a child or family	YES	**13 out of 15 reviews, or 87%**
EVALUATION	• Monitoring for changing needs • Review of effectiveness	YES	**13 out of 15 reviews, or 87%**

When working with infants and toddlers, there are two vital aspects of the case management process that are often missed: assessments and reunification planning for children in agency care. Like Phoenix, five of the 19 children were reunified with family members after spending time in care of CFS. These children did not receive adequate reunification supports. Common concerns our office identified with the reunification process included: no child assessments conducted, lack of agency follow-up post-reunification, lack of aftercare supports, and case planning that was not child-focused or, in some cases, not completed at all. The absence of good support service around a family reunification meant missed opportunities to engage the family, examine information on their needs and strengths, and evaluate the risk and safety for the children.

Assessment

> **The assessment tools provide information for the workers to make skilled decisions moving forward [in their work with the families]. How that information is gathered is critical for engagement of the family. The heart of child welfare work is building relationships/engaging with each family.**
>
> **-General Authority, Interview, August 26, 2020**

Assessment begins at first contact, is ongoing, and involves all family members regardless of age. This is particularly important for infants and toddlers who are at increased risk due to their inabilities to speak, and their total dependence on the adults around them for safety and protection.

> **If implemented properly [the assessment] can assist the case worker in addressing and assessing the family's needs and assist in the development of a case plan tailored to their needs; however, they are very often seen as punitive basing much of the risk on [the family's] entire past.**
>
> **-Southern First Nations Network of Care, Interview, September 17, 2020**

The provincial minimum service standards for CFS, specifically, s.1.1.2 (Government of Manitoba, 2009), define a child assessment as "a specialized assessment of any child to determine individual needs separate from the family and the permanency plan for the child." Assessments should encompass the following four components: include risk assessment, be strengths-based; involve face-to-face meetings; and reflect cultural safety.

> **Manitoba does not require or use a standardized risk assessment tool to determine the level of risk to children. However, agencies must ensure that staff receive appropriate training in assessing and documenting risk factors either through the provincial core competency-based training program or a recognized equivalent.**
>
> **-The provincial minimum standards, s.1.1.2**

Child welfare agencies in Manitoba use a variety of assessment tools to determine safety and risk to children, including the three noted below (Figure 6).

Figure 6. Assessment Tools to Determine Risk

Structured Decision Making® System (SDM®)

- Is a suite of assessment instruments that promote safety and well-being for those most at risk —from children to vulnerable adults.
- combines research with best practices, offers workers a framework for consistent decision making, and offers agencies a way to target in-demand resources toward those who can benefit most (Evident Change, n.d.).

The Signs of Safety® Approach (SOS®)

- is a relationship-grounded, safety-organized approach to child protection.
- was created by researching what works for professionals and families in building meaningful safety for vulnerable and at risk children (Signs of Safety, n.d.).

Awasis Case Management Model (ACM)

- The agency stated that the ACM "...is a standardized process which guides and directs all assessment and treatment activities, from initial referral to the termination of agency involvement" (Awasis Agency of Northern Manitoba, Evidence submission to MACY, 2020).

As part of our investigation, the Manitoba Advocate requested and received from the four child and family services authorities their agencies' reunification policies and practices, assessment tools specific to children under the age of five, and strengths and limitations of each (Table 5).

Regardless of which assessment tools are used, it is vital that assessments are, in fact, completed regularly, and that all family members be included. For children under the age of five, who are the most dependent, workers need to build a relationship with the family to which they are providing services, rely on their professional observations of the child, be familiar with child development, and include in their assessment information from community resources and collaterals, such as public health, pediatrician or family doctor, daycare, and other services involved with the child and their family. It is through this complete picture of a family environment and dynamic that CFS agencies can ensure their services and supports are meeting the actual and changing needs of the child and their family. And yet, while in theory these assessment models offer guidance to workers in how to provide meaningful, consistent service, this is challenging inside a system where many system-level barriers persist.

Table 5. Agency and Authority Perspectives on Assessment Tools

Tool	Strengths	Limitations
SDM TOOLS®	• Fosters objectivity and consistency • Organizes a process for best practice and transparency in decision making • Integrates multiple areas of assessment • Case plan focused • Best practice model • Reduces subsequent child maltreatment • Expedites permanency • Guides minimum contact standards • Includes periodic review, which helps measure progress and update the treatment plan • Helps prioritize specific service interventions	• Not developed for First Nations, Metis, and Inuit populations • Does not allow for the input of families and community • Are often done in a compliance-focused manner, instead of being informative • Are standardized processes and do not allow for informal solutions to problems • Does not reflect the hard work and improved situations accomplished by families • Links poverty to being a child welfare matter • Does not capture the impacts of colonialism, the residential school system, or the Sixties Scoop • Assigns higher risk levels to families who have experienced oppression and trauma • Focuses on western ideologies, including how the tools pertain to the patriarchal ideology of the nuclear family
SOS® APPROACH	• Allows for child and family engagement • Captures the voice of children • Assesses strengths and dangers • Reduces rates of child abuse and repeated maltreatment • Creates a shared language between clinicians and families	• Requires ongoing training • Requires skilled and trained staff • Requires children to be verbal and understand direction
AWASIS CASE MANAGEMENT MODEL	• Recognizes the need for culturally-appropriate practice • Is based in Indigenous practice and is trauma-informed • Identified needs are based on actual family structure and life experience • Can assist in empowering families to define their own problems and develop their own solutions, creating ownership and healing	• The crisis-based environment in which child welfare operates limits effectiveness • Offers only temporary responses rather than addressing the ongoing impacts of trauma, adverse childhood experiences, poverty, and structural racism

Reunification Practices

According to The Child Welfare Information Gateway (2006), successful reunification includes three components: a positive relationship between the worker and the family, family visits, and the involvement of foster parents. To those, we would add: ongoing post-reunification support to ensure the successful transition.

A positive relationship between the CFS agency and family includes open communication, the participation of the family in case planning and evaluation, and guiding and supporting the family through the case plan. Family visits are a way for parents, children, and siblings to reconnect with each other, for the agency and parents themselves to assess parental strengths, and an important opportunity to build parenting capacity in a supportive way. Including the foster parents in the reunification process can improve communication between the in-care supports and the family.

In addition to utilizing the same assessment tools described above as part of agency reunification practices, agencies have also incorporated other assessment tools and programs or services to measure readiness and ensure the plan is successful. These include family network meetings, community-based reunification programs, genograms, home assessments, parental capacity assessments, family group conferencing, reunification workers, and the SDM® Reunification Assessment. One agency reported to our office that they are in the process of developing an agency-specific reunification assessment tool.

Table 6. Agency Perspectives on Successful Reunification and Barriers to Successful Reunification

Successful reunification	Barriers to successful reunification
Regular family visitation	Limited on-reserve resources
Play therapy	Limited resources available after reunification
Needs-specific training for parents	Limited wrap-around community supports
Ongoing supports after the child is returned home	No foster parent involvement in the reunification process
Stable housing	Limited aftercare plans
Robust family and community networks	Collateral involvement
Partnership with family supports	Enough staffing support so workers can remain involved in the family post-reunification
Reunification funding	Provincial funding
Attachment based intervention	

> **"(Successful reunification practices include) effective and ongoing partnerships with community resources that would help allow for expedited reunification, i.e. housing, mental health resources, clinical services, addictions, peer mentorship, access to food, etc.**
>
> **-Metis Child & Family Services Authority, Interview, September 2020**

Of the 19 children featured in this special report, five spent time in care of CFS and were later reunified with their families. Four of the five children were reunified at the same time as their sibling groups. None of the children or their families received post-reunification supports after they went home, nor were any of the children provided with a child-specific assessment that addressed their developmental, physical, educational, cultural, and spiritual needs. [14]

The time period immediately following reunification can be one of increased stress on each family member. Reunification may signal a decrease or ending of services to parents, when, in fact, this is a critical time for family members to re-establish relationships, recognize strengths, address needs, and support healthy coping strategies. In other words, reunification is too often seen as the end of a process, rather than the beginning of the family living together in a new dynamic. What is important for a successful reunification is, "Being spiritually connected, through cultural involvement, Elder support, extended family, Family Enhancement. Having their own (natural) support system in place" (First Nations of Northern Manitoba Child and Family Services Authority, Interview, September 15, 2020).

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[14] A detailed description of these developmental milestones can be viewed at https://www.cdc.gov/ncbddd/actearly/milestones/index.html. Similarly, understanding the life cycle through the Medicine Wheel can be viewed at: https://resources.beststart.org/wp-content/uploads/2019/01/K12-A-child-becomes-strong-2020.pdf
Another useful resource called Inunnguiniq Childrearing Advice from Inuit Elders, can be viewed at: https://www.qhrc.ca/wp-content/uploads/2019/02/Inuinnguiniq-Brochure-ENG.pdf

For Sky and their siblings, reunification was seen by the agency as the end of a process, not the beginning of the family living together in a new dynamic they had not previously experienced. Not exploring this family's risk and protective factors was a missed opportunity to engage the family and all partners to participate in and develop a comprehensive safety and reunification plan. A meaningful reunification plan would have been an opportunity to assess the family's situation and provide the supports they required for a successful return home for all of the children. It could have provided an opportunity for family members to re-establish relationships, recognize strengths, address needs, and discuss coping strategies.

Sky's Story

"Sky" (not their real name) was apprehended and placed in agency care right after being born because their mother was unable to provide safe care; Sky's siblings had previously been placed in foster care for similar safety concerns. The agency's case plan was for Sky to have regular visits with their mother and siblings. While in agency care, regular respite care was provided to the foster parent.

A number of months went by with the children all remaining in care and then, prior to Sky's first birthday, the agency made the decision to reunify Sky and their siblings with their mother. The agency stated that Sky's mother had complied with the reunification plan and the visits with the children were going well. Supports were not offered to Sky and their family after their return home.

A few weeks after their reunification, the agency received reports from the community that Sky's mother was struggling to provide safe care. Agency records did not show any evidence that follow up or planning occurred to address these incidents and reports. Although the agency file remained open, there was little contact with the family and minimal reference to Sky.

Sky died after being at home for less than a year. At the time of their death, Sky was dehydrated, underweight, with healing bone fractures of varying ages from inflicted maltreatment.

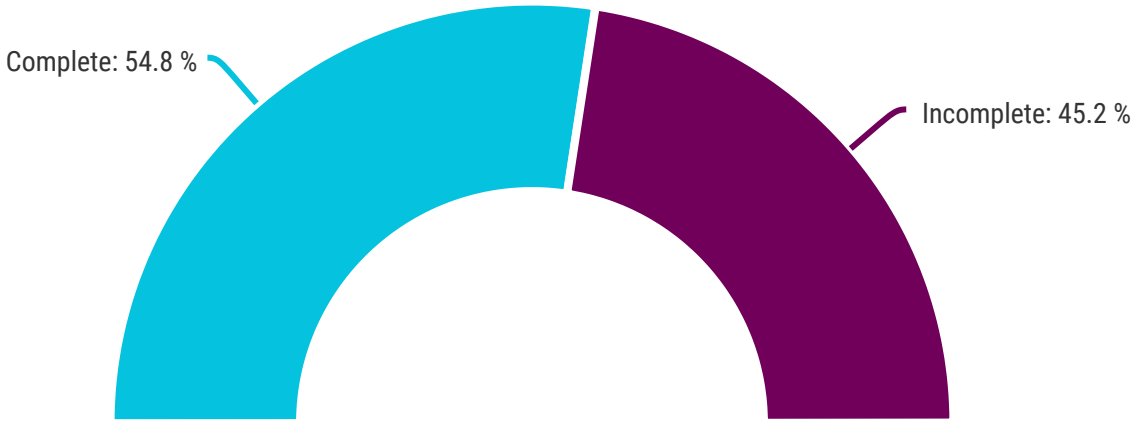
An ecological perspective at the direct service level offers child and family services workers and agencies an opportunity to examine the relationship between the child, family, and their community in the context of societal issues. Assessments depend on comprehensive information gathering from each level: the child's developmental, physical, educational, cultural, and spiritual needs; the family's understanding of and ability to meet those needs; and the resources available to the child and family both in the organization and in the community. Knowing about resources, accessing services for children and families, and advocating where service gaps are identified are all protective factors. For the same reason, in cases where insufficient information is gathered, the assessments are inadequate, and resources are not provided, as in the story of Lee, risk factors for child maltreatment increase.

Special Update

Status of the Phoenix Sinclair Inquiry Recommendations

As part of this special report into child maltreatment, the Manitoba Advocate is including an analysis of the current status of the 62 recommendations issued in the final report of the Phoenix Sinclair Inquiry (Hughes, 2014). The following analysis was completed between December 2020 and February 2021, and is based on updates and other evidence submitted by the Manitoba government to our office in response to a formal request sent by our office in 2020.

Key Findings



- As of February 2021, 55% of the Phoenix Sinclair Inquiry recommendations have been completed.
- At this rate of completion, it will be 2028 before all recommendations are completed.
- Completed recommendations to date are largely due to the enactment of *The Advocate for Children and Youth Act*, which addressed 11 recommendations at the same time.
- Progress is noted on recommendations made to increase quality assurance and some aspects of the social work profession.
- Recommendations made to improve service integration, service improvements, children's rights, and funding for early intervention and prevention have received low average compliance assessments.

Introduction

On November 24, 2016, the Office of the Children's Advocate (now the Manitoba Advocate for Children and Youth) released a status update report on the Phoenix Sinclair Inquiry recommendations titled *So Much Left To Do: Status Report on the 62 Recommendations from the Phoenix Sinclair Inquiry*.

That update, two and a half years after the release of the report *The Legacy of Phoenix Sinclair, Achieving the Best for All Our Children* (Hughes, 2014), found that 18 of the 62 recommendations had been completed (29%). This current report reviews compliance with the remaining 44 recommendations made by the Honourable Ted Hughes in the 2014 inquiry report. The objective of our office's assessment here is to evaluate the degree of compliance of reported activities with the intent of recommendations made in the inquiry, in honour of Phoenix Sinclair.

Methods

The process for assessing compliance with recommendations was adapted from the existing *Handbook for Compliance Assessment of MACY Recommendations*, currently used by our office to measure compliance with recommendations issued by the Manitoba Advocate in investigations and special reports (11(1)(d), ACYA).

On August 5, 2020, the Manitoba Advocate requested from the Department of Families an update on activities on the 44 outstanding recommendations from the Phoenix Sinclair Inquiry. A document with information for each of the recommendations was received by our office from the Manitoba government on December 9, 2020. Recommendations were reviewed and preliminarily assessed by three policy analysts and the program manager for the Advocate's Research and Quality Assurance Department. A peer review process was conducted to ensure internal compliance with the principles of assessment.

Principles of Assessment

The following principles guide assessments of recommendations:

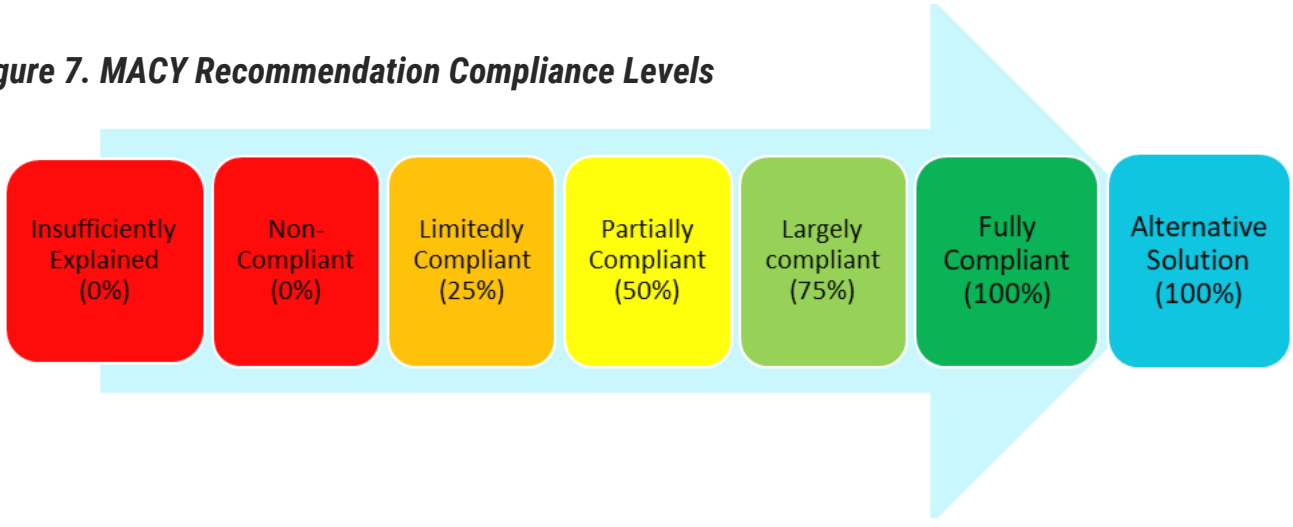
- Fairness, consistency, and transparency
- Effective communication
- Principle of proportionality
- Independence
- Child-centred

Preliminary analysis was presented to representatives from the Departments of Families, Justice, Health, the Child and Family Services Division, the four child and family services authorities, and a number of child and family services agencies at domain meetings in January 2021. For recommendations assessed as *non-compliant* or *insufficiently explained*, the Department of Families, as the government's lead department on the inquiry recommendations, was provided with an additional opportunity to submit information for consideration. The A/Manitoba Advocate and members of her staff met with senior departmental personnel from the Department of Families on February 4, 2021, to discuss responses, and re-assessments were finalized shortly thereafter.

Compliance Levels

Actions reported were categorized into one of seven compliance levels, with each level having a numerical assignment from zero to one-hundred per cent.

Figure 7. MACY Recommendation Compliance Levels



Results

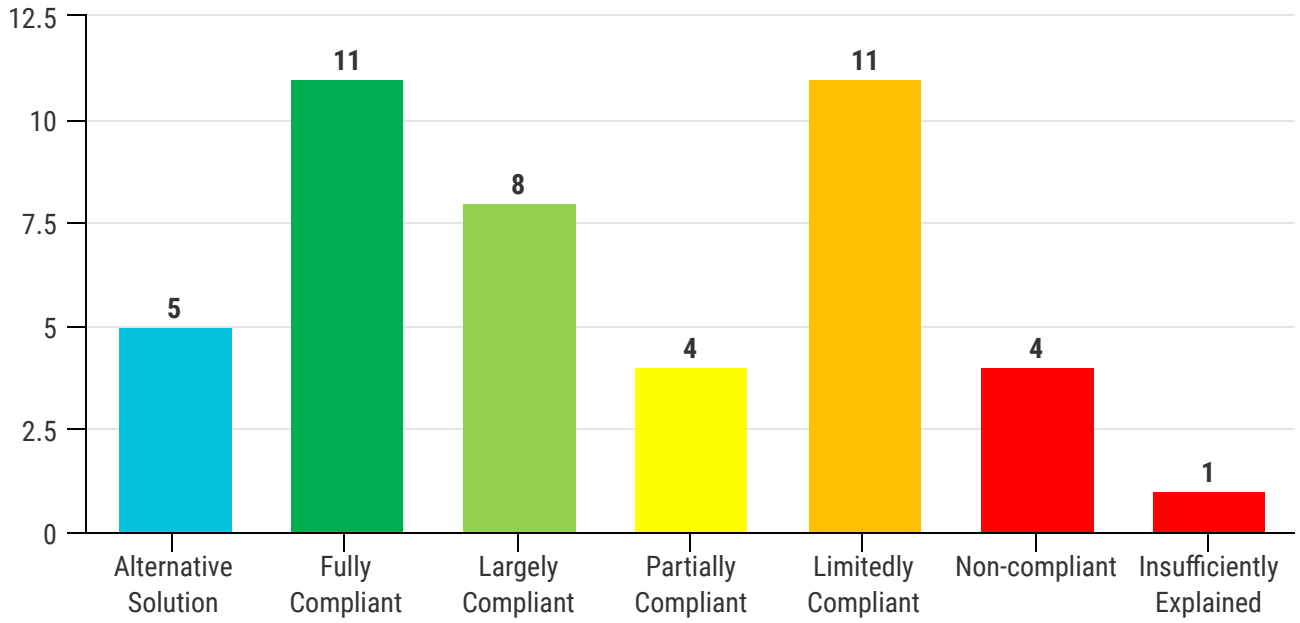
Recommendations by Compliance Level

Compliance with recommendations is relatively low with 36% of the 44 outstanding recommendations analyzed as being completed ('*fully compliant*' or '*alternative solution*') (n=16).

The remaining 64% of the recommendations analyzed are not complete (n=28). Progress is uneven, of the incomplete recommendations 43% show that actions reported meet at least some requirements of the recommendation ('*largely compliant*' and '*partially compliant*').

Importantly, for the majority of incomplete recommendations (57%), actions reported by the Manitoba government do not meet the requirements of Hughes' inquiry recommendations ('*limitedly compliant*', '*non-compliant*', or '*insufficiently explained*', n=16). A summary list of all outstanding recommendations and their compliance determination can be found in Appendix C.

Figure 8. Recommendations by Compliance Level



Progress on Recommendations

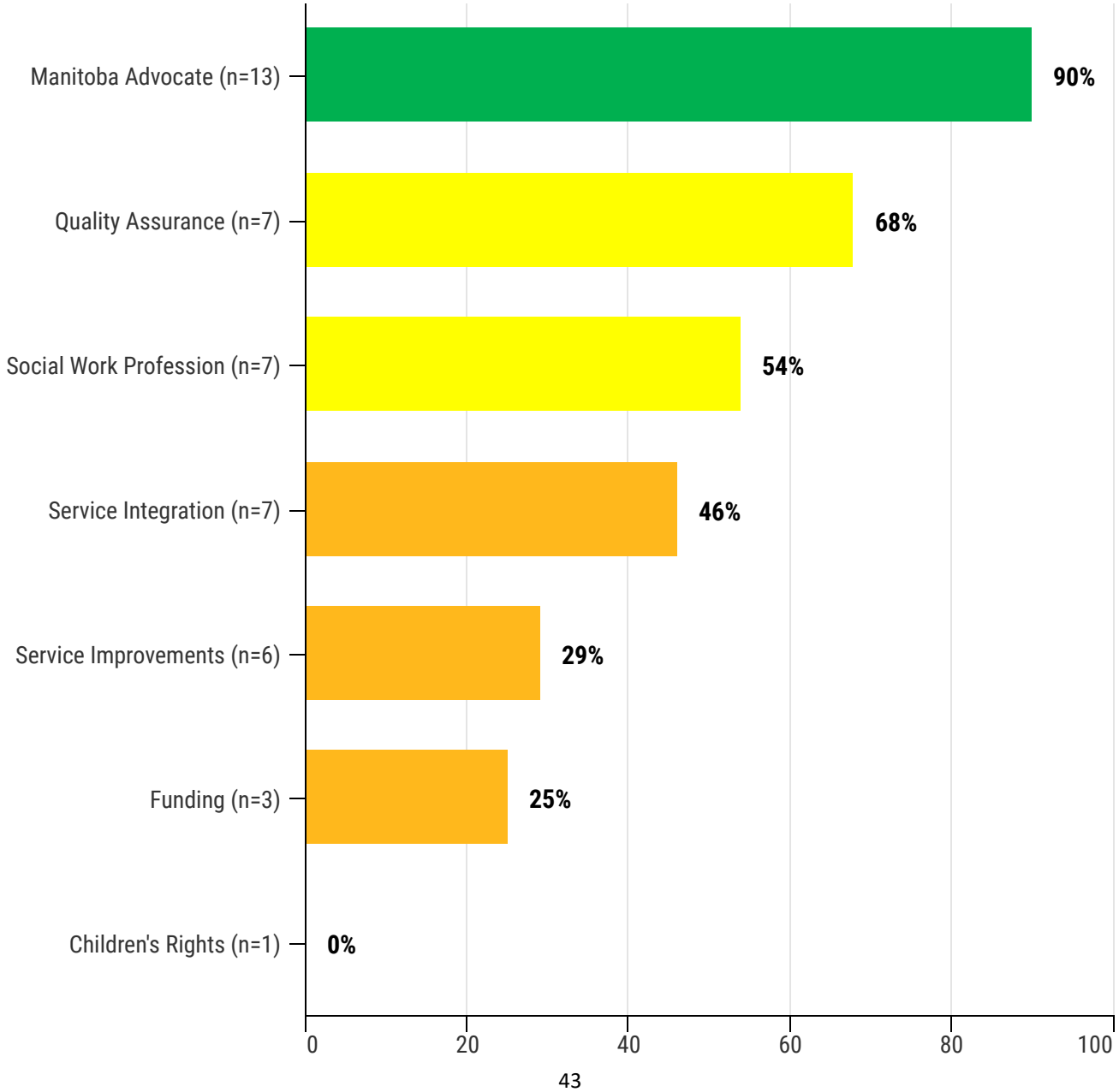
It has been seven years since Hughes issued recommendations in 2014. Progress to implement them is slow. In the Advocate's initial assessment in 2016, only 29% of the recommendations were deemed complete. As per this latest assessment, the percentage of completed recommendations increased to 55% completion. At this rate, the recommendations honouring the legacy of Phoenix Sinclair will not be completed until 2028, 14 years after the inquiry and 23 years after her death.

Results cont.

Compliance by Systemic Theme

Outstanding recommendations addressed primary systemic themes affecting children, youth, young adults, and families in Manitoba. The average compliance level with recommendations was different, depending on the issue addressed, as seen in Figure (9). Recommendations to establish an independent advocate for children in Manitoba are near complete (90% average compliance), whereas recommendations that reference service improvements (29%), funding (25%), or children's rights (0%) have very limited compliance.

Figure 9. Compliance by Systemic Theme in Phoenix Sinclair Inquiry Recommendations



Results cont.

Manitoba Advocate for Children and Youth

One in five of the recommendations made by Hughes (2014) were related to the expansion and strengthening of the responsibilities and powers of the Manitoba Advocate. The emphasis on the development of an office that, with its own legislation, is able to provide oversight over all public services to children, youth, and families was an important conclusion of his report.

> **"Manitoba needs a truly independent officer of the legislature, with authority to advocate for all Manitoba children who receive, or are entitled to receive publicly funded services, and to report on matters that concern them.**
>
> **-Hughes, 2014, p. 45**

There has been significant progress on this issue with 11 of the 13 recommendations being fully implemented through the proclamation of *The Advocate for Children and Youth Act* (ACYA) in March 2018. Importantly, Recommendation 36 of the Phoenix Sinclair Inquiry, requires that the Advocate be provided with the mandate to advocate for "**all children and youth** in the province who are receiving or are eligible to receive **any publicly funded service** [emphasis added]" and the "responsibility to review not only deaths, but **also critical injuries** [emphasis added]" (Hughes, 2014, p. 44). While the mandate of our office was expanded beyond child welfare to include youth justice, victim support services, children's disability, mental health, addictions, and some educational activities, it stops short of all publicly funded services. Of note, the ACYA excludes childcare services and public health services, both of which provide critical and early interventions for children and families and are out of scope for review by the Manitoba Advocate.

Further, the ACYA includes the responsibility to review and investigate critical injuries (also "serious injuries") as intended by Hughes (2014). However, this portion of the ACYA, while proclaimed with all-party support in the Manitoba legislature in 2018, has been held back by the provincial government from coming into force since that time. In recognizing the need and importance of investigating serious injuries, the Manitoba Advocate made a formal recommendation to support this important section of the ACYA being activated in a report titled, *The Slow Disappearance of Matthew: A Family's Fight for Youth Mental Health Care in the Wake of Bullying and Mental Illness* (Manitoba Advocate, 2020b). In summary, Recommendation 36 was deemed largely compliant because the majority of the requirements of the recommendation have been met, even if some requirements are not yet complete.

Quality Assurance

Of the remaining recommendations, there are seven which speak to the enhancement of accountability and quality assurance of child welfare services. The average compliance level of these recommendations is modest at 68%. The Department of Families was able to demonstrate that, while the information management system for child welfare (the Child and Family Services Information System, or CFSIS) was not replaced, a number of changes and adaptations have been made to improve its functionality (Recommendations 21 and 22).

Results cont.

Recommendation 11 requires the publishing of annual reports on the work of the Child and Family Services Standing Committee ("standing committee") that includes the four CFS authorities and the Department of Families, to increase transparency over the child welfare system. The activities of the standing committee have not been published and remain outside public scrutiny. Following the compliance monitoring process described herein, however, the Department of Families has, in the recent days, confirmed that annual reports will be published. As a result, our office deemed this recommendation fully compliant.

Social Work Profession

Hughes (2014) made a number of important recommendations regarding the social work profession, including three recommendations that are specific to addressing the large caseloads and workloads for case managers in child welfare. The reason for these recommendations was to ensure social workers had sufficient time to build relationships with families and focus on preventative work that, over time, would lead to a reduction in demands for protection services (Hughes, 2014, p. 39).

The responses provided to our office by the Department of Families outline a number of initiatives including the introduction of Single Envelope Funding (SEF, also known as "block funding") which they argued can be used for prevention services. The department also described their ongoing work to define roles and responsibilities and an analysis of workload they conducted which concluded that social workers have sufficient time to deliver court documents.

The actions reported, however, do not demonstrate how they have led to a reduction in workload and caseload for social workers. Importantly, workers and agencies consulted during this special report did not agree that caseload and workload pressures evident in the Phoenix Sinclair Inquiry, and which promoted those recommendations, have been sufficiently addressed in the provincial system. Further, we heard clearly that the ability to ensure good casework that meets the needs of families and which also meets provincial minimum standards is regularly and negatively impacted by the volume of work shouldered by individual workers.

Service Integration

Supporting partnerships and integrated service delivery centres were a key theme in the recommendations issued by Hughes (2014). The overall goal was to support family enhancement and prevention, as Hughes (2014) explained:

> **"To truly honour Phoenix, we need to provide all of Manitoba's children with a good start in life, and offer to the most vulnerable an escape from the cycle of poverty and vulnerability that trapped Phoenix and her family.**
>
> **-Hughes, 2014, p. 35**

Results cont.

The average compliance rate for recommendations addressing service integration is poor at 46%. There are some positive initiatives which support service integration. The government's enactment of *The Protecting Children* (Information Sharing) *Act* (PCISA), which facilitates the sharing of information between service providers, addresses the major requirements of Hughes' Recommendations 6 and 9. While the government did offer a series of information sessions on the PCISA when it was enacted in 2016, they did not report any plan for ongoing training regarding service providers' abilities (and obligations, in some cases) to share information between systems in the best interests of a child. The additional discontinuation of Core Competency Training in 2020 prevents full compliance with the intent of the recommendations. If front-line staff are not trained on their abilities to share information, then the legislative changes would have no effect in practice. Indeed, in our work as advocates we frequently encounter situations where information that ought to be shared under the terms of the PCISA is, in fact, being protected and not shared between service providers involved with the same child.

The Department of Families reported that funding investments made in 2019 and 2020 to develop child care options in community-based organizations and to support the capital expansion of early learning and child care in schools and community-based centres, led to 737 new spaces. The integration of early learning into existing schools and community-based centres meets the intent of Recommendation 60. As such, this recommendation is deemed fully compliant.

Nevertheless, significant work remains to enhance service integration. Of note is the government's repeal of *The Healthy Child Manitoba Act* on November 6, 2020. Healthy Child Manitoba was highly regarded within Manitoba, beyond our borders, and was highlighted as a best practice for service integration in the Phoenix Sinclair Inquiry. Healthy Child Manitoba was, in practice, an integrated and central body with the potential to coordinate services across departments and throughout the province. The repeal of its legislation and the dismantling of its structure leaves Manitoba without a central body with the legislative powers to address Recommendation 56. The alternative solution proposed by the government, which included a number of existing cross-departmental committees, falls short of the vision of integrating and coordinating early childhood interventions.

Service Improvements

There is a deficit in actions reported towards service improvements, with a 29% average compliance rate. Two recommendations are non-compliant since the All Nations Coordinated Response Network (ANCR) continues to provide family enhancement services (Recommendation 3) and the age of majority supports extend only to age 21, not to 25 as recommended (Recommendation 34). The new National Housing Strategy and intergovernmental efforts to enhance affordable housing following consultation are in full compliance with Recommendation 49.

Funding

There are three outstanding recommendations regarding funding and investments Hughes (2014) made within the child welfare system and in the community. The recommendations focused on increasing funds to reduce cases per worker, invest in family enhancement services, Indigenous-led community-based organizations, and integrated service delivery centres.

Results cont.

The Department of Families' response to these recommendations centred on the introduction of Single Envelope (Block) Funding in February 2019, which was intended to provide agencies with the flexibility to redirect child maintenance surpluses towards prevention and reunification and to manage caseloads for social workers. As part of the recommendations compliance process, the Department of Families shared with our office a publicly-available pamphlet stating that the Single Envelope (Block) Funding initiative resulted in an increase in prevention expenses of 2.7%. The Department of Families did not share the evaluation report on which that position was based. Prevention initiatives undertaken by the General Authority were also shared with our office. While the 2.7% increase in prevention spending is a good start and inline with the intent of the recommendations, actions and documents shared did not demonstrate a reduction in cases per worker, increased funds for family enhancement, or increased funds for Indigenous-led community-based organizations.

Children's Rights

Recommendation 54 of the Phoenix Sinclair Inquiry calls for the amendment of *The Healthy Child Manitoba Act* "to reflect the rights entrenched in the *United Nations Convention on the Rights of the Child*, in a manner similar to Alberta's *Children First Act,* stipulating that the well-being of children is paramount in the provision of all government services affecting children." As *The Healthy Child Manitoba Act* was legislation that applied cross-departmentally, Hughes (2014) reasoned that this act was the "perfect home":

> **"...what is needed is a legislative framework that protects children's rights and that can be used as a benchmark for evaluating any public policy, legislation, or program that affects the wellbeing of children.**
>
> **-Hughes, 2014, p. 32**

As noted above, *The Healthy Child Manitoba Act* was repealed by the Government of Manitoba on November 6, 2020. As part of this recommendations compliance process, the Government of Manitoba reported that the reference to the *United Nations Convention on the Rights of the Child* (UNCRC) found in the non-binding preamble of *The Advocate for Children and Youth Ac*t (ACYA) is, in its view, an alternate solution to Recommendation 54.

The intent of Hughes' (2014) focus here was to integrate children's rights into legislation guiding "the well-being, safety, security, education, and health of children…throughout government" (p. 49). The alternative solution proposed does not meet the intent of the recommendation since the ACYA governs the work of an independent officer of the Legislative Assembly, working outside and not within government, to represent the interests of children, youth, young adults, and families.

Final Thoughts

The enactment of both *The Protecting Children* (Information Sharing) *Act* in 2016, and *The Advocate for Children and Youth Act* in 2018, are responsible for the majority of complete or near complete recommendations stemming from the Phoenix Sinclair Inquiry. These substantial legislative changes are in line with the intent of the recommendations made by Hughes (2014).

The repeal of *The Healthy Child Manitoba Act* and the discontinuation of the Healthy Child Manitoba Office that coordinated early childhood intervention services across departments and with diverse stakeholders are steps backward in the work of increasing service integration, a major theme of the Phoenix Sinclair Inquiry. The impact of the recent restructuring of provincial child welfare funding to Single Envelope (Block) Funding, which is intended to increase family enhancement and prevention efforts, while promising, is not yet known and was not demonstrated.

Areas where improvement can be made is in the integration of the UNCRC into existing legislation of child-serving systems including child welfare, education, and youth justice. Further, funding family enhancement services and extending age of majority supports to youth up to the age of 25 would have a significant impact in improving outcomes for children, youth, and families. These changes would signal a clear commitment to a society that values and protects children and youth.

The Manitoba Advocate is committed to monitoring the recommendations made in the Phoenix Sinclair Inquiry and to increasing transparency and accountability for the rights of children and youth in the province.

Recommendations

Towards an Ecological Model of Family Care

Under the jurisdiction of *The Advocate for Children and Youth Act*, the Manitoba Advocate is empowered to make recommendations to the government or any public body or other person the Advocate considers appropriate. Special reports, like this one, can be summaries of child death reviews or investigations and completed for the purposes of improving the effectiveness and responsiveness of designated services.

Recommendations

As described throughout this special report, maltreatment is a serious concern in Manitoba and children in our province continue to be seriously injured from maltreatment. In honour of the 19 young children who suffered maltreatment and died since the tragic death of Phoenix Sinclair, the following recommendations are issued, and organized to highlight the ecological model of care discussed previously.

Systems Level

1 The Manitoba Advocate for Children and Youth recommends that the Government of Manitoba implement the outstanding recommendations from the Phoenix Sinclair Inquiry.

Details:

- The Government of Manitoba is to submit progress reports to the Manitoba Advocate on a bi-annual schedule, following the existing MACY Handbook for Compliance Assessment.
- The Manitoba Advocate will undertake an assessment of these updates, and report publicly on the status of implementation annually, until completed.

Community Level

2 Consistent with *Call to Action* 5 of the Truth and Reconciliation Commission, the Manitoba Advocate for Children and Youth recommends that the Government of Manitoba work with First Nations and Metis governments and community stakeholders to ensure access to evidence-informed and culturally-safe parenting programs and resources for caregivers of children under the age of five in every community across Manitoba, with attention to rural and remote communities.

Details:

- Assess available parenting resources in Manitoba for children under the age of five.
- Identify geographic gaps in resources and/or areas where existing resources can be improved.
- Develop and/or enhance resource supports for caregivers.
- Integrate parenting resources within existing community infrastructure (schools, community resource centres, etc.), where possible.
- Create and implement a strategy that ensures the ongoing dissemination of information regarding available parenting resources to caregivers of young children across Manitoba.

Organization Level

3 The Manitoba Advocate for Children and Youth recommends that each child and family services authority develop and provide the necessary resources to implement a culturally-appropriate reunification policy with their agencies. If a reunification policy exists, the authority should review and revise the policy with their agencies to ensure compliance with the details of this recommendation.

Details:

- Worker facilitated, ongoing, meaningful involvement with the family throughout the duration of the reunification process, which requires small worker to family ratios and availability of supports.
- A review of risk and protective factors specific to the child and their family at reunification.
- An assessment of the child and the caregivers explicitly addressing the developmental, physical, educational, cultural, and spiritual needs of each child being reunified with their family.
- A case reunification plan addressing initial safety concerns, and areas in which the parent caregiver may require supports or augmentation of their knowledge or skills in order to provide safe care for their child.
- A detailed reunification plan for the individual child based on their specific needs and the family's ability to meet those needs.
- Documented communication with the child's foster parents (or caregivers) to ensure the transfer of information about the child and their responses to the reunification process that should involve extended family, friends, and community networks.
- Recognizing the change in family dynamics with reunification and the possibility of increased stress for the family and increased risk for the child, a post-reunification plan should include regular support for the child and family; mandatory face to face engagement with the child and the family; parenting supports (including supports managing difficult child behaviours), and ongoing evaluation of the supports available to the family.
- Post-reunification plans should be holistic and include assistance with transportation, employment, housing, respite care, mental health and addictions supports, social support networks, and daycare.
- Regular consultation between the case manager and supervisor to evaluate the reunification process;
- Expectation of complete documentation of the reunification process.
- Case audits by the authority to ensure post-reunification services are in compliance with agency's reunification policy.

Direct Service Level

4 The Manitoba Advocate recommends that all child and family services authorities ensure that their agencies complete case reviews for every child in care under age five, for whom reunification is planned.

Details:

- Ensure the case reviews reflect the reunification policy.
- Completed case reviews need to be reviewed and signed by a Supervisor.

5 The Manitoba Advocate recommends that the Department of Families, through the Joint Training Team, develop and administer mandatory training for front line workers and supervisors on the risk and protective factors of child maltreatment and best practices for reunification.

Details:

- Develop training on the risk and protective factors of child maltreatment and best practices for reunification.
- Schedule and administer the training regularly.
- Track the number and percentage of existing and new front line staff and supervisors who have received the training.

Conclusion

Child maltreatment remains a serious concern in Manitoba. Children are born completely dependent on the adults around them for survival. The younger the child, the more dependent they are on their caregiver and the greater the risk for maltreatment. Phoenix Sinclair and the 19 other children featured in this special report remind us that utilizing an ecological approach is essential in order to keep young children safe and prevent child maltreatment. This perspective is a best practice when providing child welfare services to children, youth, and families. Importantly, it is an approach to child-caring that draws from traditional wisdom from cultures here at home and around the globe.

Though we have witnessed changes to child welfare services over the years, these changes have not resulted in consistent or equitable services for children, youth, and families, and Manitoba still has almost 9,000 First Nations and Metis children in care. The child welfare system remains rooted in structural inequities and systemic racism and when left unaddressed, children are placed at risk of harm and even death.

Applying an ecological approach to child welfare practice positions the child within their environment, recognizes all aspects of the individual's and family's life, and challenges the impacts of systemic oppression that families face. This approach compels child welfare practice to understand the needs of a family in a holistic manner.

Additionally, in order for children to thrive, it is imperative that all families and every community have access to healthy food, cultural and recreational activities, quality education, health care, and positive community programs. These are the protective factors that will help minimize child maltreatment and reduce child injuries and deaths. Many of these basic needs are beyond the scope of the child and family services system and require meaningful and sizeable investments from local authorities, other provincial departments, as well as from the federal government.

It is also important to recognize that the quality of services delivered by CFS agency staff to children and their families is directly connected to the level of support from the organization and the organization's capacity and functioning. Ongoing evaluation and quality assurance are essential in identifying areas for child welfare service improvement and, ultimately, better outcomes for children, youth, and families.

The stories shared in this special report describe service gaps in the areas of assessment, case planning, service provision, evaluation, and the missed opportunities for successful intervention. The stories shared closely mirror elements of Phoenix Sinclair's story. Unfortunately, the needs of these children were not identified, adequate child assessments were not conducted, case planning was not child-focused, and reunification practices were insufficient, not meeting even minimum provincial CFS service standards in many of the cases. These children and their families had a right to CFS agency services that ultimately ought to have ensured their safety.

Despite the time and commitment of the broad public inquiry presided over by the Honourable Commissioner Hughes and contained in his final report, as well as the significant public investment made by Manitoba taxpayers into the public inquiry process, there has never been a single report released publicly by the provincial government detailing the status of the 62 recommendations Hughes made. This report by the Manitoba Advocate seeks, in part, to address that gap towards a better understanding of the impact of the inquiry. Accountability to the public is foundational to public trust and is demonstrated when evidence-informed recommendations are implemented in timely ways. It is also crucial that governments provide the public with information about how identified gaps in systems are being addressed so children will not be injured or die when facing similar circumstances in the future. We owe as much to all of the children in Manitoba: to honour the life and legacy of Phoenix and all of the other young children who have since died in similar and preventable ways.

Finally, it is also imperative that the Canadian government demonstrates the will to fully support child welfare as it goes through substantial change and as First Nations, Metis, and Inuit communities and governments reassert sovereignty over the care of children and families. While previous system overhauls have been marked by inadequate funding, unclear jurisdiction, and discordant reinforcing of colonial structures and service barriers, our province and country hold an opportunity to make real changes that will secure better futures for all children, as are their rights. Child protection means protecting every Manitoba child in effective, equitable, and culturally-appropriate ways. Like the 19 children featured in this special report, child safety and well-being, when left unaddressed, place children at risk of maltreatment, significant harm, and early death.

> **My hope is that the heart wrenching evidence I heard in Phase One of this inquiry will serve as a catalyst to ensure that the recommendations that emerge from this special report are wholeheartedly embraced and implemented. The protection of children is a shared value of the whole community. The public interest that this Inquiry has received encourages me in the belief that achievement of the better protection of all Manitoba's children, and especially the most vulnerable, will be the true legacy of Phoenix Sinclair.**
>
> **-Hughes, 2014, p. 35**

Appendix A: Risk and Protective Factors

	Risk and Protective Factors
Individual	RISK FACTORS FOR VICTIMIZATION -Younger than 4 years of age -Special needs that may increase caregiver burden (e.g., disabilities, mental health issues, and chronic physical illnesses) RISK FACTORS FOR PERPETRATION -Caregivers' lack of understanding of children's needs, child development and parenting skills -Caregiver history of child abuse and or neglect -Substance abuse and/or mental health issues including depression in the family -Caregiver characteristics (young age, low education, single parenthood, large number of dependent children, low income) -Non-biological, transient caregivers in the home -Thoughts and emotions that tend to support or justify maltreatment behaviours
Family	RISK FACTORS -Social isolation -Family stress, separation or divorce, and violence, including intimate partner violence -Parenting stress, poor parent-child relationships, and negative interactions PROTECTIVE FACTORS -Supportive family environment and social networks -Concrete support for basic needs -Nurturing parenting skills -Stable family relationships -Household rules and child monitoring -Caregiver employment -Caregiver education -Adequate housing -Access to health care and social services -Caring adults outside the family who can serve as role models or mentors
Community	RISK FACTORS -Community violence -Concentrated neighborhood disadvantage (e.g., high poverty, high unemployment rates, and high density of alcohol outlets), and poor social connections PROTECTIVE FACTORS -Communities that support caregivers and take responsibility for preventing abuse
	Source: National Center for Injury Prevention and Control, Division of Violence Prevention

Appendix B: Methods

In accordance with s. 20(3) of the ACYA, deaths of all children, youth, and young adults are currently reviewable by the Manitoba Advocate if there has been child and family services (CFS) involvement in the year leading up to the date of death; those deaths with CFS involvement are assessed as "in scope" for a review. [17]

Of the 19 children featured in this special report, nine of the deaths were investigated by The Office of the Children's Advocate (now known as the Manitoba Advocate for Children and Youth), between 2008 and 2018, in accordance with s.8.2(3) of *The Child and Family Services Act* (CFSA), which preceded the Manitoba Advocate's current legislation. For those nine investigations, the investigator was authorized to examine child and family services' agency records, interview child and family service's agency staff, service recipients, and other service providers, and exercise any other investigative powers under CFSA, s.8(3).

In accordance with the ACYA, ten of the 19 deaths had a review completed between 2018 and 2020. The ACYA empowers the Manitoba Advocate to conduct a review of services following a child, youth, or young adult's death if there has been any form of child and family services involvement in the past year.

Notifications advising of this special report were sent to the appropriate Ministers and relevant departmental representatives within the Government of Manitoba. In addition, the four child and family services authorities were notified that a review of services would be conducted.

[17] Further details of the child death review process can be found at, https://manitobaadvocate.ca/wp-content/uploads/2018-2019-Child-Death-Review-Roll-Up.pdf.

Appendix C: Compliance

Compliance Determinations with Phoenix Sinclair Inquiry Recommendations

No.	Summary	Theme	Compliance Level
26	That a BSW or equivalent be required of all social workers hired by agencies	Social work profession	Alternative Solution 100%
40	Advocate report annually to the Legislature	Manitoba Advocate	Alternative solution 100%
21	That the department complete its solution-scoping phase for the replacement of the information management system	Quality Assurance	Alternative solution 100%
42	Annual reports and service plans to be public	Manitoba Advocate	Alternative solution 100%
44	Transition from one legislation to another through an Acting Advocate position	Manitoba Advocate	Alternative solution 100%
11	That the Standing Committee issue public annual reports	Quality Assurance	Fully compliant 100%
31	That the four Authorities ensure tht the findings and recommendations in this report are shared and discussed with all child welfare staff and management	Social work profession	Fully compliant 100%
38	Appointment for five year term with an option for a second term, no position beyond 10 years	Manitoba Advocate	Fully compliant 100%
39	A Deputy Advocate is appointed	Manitoba Advocate	Fully compliant 100%
41	Advocate to prepare an annual service plan and annual report	Manitoba Advocate	Fully compliant 100%
43	In hiring at the Advocate for children and youth consideration be given to applicant's understanding of the lives of Indigenous children and families	Manitoba Advocate	Fully compliant 100%
45	Act must be similar to the Act in British Columbia	Manitoba Advocate	Fully compliant 100%
46	Consideration of the Act in British Columbia in developing the Manitoba Act	Manitoba Advocate	Fully compliant 100%
47	Ombudsman responsibility to monitor recommendations be removed	Manitoba Advocate	Fully compliant 100%
49	To develop further strategies to increase availability of affordable housing in collaboration with different levels of government	Service Improvements	Fully compliant 100%
60	Establish integrated service delivery centres to provide a range of services in addition to early childhood education, including public health, employment and income assistance, housing, child welfare and adult education. They should be located within existing infrastructures or community-based organizations.	Service Integration	Fully compliant 100%

No.	Summary	Theme	Compliance Level
6	That CFS agencies strive for greater transparency and information sharing with caregivers, which may require legislative changes	Service Integration	Largely compliant 75%
9	Amend legislation to allow service providers to share relevant information with each other and with caregivers for the protection, safety, or best interest of children	Service Integration	Largely compliant 75%
16	That when an agency engages a consultant, such as a medical professional, in the course of delivering services to a family, it must obtain a written report from the consultant and retain it in the relevant file.	Quality Assurance	Largely compliant 75%
27	Promote social work as a career choice for Indigenous peoples by removing barriers to access educational programs	Social work profession	Largely compliant 75%
30	That the findings and recommendations be shared by Authorities to agencies	Social work profession	Largely compliant 75%
36	Create an independent Advocate for children with a mandate to advocate in all publicly funded services and ability to review serious injuries, ability to make special reports to the legislative assembly and monitor compliance with recommendations	Manitoba Advocate	Largely Compliant 75%
22	That the new information management system be capable of interfacing with other public system, tracking all children in care, using alert features to flag offenders and improve efficient file recording.	Quality Assurance	Largely Compliant 75%
37	Required by the Act to consider the skills, qualifications, and experience of the candidate, including an understanding of Indigenous children and families in Manitoba	Manitoba Advocate	Largely Compliant 75%
4	Ensure continuity of service by ensuring the same worker provides services throughout involvement in the child welfare system	Quality Assurance	Partially compliant 50%
2	That family enhancement services that support the differential response practice model are developed, coordinated and made accessible through partnerships and collaboration between child welfare, other departments, and community-based organizations	Service Integration	Partially compliant 50%
20	The Authorities perform and publish annual composite reviews of the wellbeing of children in their agencies, whether in or out of care	Quality Assurance	Partially Compliant 50%
57	That child welfare agencies accommodate reasonable requests by parents or other caregivers and children and youth for participation of an individual they identify as a support in their dealings with the child welfare system.	Service Improvements	Partially compliant 50%

No.	Summary	Theme	Compliance Level
7	That the Authorities enhance availability of voluntary early intervention services by placing workers in schools, community centres, housing developments, and other community facilities.	Service Integration	Limitedly compliant 25%
48	A public awareness campaign be undertaken to inform the public about the expanded mandate and role of the Advocate	Manitoba Advocate	Limitedly Compliant 25%
1	That the Province and the four child welfare Authorities adhere to the following principles: a) Offer early intervention through both universal and targeted services; b) Child welfare services are provided on a continuum, almost always working with a family enhancement approach c) The children's safety and well-being must be assessed through face-to-face contact. d) Assessment tools must be used as an aid to the exercise of clinical judgment. e) Assessment tools must be used in a way that takes into account a family's cultural, social, and economic circumstances. f) After an assessment the necessary services must be available. g) When a child has been found to be in need of protection, the goal of the child welfare system is to prevent recurrence of maltreatment. h) The goal of the child welfare system is to keep as many children safe at home as possible.	Service Improvements	Limitedly Compliant 25%
13	Reduce administrative burdens on social workers through technology and administrative staff	Social work profession	Limitedly compliant 25%
19	The Authorities develop and implement a supervision policy	Quality Assurance	Limitedly Compliant 25%
25	Authorities be funded to a level that supports the differential response approach including: (a) funding to allow caseload ratio of 20 cases per worker; (b) increasing the $1,300 fund for family enhancement, and (c) determine necessary funding following meaningful consultation	Funding	Limitedly Compliant 25%
52	Expand supports for families transitioning from First Nation communities to urban centres in collaboration with First Nations and other levels of government.	Service Improvements	Limitedly compliant 25%
55	Enhance capacity of community-based organizations through sustained long-term funding to allow for the delivery of holistic services, with emphasis on supporting Indigenous-led organizations and programs	Funding	Limitedly Compliant 25%
56	That a legislated committee, functioning under The Heathy Child Manitoba Act (a) coordinate services provided by government and community-based organizations, (b) allocate government funding through meaningful and inclusive consultation, governed by a committee that is culturally diverse and representative of Manitoba	Service Integration	Limitedly compliant 25%
58	That CFS agencies meet regularly with community-based organizations to avoid gaps in services.	Service Integration	Limitedly compliant 25%
61	Support integrated service delivery centres be allocated, following meaningful and inclusive consultation by a committee that reflects Manitoba's various regions and cultural diversity	Funding	Limitedly Compliant 25%

No.	Summary	Theme	Compliance Level
54	That the Healthy Child Manitoba Act reflect the United Nations Convention on the Rights of the child, embedding the rights of children throughout government.	Children's Rights	Non-compliant 0%
3	That All Nations Coordinated Response Network (ANCR)—whose role is triage and delivery of short-term services—no longer provide family enhancement services but should transfer families who need those services to a family services unit as soon as possible.	Service Improvements	Non-Compliant 0%
14	Authorities to designate staff who are available to locate and serve court documents	Social work profession	Non-compliant 0%
34	That The Child and Family Services Act be amended to allow for extension of services to any child who at the age of majority was receiving services under the Act, up to age 25.	Service Improvements	Non-Compliant 0%
12	Services should be delivered on the basis of 20 cases per worker	Social work profession	Insufficiently Explained 0%

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