

# OFFICE OF THE CHILDREN'S ADVOCATE

## Special Investigation Review Program Evaluation

### *Executive Summary*

March 2015  
Manitoba



OFFICE OF THE CHILDREN’S ADVOCATE  
SPECIAL INVESTIGATION REVIEW:  
PROGRAM EVALUATION EXECUTIVE SUMMARY

**INTRODUCTION**

The Office of the Children’s Advocate (OCA), an independent office of the Manitoba Legislative Assembly, represents the rights, interests and viewpoints of children and youth throughout Manitoba who are receiving, or are entitled to receive, services under *The Child and Family Services Act* and *The Adoption Act*. The OCA does this by advocating directly with children and youth and by reviewing public services after the death of any child who had received services, or whose parent or guardian had received services, from a child welfare agency within one year before the death.

The Children’s Advocate is empowered by legislation to review, investigate, and provide recommendations on matters relating to the welfare and interests of children and youth. Our office has continued to change and evolve based on the work we do and the feedback we receive from youth and other stakeholders. As a result, we have four main areas of activity at the OCA. These include:

1. The Advocacy Services program works with children and youth currently receiving services from child welfare, and those young people who may be entitled to receive services under *The Child and Family Services Act* and *The Adoption Act*. Staff members provide a wide range of activities which entail reviewing child welfare involvement; establishing contact with the appropriate Child and Family Services (CFS) agency; meeting with children and youth to help them understand the decisions being made by stakeholders in their care plan; and attending meetings to provide direct advocacy support for a child or youth.
2. The Special Investigation Review program is responsible to conduct a review of services after the death of a child when the child was in the care of or received services from an agency, or whose parent or guardian received services from an agency, as defined in *The Child and Family Services Act* within one year before the death.
3. The Communications, Research & Public Education program works to expand public awareness of our office and educate the public on various issues related to children, children’s rights, and child welfare.
4. The Quality Assurance program works to ensure that the quality of services and activities at the OCA remain at a high standard and responsive to the needs of children and youth. One of the primary objectives of this program is to look within our organization for areas of service enhancements. Therefore, in the 2014/2015 fiscal year, a program evaluation was conducted on the Special Investigations Review program. This executive summary provides a brief summary of the evaluation conducted along with the recommendations that were developed.

## **SCOPE AND PURPOSE OF THE EVALUATION**

The purpose of this program evaluation is to provide an opportunity for positive learning that builds upon achievements, strengths, competencies and interests. A collaborative approach to program evaluation is required if proper and realistic planning and implementation is to be sustainably achieved. Considering this is the first internal evaluation conducted with the Special Investigation Review (SIR) program, a process evaluation (as opposed to an outcomes evaluation) was conducted in an effort to assess where we are optimizing the most effective processes, and also where there could be improvements made to enhance service delivery.

There are three primary objectives of this evaluation:

1. To assess the development of the SIR program
2. To enhance the stabilization of the SIR program
3. To look at the future direction of the SIR program

The first objective of this evaluation is to look at the development of the SIR program in an effort to consider the transitions the program has gone through, and to gain a sense of the current state of the program. The second objective of this evaluation is to observe areas where stabilization has occurred and comparatively, where continued improvements or areas of clarification are still required. The final objective of this evaluation is to identify how to progress in a forward moving, meaningful way. It is important to be cognizant that this evaluation has taken place at one point in time and is representative of opinions, perspectives and findings that reflect this stage of the program.

Essentially, the questions we strive to answer are:

- What activities are we conducting to fulfill our legislative mandate?
- How well are we doing the work within the SIR program?
- How can we improve?

## METHODOLOGY

A mixed-methods approach was designed for this evaluation, meaning that both qualitative and quantitative methods were utilized. In order to conduct a thorough program evaluation, there were four phases of data collection:

1. Semi-structured interviews with all SIR staff: In total 12 SIR staff interviews were conducted.
2. Focus groups held with external collateral stakeholders: In total, 15 focus groups were held and included representative participants from all 4 Child and Family Services Authorities, 7 Child and Family Services agencies, the Child and Family Services Division, the Office of the Chief Medical Examiner, the Manitoba Ombudsman and the Minister of Family Services. Agencies were selected based on the following criteria:
  - a. The agency had to have had a reviewable child death within the past two years.
  - b. The number of SIRs completed, that were geographically represented across the 4 Authorities.
3. Survey's distributed to internal OCA Advocacy staff members.
4. Secondary data collection of materials and documents that predate the SIR program (2006) until March 2014, including a review of 12 selected SIR reports.

## HISTORICAL DEVELOPMENT

Prior to the existence of the SIR program, child death reviews were conducted by the Office of the Chief Medical Examiner. Section 10 of *The Fatalities Inquiry Act* provided the Chief Medical Examiner (CME) with the mandate to conduct reviews of all children who died in care, who were currently receiving child welfare services, or who had received child welfare services in the twelve months prior to the death.

An external review, "*Strengthen the Commitment (2006)*" was released and recommended that the responsibility for child death reviews be transferred from the CME to the Office of the Children's Advocate (OCA).<sup>1</sup> This recommendation was accepted and legislative changes were enacted that removed the function of child death reviews from *The Fatalities Inquires Act* and placed this duty with the OCA through an amendment to *The Child and Family Services Act*. This transfer in legislative mandate was also accompanied by an enhanced scope of child death reviews that would include examination of publicly funded social services.

On September 15, 2008, *The Children's Advocate's Enhanced Mandate Act (Various Acts Amended)* came into effect whereby the Children's Advocate was empowered and given the responsibility to conduct a review of services after the death of child who was in the care of, or received services from an agency or whose parent or guardian received services from an agency as defined under *The Child and Family Services Act* within one year before the death. Upon completion of the review, the Children's Advocate may make recommendations identifying ways in which programs and services could be improved to enhance the safety and well-being of children and reduce the likelihood of a death occurring in similar circumstances. At time of proclamation, 106 outstanding cases requiring review were transferred over from the CME to the OCA.

From the time the enhanced mandate was proclaimed (in 2008,) until 2012, full investigations were carried out on every child death case that fell under the legislative mandate. Full investigations entail a lengthy investigative process that may include reviewing agency files, interviewing agency staff, family members and other collaterals, travelling to communities, describing in detail the service delivery provided by an agency and/or authority, and developing findings and/or recommendations that would enhance service to better meet the needs of similar children in the future, which in turn may prevent the death of a child in a similar circumstance. Full investigations, while in some circumstances necessary, take a long time to complete, and SIR staff and management soon discovered that it was not feasible to conduct full investigations on every case *and* produce timely reports. Therefore, in February 2012, brief focused reviews (reviews) were introduced as an alternative report to full investigations. Reviews at this time were carried out if the child's death was not preventable (e.g. natural) and where no recommendation could be identified regarding the services provided by the agencies which could reduce the likelihood of a death occurring in similar circumstances in the future. In April 2014, a third

---

<sup>1</sup> Hardy, M., Schibler, B., & Hamilton, I. (2006, September). Strengthen the commitment: An external review of the child welfare system. *Department of Family Services and Housing: Government of Manitoba*.

type of report was introduced that provided a 'middle' ground between the full investigation and the review. This report would include investigators reviewing agency file information, but would not necessarily include interviews and/or community visits thereby going beyond the review but not to the extent of a full investigation. In addition to the above three reports, investigators may conduct an Aggregate investigation where a number of child deaths are investigated as a group to address identified systemic issues.

Other developments that have occurred within the SIR program over the course of its 6 years of development include:

- Development of the peer review within the SIR program which was intended to identify and provide feedback to the report writer on findings and recommendations; clarity of the report; and examples of exceptional 'best practice' or innovative service by an individual or organization
- Development of the Advisory Council
- Increase in staff
- Development of process-related materials (e.g. forms, recommendations tracking spreadsheet, Policy and Procedures manuals, tools as they relate to the investigative process)

### **CONTRIBUTIONS OF THE SIR PROGRAM**

SIR investigators are a committed group of individuals who work towards improving the lives of children and youth. The SIR program is one of just a few of its kind in Canada, whose approach to advocacy entails the task of looking into the deaths of children whose families were connected with child welfare services.

External collateral participants described the overall importance of the SIR program, stating that they provide independent oversight into child death cases, which is critical from a public policy perspective. Additionally, the SIR staff is reported to have the skill set necessary to:

- Provide insight into the child welfare system
- Engage with communities and family members
- Effectively produce meaningful reports that can initiate system-wide change

Other OCA staff members state their SIR colleagues are professional, have depth of knowledge and their commitment to working with agency and authority representatives enhances the credibility of the SIR reports which results in better outcomes for children and youth.

## THE SPECIAL INVESTIGATIONS REVIEW PROCESS

One of the objectives of this evaluation was to gain a sense of what processes are currently working and which can be improved. There are many processes involved in SIR investigations that contribute to the final reports produced by staff. These processes have developed and become more refined over time and the following recommendations are made to continue that positive evolution.

### **I. Community Visits/Travel**

Often as part of the investigative process, SIR staff travel to various communities in order to interview family members, community members, agency workers and others who may be able to provide information regarding the case they are working on. There was wide agreement internally and externally on the additional value of travel to communities when investigators are not on case-related business. It was acknowledged that this type of travel to communities enhances on-going relationship building and builds critical knowledge for the staff of the OCA on challenges experienced by children, youth, and service providers in the community. Feedback highlighted, in particular, a desire to see more travel to the North.

**RECOMMENDATION ONE:** Quality Assurance recommends that the SIR Program Manager develop a process whereby non-case related travel is determined. Further discussion with external collaterals may aid in identifying the needs in remote communities, and how travel can be most effective. In order to keep within budgetary provisions, it may be beneficial for the SIR program to determine an annual plan for community outreach and engagement.

**RECOMMENDATION TWO:** Quality Assurance recommends that the SIR Program Manager update the policies and procedures to reflect the considerations used when determining case related travel. It would be beneficial for the SIR Program Manager to inform the Authority child death representatives of these considerations at the next scheduled meeting.

### **II. Agency/Authority/Division Meetings**

Meetings with agencies, authorities and the Child and Family Services Division (the Division) occur when a recommendation and/or finding has been directed to an organization and members from that organization are invited to meet with the SIR program manager and investigator. Currently, agencies, authorities and the Division receive a draft copy of the report in its entirety to review prior to this meeting. This process is in alignment with a protocol that was developed in partnership between the OCA and the four child welfare authorities. *The Protocol for the Review of Draft Special Investigation Reports* (dated September 2013) was finalized following a collaborative process involving the OCA and representatives of the four child welfare authorities that began in 2011. The protocol helps to outline the goals and objectives of the agency/authority/Division meetings.

From SIR staff perspective, positive attributes of having this meeting are that the receiving organization is able to better understand why the recommendation is being made, and what impact the recommendation is intended to have. This educational process is more collaborative and enables each party to ask questions and work together on what the recommendation is envisioned to look like at the ground level. Generally agency/authority/Division meetings have been an asset to the overall report writing process as they provide an opportunity for investigators to clarify points of confusion, and obtain additional information, for example, on any action that has been taken following the death of the child. External participants also commented on the benefit of these meetings, stating that they appreciate the opportunity to discuss the findings and recommendations and clarify questions they may have regarding recommendations.

**RECOMMENDATION THREE:** Quality Assurance recommends the following suggestions for improvement of agency/authority/Division meetings:

- That the *Protocol for Review of Draft Special Investigation Reports* (dated September 2013) for information sharing signed by all four CFS authorities be reviewed by the Children’s Advocate with authority representatives to ensure that it continues to clearly outline the purpose, goals and objectives of the meeting, and to ensure that all parties understand their roles and responsibilities.
- Quality Assurance further recommends that the SIR Program Manager ensure that any new/additional findings and/or recommendations (if not previously discussed with the relevant agency/authority/Division) are communicated prior to the finalization of the report.
- Quality Assurance further recommends that the SIR Program Manager collaborate with external stakeholders and develop a more streamlined administrative process to scheduling the timing and location of meetings and delivering the SIR draft report.

### **III. The SIR Advisory Council**

The SIR Advisory Council was initially comprised of approximately 12 members who were recognized as leaders or experts in a range of professional disciplines relevant to the SIR report process. The Advisory Council was established to advise and assist the OCA in carrying out its mandate by providing expert consultation on the content of SIR reports, identifying additional case-related, systemic, or cross-jurisdictional issues for consideration, and assisting the OCA in the development of recommendations. In addition, members of the Advisory Council provide consultation to the investigators on an as-needed basis.



Internal SIR staff feedback indicates the desire to enhance utilization of the Advisory Council and it has been suggested that there may be office-wide benefit in widening the terms of the Advisory Council to provide access to the council experts for all staff at the OCA.

**RECOMMENDATION FOUR:** Quality Assurance recommends that the Deputy Children’s Advocate engage in an office-wide discussion to determine if Advisory Council should be expanded to include both SIR and Advocacy programs. Once that decision has been made, clear Terms of Reference should be developed.

#### **IV. Notification of Changes to the SIR Process**

External participants recognize the need for change as the SIR program continues to develop and evolve, and suggest that notification of changes in the processes that affect them should happen prior to implementation so that they can prepare for the change.

**RECOMMENDATION FIVE:** Quality Assurance recommends that if there are changes made within the SIR program that the Children’s Advocate determines would significantly affect external collaterals notification of such changes be made in advance of the planned implementation to allow externals the opportunity to prepare to receive the changes.

## THE SPECIAL INVESTIGATIONS REVIEW REPORTS

This section outlines feedback provided regarding the SIR reports. Specifically discussed will be feedback from external participants on how the reports are written (e.g. language, context, incorporated materials etc.) along with suggestions for improvements to the reports.

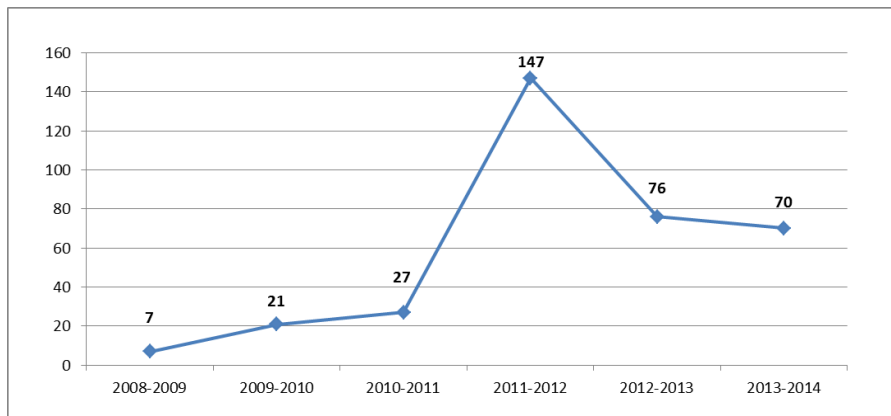
### **Feedback and Suggestions for Improvement to SIR Reports**

External participant feedback regarding the reports produced within the SIR program indicated that much advancement has been made over the past 6 years, including:

- Improved timeliness of the report being sent out
- Improved use of objective language throughout the SIR report
- An increase in positive feedback directed towards agencies and/or authorities
- Representation of the perspective of the child

According to Figure 1, there has clearly been an increase in timeliness regarding how long it takes for a report to be completed. Fast turn-around times increases relevancy of the findings and/or recommendations which is helpful for the receiving agency and/or authority.

**FIGURE 1: Number of SIR reports completed per fiscal year**



These numbers reflect total reports sent, not number of child deaths reviewed due to completion of 6 aggregate reports: 2 aggregates in 2011-12 (9 children); 3 aggregates in 2012-2013 (16 children); and 1 aggregate in 2013-2014 (14 children).

The introduction of reviews in 2011/2012 allowed for investigators to complete the back-log of cases that were brought over from the OCME. Therefore, the number of SIR reports completed per fiscal year following 2011/2012 represents only cases that arose after Proclamation.

The structure, process, and child-focused lens of child death reports have grown since the time of the program's beginnings. Investigators also spoke to their commitment to ensuring community and cultural context forms a central thread that is woven throughout the process and final report. As discussed, travel to community and opportunities for discussions with relevant service providers, family members,

and other individuals who knew the child have long formed parts of the report development process. External participants acknowledged that many improvements have been made to the reports, and provided further suggestions for continuing to enhance vital aspects of the final report such as the context in which the child lived.

### **I. Enhanced Contextualization of Reports**

Attaining a comprehensive understanding of context (including community and culture) is important in order for the report to reflect the child's situation and ultimately for recommendations to be successfully implemented. SIR staff members travel frequently throughout the province to rural and remote communities in an attempt to obtain cultural and community information that would impact the development of the report. As part of those community visits, investigators typically meet with service provider staff and other relevant community members. Visiting the community and gathering information about the various services and amenities while in community also contribute to an enhanced understanding of the life of the child. If surviving family is present in the community, invitations to meet with the investigator are offered. In some cases, investigators spend multiple days in community or return more than once to build on their local understanding. External participants in this evaluation see tremendous value in having SIR investigators observe community context first-hand and encourage the office to continue to prioritize and develop these opportunities for investigators.

**RECOMMENDATION SIX:** Quality Assurance recommends that the SIR Program Manager engage with the Authority child death representatives at the next scheduled meeting to begin a discussion and obtain feedback on ways in which the contextualization of SIR reports (e.g. community/cultural context and relevancy) may be enhanced moving forward. As this is an area that will evolve over time, it may be beneficial for this to be a standing item for the Authority child death representatives meeting.

### **II. Evident connecting theme for aggregate reports**

Aggregate reports involve investigating the deaths of multiple children and may be used in order to examine the services provided by a specific agency and/or authority and/or to analyze the systemic issues or broad level themes. Aggregate reports have been typically connected either by manner of death (e.g. all the children in the aggregate report died by suicide), or by the agency who provided the service. External participants generally consider aggregate reports to be useful, and an opportunity for investigators to delve deeper in to an investigation, but suggest that having an evident connecting 'theme' beyond solely an 'agency' is important, as is having clearly identified objectives of the aggregate report.

**RECOMMENDATION SEVEN:** Quality Assurance recommends that the intent of an aggregate report and the underlying themes connecting the cases presented are clearly communicated to the parties to whom the findings and/or recommendations are directed.

### **III. Use of the Child's Picture**

Frequently, the front of an SIR report will contain a picture of the child who has died. Some external participants believe that the picture helps convey the importance of the reports as it serves as a reminder that the report is a reflection of the child's life. Likewise, SIR investigators noted that they have a commitment to write "through the eyes of the child," and believe that this commitment is visually represented through use of the child's picture. In addition, SIR staff indicated that while the pictures may come from a variety of sources, they are often provided as part of the investigator's interactions with surviving family members. SIR staff noted that there is careful thought and consideration given to the decision of whether to use pictures and that cultural tradition play a role in that decision-making process. Given that some external participants expressed concern about the use of the child's picture, further clarity is warranted. Currently, the SIR Policy and Procedures Manual does not reflect the discussions and decision-making processes that occur on the use of pictures.

**RECOMMENDATION EIGHT:** Quality Assurance recommends that the SIR Policy and Procedures be updated to address the use a child's picture in all levels of reports. It would be important for the procedures to address cultural considerations and sensitivity as well as the documentation of the source of the picture in the final SIR report.

### **IV. Development of Recommendations**

Main components of the SIR reports are the 'findings' and 'recommendations' that are developed out of the investigation. Recommendations are developed for the purpose of improving the quality of care and services provided to children and youth, and to reduce the likelihood of a death occurring in similar circumstances.

External participants noted that over the six years, the development of report recommendations has continued to evolve and improvements have been made in the development of recommendations, including:

- Increased use of objective language
- Simplifying the process for recommendation responses by ensuring that only one party is named in each recommendation.
- Improved relevancy of the recommendation
- Increased recognition of agency worker case load and other variables that impact workers' abilities to follow Provincial Standards

External participants generally responded positively when asked about the development of recommendations. There were suggestions for improvement which included: equitable response to

similar issues across the system; simplified recommendations that directly speak to action points the agency and/or authority must take; stronger incorporation of cultural context; consideration of funding the agency and/or authority has available to implement the recommendation; and identical wording on repeat recommendations. External participants also suggested that it is difficult to implement recommendations that suggest CFS organizations ‘take the lead’ with non-CFS collaterals.

Internal participants indicated that as the program has continued to evolve there has been recognition of areas where recommendations could be enhanced. Specifically, the development of the Recommendations Spreadsheet, used to track findings and recommendations made in SIR reports, now permits SIR investigators to view previous recommendations made so as to ensure equitable response to similar issues across the system. The Recommendations Spreadsheet also allows SIR Investigators to observe what language was used in previous recommendations to ensure consistent wording is used if a repeat recommendation is issued. SIR Investigators also recognize the need for simplified recommendations and currently make separate recommendations to each party identified in a recommendation. The SIR program has also incorporated the agency/authority/ Division meetings whereby representatives are asked to meet with SIR investigators prior to finalization of the SIR report. This meeting provides an opportunity for external representatives to clarify information in the report, address questions and/or concerns regarding recommendations within the report and provide additional information.

#### **V. Clarification over the use of Findings**

‘Findings’ are summary statements that describe specific elements of the investigative analysis. External collaterals have greatly appreciated the increase in ‘Positive’ findings, or findings that acknowledge when an agency and/or authority has performed well. Some externals asked clarification questions over the purpose of a finding, specifically asking when and why is a finding made? What is expected of agencies/authorities/and the Division in circumstances where there is a finding but no recommendation? Do findings need to be tracked internally and/or externally and if so, why?

**RECOMMENDATION NINE:** Quality Assurance recommends that the SIR Program Manager update the policies and procedures to accurately describe the use of findings and in what circumstances findings are issued. It would be beneficial for the SIR Program Manager to inform the Authority child death representatives of this at the next scheduled meeting.

#### **VI. Clarity over the process involved when a recommendation is made to a non-CFS organization/department**

One primary objective of *The Children’s Advocate’s Enhanced Mandate Act*, and a reason why the responsibility was transferred from the Office of the Chief Medical Examiner’s to the OCA, is for SIR to review the standards and quality of any publicly funded social service that was provided to the child. In other words, the intent of the enhanced mandate was to broaden the scope of the review beyond the CFS system. Internal and external participant feedback indicates that there continues to be

confusion about the development of recommendations made to non-CFS organizations. Furthermore, there is confusion by external stakeholders on how to ensure recommendations made to non-CFS organizations are assessed and implemented.

**RECOMMENDATION TEN:** Quality Assurance recommends that the Children’s Advocate communicate with external stakeholders, specifically the Child and Family Services Division and the Manitoba Ombudsman, in an effort to develop a comprehensive understanding of the process involved when a recommendation is made to non-CFS organizations and/or departments.

### **FUTURE DIRECTION**

External and internal participants expressed feedback on what their hopes for the future of the SIR entail. Several ideas as suggested by external participants include:

- An expansion of advocacy within the SIR program. External participants communicated that when SIR was first initiated, they had hoped that SIR would provide more systemic advocacy in order to put pressure on the government to ‘do more’. Externals express a desire to see a stronger move to address fundamental issues that are underlying systemic concerns.
- When considering the involvement of other, non-CFS related systems, agencies are looking to SIR for suggestions on how to move forward in addressing the overlap over systemic issues as experienced in multiple systems.
- Externals would like to see SIR reports advocate for the availability of funding that would adequately support service delivery.

External participants recognize the need for system-wide improvements, and acknowledge the limitations SIR experiences legislatively and provisionally. SIR is limited by its provincial jurisdiction in terms of the ability to compel some federally funded organizations to provide case-related materials. The legislative mandate also restricts publicly distributing SIR information which limits community outreach work and public accessibility to knowing what is in the reports.

SIR staff desire increased responsibilities that would be derived from having a stronger legislative mandate. Specifically, SIR staff would like enhanced ability to:

- Advocate systemically
- Look at what funding is available for service delivery and assess how funding is being utilized
- Provide information to the community, especially to family members of the child who has died, and to disseminate knowledge as acquired through conducting SIR investigations via public reporting, education workshops and other forums such as conferences

## **CONCLUSION**

The primary goal of this program evaluation is to collaboratively identify the strengths of the SIR program and the areas that could be improved upon for the purpose of enhancing the value, meaning and performance of SIR work as we move forward. Commitment by SIR staff, OCA staff, and external collaterals demonstrated by their participation in this evaluation, is evidence of the collective desire to achieve future success within the SIR program. The recommendations derived from the findings in this evaluation are intended to strengthen and stabilize the program as the program continues to develop, while recognizing the accomplishments the SIR program has attained thus far. It is therefore desired that this evaluation will promote acknowledgement and recognition of the work conducted within the SIR program, along with a well-informed understanding of areas that should be addressed in the future. The Quality Assurance program will assess implementation of recommendations derived from the SIR Program Evaluation (March 2015) for annual reporting purposes.

## **ACKNOWLEDGEMENTS**

On behalf of the Children's Advocate, the Quality Assurance program would like to extend our sincere gratitude to all those who participated in this evaluation. The feedback that was provided by both internal and external stakeholders was instrumental in the development and completion of this evaluation. Specifically we would like to thank:

- Minister of Family Services
- Office of the Chief Medical Examiner
- Office of the Manitoba Ombudsman
- Child and Family Services Division
- First Nations of Northern Manitoba Child and Family Services Authority
- General Child and Family Services Authority
- Metis Child and Family Services Authority
- Southern First Nations Network of Care Child and Family Services Authority
- Seven (7) child and family services agencies who participated
- Office of the Children's Advocate staff members



# Children's Advocate

Unit 100-346 Portage Avenue

Winnipeg, Manitoba CANADA R3C 0C3

Tel: (204) 988-7440      1-800-263-7146      Fax: (204) 988-7472

Facebook: [facebook.com/OCAvocate](https://www.facebook.com/OCAvocate)

Twitter: [@OCAvocate](https://twitter.com/OCAvocate)

[www.childrensadvocate.mb.ca](http://www.childrensadvocate.mb.ca)