



COMMISSION OF INQUIRY INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF PHOENIX SINCLAIR

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listen, you
can't hear
METM



MANITOBA'S
Children's Advocate

ANNUAL REPORT

April 1, 2008 - March 31, 2009

April 1, 2009 - March 31, 2010

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Annual Report of the Office of the Children's Advocate of Manitoba

April 1, 2008 - March 31, 2009

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Acknowledgements

The Children's Advocate wishes to extend acknowledgement and gratitude to:

The people who work in the Office of the Children's Advocate, from our administration reception people who greet callers and welcome all who come through our door, to our intake assessment officers, advocacy officers, special investigators and managers who work so diligently with some of the most disturbing and tragic situations, and put forward such commitment, strength and dedication on behalf of the children they represent.

Even more than the hardship of witnessing these tragic situations, is the knowledge that many of Manitoba's children have to live through these horrific realities. Some die before they can be helped.

The OCA would also like to welcome the members of the newly formed Advisory Council to the Special Investigations Review Team. We appreciate the wisdom and years of practice experience they bring to share with the team.

Bright Spots

We commend caring foster and adoptive parents; schools, health care workers, child and youth care workers, shelter staff and all those working toward bettering the lives of children. With the number of children in the care of Manitoba's child welfare system being equal to the population of a town the size of Dauphin, Manitoba (approx. 7,906), we urge them to never give up but to continue in their role of providing strong support to the children and youth of Manitoba.

We would also like to acknowledge the four authorities for their involvement with the Youth Engagement Strategy; the goal of which is to ensure that young people who come into contact with the child welfare system have as good an experience as possible, and have an active part in their planning.

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The History and Role of the Children's Advocate in Manitoba

The Office of the Children's Advocate (OCA) was created under *The Child and Family Services Act* and proclaimed April 1, 1993. The office originally operated under the umbrella of the Department of Family Services and the Children's Advocate reported to the Minister of Family Services. In 1996, consistent with legislative requirements, an all-party committee was established to conduct a review of the office with public hearings commencing in May 1997.

On March 15, 1999, in response to recommendations arising from the review, the Office of the Children's Advocate became an independent office of the Legislative Assembly. It currently operates at an arm's length relationship to the child and family services system. It exists to represent the rights, interests and viewpoints of children and youth who are receiving, or are entitled to receive, services as prescribed under *The Child and Family Services Act* and *The Adoption Act*. The Children's Advocate is empowered to review, investigate, and provide recommendations on matters relating to the welfare and interests of these children. The Children's Advocate prepares and submits an annual report to the Speaker of the Legislative Assembly.

On April 8, 2005, the Lieutenant Governor in Council, on the recommendation of the Standing Committee of the Assembly on Privileges and Elections, appointed Ms. Billie Schibler as the Children's Advocate for a three-year term and a reappointment for another three-year term, which commenced on April 8, 2008.

On September 15, 2008 *The Child and Family Services Act* was amended, making the Children's Advocate responsible for conducting a review of services after the death of a child who was, or had been, receiving services through the child welfare system within a year of the date of his/her death.

The Mission And Principles Of The Children's Advocate

The Office of the Children's Advocate, in carrying out its function, is tied to best interest provisions of both Acts. The best interests of the child, shall be given paramount consideration in all activities carried out by the Office of the Children's Advocate staff when representing a child.

Provision of Advocacy Services

Mission Statement

The Office of the Children's Advocate is to advocate on behalf of, and with children and youth, to animate their voice and ensure their rights, interests and viewpoints are valued, respected and protected.

Principles

- The principle of **empowerment** for children and youth.
- The principle of respect for the **dignity** of children and youth, and to their **right to be heard**.
- The principle of **the family** as the primary source of nurturing, support and advocacy for children and youth.
- The principle of **equity** for all children and youth and the principle of **respect for diversity**.
- The principle of **the least adversarial approach** to finding solutions for children, youth and their families.
- The principle of the **community's collective responsibility** for providing resources and services to children, youth and their families.
- The principle of a system that is **responsive** to the needs of children, youth and their families.
- The principle of **community outreach** as an ongoing process.
- The principle of respect and recognition of the **relevance and impact of culture in First Nations and Métis communities** as it relates to their children and youth.
- The principle of respect and recognition of the **diversity and importance of culture in minority groups** as it relates to their children and youth.
- The principle of recognition and acknowledgement of the **existence and relevance of youth sub cultures** within the dominant cultures of communities served by the Office of the Children's Advocate.
- The principle that the **vision of the United Nations Convention on the Rights of the Child** is the cornerstone of the advocacy principles, practices and efforts embraced by the Office of the Children's Advocate.

Provision of Special Investigation Reviews

Vision

By honouring the spirits of children who have died, our vision is a society in which the safety, well-being and best interests of all children are paramount.

Mission

Our mission is to advocate for the rights of all children to quality services by:

- Giving voice to children who have died.
- Investigating and reviewing standards, programs and services that were or could have been provided.
- Reviewing circumstances surrounding the death of a child related to standards or quality of care.
- Identifying ways in which programs and services can be improved.
- Making relevant and culturally appropriate recommendations.

Principles

- In a manner that respects the inherent dignity of all persons.
- By conducting timely reviews that are inclusive and accountable.
- By honouring the voice and life of the deceased child and the privacy of the surviving children and their families.
- Viewing services as integrated, seamless and child-focused.
- Through the eyes of the child.

In practice, the principle of working "**through the eyes of a child**" means: Maintaining a primary focus on the needs of the child and the extent to which standards, programs and services met, or could have met, those needs.

- Considering the context in which services are delivered.

In practice the principle of **considering the context** in which services are provided means: Investigating the systemic and community factors that impact the reality of service delivery.

The Importance of Having an Independent Children's Advocate

Advocates challenge the system. They point out current practices, policies or legislation that are not meeting needs and expectations. Advocates work for change ... and change is not always easy for people to accept. Advocacy can create tension, but can improve the system.

Children especially need advocates. They live in a world where adults make decisions about their lives. They have a voice but they have virtually no legal power to make anyone listen to that voice. Our experiences speaking with children and youth in the child and family services system have shown us they often feel they have no say in what happens to them.

Our mission is to animate their voices and ensure their rights, interests and viewpoints are valued, respected and protected. Our advocacy efforts and services are child-centered, family-oriented and anchored in the community. They are delivered in an ethical, culturally sensitive and respectful manner.

A Note about the 2008-2009 Report

Billie Schibler took leave from her post as Children's Advocate in April 2010, prior to the completion of the 2008-2009 annual report. As a result, this report primarily represents the views, comments and perspectives of Ms. Schibler, supplemented or revised as necessary by the comments of the Acting Children's Advocate, Bonnie Kocsis.

A Message from the Children's Advocate



In accordance with Section 8.2 (1)(d) of *The Child and Family Services Act*, I respectfully submit this document as my annual report for the time period beginning April 1, 2008 to March 31, 2009.

This is my first annual report since being re-appointed for a second three-year term as Manitoba's Children's Advocate, which sadly is the shortest term of any of Manitoba's Independent Officers and of any Canadian Children's Advocate. I note this because as I work toward completing my final term, I am reminded of the continued challenge of maintaining knowledge and awareness of the ever-changing world of child welfare. I feel that I am just beginning to hit my stride understanding the complexities of this important role of providing a consistent voice for the children of this province. One gains all this knowledge and insight and then it is time to move on and someone new must begin the vast learning process once again of managing the complexities and responsibilities of this role. Previous advocates have noted the same limitations of a maximum of two three-year terms.

In a world where children and youth in the child welfare system most often face a revolving door of workers, foster families, schools and attachments, they deserve to have at least one consistent voice to advocate for them. It cannot be overstated that this gained knowledge provides strength and power to the voices of those children and youth who too frequently are otherwise unheard.

In this past year, the OCA has provided advocacy services for 1803 children, youth, and families. With our new storefront location in the heart of downtown Winnipeg, we have increased our visibility and can now provide easier access to those seeking our services. The decision to move our office was necessitated by the rapid growth of the OCA with the addition of Special Investigation Reviews into the death of a child or youth who had been (or whose family had been) receiving service from the child welfare system within one year of the date of the child's death.

In the past, we have talked about the roles of the child welfare system to strengthen families and we



have talked about the need for families to heal when there has been a crisis or a failure to provide a safe environment for their children. We spoke about how all families will encounter a time where they will need help and that it is not helpful if society views the seeking of help as being weak or deviant. We emphasized that reaching out for help shouldn't be seen as something shameful or bad. We asked how to change the tone of child welfare. What does the child welfare system need to do to help the public view them as more of a supportive resource rather than one that breaks families apart?

As Manitobans, we all have a responsibility toward the health and well being of our province's children. You can't say it takes a village to raise a child and then walk away! We all have a hand in it!

Respectfully Submitted by

Billie Schibler
Children's Advocate





AN OVERVIEW OF THE MAJOR INITIATIVES UNDERTAKEN BY THE OCA

2008 - 2009

Special Investigation Reviews

On September 15, 2008 *The Child and Family Services Act* was amended, making the Children's Advocate responsible for conducting a review of services after the death of a child who was, or had been, receiving services through the child welfare system within a year of the date of his/her death. The amendments also authorize the Children's Advocate to review the standards and quality of any other publicly funded social services, or publicly funded mental health services, or addiction treatment services that were provided to the child or in the opinion of the Children's Advocate should have been provided. This review is known as a "Special Investigation Review."

The formation and development of the Special Investigation Review Unit (SIRU) was a priority following the rolling out of the Children's Advocate's Enhanced Mandate. This required considerable effort in familiarizing agencies and publicly funded social services with our new mandate and responsibilities and establishing protocols with key organizations.

The broadened mandate has allowed Special Investigators to move beyond a file review and significantly increase the scope of their enquiry into service provision. Review findings are supported by information on the community context in which services are provided. In addition, surviving family members and/or caregivers are invited to contribute their perspective on service delivery. This has required travel to communities which has been critical in understanding the complex environment of service provision to families by agencies providing service to both "on" and "off" reserve communities. Interviewing families and speaking with key stakeholders in the communities visited (as well as interviews with staff) has provided a more comprehensive understanding of the issues facing service delivery. Overtime, this will provide for improved recommendations that speak to the complex issue of service delivery in a multi-jurisdictional environment.

Residential School Apology by Federal Government

On June 11, 2008, the Government of Canada formally apologized to the First Nations, Inuit and Métis people of this country who had been victims of abuses and violations in the residential school system.

The Government of Manitoba followed this apology with its own. Through discussion in Manitoba's Legislative Assembly, it was recognized that the breakdown of family units, the over-representation of Aboriginal people in correctional facilities, addiction facilities and in child welfare could be attributed to the effects of the residential school system. While the apology was necessary and long awaited, it did not include a direct apology to the children and youth who are currently impacted, many of those in our child welfare system.

As of March 31, 2008, Manitoba Family Services and Housing, in its annual report, listed 7,837 children in the care of a child welfare agency. Of the 7,837 children in care, 86% were of Treaty Status, Non-Treaty, Inuit or Métis ancestry.

The Children's Advocate puts forward a call to action for Canada to recognize the state of Aboriginal children in this country. As the generational victims of the effects of residential school, they need to be heard as an important voice in the Federal Truth and Reconciliation process. We need to move beyond the initial adult survivors to understand the perspective of the youth who have inherited this sad legacy.

***Child welfare
also needs
to say sorry!***

Can You Hear Me Through the White Noise?

By Laurie Harding

Can you **Hear** what I am telling you?
When I look away,
When I don't answer,
When I look blankly through you?

Do you **Want** to know?
Or is it too uncomfortable?
Too awkward?
Too ugly?

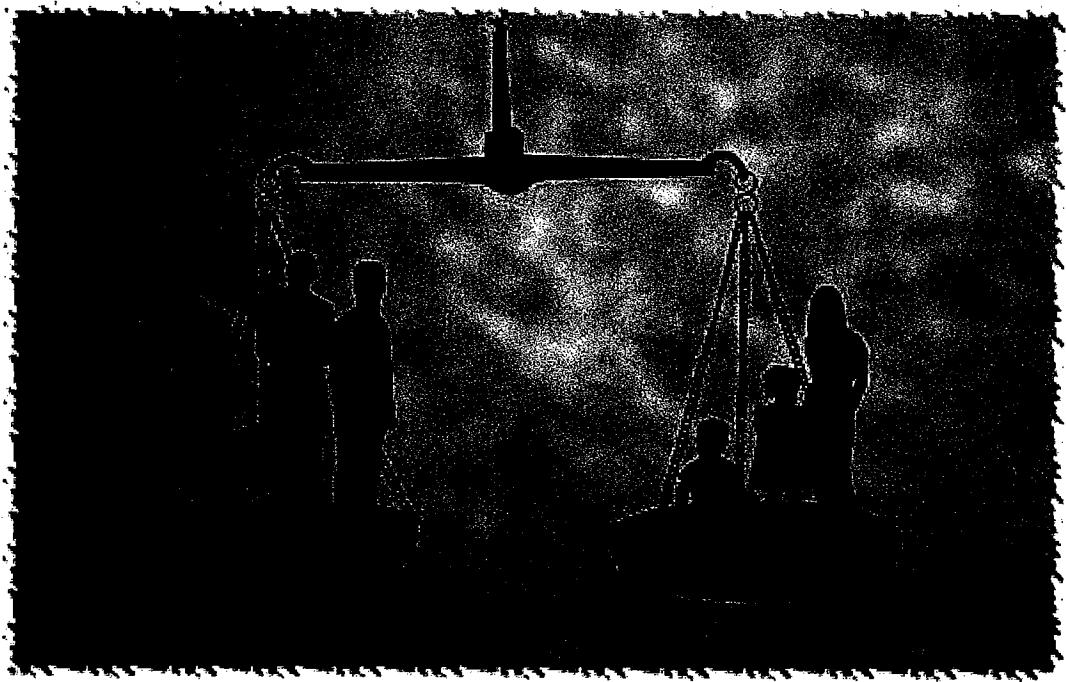
Speak to me with your Eyes,
Your Heart,
Your Soul,
Your Being.
Can you, hear me, see me, Feel my Pain?

Are you **Worth** my time?
Or is this all the same boring Rhetoric?
Hearing your-Self speak?

Already hearing what **You** want to know.
Validating
Measuring
Quantifying,
Proving **Your** point.

What about Mine?
Does it even matter,
..... **Do I?**

Poem as published in the First Peoples Child & Family Review, 2009, Volume 4, Number 1, p. 9





LETTER TO AGENCIES

Letter to Agencies

In the 2007/08 annual report, we talked about the professional accountability of those working within the child welfare system. This year, the OCA encountered several incidents where its requests for information relating to services provided to children and families were met with no response.

Under Section 8.6 of *The Child and Family Services Act*, it is clearly defined that requests for information must be furnished to the Children's Advocate, subject only to solicitor/client privilege. Failure to do so, contravenes the law. Yet, despite numerous, repeated requests over prolonged periods of time, no information was provided nor was any explanation given for the non-compliance.

As a result, in the spring of 2009 the Children's Advocate issued a letter to the Provincial Director of Child Welfare and the CEOs of the four child welfare authorities advising that further violations of non-compliance to the Act in replying to requests for information would result in legal action; the CEOs were requested to share that information with their agencies.

It is important to note that the majority of agencies have historically been quite responsive in honouring their commitment to the legislation and the authority of the Children's Advocate by delivering their information in a timely manner upon request.

It is sad and unfortunate that in light of the many serious issues that have come to the public's attention regarding service delivery and accountability that we would have to be addressing a matter that is so obviously and clearly written in the legislation.

No one is above the law relating to compliance with child and family services legislation, which is designed to reflect the best interests of children.

The Office of the Children's Advocate is accountable to the children and youth it serves. We have a legal and moral responsibility to ensure that their rights under legislation are protected. Failure to comply with our office in furnishing the necessary information prevents us from fulfilling our legal obligations to the children and youth of Manitoba. A child's legislated right to advocacy is seriously undermined when agency personnel and management disregard requests by the Children's Advocate.



UPDATE ON YOUTH JUSTICE PROGRAM REVIEW

Update On Youth Justice Program Review

In two previous annual reports, the OCA brought forward concerns relating to the youth justice system. As a result of our concerns and others brought forward, Manitoba Justice implemented an internal working group (called *Going Forward*) and an external review (Artz/Meyer Review) on the behaviour management practices in youth correctional centres including the use of Lakewood¹ to house special needs youth. Female youth were also housed in Lakewood and received the same treatment as their male counterparts with no recognition of their needs specific to gender. The reviews examined the use of restraints and the inadequacy of services to manage those with special needs including female offenders.

Manitoba Justice reports some significant strides in addressing some of the recommendations stemming from these two reviews and is committed to the continued evolution of programs and services to better meet the needs of youth.

The OCA commends Manitoba Justice for beginning to recognize that a totally different kind of service is needed for youth criminal offenders who commit their acts due to the effects of mental illness, addictions, and fetal alcohol spectrum disorder (FASD).

¹ Agassiz is a youth correctional centre for young offenders. Within the centre is Lakewood, a high security special-handling unit for young male and female offenders.



DISCREPANCY IN SERVICES TO CHILDREN AGING OUT OF CARE

Discrepancy in Services to Children Aging Out of Care

We are pleased that following our 2007 report titled "*Strengthening Our Youth*", there has been a noted increase in the number of young people who have received an extension of care through child welfare services.

In 1999, 19 youths were provided with extensions of care in the child welfare system. A year after our *Strengthening Our Youth* Report was released the number of youth receiving care extensions was 143. However, we did identify that about 500 youth are reaching the age of 18 and leaving the CFS system annually. The question remains; what happens to the other 350 youth? Does this suggest that the other 350 were adequately supported and secure enough to venture out on their own once they reached age of majority?

We continue to receive calls from youth who struggle significantly. We advocated for one youth, for example, who was denied support and age of majority start up costs. The agency cited that they were not obligated to assist as the youth was a temporary ward rather than being under permanent guardianship. Investigation by the OCA found that despite the "temporary" status, this young person had actually been under CFS care for close to 12 years. This was a disturbing fact in itself given that for over a decade, this child had no permanent care plan. That aside, the fact is the agency's lack of support contravened written policy stating that all agencies will provide youth reaching age of majority and exiting the child welfare system, with start up costs and supports that meet best practice.

Unfortunately, discrepancies in services exist throughout the province. This office has seen examples where two youth receiving services from separate child welfare agencies but residing in the same group home, received vastly different service with respect to age-of-majority support.

It often comes down to a different situational assessment and agency policy. Consider, for example, two youth reaching age of majority who present with obvious challenges, such as difficulty following through on expectations. One agency may regard this as a young person requiring additional assistance, not yet ready to launch out on his own. Another agency may see it as a young person who is demonstrating behaviours that suggest a lack of commitment or cooperation and maturity. While the first agency extends the care of the youth to allow him time to develop those needed skills, the other agency may discharge the youth it is caring for, regarding him as non-compliant. Additionally, one agency may provide up to \$1,000 in start up costs per youth to assist as he/she leaves the care of the child welfare system while the other agency provides less than \$700.

It is the OCA's opinion that all children and youth receiving child welfare services are entitled to the same level and quality of care no matter what agency or authority they or their families have chosen, and no matter where they reside in Manitoba. Extensions of care should also be based on comprehensive and individual assessment of need rather than relying on policy alone.



The number of children in care is equivalent to a town the size of Dauphin, Manitoba. Many have severe needs.



UPDATE TO THE SHELTER REPORT

Update to the Shelter Report

On March 26, 2009, the Children's Advocate released "*Emergency Placements for Children in Manitoba's Child Welfare System*", a 397-page report reviewing the Manitoba Government's progress in implementing the 90 recommendations made in the previous Children's Advocate's 2000 Hotel Review and 2004 Shelter Review.

The Children's Advocate found that 25% of the recommendations made in the previous reports have been implemented by the Manitoba Government and another 38% are in progress, but the state of emergency placement resources for children and youth who require emergency care remains concerning.

When children come into emergency care, it is a time of high emotions and potential volatility. While the OCA cannot support hotels and emergency shelters being the ideal place for children and youth, we understand that the staff in hotels and shelters is largely doing an admirable job in extremely difficult, sometimes dangerous, circumstances. The sample of children and youth we spoke to, primarily regarded the staff and their experiences in shelters positively.

Several factors impact on the emergency shelter system and include the following:

- Emergency placement resources continue to be used for longer periods of time than intended.
- There is a shortage of foster homes and alternative longer-term placement facilities for large sibling groups and for youth with multiple needs and high-risk behaviours.
- There are no standards in place that specifically regulate short-term emergency facilities. A two-tiered system has emerged where some facilities are being developed under the Places of Safety designation, where monitoring is the responsibility of the placing agency. This may differ from the provincial licensing standards developed for longer-term residential treatment facilities.

- The number of children in care has increased by over 1,700 in the last five years.
- Majority of children and youth in care are Aboriginal.

To improve the emergency shelter system to adequately meet the needs of this population of children and minimize risk, we need the following:

- A centralized office, housed as part of Manitoba Family Services and Housing that is responsible for monitoring, tracking and regulating short-term emergency placements.
- Commitment by agencies to ensure their staff is entering information on children and youth on the Child and Family Services Information System (CFSIS) in a timely manner including placement information.
- Enhanced skill development and training for shelter staff.
- Additional services such as health and education specialists attached to the shelters.
- Formal assessments on the children in order to better plan for them.
- Collaboration between government departments such as Family Services and Housing, Education, Justice, and Health to determine the services required for each individual child coming into emergency shelters, and to develop a seamless service delivery to meet their specific needs.
- Collaboration between government departments to develop specialized residential resources for longer-term placements for children and youth with severe high needs and risks.

The Children's Advocate is troubled by seeing instances where workers are not entering information on children and youth into CFSIS in a timely manner so the system may not have updated information on where that child is or what is taking place in his/her care plan. This is a concern the OCA has voiced to the child welfare system many times over the years.

The Children's Advocate is also very concerned by the high number of reported incidents of aggression and assaults by children and youth in emergency placements.

Emergency shelters are highly complex environments and some can be potentially volatile. Often little background is known of the child's emotional and medical state coming into the shelter. Shelter staff needs the highest level of skill and training to be able to immediately assess risk, defuse crisis situations and accurately determine the emotional needs of the children and youth who are suddenly thrust into emergency care.

We knew emergency shelters were being used for sibling groups and children and youth with highly complex special needs, but we discovered that the complexities of those with special needs were much more profound than we had assumed.

Some children and youth remain in emergency shelters far too long because they are extremely difficult to place with foster families. These children have severe physical or emotional needs or exhibit behaviours that may cause harm to themselves or others.

Locating suitable long-term placements for children and youth in emergency care is further compromised by the absence of a standardized, province-wide placement information system that tracks and shares all bed space vacancies and related information between agencies.

We will continue to voice recommendations made by the previous Children's Advocate, Janet Mirwaldt, around the need for a centralized placement system for the province. It makes practical sense to have one, province-wide database that is immediately available to all workers that can identify current placement resources, the level of skill and expertise at each placement, and its availability. This is imperative because everything happens at lightening speed when kids come into the child welfare system on an emergency basis.

Presently, there are 25 child and family services agencies in the province, each with its own set of foster homes and no standardized system of assessing information on vacant foster bed spaces between the agencies. Inequities in resources exist between jurisdictions.

Also concerning is that a foster home may be shut down due to concerns in one jurisdiction only to resurface as a placement resource in another. This happens because there is no central monitoring body or system to ensure that a closed placement does not re-open elsewhere. A centralized database would allow for accessing and sharing information such as restrictions and alerts on caregivers/foster parents, as well as conditions that might be detrimental to children and youth in their care.

This tool could also identify those in the system with specialized skills and strengths so they can be matched to those children and youth who present with exceptional needs (E.g., fragile health, chronic illness, FASD etc.).

Information contained in the *Emergency Placements for Children in Manitoba's Child Welfare System Report* is based on data and facts obtained during and prior to the period from April 2007 to September 2008. The complete report is available at www.childrensadvocate.mb.ca.



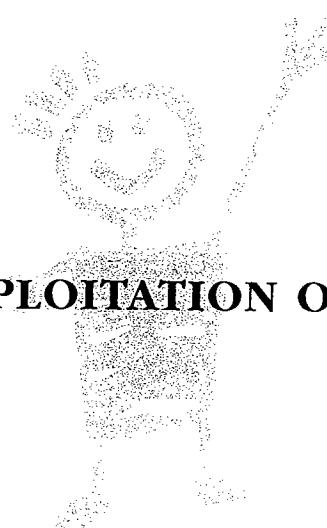
INFORMING CHILDREN AND YOUTH OF THEIR RIGHTS

Informing Children and Youth of Their Rights

At this time, the right to information is not well addressed in child welfare. *The Rights of Youth: Youth in Care* publication, dated April 2007 was produced jointly by the Manitoba Human Rights Commission, the Ombudsman's Office and the Office of the Children's Advocate. It tells youth that they have the right to be involved in their case planning.

Therefore, the Office of the Children's Advocate recommends the following:

- That agencies recognize the importance of sharing information with children and youth in their care, and furthermore, provide the time, training and resources necessary to consistently provide this service to these young people.
- That provincial case management standards be developed to include guidelines for providing children/youth with ongoing information about their history and life circumstances.
- That agencies develop processes to gather thorough information at the point when the child enters the child welfare system and ensure it is included on their file.
- That agencies review their child-in-care files to determine if the child's information is thorough and develop a plan to locate missing information, as per the proposed provincial standards noted in point two of these recommendations.



SEXUAL EXPLOITATION OF CHILDREN

Sexual Exploitation of Children

In last year's annual report, we advised that there were major voids in the system regarding sexually exploited youth and children. Society's most victimized, at-risk children were routinely falling through the cracks in our child welfare system.

At the time of the writing of this annual report, there has been a lot of recognition and community action, including initiatives from both the provincial government and First Nation's leadership, on the need to develop a complete strategy to protect vulnerable children and youth who are being sexually exploited, many of whom have gone missing and some of whom have been found dead.

A community coalition of those involved in providing service to these youth met with members representing the Healthy Child Committee of Cabinet on January 29, 2008 to present recommendations on ways to assist these children. The primary issue that brought this coalition together was the lack of response from CFS and the lack of resources for those who identify and wish to help these children, including the police and outreach workers in various organizations. The recommendations attempt to address five primary needs:

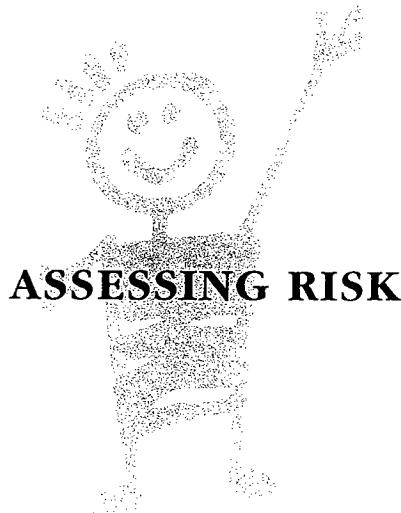
- Outreach and emergency intervention
- Emergency shelter
- A rural healing lodge
- Training and education
- System linkages

The Minister of Family Services and Housing facilitated a summit entitled, "Front Line Voices: Manitobans Working Together to End Child Sexual Exploitation." He invited a broad range of service providers and survivors of sexual exploitation to make recommendations. There were two gatherings

in March 2008, one in Thompson and the other in Winnipeg. The province gathered recommendations. By March 2009, we had not received any response from the government to the recommendations, nor had we been given the compiled list of recommendations that came from these gatherings.

The Children's Advocate recommends:

- Provision of a liaison worker who would work with youth, the agencies and community through the abuse units based out of the All Nations Coordinated Response Network (ANCR).
 - While there have been a number of meetings with ANCR and the Southern Authority regarding this important matter, and all parties recognize its importance, there has not yet been a liaison assigned to this position. While we appreciate that there has been a lot of discussion about the situation, there has not been a lot of action.
 - Manitoba Family Services and Housing says ANCR has the responsibility to allocate a position and ANCR says they are overworked and don't have the staff for this position. Some of our province's most vulnerable youth remain at risk. This has to happen NOW!
 - There is also a need to have a resource that specializes in this field that is available to the many communities outside of Winnipeg who are struggling with this issue.
- Provision of resources necessary to continue in the development of regional teams, and to implement the strategies that are identified by those teams to better allow for regional differences in the sexual exploitation of the youth in their community.
 - We understand there has been a recent decision to hire another staff person to work within the Child Protection Branch to help develop regional teams to work on the Manitoba Strategy. There will also be funding provided for the development of these teams. There is also discussion regarding the scope of these regions. Although the Northern Region serves both Thompson and The Pas, there may need to be a separate team for each community. There are additional challenges in addressing this issue in small, remote communities where sexual exploitation is sometimes rampant.
- Provision of an updated definition of Child Sexual Exploitation in *The Child and the Family Services Act* to ensure that agencies understand their responsibilities toward these children.
- Emergency resources to care for these children when they are identified. A drug stabilization facility is needed for those who are struggling with substance abuse. Those with addictions must address those issues before they can heal in other areas. Some youth experience ridicule and shaming by other residents if they are placed in the same shelter with a generic population. Therefore, it would be ideal to have shelters dedicated specifically to this population.
- A rural healing lodge for longer term healing and care, providing these youth with the nurturing they so desperately require. A rural setting is vitally important, as youth have reported to us that when they are placed in the city, it is often too difficult for them not to be lured back to the 'streets'.



ASSESSING RISK

Assessing Risk

At the time of writing this report, the public has become aware of a number of child death tragedies and brutalities that occurred through violence and homicides. The media have covered these deaths extensively.

This has led many to ask, "When is a child seen to be in need of protection and how do we define risk?"

Training for risk assessment has become a consistent concern identified by this office in various reports. Part of risk assessment is being able to determine what abuse is. We know it is value-based by the person making the initial assessment. Bias is influenced by factors of severity or caseload size, urgency of other matters, opinions and how relevant these situations are to the assessor's personal experience. This can also be impacted by how much the worker likes the caregiver and if the caregiver is cooperative. How well the child or youth is liked by the worker as well as the worker's own experience or personal exposure to abuse and victimization may also play a role.

The purpose of risk assessment is to allow service providers the ability to predict and evaluate risks present in families and in particular, to determine the risk of future maltreatment in order to develop necessary interventions². Risk assessment needs to be ongoing as part of everyday service planning.

What happens when children return home? How well and how often and for how long does the child welfare system continue to assess safety, or how well the reunification is going? These are questions asked of us by people calling the OCA with concerns regarding children.

Our office sees examples where risk assessment is not being fully utilized as part of family assessment. For example, the basic risk assessment for child maltreatment may be done but may not note environmental factors such as violence in the home and the role this plays in safety for a child or youth. The role addiction issues play is another area that is often seen in isolation apart from risk and family assessment.

We need a standardized risk assessment tool and we need workers to be trained in risk assessment. It is our understanding that such a tool is currently being developed by the Child and Family Services Standing Committee; Changes for Children Initiatives.

² Trocme, Nico (2004)



ADDICTION AND CHILD WELFARE

Addiction and Child Welfare

Based on comments by addiction specialists and media reports, the availability and multitude of dangerously addictive drugs that have a serious impact on the safety and development of children are becoming more prevalent in the community. Reports on the lack of services are commonplace and workers tell us of the difficulty in securing treatment for their clients. The result is a longer period of care for children whose parents need to complete addictions treatment. This is compounded by a lack of specialized treatment for substances such as OxyContin and crack cocaine.

The province needs to be flexible and address the various trends in substance abuse and develop resources to meet those changing needs.

Presently, there are not enough resources for the number of people requiring addictions help. The access to drug addiction services is not readily available in a seamless process without a multitude of hurdles and "wait lists" and there is no recognition of the need for longer-term resources to effectively change people's lives. Most programs end within 28 days and that is simply not enough support time for the addicted person to make the kind of lasting lifestyle and behavioural changes needed to ensure safety for the children involved.



YOUTH ADDICTIONS

Youth Addictions

The Provincial Government has been able to intervene with respect to youth addiction through legislation entitled, *The Youth Drug Stabilization Act*, in order to protect a child or youth from his/her own addictions.

This legislation was designed to assist parents to keep their children safe when their children's addiction issues have become so severe that they are unable to make sound decisions on their own behalf. For some advocates and protectors of youth rights, this piece of legislation continues to raise great concern as to whether or not government has overridden or violated a young person's rights and freedoms, particularly given that these children and youth are detained against their will through the powers of the Act.

As a committed proponent of children's rights as outlined in the United Nations Convention on the Rights of the Child, this creates a significant dilemma for the Children's Advocate. While we may agree that it is sometimes necessary to put youth in locked facilities to keep them safe, we continue to state the importance of making it mandatory to have access to a Children's Advocate to insure that their right to be heard is being protected, consistent with Article 12 of the United Nations Convention on the Rights of the Child which states:

"Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

The debate between safety versus rights continues, however, there can be a middle ground that ensures both if youth are afforded an opportunity to speak to any plan being developed for them. It is our understanding, that the *Youth Drug Stabilization Act* has seen a number of youth challenge their placement in this secure facility.



COMMUNITIES NEED TO DO THEIR PART TOO

Communities Need To Do Their Part Too

The high demands on child welfare agencies are indicative of communities that are not healthy and strong (whether urban or rural). These communities cannot stand back and rely solely on the child welfare system to address their pains. It is essential for communities to assume the greater part of the responsibility to strengthen and heal themselves, protecting their most important citizens (the children) and making them the focus of their community's future and present wellbeing.

Clearly, some communities have very limited capacity. It is always easier when there is something to start with – something that you can strengthen. The community's social determinants for health and well-being need to be assessed to see what capacity is available and build on those capacities. The response to the question of who is responsible for addressing capacity building and supporting and sustaining healthy environments for children and youth is a resounding, "all of us".

In addition, systems also need to work together in tandem with the community. Various departments need to come together to implement "wrap around services".



YOUTH RIGHTS TO LEGAL COUNSEL

Youth Rights to Legal Counsel

This year the OCA has been made aware of cases where youth have been charged with abuse offences and, subsequently, may be placed on the Child Abuse Registry. There is nothing in *The Child and Family Services Act* that ensures legal representation for youth in matters pertaining to them, including when an application is made to place a youth on the Child Abuse Registry.

The OCA believes that youth should be provided the opportunity to have their views heard, including in judicial matters and settings. In cases where the youth's views or actions may be in contravention of a child protection agency's vision, principles, or mandate, agency legal counsel would be in a position of conflict of interest in providing legal counsel to the youth. With this in mind, youth should be provided the opportunity to have an independent legal advocate whose role is to ensure that the youth's views are heard and that their legal rights are represented. Youth should not be expected to rely on agency legal counsel to represent their views – especially when their views may differ from those of the agency.

Who speaks on behalf of the youth's best interests? Many youth do not even know they have the right to independent counsel. In 2001, Legal Aid Manitoba ceased to fund amicus curiae appointments made by the court. While amicus curiae are not a legally recognized party to a proceeding, they are able to advise the court on legal issues related to the specifics of a case in question. Where a youth is a ward of an agency, the agency, as the legal guardian, can refuse to provide the youth independent legal counsel. The OCA has been made aware of this occurring within the child welfare system.

Article 12(2) of the *United Nations Convention on the Rights of the Child* recognizes a child's right to be heard in judicial settings and administrative proceedings. The onus to ensure this occurs should not rest on the children and youth.

The Children's Advocate recommends that youth be advised of their right to independent legal counsel and, that every youth who requests it be given independent legal counsel.

The Children's Advocate recommends that when an application is made to place a youth on the Child Abuse Registry, the youth be given independent counsel - apart from the agency's legal counsel.



COMMUNITY INVOLVEMENT

Community Involvement:

The Children's Advocate continues to be involved in youth rights activities on a national and international level. This is carried out mainly through involvement with other youth serving organizations or advocacy offices such as:

- Canadian Council of Provincial Child and Youth Advocates (CCPCA)
- Child Welfare League of Canada Board of Directors

The Children's Advocate also attended conferences that focused on child and youth issues such as:

- Building on Strengths Stone by Stone FASD Conference, Banff, AB
- 9th Annual National First Nations CFS Conference, Edmonton, AB
- Alberta Justice Ministry and Sundance Centre, Edmonton, AB
- The Path to Justice: Access to Individuals with FASD, Whitehorse, Yukon

On a provincial level, the Office of the Children's Advocate attended the following conferences and workshops:

- UNESCO Conference on Rights of the Child, Winnipeg, MB
- Elizabeth Fry: Canada's Missing and Murdered Aboriginal Women, Winnipeg, MB
- Caring Across the Boundaries Conference, Winnipeg MB
- Manitoba Foster Family Network Conference, Winnipeg, MB
- MB Conversation on Youth Resilience Overcoming Challenges, Winnipeg, MB
- National Aboriginal Women's Summit Roundtable, Winnipeg, MB
- 10th Annual Child and Youth Care Grad Luncheon, Winnipeg, MB
- CFS of Western Manitoba Annual General Meeting, Brandon, MB
- CFS of Central Manitoba Annual General Meeting, Portage la Prairie, MB

- RAY Annual General Meeting, Winnipeg, MB
- Honouring Survivors and Those Affected by Residential Schools Reception, Legislative Bldg., Winnipeg, MB
- Cultural Teachings for FASD, Winnipeg, MB
- Knowles Centre Inc., Annual General Meeting, Winnipeg, MB.
- Agassiz Cultural Day, Portage la Prairie, MB
- Awasis 25th Anniversary Celebration, Portage la Prairie, MB
- World Congress on Sexual Exploitation of Children and Adolescents, Winnipeg, MB
- Peguis CFS Annual General Meeting, Peguis First Nations, MB
- Annual Foster Care Conference, Winnipeg, MB
- MB Aboriginal Youth Achievement Awards, Winnipeg, MB
- MKO Chief's General Assembly, Norway House, MB
- National Dialogue on Resilience in Youth, Winnipeg, MB
- Project Neecheewam Annual Board Meeting, Winnipeg, MB
- West Central Women's Resource Centre Children's Rights Workshop, Winnipeg, MB
- Métis CFS Celebration Honouring Our Youth, Winnipeg, MB
- Multi-System Training: Response to High Risk Victims, Winnipeg, MB
- Aboriginal Leadership Initiative, Voices of Aboriginal Adoptees and Foster Children, Winnipeg, MB
- Aboriginal Justice Day, 5th Anniversary of AJI-CWI, Winnipeg, MB

This year, the Children's Advocate and staff traveled to the following communities to provide information on child and youth rights and to address specific concerns regarding children and youth:

- Portage La Prairie
- Brandon
- Sagkeeng First Nation
- Thompson
- Lynn Lake
- Winkler
- Dauphin
- Birdtail Sioux First Nation
- Fisher River First Nation
- Sandy Bay First Nation
- Rolling River First Nation
- Steinbach
- Norway House
- Fort Alexander
- Eriksdale
- Brokenhead First Nation
- Ille de Chenes
- Pansy
- The Pas
- Landmark
- Cross Lake
- Stuartburn
- Blumenort
- Garden Hill

- Riverton
- Rosseau River
- Ashern
- St. Laurent & St. Ambroise
- Birtle
- God's Lake

Presentations and Submissions

This fiscal year, the Children's Advocate and staff of the OCA made presentations to the following organizations:

- Information Matters project team
- UNESCO Conference on Rights of the Child
- CFS of Central Manitoba
- Knowles Centre
- Rolling River School Division, guidance counselors and mentorship program facilitators
- Manitoba Foster Family Network Conference, presenting on youth aging out of the system
- SECFS Training Services, presentation on role and function of the OCA
- Villa Rosa
- Sage Outreach Network
- Needs Inc. re: War Affected Children and Youth
- Sagkeeng Mino Pimatisiwin Family Treatment Centre
- Klinik, Teen Services Network
- World Congress against the Sexual Exploitation of Children and Adolescents
- Peace Begins at Home Program, North End Women's Centre
- Annual Foster Care Conference
- Elizabeth Fry
- MKO Chiefs' General Assembly
- Project Neecheewam Annual Board Meeting (keynote speaker)
- Sagkeeng Family Treatment Centre
- Manitoba Justice
- Youth Recreation Activity Worker Class
- University of Winnipeg, Criminal Justice Students
- Frontier School Division, Teacher In-Service Day
- Inner City Social Work Program 4th year social work graduating class
- Villa Rosa
- Child and Youth Care Worker Students, Red River College

OCA Involvement on Committees

This year the Children's Advocate and the staff of the OCA participated on the following community committees:

- Child Inquest Review Committee (CIRC)
- Provincial Advisory Committee on Child Abuse (PACCA)
- Voices, Manitoba Youth in Care
- Canadian Council of Provincial Child and Youth Advocates

- Advisory Committee for Sexually Exploited Youth
- Child Health Committee, Children's Hospital
- Social Planning Council of Winnipeg
- Child Welfare League of Canada
- CIS Steering Committee (Canadian Incidence Study of Reported Child Abuse and Neglect)

Web Site Statistics

Visits to our website continue to be very popular, largely driven by people viewing and downloading information from the major child welfare reviews we completed and posted on the website. This year more than 184,000 people visited www.childrensadvocate.mb.ca.



Year-end Statistical Analysis Advocacy Services

April 1, 2008 to March 31, 2009

Advocacy Services Program

Year End Statistical Report for 2008 – 2009

April 1, 2008 to March 31, 2009

Advocacy Services	2007-2008	2008-2009
Total Requests for Service	1444	1803
Total Case Files Opened from requests in 2007-08	715	693
Child Inquest Review Committee (CIRC) files	3	—
System Issue Files	10	18
Case Files Open from Previous Year	246	334
Total Cases worked on in Fiscal 2008-09	974	1045
Total Case Files Closed	640	811
Case files remaining open at end of fiscal year	334	234

Systemic Issues and special investigations continue to be an integral part of the mandate of the OCA. This fiscal year, the OCA reports an increase in systemic issue files opened. Systemic reviews are completed where systemic (program specific or system wide) issues are evident; for example, lack of specialized mental health placements for youth. The reviews are usually generated from data gathered at the Information Self Advocacy Assistance (ISAA) level but can be revealed at the advocacy intervention level. The decision to conduct a review occurs when:

- The concern raised is not an isolated or singular incident but occurs across the program or system.
- The incident is of a serious nature where a child's or youth's safety was and continues to be a concern and/or there is a clear violation of a child's or youth's human rights.
- The system has continually failed to effectively respond to the complaints raised.

Some examples of systemic files opened this year are:

Use of Tasers on youth following the death of a teen after a Taser had been used on him. The OCA joined with other provinces such as Ontario to call for a stop to use of Tasers on children/youth.

Another example is a lack of placement resources for special needs youth, such as those suffering from a mental illness who require very specialized placements.

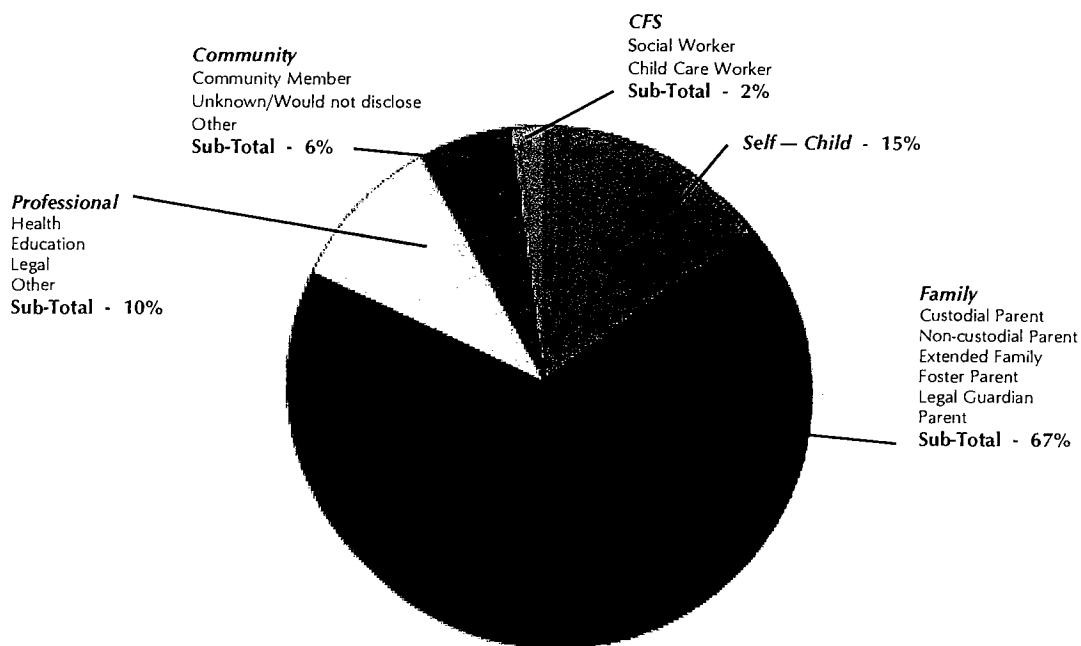
Advocacy Findings and Recommendations

As a result of the concerns raised during our casework in the 2008-09 fiscal year, the OCA made 89 formal, written recommendations to agencies providing child welfare services. These recommendations related to the following:

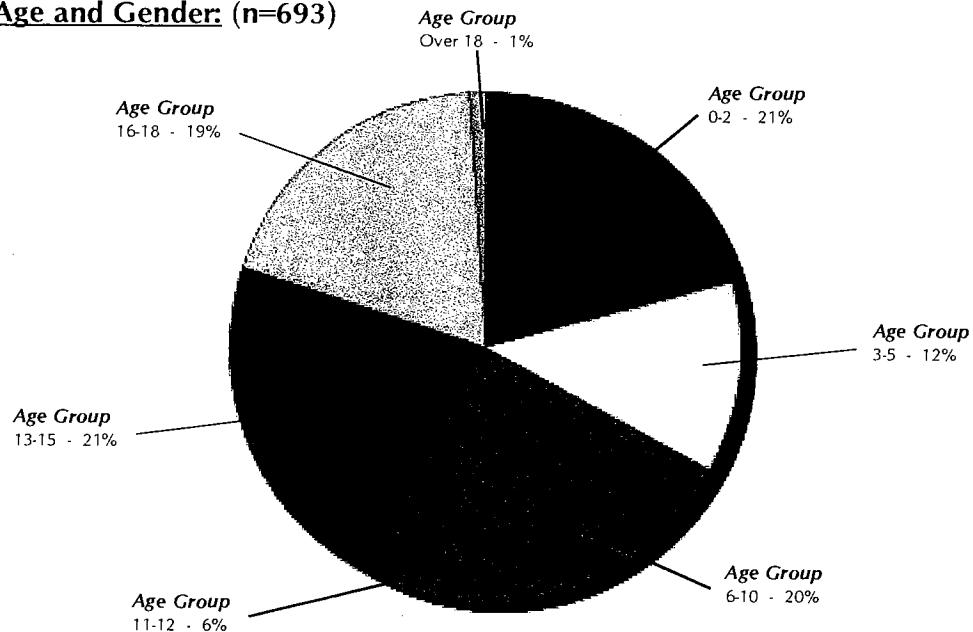
- Developing appropriate placement and support resources for high-risk youth
- Lack of extension of care/age of majority service planning for youth
- Breach of service standards, policies, and best practices related to the following:
 - Licensing places of safety as foster homes where children and youth were staying for extended periods of time.
 - Smoking in front of children in foster homes.
 - Not completing safety plans for foster children to help them take action if they are not feeling safe or comfortable.
 - Placing children in foster homes prior to the completion of criminal record and child abuse checks.
 - Workers not returning phone calls and a number of instances where face-to-face contact with children and youth did not occur in a timely, regularly-scheduled fashion.
 - Allowing access to children by parents and other parties against the best interests of the child.
 - Ensuring specialized training is proved to foster parents, consistent with the needs and level of care that children placed with them required.
 - Lack of action to ensure that significant medical and emotional needs of children were being addressed.
 - Inadequate assessment, recording of information and reunification plans for children returning to their family home after being removed for an extended period due to protection concerns.
 - Protection cases incorrectly designated as a Voluntary Family Service file and transferred as such between agencies.
 - Not providing appropriate support for children and families (E.g., assigning family support workers/counselling)
 - Not updating files on CFSIS.
 - Removing high-needs children from a seemingly sound foster home as a result of fairly minor concerns raised by the children without addressing the concerns with the foster parents or seeking to find solutions or offer supports to keep the foster family together.
 - Denying a youth access to call the Children's Advocate from his group home.
 - A group home not addressing concerns and grievances by youth of unfair treatment they brought forward as well as not providing the Children's Advocate with information requested to investigate the allegations.
 - Lack of placement monitoring where allegations of neglect had been raised, which was further compromised when these allegations were not documented and passed on to the four different caseworkers who were assigned the case in the period reviewed by the OCA.
 - Agency delays to request for services to a family.
 - Numerous instances of long overdue updates on case files.
 - Places of Safety foster homes not being licensed in a timely manner as per CFS Act, 8.1.
 - Poor written and verbal communication between CFS and foster families
 - Instances where paperwork was not completed in a timely fashion, delaying services or funding to families and causing emotional or financial stress.
 - Agencies habitually not responding to repeated requests for information, not returning phone calls or providing correspondence requested by the OCA.
 - A file was closed with no formal risk assessment or outreach component by an agency where a child's health risk remained unresolved at closure.

Who Contacted the OCA: (n=693)

Consistent with past years, about 2/3 of OCA case files (67%) were brought to our attention by parents, extended families, and foster parents. Children and Youth made up 15%

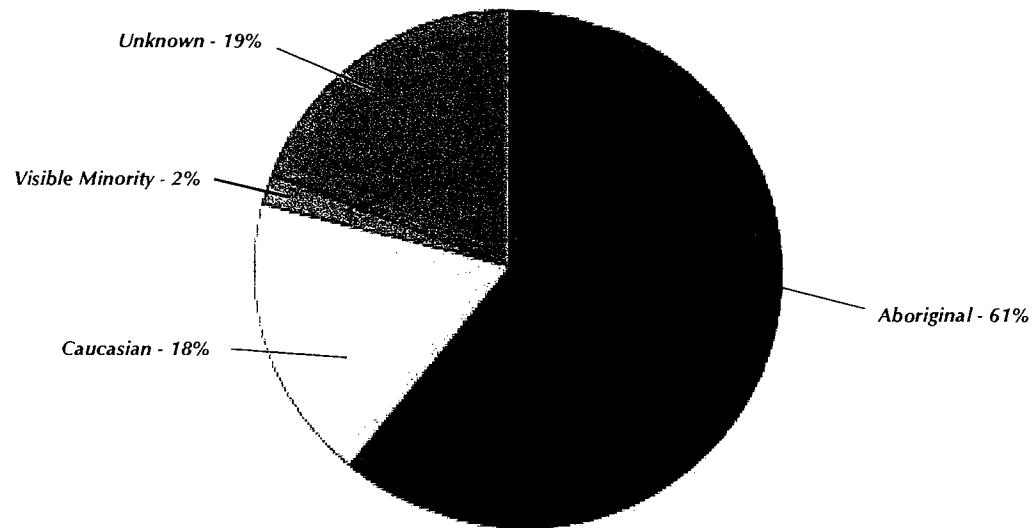


Child's Age and Gender: (n=693)



- Historically, OCA services have been divided relatively equally between male and female. This year we served 81 more females than males.

Racial Origin: (n=693)



- Racial origin is not determined by the OCA. Individuals must self-declare.
- Aboriginal includes Status, Non Status, First Nations, Inuit, Dene, and Métis.

Whereabouts of children/youth when they are not living with their intended placements:

Often when people call the OCA their situations have reached a crisis point. Many youth have run from placements or left home. Parents, at times, will remove children from "care" situations approved by a private agreement or other formalized custodial arrangements. In order to determine how many children/youth are living away from their intended placements, the OCA tracks this information. However we are only able to track those who contact the OCA and share this information with us. There could be more children and youth who are not at their identified placement at any point in time.

Since we began tracking this information in 2002, the number of cases where children and youth were not living in their intended placements has steadily dropped from 17% to 5% (36 cases) this fiscal year. The number increases as children get older.

Intended Placement: (n=693)

Placement Type	Number	Percentage
Non-Relative Foster Home	229	33%
Parent/Guardian	165	24%
Unknown	60	9%
Place of Safety	43	6%
Relative Foster Home	40	6%
Receiving Resources/Shelter	36	5%
Relative/Friends	28	4%
Residential Facility	27	4%
Group Home	23	3%
Mental Health Facility	11	2%
On Own	10	2%
Youth Correctional	9	1%
Hotel/Motel	5	1%
Other	4	1%
Hospital	3	1%
Total	602	100%

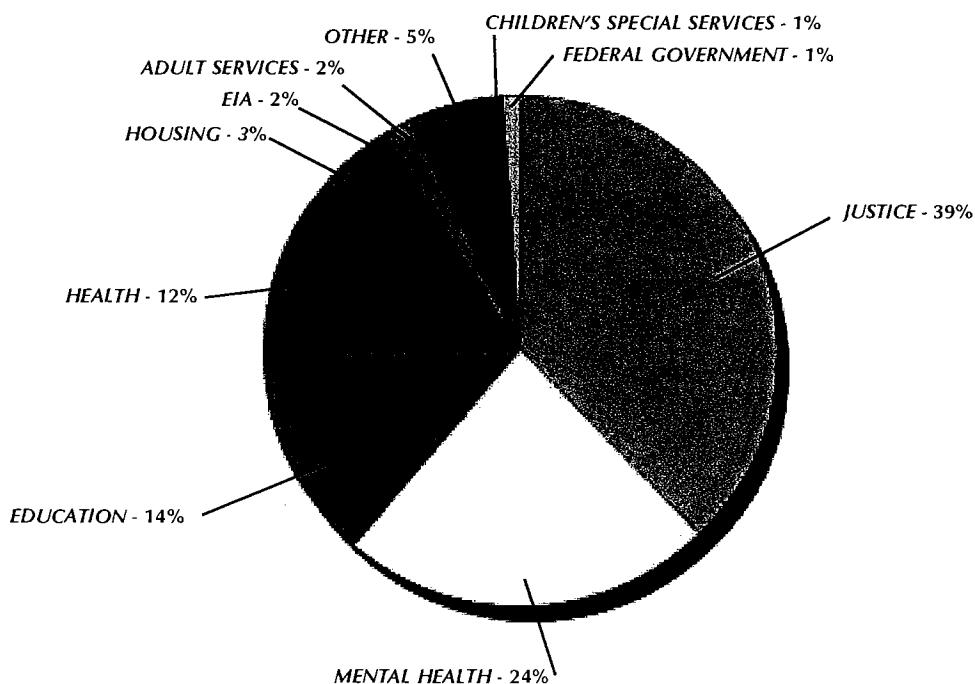
Where the Child or Youth was Living Instead of the Intended Placement:

Whereabouts	Number
Parent/Relative	14
AWOL	9
Friend/Community Member	7
Unknown/Would not disclose	5
Street Shelter	1
TOTAL	36

Dual Mandate Cases:

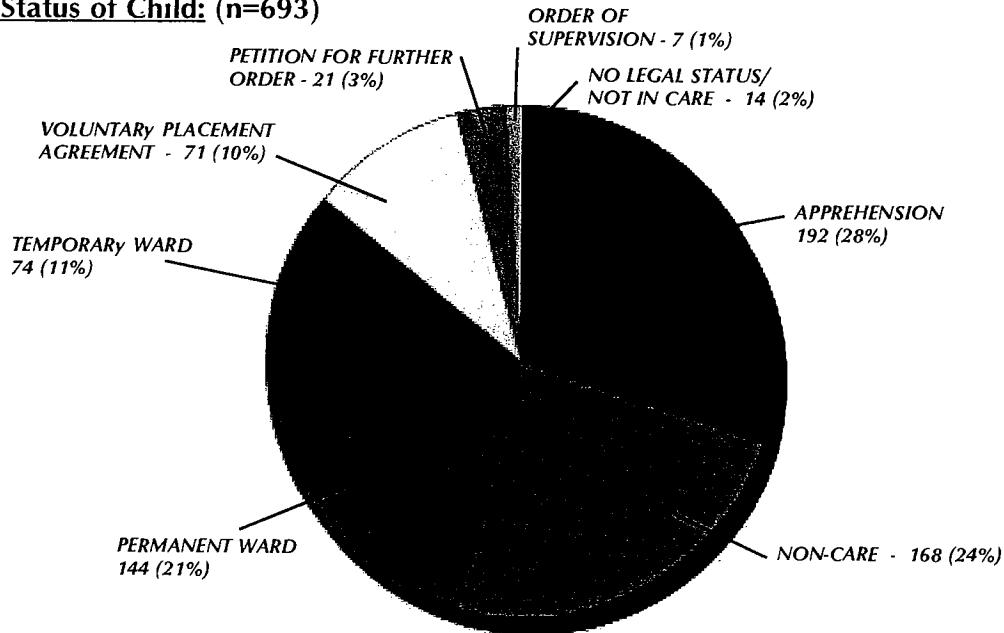
Of the total advocacy case files the OCA opened, 26% were dual mandate cases, meaning the children or youth had involvement with other service systems in addition to a CFS agency. The majority of these cases fall into the youth criminal justice, children's mental health and/or education systems.

Dual Mandate Cases: (n=254)(180 Case Files)



- Children and youth involved in the CFS system often have multiple service providers. The advocacy issue maybe central to the CFS system or to other child caring systems.
- Though CFS workers may be the individuals who hold final, often definitive responsibility for the child, their ability to influence, control and or direct resources of another system to address the needs of the child may be limited in many cases.
- To be considered a dual mandate case, the case characteristics need to include:
 - (i) Child/youth had to have current involvement with the CFS system.
 - (ii) Child/youth is not involved with the CFS system but entitled and refused services by a CFS agency.
 - (iii) The case issue resulting in a referral to the OCA was identified as cross-jurisdictional involving another child caring system other than CFS.

Legal Status of Child: (n=693)



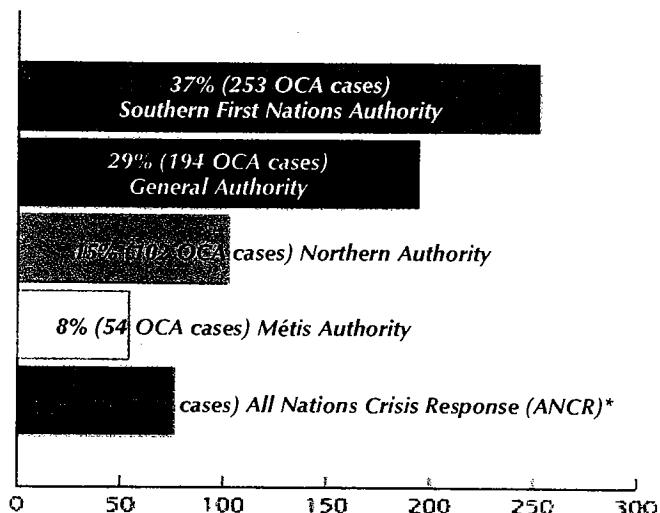
*Included in the total were 7 cases involving Orders of Supervision and 2 cases involving youth over 18 years of age. Combined, these cases account for 1% of this year's cases and are therefore not reflected in the graph.

74% of the case files involved children and youth in CFS care where the system had a legal responsibility for the child.

96% of the cases had an active protection file with a CFS agency prior to requesting advocacy services.

98% of the cases had open and active involvement with a CFS agency.

Case Breakdown of CFS Agencies: (n=693)

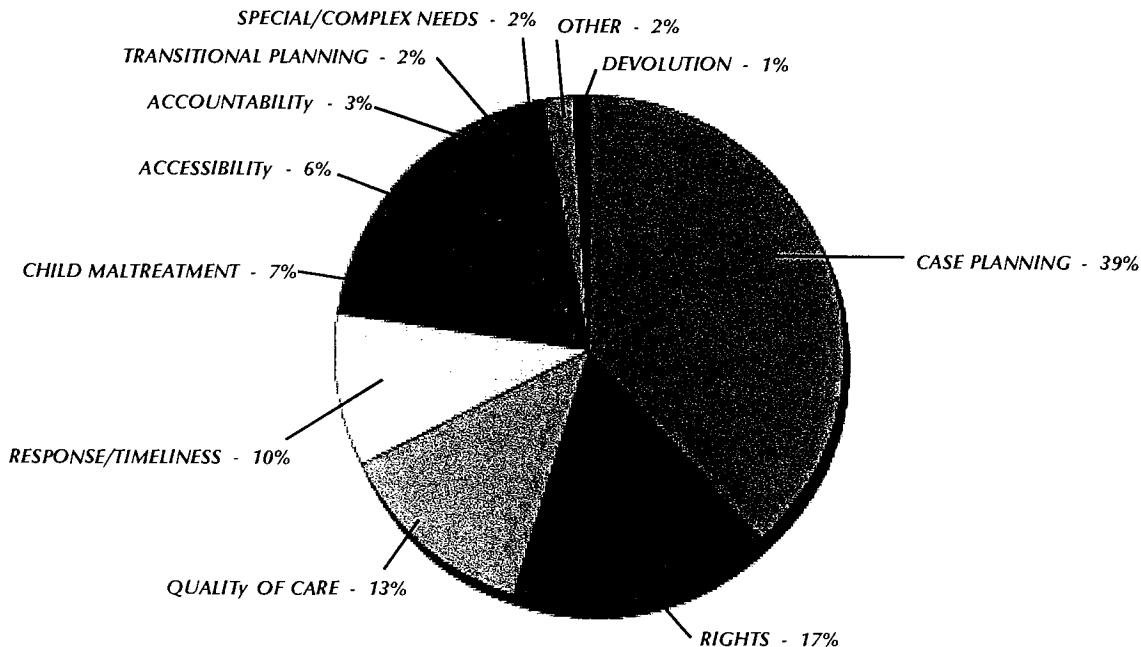


Of the 693 case files, 14 had no CFS involvement at the time contact was made with the OCA. The remaining 679 did have CFS involvement with agencies under the following authorities:

**(While the Southern Authority oversees ANCR, it is listed separately in this report as it provides crisis and intake service for Winnipeg and the surrounding area on behalf of all four authorities.)*

Top CFS Related Concerns: (n=3212*)

Advocacy cases may have multiple concerns. This year our casework yielded 3,212 concerns.



- Case planning, youth rights and quality of care issues were the top concerns of 2008-09.
- Year over year, the top concerns have been case planning, rights, quality of care, child maltreatment and responsiveness by service providers.
- In 2008-09 we now see an increase in concerns regarding responsiveness, accessibility, accountability, transitional planning, special needs and devolution.

Total CFS Related Concerns by Age by Category: (n=3212)

ISSUE	0-2	3-5	6-10	11-12	13-15	16-18	18+	TOTAL	%
Case Planning	239	162	237	89	316	201	8	1252	39%
Rights	114	71	95	28	153	87	0	548	18%
Quality of Care	67	35	52	26	148	76	1	405	13%
Responsiveness/Timeliness	53	43	42	29	85	62	0	314	10%
Child Maltreatment	39	33	51	18	52	29	0	222	7%
Accessibility	27	18	35	9	51	40	0	180	6%
Special/Complex Needs	2	7	9	0	22	19	0	59	2%
Other	10	6	10	4	15	13	0	58	2%
Transitional Planning	3	0	0	0	7	57	1	68	2%
Accountability	18	16	11	3	15	11	0	74	2%
Devolution	3	4	4	2	9	6	0	28	1%
Adoption	2	1	1	0	0	0	0	4	-
Total	577	396	547	208	873	601	10	3212	100%

Total Issues (CFS Related): 2008-2009

Case Planning remains the primary issue identified by our office. Case planning is further broken down as noted below.

Category	Number	Percentage
Case Planning		
Disagree/Refusal of/with CFS	449	36%
Lack of planning for family	163	13%
Lack of parental/family participation	132	11%
Lack of case planning	122	10%
Poor reunification planning	96	8%
Lack of child participation	76	6%
Lack of appropriate protection plan	68	5%
Lack of permanency planning	38	3%
Lack of service standards	37	3%
Other	37	3%
Change of worker	34	2%
Lack of worker contact	0	-
	1252	100%
Rights		
Lack of information	179	33%
Lack of consideration	178	33%
Lack of participation	121	22%
Lack of knowledge of advocacy	47	9%
Lack of legal advocacy	23	3%
	548	100%
Quality of Care: Child in Care		
Access/visitation to CIC	123	30%
Lack of appropriate care resources	52	13%
Other	33	8%
Mental health intervention/treatment	31	8%
Inappropriate use of intrusive measures	26	6%
Too many placement moves	24	6%
Lack of education program	23	6%
Child AWOL	21	5%
Lack of health care	21	5%
Lack of clothing	17	4%
Inappropriate disciplinary acts	14	4%
Lack of food	9	2%
Lack of privacy	5	1%
No contact with peers	3	1%
Lack of recreation	3	1%
	405	100%
Response/Timeliness		
Unresponsive	95	48%
Service delays	54	27%
Over response	31	15%
Administrative delays	19	10%
	199	100%



Year-end Statistical Analysis Special Investigation Reviews

April 1, 2008 to March 31, 2009

SPECIAL INVESTIGATION REVIEWS

An Overview

On September 15, 2008 *The Child and Family Services Act* was amended making the Children's Advocate responsible for conducting a review of services after the death of a child who was, or had been, receiving services through the child welfare system within one year of the date of death. This review is known as a "Special Investigation Review."

Purpose

The purpose of the Special Investigation Review is to identify ways in which the programs and services under review may be improved to enhance the safety and well-being of children and reduce the likelihood of a death occurring in similar circumstances.

Scope of Review

In conducting the review, the scope has been broadened by an amendment to the current legislation to include a review of the standards and quality of service of any publicly funded social service that was provided to the child or, in the opinion of the Children's Advocate, should have been provided.

"Publicly funded" is defined in *The Child and Family Services Act* as:

"...a program or service is publicly funded if it is operated or provided by the government or by an organization that receives funding from the government for the program or service."

Review Process

Reviews are conducted by an assigned "Special Investigator". This individual is a staff member of the Office of the Children's Advocate – Special Investigations Review Unit.

The special investigator begins the review process by collecting and compiling information relevant to the Special Investigation Review. This involves conducting related background research, reviewing files and reports, and interviewing involved individuals/service providers. Sources of information may include the following:

- Child and family services agencies
- Publicly funded social service records/files
- Police reports
- Fire commissioner reports
- Hospital and medical records
- School records
- Private therapists, counselors, clinic or other treatment centers
- Family members
- Community members/service providers

The special investigator completes an analysis of the information, including the review findings and recommendations. These findings are then presented to the Advisory Council.

A copy of the confidential report, containing review findings and recommendations, is provided to the Minister of Family Services and Housing, the Manitoba Ombudsman, and the Chief Medical Examiner.

A summary of the recommendations is made public through the Children's Advocate's annual report. Further, the Ombudsman monitors and reports on the implementation of the recommendations made by the Children's Advocate.

Advisory Council

Following the transfer of responsibility for the review of child deaths to the Office of the Children's Advocate, the OCA determined that a multi-disciplinary advisory team would be beneficial. This team could provide timely, expert feedback on Special Investigation Review recommendations. Towards that end, the OCA assembled a group of (approximately) 15 professionals who would meet four times a year to hear case review summaries, providing feedback to the team of investigators regarding specific practice or policy issues. These are experts in Manitoba who work in specific areas affecting children, youth or families, who can speak to best practice in their area of expertise.

***Advisory Council Members for Special Investigations 2008-2009**

Sgt. Chris Ballard	RCMP Criminal Operations Branch
Judge Arnold Connor	Retired Justice
Ms. Anna Fontaine	Director Indian & Northern Affairs
Mr. Selamawi Ezez	Services to Newcomers/Immigrants
Dr. Charles Ferguson	Director, Child Protection Unit
Ms. Marie Christian	Director, Voices-Youth in Care
Dr. Peter Markestyn	Former Chief Medical Examiner
Ms. Margaret Lavallee	Elder, University of Manitoba
Dr. Don Fuchs	Dean, Faculty of Social Work
Ms. Myra Laramee	MB First Nation Education Resource Center
Ms. Cheryl Fontaine	Therapist, FNIHB
Mr. Peter Rogers	Senior Advisor, Heath Canada
Mr. Cecil Sveinson	Program Manager, Aboriginal Diversity WPS
Ms. Doris Young	Assistant to the President on Aboriginal Affairs University College of the North

We gratefully acknowledge their dedication to the children of Manitoba.

**Complete biographies of Council Members are available on the OCA website at www.childrensadvocate.mb.ca*

Themes arising from the Special Investigation Reviews

Seven reports were completed during the period providing 40 recommendations to Agencies (24), Authorities (5), The Standing Committee (2), The Child Protection Branch (7) and the Department of Family Services and Housing (2). All of these reports related to children who had died prior to the new mandate being enacted and were transferred from the Office of the Chief Medical Examiner.

As can be seen, the majority (24) of the recommendations were directed primarily toward specific agencies concerning the service being provided. Some familiar themes emerged from reviewing the service provided:

- Ensuring that agencies follow standards concerning response times to new intakes.
- Ensuring that agencies make face to face contact with all family members when investigating child protection matters.
- Ensuring that agencies conduct thorough assessments of new intakes or when the family's circumstances change significantly.

The number of the recommendations related to a Designated Intake Agency resulted in a recommendation for a complete program evaluation. The service issues identified indicated significant workload pressures that exacerbated staffing concerns. In a stressful work environment with high case numbers, staff burnout is high. Losing and replacing staff further complicates managing the workload. New staff require training and mentorship (through consistent supervision) to reach competency within a reasonable time frame. Recommendation was made to the Department of Family Services and Housing and to Standing Committee regarding the completion of a comprehensive workload management strategy for the Province and the development of work competency processes for front line workers.

An ongoing concern of the Children's Advocate is service provision to adolescent youth. Again, it has been noted that attitudes toward adolescents impact service decisions. Youth who have experienced maltreatment may be impacted in their ability to problem solve and assess situations of safety. Given that youth who attempt to access supports from the system may well experience developmental delays, age is not the only factor that needs to be assessed in providing service. Identifying barriers for youth to access services is an important part of the assessment process. Therefore, recommendation has been made that youth engagement strategies undertaken by each Authority include training to heighten the awareness of service providers to the needs of adolescents.

The Children's Advocate identified the need to strengthen the wording of Duty to Report in *The Child and Family Services Act* to better reflect the intent of this provision. At present the provision indicates that people have a choice to report a child in need of protection to either a parent/guardian OR an agency. Further, that the reporting person is required to assess the ability of the parent/guardian to protect a child. The Children's Advocate feels that an agency may be better able to assess the protection needs of a child and should be contacted under Duty to Report.

Special Investigation Review Unit (SIRU)

Year End Statistical Report for 2008 – 2009

September 15, 2008 to March 31, 2009

Special Investigation Review

Child Death Notifications (September 15/08-March 31/09)

Non-resident deaths
Manitoba child deaths
Total child deaths

2008-2009

9
90
99

Open Files (September 15/08 to March 31/09)

Pre-proclamation transferred from OCME
Child Death Notification intakes
Total opened files

106
99
205

Files Closed (September 15, 2008 - March 31, 2009)

Pre-proclamation cases with reports
SIR reports not necessary
SIR with reports required
Total closed files

7
57
0
64

Files Carried Over to April/09

Pre-proclamation transferred cases
SIR reports required
SIR determination pending
Total files carried over

99
29
13
141

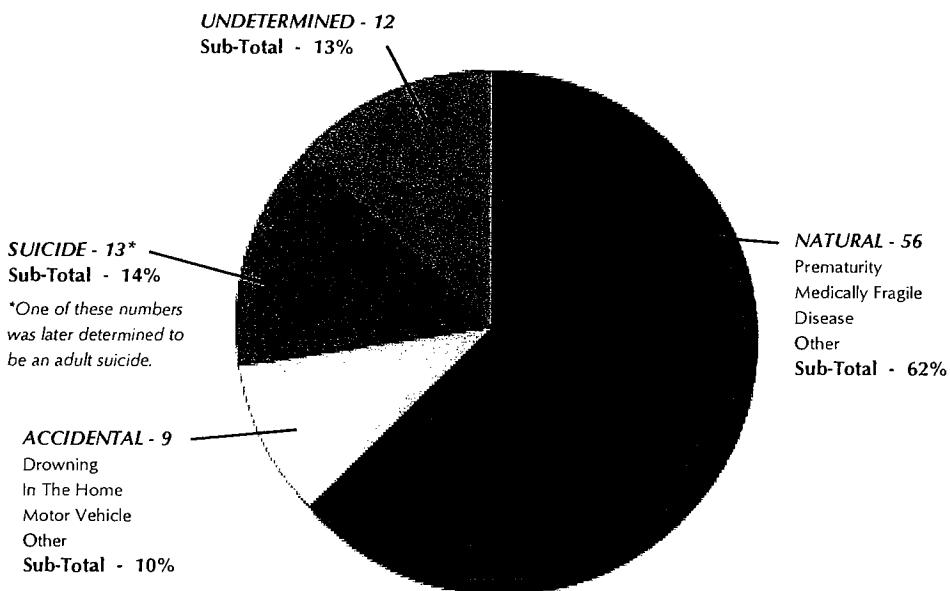
Upon Proclamation of *The Children's Advocate's Enhanced Mandate Act* on September 15, 2008, 106 outstanding cases requiring review were transferred from the Office of the Chief Medical Examiner (CME) to the Office of the Children's Advocate for completion as Special Investigation Reviews.

The Office of the Children's Advocate completed investigations on seven of those cases by year end.

Between September 15, 2008 and March 31, 2009 there were 99 child deaths in Manitoba. Of those, nine involved children who were not Manitoba residents. A review of the remaining group revealed that the majority of child deaths (62%) were related to natural causes¹.

¹ The official Manner of Death is determined by the Chief Medical Examiner. Where an official determination was not provided, an unofficial determination has been included.

Manner of Death - Manitoba Child Death Notification: (n=90)



A more detailed review of the deaths revealed that:

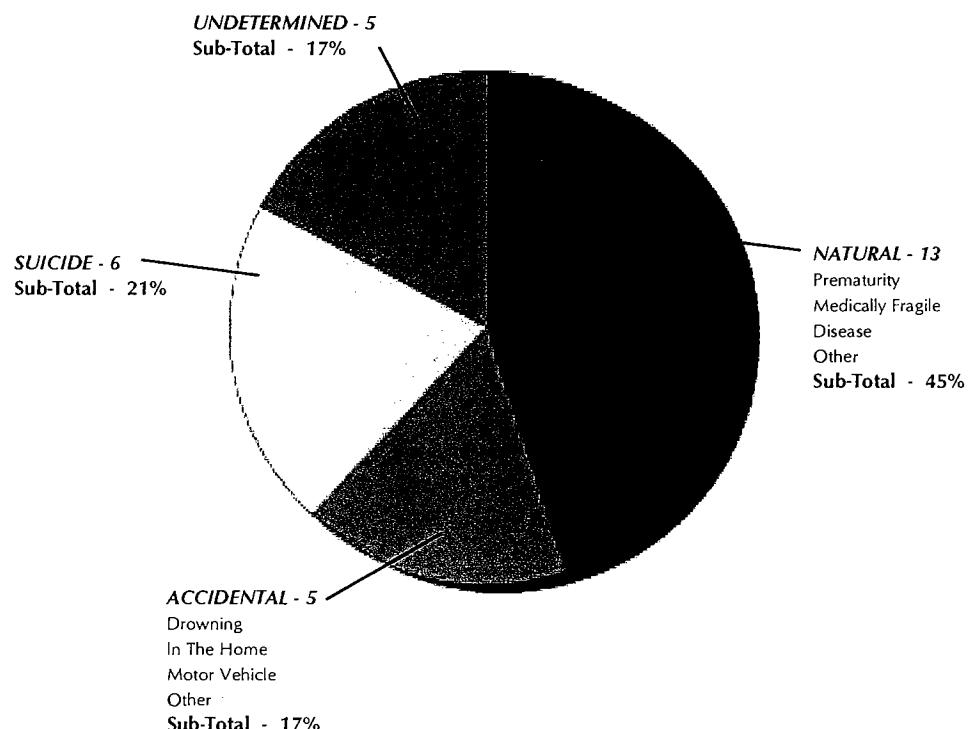
- More than half (59%) of the deaths occurred in children aged 0-2 years and the most common cause in that age group was related to prematurity.
- Death by suicide occurred three times more often among young women than among young men.

In accordance with the mandate of the OCA, a review was conducted to determine if children or families were involved with a child and family services agency either at the time of the child death or in the 12 months preceding the child death.

At March 31, 2009, 29 of the 90 cases were identified as having child welfare involvement and therefore requiring a Special Investigation Review. Reviews were not required in 57 cases and 13 cases remained undetermined pending the receipt of further information.

- In 39 of child deaths, there was no record of the child and or family ever having any contact with a child and family services agency.
- In 9 cases, a review was required because the family had some involvement with an agency within the 12 months preceding the child death.
- In addition, there was current agency involvement with 20 children at the time of their death. Of those, 7 were known to have been in care.

Manner of Death - SIR Reports: (n=29)

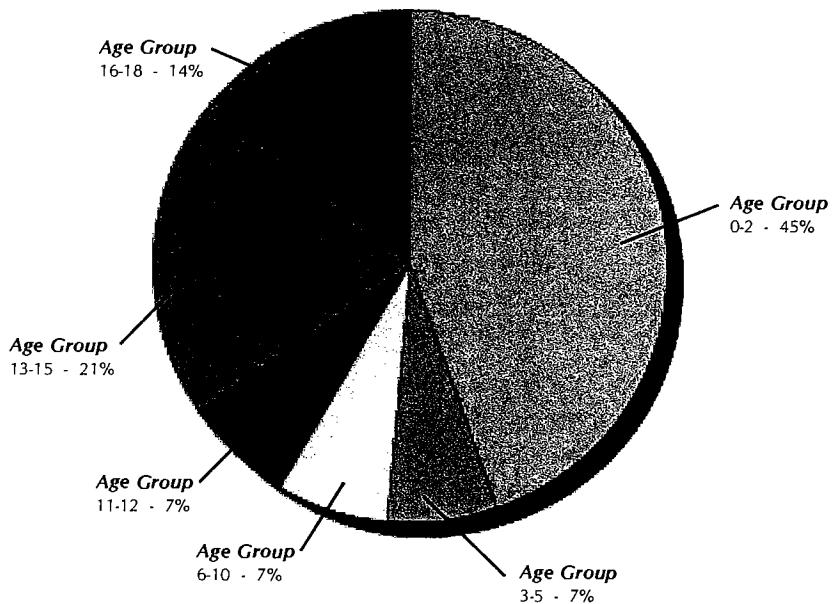


No Special Investigation Reviews of services provided to children whose death occurred subsequent to proclamation were completed by March 31, 2009. A number of factors increased the time required to complete a Special Investigation Review including the following:

- Development of information sharing relationships with the four child welfare authorities, their agencies and collateral service providers.
- Formalizing policies and procedures to support the new format for review of child deaths.
- Travel to communities to ensure knowledge of community context.
- Orienting and training new special investigators.
- Establishment of an advisory council.

Seven reports were completed on children who were part of the outstanding backlog of files transferred by the Office of Chief Medical Examiner. Those investigations were completed by investigators provided by the Child Protection Branch. The seven reports included 40 recommendations for agencies, authorities and/or the Child Protection Branch. The most common theme of the recommendations related to case management (18) where assessment, service delivery and risk assessment were most often cited for improvement. A number of systemic issues were identified, particularly large caseload sizes. Coordination between service providers, placement issues and service provider issues were also noted.

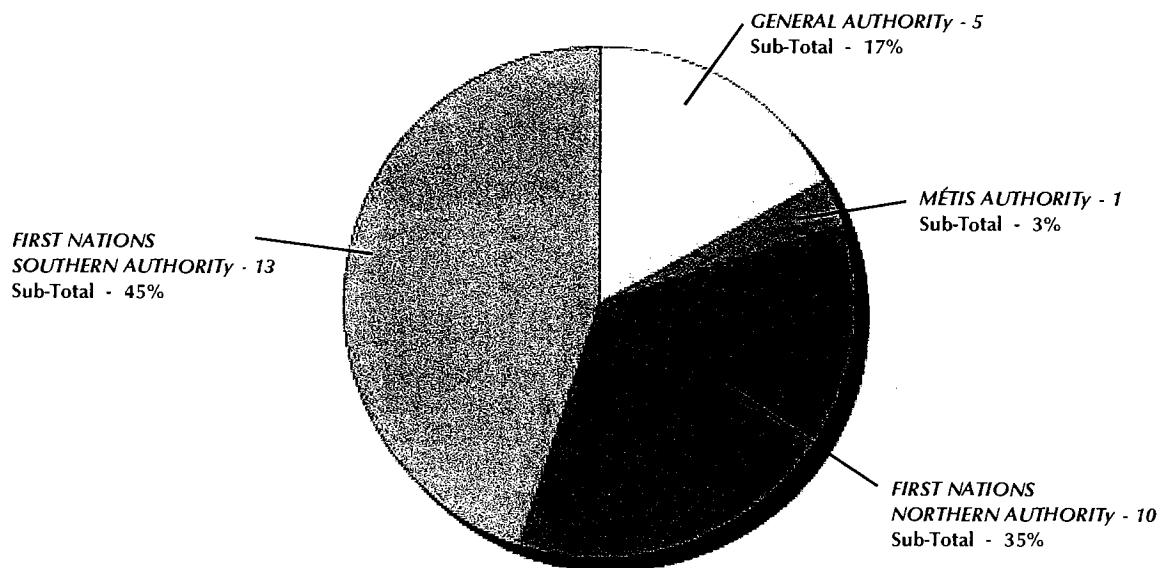
SIR Child Deaths: Child's Age and Gender: (n=29)



SIR Child Deaths: Nature of CFS Involvement: (n=29)

CFS Involvement	Number	Percent
Closed case within one year	9	31%
Open case	20	69%
Legal status in open cases		
Permanent ward	1	
Temporary ward	1	
VPA	5	
Non-care	10	
Unknown	3	
Total	20	
Total cases with CFS involvement	29	100%

SIR Child Deaths: Agency: (n=29)



The Fiscal Year Budgets for The Office of the Children's Advocate

Expenditures	\$(000)	FTE
2008-2009		
Total Salaries and Employee Benefits	\$1,306.3	18
Total Operating Expenses	\$ 763.4	

The Office of the Children's Advocate Staff List

Billie Schibler, Children's Advocate
Bonnie Kocsis, Deputy Children's Advocate
Patsy Addis Brown, Manager, Administration & Finance
Debra Swampy, Administrative Secretary
Reji Thomas, Administrative Support, Casual
Nancy Blair, Administrative Support, Casual

Advocacy Services Unit:

Thelma Morrisseau, Children's Advocacy Officer
Jacek Beimcik, Children's Advocacy Officer (November 2008)
Gerald Krosney, Children's Advocacy Officer
Kevin Barkman, Children's Advocacy Officer
Rosie O'Connor, Children's Advocacy Officer
Carolyn Parsons, Children's Advocacy Officer
Kirstin Magnusson, Children's Advocacy Officer
Debra Babey, Advocacy Assessment Officer - Intake
Dawn Gair, Advocacy Assessment Officer - Intake
Sarah Arnal/Michelle Hykawy, Advocacy Assessment Officers - Intake

Special Investigations Unit, including contract and seconded staff

Jan Christianson-Wood, Special Investigator (until October 2008)
James Turk, Special Investigator
Shelagh Marchenski, Special Investigator
Maxim Kryukov, Special Investigator (until December 2008)
Angie Balan, Special Investigator
Joanne Wityshyn, Special Investigator
Bob Christle, Special Investigator
Don Wells, Special Investigator
Aaron Klein, Special Investigator
Tannis Yaseniuk, Support Investigator
Terese Mojica, Administrative Assistant



*We all have a hand
in it!*

unless you
listen, you
can't hear
METM

Annual Report of the Office of the Children's Advocate of Manitoba

April 1, 2009 - March 31, 2010

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Acknowledgements

The OCA would like to acknowledge the children and youth who choose to trust that we will help their voices "be heard".

I would also like to acknowledge our very dedicated advocacy program staff who continue to commit themselves to the work of ensuring children and youth are heard by those who serve them and that their needs are first and foremost in all decisions made that involve them.

I also want to acknowledge the commitment and compassion of the Special Investigators who ensure that no child, nor their story, will be forgotten as they animate the voices of those children and youth who died. That by animating their voices improvements will be made for future children and youth.

And finally I would like to acknowledge those agencies, workers and foster parents who continue to provide service and care to the children and youth of Manitoba despite the challenges and lack of acknowledgment for the hard work they do on everyone's behalf.

I am excited to report that four staff have taken part in preparing pieces for the Annual Reports for 2008-2009 and 2009-2010. They are Justine Grain, Ainsley Krone (special investigators), Angie Balan (Program Manager-Advocacy Services) and Shelagh Marchenski (Program Manager – Special Investigation Reviews).

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The History and Role of the Children's Advocate in Manitoba

The Office of the Children's Advocate (OCA) was created under *The Child and Family Services Act* and proclaimed April 1, 1993. The office originally operated under the umbrella of the Department of Family Services and the Children's Advocate reported to the Minister of Family Services. In 1996, consistent with legislative requirements, an all-party committee was established to conduct a review of the office with public hearings commencing in May 1997.

On March 15, 1999, in response to recommendations arising from the review, the Office of the Children's Advocate became an independent office of the Legislative Assembly. It currently operates at an arm's length relationship to the child and family services system. It exists to represent the rights, interests and viewpoints of children and youth who are receiving, or are entitled to receive, services as prescribed under *The Child and Family Services Act* and *The Adoption Act*. The Children's Advocate is empowered to review, investigate, and provide recommendations on matters relating to the welfare and interests of these children. The Children's Advocate prepares and submits an annual report to the Speaker of the Legislative Assembly.

On April 8, 2005, the Lieutenant Governor in Council, on the recommendation of the Standing Committee of the Assembly on Privileges and Elections, appointed Ms. Billie Schibler as the Children's Advocate for a three-year term and a reappointment for another three-year term, which commenced on April 8, 2008.

On September 15, 2008 *The Child and Family Services Act* was amended, making the Children's Advocate responsible for conducting a review of services after the death of a child who was, or had been, receiving services through the child welfare system within a year of the date of his/her death.

The Mission And Principles Of The Children's Advocate

The Office of the Children's Advocate, in carrying out its function, is tied to best interest provisions of both Acts. The best interests of the child, shall be given paramount consideration in all activities carried out by the Office of the Children's Advocate staff when representing a child.

Provision of Advocacy Services

Mission Statement

The Office of the Children's Advocate is to advocate on behalf of, and with children and youth, to animate their voice and ensure their rights, interests and viewpoints are valued, respected and protected.

Principles

- The principle of **empowerment** for children and youth.
- The principle of respect for the **dignity** of children and youth, and to their **right to be heard**.
- The principle of **the family** as the primary source of nurturing, support and advocacy for children and youth.
- The principle of **equity** for all children and youth and the principle of **respect for diversity**.
- The principle of **the least adversarial approach** to finding solutions for children, youth and their families.
- The principle of the **community's collective responsibility** for providing resources and services to children, youth and their families.
- The principle of a system that is **responsive** to the needs of children, youth and their families.
- The principle of **community outreach** as an ongoing process.
- The principle of respect and recognition of the **relevance and impact of culture in First Nations and Métis communities** as it relates to their children and youth.
- The principle of respect and recognition of the **diversity and importance of culture in minority groups** as it relates to their children and youth.
- The principle of recognition and acknowledgement of the **existence and relevance of youth sub cultures** within the dominant cultures of communities served by the Office of the Children's Advocate.
- The principle that the **vision of the United Nations Convention on the Rights of the Child** is the cornerstone of the advocacy principles, practices and efforts embraced by the Office of the Children's Advocate.

Provision of Special Investigation Reviews

Vision

By honouring the spirits of children who have died, our vision is a society in which the safety, well-being and best interests of all children are paramount.

Mission

Our mission is to advocate for the rights of all children to quality services by:

- Giving voice to children who have died.
- Investigating and reviewing standards, programs and services that were or could have been provided.
- Reviewing circumstances surrounding the death of a child related to standards or quality of care.
- Identifying ways in which programs and services can be improved.
- Making relevant and culturally appropriate recommendations.

Principles

- In a manner that respects the inherent dignity of all persons.
- By conducting timely reviews that are inclusive and accountable.
- By honouring the voice and life of the deceased child and the privacy of the surviving children and their families.
- Viewing services as integrated, seamless and child-focused.
- Through the eyes of the child.

In practice, the principle of working "**through the eyes of a child**" means: Maintaining a primary focus on the needs of the child and the extent to which standards, programs and services met, or could have met, those needs.

- Considering the context in which services are delivered.

In practice the principle of **considering the context** in which services are provided means: Investigating the systemic and community factors that impact the reality of service delivery.

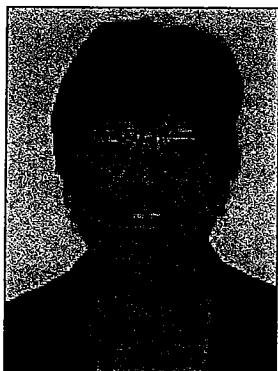
The Importance of Having an Independent Children's Advocate

Advocates challenge the system. They point out current practices, policies or legislation that are not meeting needs and expectations. Advocates work for change ... and change is not always easy for people to accept. Advocacy can create tension, but can improve the system.

Children especially need advocates. They live in a world where adults make decisions about their lives. They have a voice but they have virtually no legal power to make anyone listen to that voice. Our experiences speaking with children and youth in the child and family services system have shown us they often feel they have no say in what happens to them.

Our mission is to animate their voices and ensure their rights, interests and viewpoints are valued, respected and protected. Our advocacy efforts and services are child-centered, family-oriented and anchored in the community. They are delivered in an ethical, culturally sensitive and respectful manner.

A Message from the Acting Children's Advocate



In accordance with Section 8.2 (1)(d) of *The Child and Family Services Act*, I respectfully submit this annual report for the time period beginning April 1, 2009 to March 31, 2010.

I took on the role of acting Children's Advocate when Billie Schibler took an extended family related leave in April 2010. In this role, as well as the one I held previously as Deputy Children's Advocate, I have been heartened by the scores of Manitobans who care deeply about the rights and welfare of children and youth in care. From the foster parents who open their homes and hearts, to the social workers balancing heavy workloads while trying to maintain children's best interests, to educators who provide academic and social learning opportunities to students who are often in emotional turmoil; these individuals consistently strive to make the lives of our most vulnerable children better.

Although Manitoba's child welfare system continues to take steps to improve services to children and their families, the OCA is concerned that many child and youth rights remain unfulfilled. In this annual report we will be presenting three of these areas where specific rights are not being upheld and including case examples of the effect this has on a child and youth or their family.

Upon examination of the 2,296 concerns that came to the OCA over the past year, a significant number appear to have root causes relating to issues of poor communication. It's ironic that in an age when there has never been more information available to us, it is often a hurdle to get that information to those who need it in a clear and understandable form.

Of greatest concern is that there is still no seamless, fully integrated information system that shares case and resource information between offices, agencies and authorities. This further complicates a system that has never been easy to navigate for those needing access. Our office receives many calls from those within and outside of the system who are unclear about whom to contact for their particular situation. There doesn't appear to be much in the way of a communications strategy to inform the public about services available, responsibilities or appeal processes.



The OCA has its part to play with respect to communication too. Toward that end, this year we increased our efforts to reach out and engage with youth and their families and to continue to educate them about their rights.

We also celebrated the OCA's 10th anniversary which coincided with the 20th anniversary of the United Nations Convention on the Rights of the Child this year. We reflected on the progress Manitoba and indeed, Canada has made towards meeting those rights. Rights such as an adequate standard of living including adequate food and housing remain out of reach for many children, particularly those who are Aboriginal. Indeed, Aboriginal children and youth are far more likely to live in poverty, be involved in youth criminal justice and child protection systems and face significant health problems compared with their non-Aboriginal counterparts. We look forward to Canada's report to the Senate hearings on the implementation of the Convention later in 2010, but we are left asking what we as Manitobans have done to move towards action to ensure equity for all.

Respectfully Submitted by

Bonnie Kocsis
Acting Children's Advocate



AN OVERVIEW OF THE MAJOR INITIATIVES UNDERTAKEN BY THE OCA

2009 - 2010

It is important to acknowledge those events which brought about systemic change for our most vulnerable citizens. The 10th anniversary of the independence of the Office of the Children's Advocate gives us the opportunity to acknowledge the changes made in ensuring that children and youth voices are heard and their rights respected. To rededicate ourselves to the work of ensuring that children, youth and their caregivers are aware that they have rights and work to uphold them.

The 2009-10 fiscal year has been a busy and energizing time for the office as we prepared to celebrate our 10th year as an Independent Office as well as the 20th Anniversary of the United Nations Convention on the Rights of the Child.



10TH ANNIVERSARY OFFICE OF THE CHILDREN'S ADVOCATE

10th Anniversary

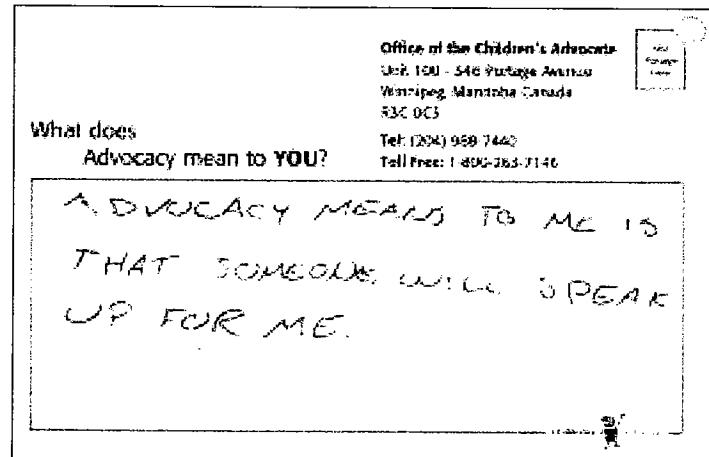
To mark our 10th year of legislated independence, we held a commemorative event at our new office located at 346 Portage Avenue. Many helped us to celebrate including various dignitaries, children and youth from care, parents and community stakeholders.

Members of VOICES: Manitoba's Youth in Care Network shared personal experiences of their time in care and how advocacy made a difference in their lives. They all recognized the importance of having an independent voice to listen to them and speak on their behalf.

We invited children and youth in care to share their thoughts about advocacy on postcards, which we hung throughout the office as a visual display of what advocacy means to them.

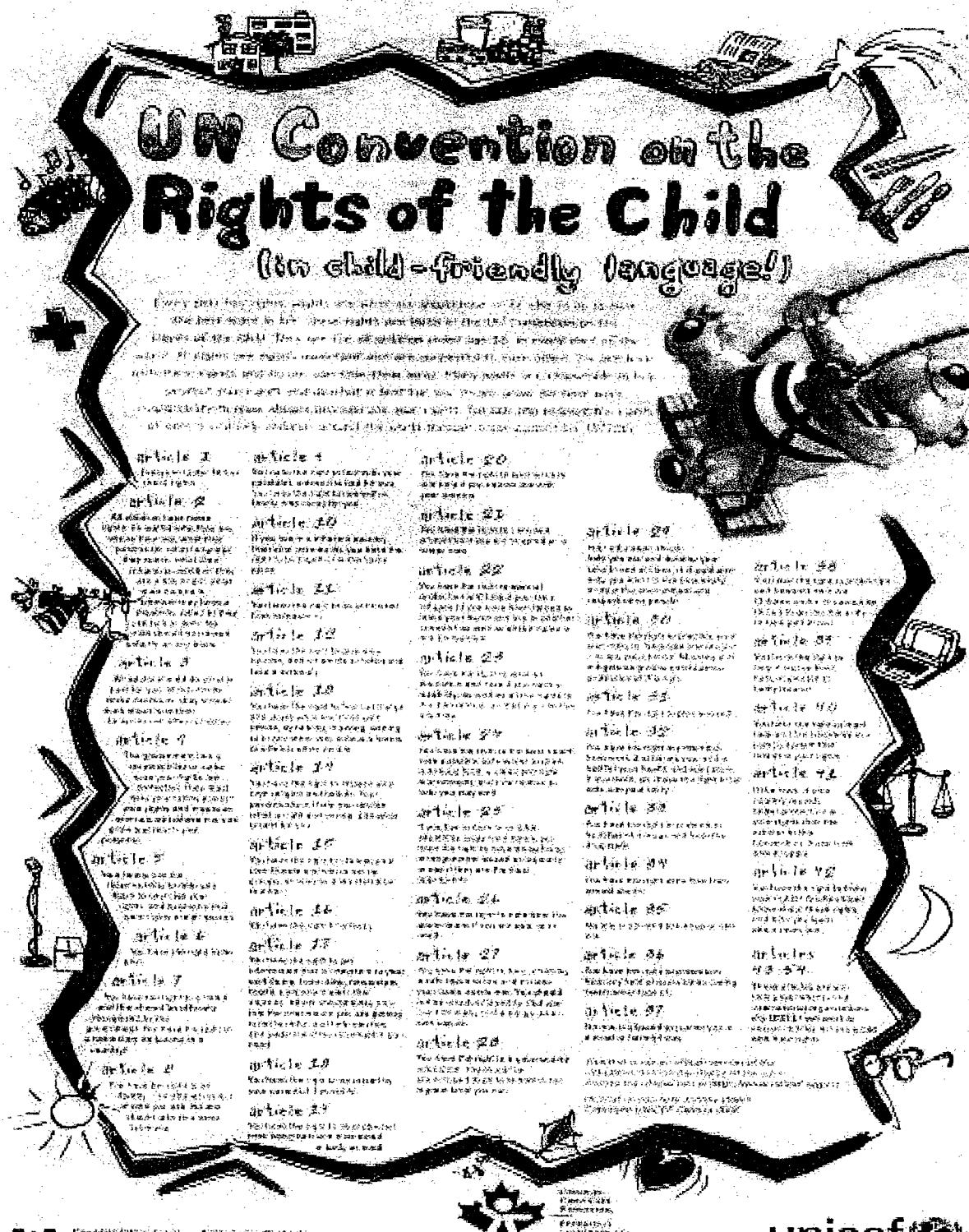
Other highlights of the celebration included a performance by Winnipeg's premier lion dance troupe, Ching Wu Athletic Association, face painting and activities for the children who attended from Sister McNamara Elementary School. Young artists performed original poems and songs and we had a special art piece completed live at the event, which we raffled off to an attendee at the end of the day.

The Office of the Children's Advocate would like to thank all those children and youth who attended and assisted with hosting our event as well as the many dignitaries who were present.



UN Convention on the Rights of the Child

Every child has rights which are protected by law. It is also important to have the best interest of the child first and the children's needs should be met above all else. The child has the right to be treated with respect and dignity. The child should be given the opportunity to express their own opinions and feelings. The child should be given the opportunity to learn and grow at their own pace. The child should be given the opportunity to play and have fun. The child should be given the opportunity to be safe and secure. The child should be given the opportunity to be happy and healthy. The child should be given the opportunity to be loved and cared for.





20TH ANNIVERSARY UNCRC

20th Anniversary of the United Nations Convention on the Rights of the Child

On Friday, November 20th, 2009, people around the world recognized and celebrated the 20th anniversary of the United Nations Convention on the Rights of the Child (UNCRC).

The Convention on the Rights of the Child was adopted by the General Assembly of the United Nations on November 20th, 1989. As a signatory to the Convention, Canada has an obligation to ensure its laws, policies and services, provide for and protect the rights of children.

Jasmine [REDACTED]
[REDACTED]
Winnipeg, Manitoba

What does
Advocacy mean to YOU?

Advocacy means to me about an adult or someone you trust listening to you about something that is bothering you

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Canada ratified the Convention on the Rights of the Child 18 years ago, on December 13, 1991. When governments ratify the Convention they are expected to comply with its standards and to continuously strive to take all necessary measures to ensure the rights of children are respected and upheld. This is a serious commitment and the children and youth of this country depend on those of us who speak on their behalf to continue to push for action on this commitment.

This year was particularly important for children's rights in Canada as the Canadian government reported on the implementation of the Convention through the UN Senate Committee hearings on the Rights of the Child. The children born in Manitoba at the time the Convention was ratified have now reached the age of majority. It remains to be seen how Canada's commitment to the principles of the Convention have made a difference in the lives of Canadian children born within this time period.

When it comes to rights, children appear to be the forgotten group. Most children and youth that we encounter are unaware of the Convention. The reality is that most Manitoban adults are not aware of its existence, what it states, or what it means for the rights of children and youth.

The 20th anniversary of the Convention on the Rights of the Child provided our office with opportunities to raise awareness about child and youth rights. The Children's Advocate joined the Manitoba Human Rights

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What does
Advocacy mean to YOU?

I think advocacy means help, and be there when others are not!
Because when my social workers don't call me or attend to my needs, Childrens Advocate is! Thanks!

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What does
Advocacy mean to YOU?

To me Advocacy means to help children and listen to their thoughts and problems.

Commission, The Manitoba Ombudsman, UNICEF and VOICES: Manitoba's Youth in Care Network in developing a DVD containing a copy of the Convention and youth rights information and resources.

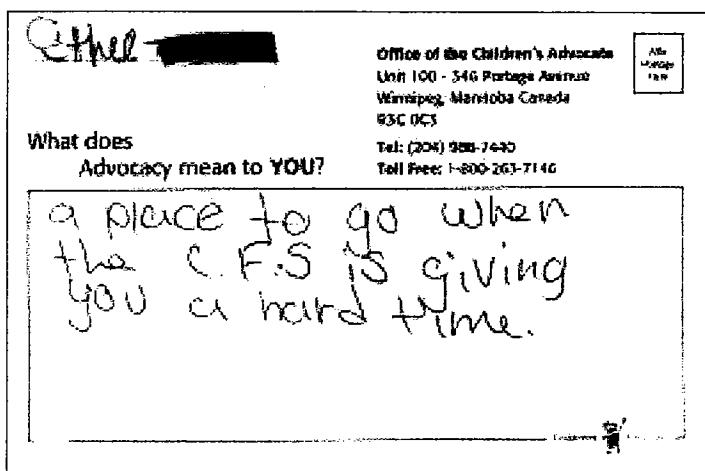
The DVD was distributed to 300 Manitoba teachers. An additional 300 DVDs were distributed to students attending Manitoba Human Rights Commission events in both Winnipeg and Brandon. The OCA continues to send out copies to those working with children and youth who request information on resources for them.

In addition the Office of the Children's Advocate has prioritized visits to child and youth care facilities to ensure they, and the staff caring for them, are aware of child and youth rights. Advocacy Officers have been traveling to communities throughout the province promoting the Convention while doing their advocacy work. UNICEF and its partners developed a United Nations Convention on the Rights of the Child poster in child friendly language. We continue to distribute the poster to all those who request one and to the child

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What does
Advocacy mean to YOU?

To me advocacy means that my rights will be looked after.



serving facilities we visit around the province.

As we acknowledge this 20th year anniversary, we urge all Manitobans to become familiar with the United Nation Convention on the Rights of the Child and to speak out for those rights to be recognized. The Convention on the Rights of the Child can be downloaded at www.childrensadvocate.mb.ca.

Youth Engagement

The 10th anniversary of our independence as an office coupled with the 20th anniversary of the United Nations Convention on the Rights of the Child underscored for us the importance of hearing the voices of youth.

In early 2010, we began discussions to critically assess our outreach efforts and how to further animate and reflect the voice of youth in the work of the OCA. In March 2010, advocacy program staff engaged in a strategic "path" exercise to develop key goals, objectives and steps required to reach our vision.

Subsequently, we committed funds to begin the foundational work towards the implementation of a youth engagement strategy to begin in 2010/2011. This work will include the following:

- Develop a new, more child and youth friendly website
- Review and revised our outreach and print materials to ensure they are up to date and relevant.
- Ensure above materials are provided in English and French.
- Provide ways to bring the voices of youth in care to a broader audience. Working closely with VOICES: Youth in Care Network Manitoba, we will showcase the thoughts, prose and artwork of youth in care that reflect their experiences on the OCA website and in its annual reports.
- Explore the development of a youth advisory council to better inform our services and assess the OCA's effectiveness.



ISSUES AND RECOMMENDATIONS

Over the past year, three areas of significant concern have continued to emerge in our office. We view each of these issues as a violation of children's rights.

Involve ment in planning

The OCA continues to see many cases where young people have been routinely denied the right to be involved in planning and decision-making with respect to their care. Many times, there has been no effort to actively engage a young person in planning that will directly affect their lives. At the extreme, we've seen situations where a new worker has been assigned and no one has bothered to tell the child. Sadly, there have been situations where a child's foster placement has changed and the first they learn of it is when the worker arrives to pick them up to make the move.

Even very young children can and should have age-appropriate information about their care arrangements. Older children are entitled to have the opportunity to be part of the planning process and to express their opinions and desires. Their wishes should be respected and considered, when possible in accordance with Article 12 which states:

The Convention on the Rights of the Child

Article 12: You have the right to give your opinion and for adults to listen and take it seriously.

Recommendation:

That agencies and authorities uphold child and youth rights to have their opinions heard in planning that affects them.

That agencies ensure their staff are aware of youth rights.

Voluntary Placement Agreements for Care in Residential Medical Facilities

In Manitoba, if a child requires ongoing care in a residential medical facility, that child's parents must place him/her in the care of a child and family services agency under a voluntary placement agreement (VPA). This holds regardless of whether there are any child protection concerns.

The procedure is a relic of an obsolete funding structure that allowed the province to recover costs associated with the institutional placement of children with disabilities under the long defunct Canada Assistance Plan. This provision has never been updated to reflect current funding strategies and negative consequences remain.

Families who care for children with severe mental and/or physical disabilities at home receive support services from Children's Special Services (CSS), a program of Manitoba Family Services and Consumer Affairs. CSS staff has training and experience in this specialized area of practice. However, there are times when the child's medical and/or physical condition deteriorates to the point where it is no longer possible for the family to meet the child's care needs at home. When that happens, the parents must sign a VPA and the CSS worker ceases to be involved. The child and family services worker then takes over case management and may not have specialized training in this area.

This situation is disruptive and at times overwhelming for the family, who is already dealing with the difficult decision to place the child in a medical facility. Often the family's level of support drops significantly as this family's case (not being of a child protection nature) becomes a lower priority for the worker who is already managing multiple demands on his/her time.

Psychologically, the parents also have to grapple with the psychological impact that they are "signing over care" to a child protection agency – despite acting in the best interests of their child.

Convention on the Rights of the Child

Article 18: You have the right to be raised by your parent(s), if possible.

Recommendation:

The OCA calls on the government to review this funding structure and to prevent the continuing disruption and degradation of support services to children with complex needs and their families.

***Gavin's Story**

Making a difficult situation worse

Gavin died at the age of three years as the result of medical complications. At the time of his death, Gavin* was in the care of a child and family services agency under a voluntary placement agreement (VPA). As is required under legislation, The Office of the Children's Advocate completed a Special Investigation Review of the services Gavin received.

Although he was born healthy, at the age of two Gavin was diagnosed with a serious health condition. Gavin was well loved by his parents who worked very hard to meet his increasingly

complex needs in the family home. Children's Special Services, a provincial program through Family Services and Consumer Affairs, provided support to the family and this allowed Gavin to remain at home.

As time went on, however, Gavin's needs became greater and his medical needs more complex. His parents came to the difficult conclusion that Gavin's needs would be best met at St. Amant, a residential medical facility. They were surprised to learn, however, that in order to access this specialized care, they would need to place him in the care of a child and family services agency. This despite the fact that there had never been any child welfare concerns identified with the family.

Through our review, we learned that Gavin's involvement with the child welfare system was a stressful and confusing turn of events for his family at an already very difficult time. We learned that the child welfare agency overseeing the VPA failed to explain its role with the family and did not provide adequate case management. Further, the much-needed specialized supports the family had received through Children's Special Services ceased when child welfare became involved.

The conclusion of this office's review made recommendations to Manitoba Family Services and Consumer Affairs to abolish the practice of requiring parents to place their child in care in order to access placement at St. Amant when there are no child protection concerns. Further, case management in these situations should remain with Children's Special Services as they often have been involved extensively and have developed significant working relationships with the family that should not be severed at a time of extreme stress. Funding implications should be adjusted accordingly.

**Name changed to protect confidentiality.*

Aging out of care

The inconsistency of services for young people leaving care at the age of majority continues to be of great concern for the Office of the Children's Advocate.

At a time when young Canadians are living with parents longer into adulthood than previous generations, we continue to expect young people in care to be on their own and fully functional at age 18. Yet we know that young people in care face many more challenges than average in terms of readiness for independence. Even when the very best supportive services are made available to youth aging out of care, independence is a big step. Unfortunately, we continue to see a great many cases where independent living services are not offered in a consistent manner province wide.

Young people with limited functioning are particularly vulnerable after turning 18 as they require greater support than those without challenges. Although, these young people may be eligible for services under the province's Special Needs Program, these services are frequently unavailable to those living outside of Manitoba's urban centres.

We have seen some progress with regard to an increased number of youth in care being granted extended care services beyond age 18, however, a new gap has emerged. In some extended care

situations, a young person may appear and feel prepared to live independently but then experience a set back once out on his/her own. This is a common occurrence among their non-care cohorts who may move between a parent's home and independence a number of times in early adulthood. However, when this happens to a young person in extended care, there is no provision allowing him/her to come back into care once he/she is over the age of 18.

In some fortunate cases, young people who have aged out of care maintain positive, supportive relationships with foster caregivers who offer financial and emotional support on an informal basis. Although the foster parent may see maintaining this connection as a natural extension of his/her foster parent role, there is no support available for those continuing this role after the age of majority. Indeed, some foster parents take on this role despite emotional and financial hardship because there is no one else for the young person to turn to.

To truly offer children in care the benefits and support enjoyed by the average Canadian, Manitoba needs to systematically and consistently provide comprehensive supportive and educational services to young people entering adulthood. Extension of care services at least until the age of 21 should be the norm rather than the exception.

Convention on the Rights of the Child

Article 20: You have the right to special care and help if you cannot live with your parents.

Recommendations:

That the Province give consideration to "flexible" extensions of care that allow youth to re-enter care if needed and that these be pursued for all youth in care.

***Jade's Story**

Sometimes turning 18 is no cause for celebration

Three weeks before her 18th birthday, an individual called the Office of the Children's Advocate concerned about Jade. She said that Jade was to be discharged from the permanent care of a CFS agency without having received any supports to prepare her for independence. The caller reported that Jade would not even have a place to live once she aged out of care. We spoke to Jade and, indeed, she said she was nervous about turning eighteen. She confirmed that she had no plan in place beyond being told she'd be "on her own" once her birthday came. Jade wished she could be in an independent living program so she could learn skills, and become more confident about being on her own.

According to the Child and Family Services Standards Manual (Section 1.1.3) child and family service agencies are to ensure that a plan for a child aged 16 and older includes preparations for becoming an adult such as: referral to appropriate adult services; extension of support services and development of other support systems, and assessment and development of skills for independent living. There are also provisions under the *CFS Act (50(2))* for extending support to a permanent ward beyond termination of guardianship up to the age of 21 years.

Our advocacy officer found out that two months prior to Jade's 18th birthday, her foster placement broke down leading to her placement in an emergency shelter. Prior to the placement breakdown, the plan was for Jade to age out of care from the foster home to a relative in her home community. Jade had expressed that she did not want to return to her home community and the agency revealed that locating housing for her in Winnipeg had been difficult.

The advocacy officer facilitated a meeting including Jade and the agency. Jade was able to express her concerns and views to the agency worker and as the result, the worker agreed to apply for a six-month extension of care. During the extension, Jade would move into a different foster home and a one-on-one support worker would help Jade acquire skills necessary for independent living including basic life skills, employment search skills and job training.

**Name changed to protect confidentiality.*



COMMUNITY INVOLVEMENT ACTIVITIES

Community Involvement Activities:

The Children's Advocate continues to be involved in youth rights activities on a national and international level. This is carried out mainly through involvement with other youth serving organizations or advocacy offices such as:

- Canadian Council of Provincial Child and Youth Advocates (CCPCYA)
- Child Welfare League of Canada Board of Directors
- CIS Steering Committee (Canadian Incidence Study)

The Children's Advocate also attended conferences that focused on child and youth issues such as:

- Connecting Now for the Future CWLC conference, Montreal, QC
- Second National Invitational Symposium on Child & Youth Mental Health, Ottawa, ON

On a provincial level, the Office of the Children's Advocate attended the following events:

- Suicide among First Nations, Métis and Inuit Youth in Canada, Winnipeg, MB.
- Manitoba Youth Centre Pow Wow.
- Manitoba Foster Family Network 2009 Conference, The Pas, MB.
- Keeping the Fires Burning, Winnipeg, MB.
- Social Work Homecoming 2009, Winnipeg, MB.
- General Authority AGM, Winnipeg, MB.
- Manitoba Youth Centre Conference, Winnipeg, MB.
- CASP 2009 National Conference.
- MATC Annual General Meeting, Winnipeg, MB.
- MB Aboriginal Youth Achievement Awards, Winnipeg, MB.
- Western CFS Agency AGM, Carmen, MB.
- Boys & Girls Club of Winnipeg, President's Lunch, Winnipeg, MB.

This year, the Children's Advocate and staff travelled to the following communities to provide information on child and youth rights and address specific concerns regarding children and youth:

- Winkler
- Waterhen
- Teulon
- Thompson
- Nelson House
- Lac Brochet
- The Pas
- Swan River
- Steinbach
- Split Lake
- Sioux Valley
- Skownan
- Shamattawa
- Selkirk
- Sandy Bay
- St. Theresa Point
- St. Pierre
- St. Clement
- Sagkeeng
- Pine Falls
- Roseau
- Rolling River
- Powerview
- Portage la Prairie
- Peguis
- Fisher River
- Pauingassi
- Lorette
- Lockport
- Little Grand Rapids
- Kleefeld
- Hollow Water
- Grunthal
- Flin Flon
- Eriksdale
- Camperville
- Dauphin
- Clandeboye
- Brandon
- Bloodvein
- Berens River
- Beausejour
- Norway House
- Poplar River

Presentations and Submissions

This fiscal year, the Children's Advocate and staff of the OCA made presentations to the following organizations:

- Family Violence Prevention Branch
- AFM youth services staff at 200 Osborne St.
- Student Services Forum, MB Education
- Voices, Manitoba Youth in Care – Diva Day
- Kiwanis Group
- Urban Circle Training Centre
- Sex Workers Addressing Treatment Training
- Inner City Work Program, U of M.
- Youth Recreation Students, Red River College
- Frontier School Division, 32nd Annual School Conference
- WCFS, Foster Parents, Social Workers, Support Workers

OCA Involvement on Committees

This year the Children's Advocate and the staff of the OCA participated on the following community committees:

- Child Inquest Review Committee (CIRC)
- Provincial Advisory Committee on Child Abuse (PACCA)
- Voices, Manitoba Youth in Care
- Canadian Council of Provincial Child and Youth Advocates
- Advisory Committee for Sexually Exploited Youth
- Child Health Women's Health and Child and Family Services Working Group
- Social Planning Council of Winnipeg
- Child Welfare League of Canada
- CIS Steering Committee (Canadian Incidence Study of Reported Child Abuse and Neglect)

Web Site Statistics

In January 2010, the OCA launched its new website.

Visits to our website continue to be very popular, largely driven by people viewing and downloading information from the major child welfare reviews we completed and posted on the website. This year more than 243,634 people visited www.childrensadvocate.mb.ca.



Year-end Statistical Analysis Advocacy Services

April 1, 2009 to March 31, 2010

Advocacy Services Program

Year End Statistical Report for 2009 – 2010

April 1, 2009 to March 31, 2010

Advocacy Services	2008-2009	2009-2010
Total Requests for Service	1803	2296
Total Case Files Opened from requests in 2007-08	693	836
Child Inquest Review Committee (CIRC) files	—	1
System Issue Files	18	7
Case Files Open from Previous Year	334	234
Total Cases worked on in Fiscal 2008-09	1045	1078
Total Case Files Closed	811	735
Case files remaining open at end of fiscal year	234	343

Systemic Issues and special investigations continue to be an integral part of the mandate of the OCA. Systemic issues continue to be a fundamental part of the mandate of the OCA. This fiscal year, the OCA opened 7 systemic files.

Systemic reviews are completed where systemic (program specific or system wide) issues are evident. The reviews are usually generated from data gathered at the Intake level but can also be revealed during the advocacy intervention level. These reviews are conducted when;

- The concern raised is not an isolated or singular incident but occurs across the program or system.
- The incident is of a serious nature where a child or youth's safety was and continues to be a concern and/or there is a clear violation of a child's or youth's human rights.
- The system has continually failed to effectively respond to the complaints raised.

Systemic reviews remain an integral part of the OCA mandate but our ability to complete these specialized investigations and reviews continues to challenge our existing resources. An example of one of the reviews we closed this year was in relation to a concern raised by a community that the agency serving them was not responding to their concerns. Community members and groups reported children in the community were out at all hours and not under the control of their parents. An additional concern was that the children and families had lost a major support when their friendship center had closed down. An additional concern raised by collaterals in the community was, that there was no agency worker attached to the community; the nearest worker being a few hours away. This meant community members often felt that they had to intervene and support children at risk until the agency could send out a worker. And finally there appeared to be some confusion as to which agency was responsible for the community.

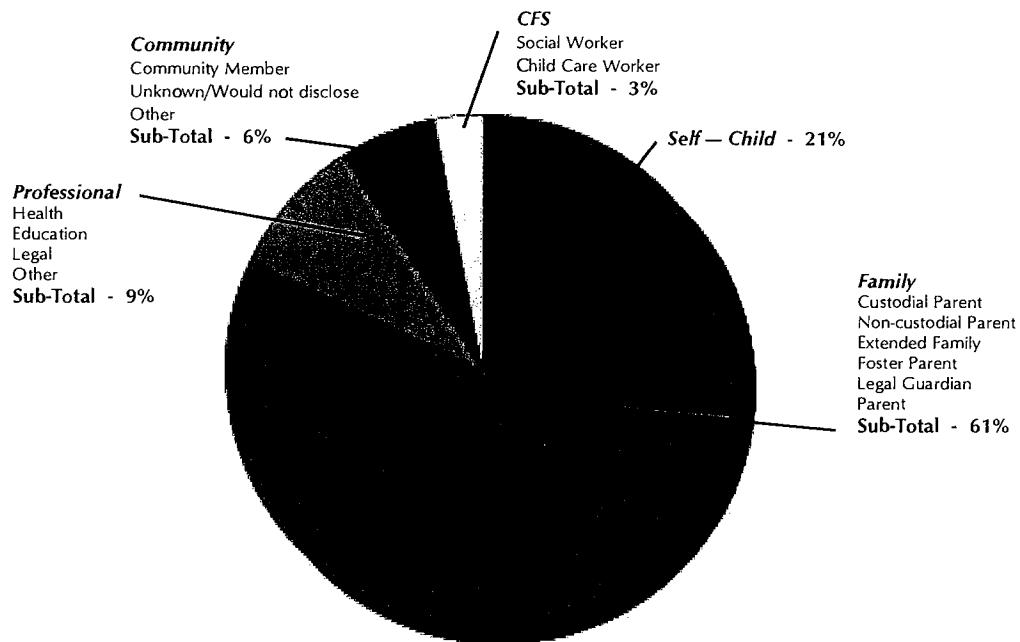
The OCA became involved and held two meetings with the various community residents and groups to assess further the various concerns and what supports were available locally to address the issues. The OCA invited both the Authority and the agency responsible to meet with the community in a "town hall" style of meeting to address the communities concerns. The outcome was that the Authority and agency worked together with the community to develop a plan that addressed the safety needs of the children in the community while adding additional supports to the families in the community who were struggling. The Authority also provided information and education to the community groups to assist them in knowing whom to contact and how. And finally the agency assigned a full time worker to the community and also assigned an Authority specialist to support the worker and liaison between the community and the agency and to assist in developing supports for the community. The friendship center was re-opened as was a group home for children and youth who required placement out of home until their family issues could be addressed.

The OCA continued to monitor the success of the process and provided information and support wherever possible as the community developed skills in advocating for their own children and youth.

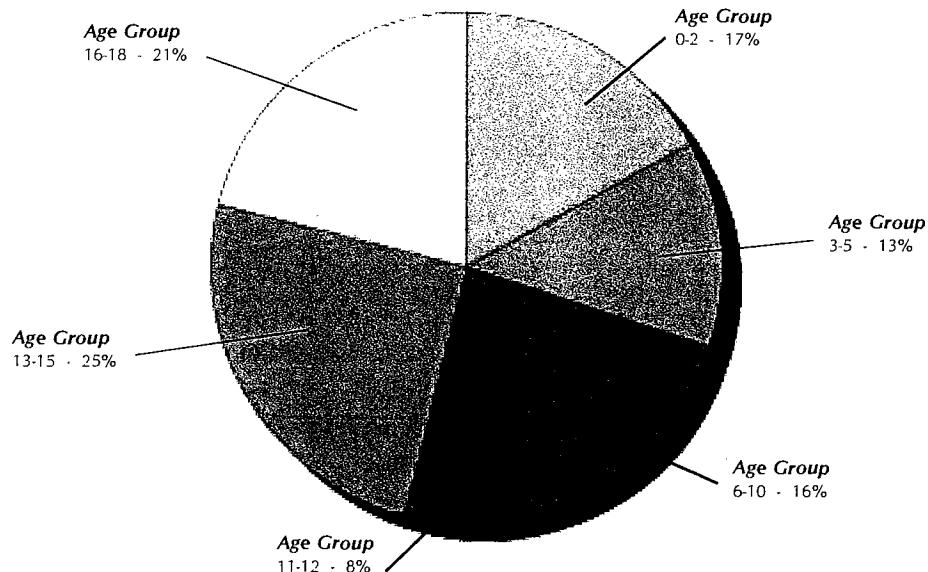
Another systemic concern raised to the OCA was the lack of child-in-care photos on a number of child files. When some of these young persons went missing, the lack of photos made locating them more difficult. Maintaining up-to-date photos on the child's file is a crucial piece in helping stop the sexual exploitation of our youth and is now supported by a directive from the Child Protection Branch requiring all agencies to maintain photographs of all children on their file.

Who Contacted the OCA: (n=836)

Consistent with past years, about 2/3 of OCA case files (61%) were brought to our attention by parents, extended families, and foster parents. Children and youth made up 21% of calls for service.

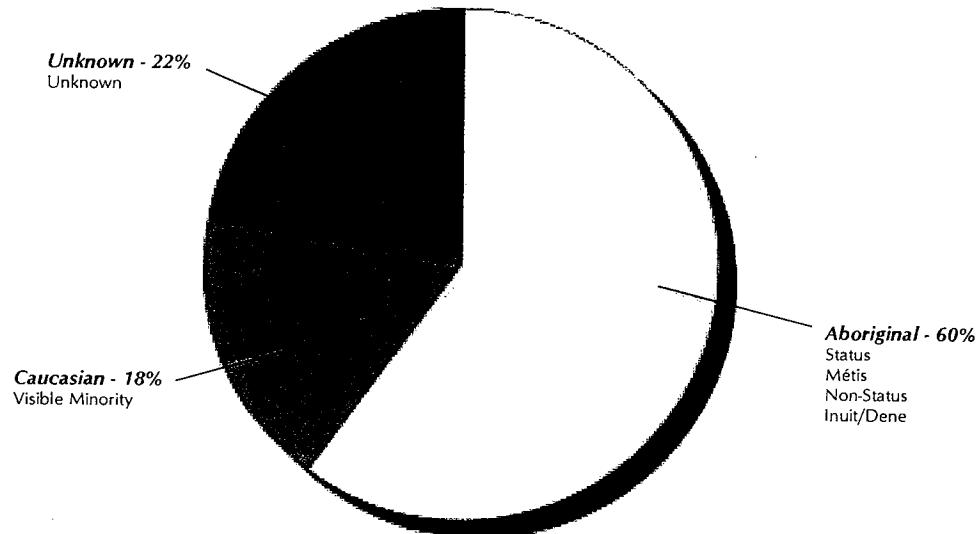


Child's Age and Gender: (n=836)



- Historically, OCA services have been divided relatively equally between male and female. This year we served 81 more females than males.

Racial Origin: (n=836)



- Racial origin is not determined by the OCA. Individuals must self-declare.
- Aboriginal includes Status, Non Status, First Nations, Inuit, Dene, and Métis.

Whereabouts of children/youth when they are not living with their intended placements:

Often when people call the OCA their situation has reached a crisis point. Many youth have run from placements or left home. At times, parents will remove children from "care" situations approved by a private agreement or other formalized custodial arrangements. The OCA tracks this information in order to determine how many children/youth are living away from their intended placements at time of contact.

Since we began tracking this information in 2002, the number of cases where children and youth were not living in their intended placements has steadily dropped from 17% to 5% of youth contacting us or 38 cases this fiscal year. The number increases as children age.

Intended Placement: (n=836)

Placement Type	Number	Percentage
Non-Relative Foster Home	340	41%
Parent/Guardian	162	19%
Receiving Resources/Shelter	56	7%
Relative Foster Home	52	6%
Place of Safety	44	5%
Relative/Friends	44	5%
Group Home	42	5%
Residential Facility	29	4%
On Own	25	3%
Unknown	12	1%
Youth Correctional	11	1%
Mental Health Facility	7	1%
Other	5	1%
Hospital	4	1%
Hotel/Motel	3	-
Total	836	100%

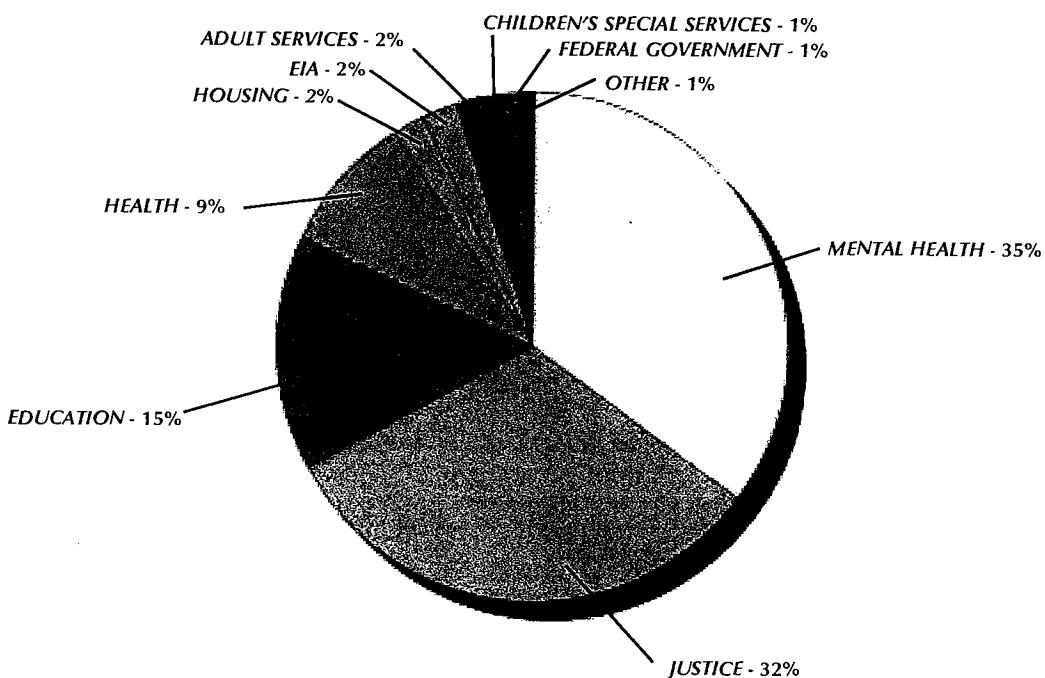
Where the Child or Youth was Living Instead of the Intended Placement:

Whereabouts	Number
Parent/Relative	13
AWOL	9
Friend/Community Member	7
Unknown/Would not disclose	8
Street Shelter	1
TOTAL	38

Dual Mandate Cases:

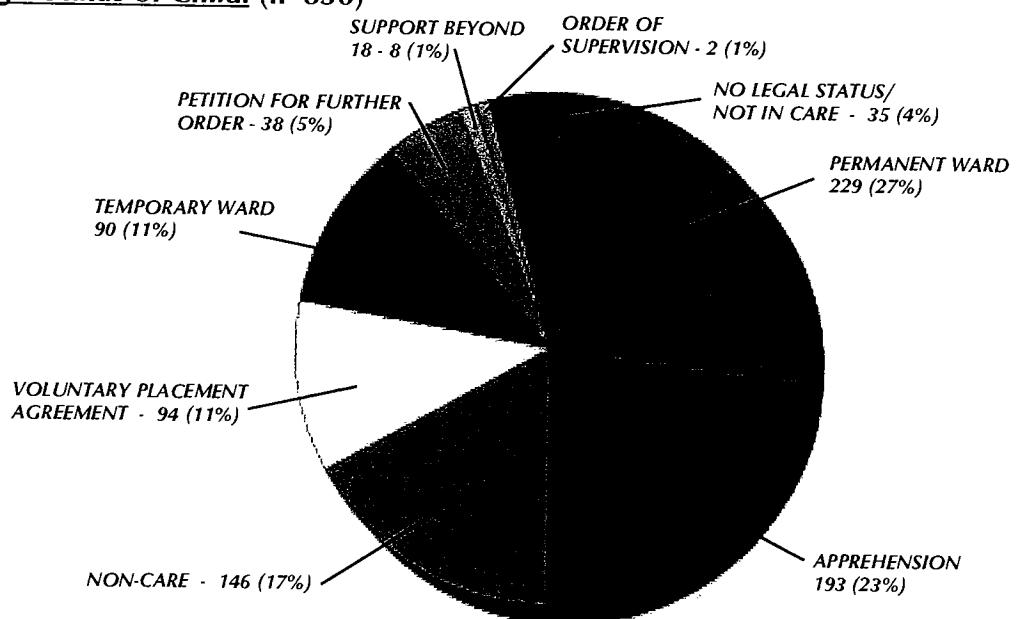
Of the total advocacy case files the OCA opened, 24% were dual mandate cases, meaning the children or youth had involvement with other service systems in addition to a CFS agency. The majority of these cases fall into the youth criminal justice, children's mental health and education systems.

Dual Mandate Cases: (n=198)(836 Case Files)



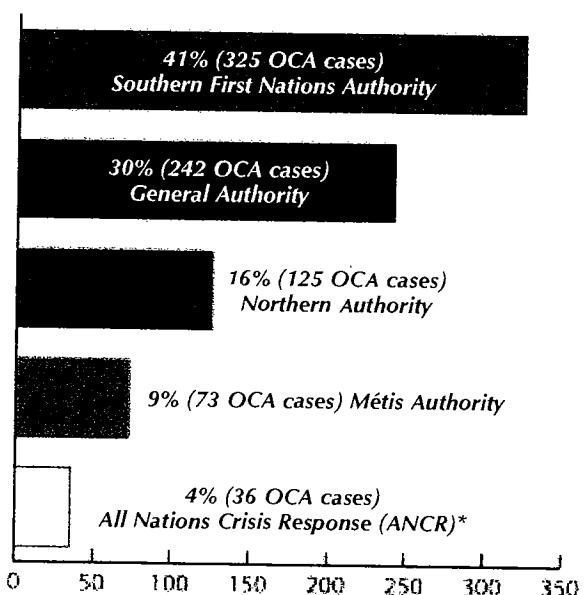
- Children and youth involved in the CFS system often have multiple service providers. The advocacy issue may be central to the CFS system or to other child caring systems.
- Though the CFS worker may be the individual who holds final, often definitive responsibility to and over the child, his/her ability to influence, control and or direct resources of another system to address the needs of the child may be limited in many cases.
 - To be considered a dual mandate case, the case characteristics must include the following:
 - (i) Child/youth had to have current involvement with the CFS system.
 - (ii) Child/youth is not involved with the CFS system but entitled and refused services by a CFS agency/regional office or First Nations agency prior to referral to the OCA.
 - (iii) The case issue resulting in a referral to the OCA was identified as cross-jurisdictional involving another child caring system other than CFS.

Legal Status of Child: (n=836)



78% of the case files involved children and youth in CFS care where the system had a legal responsibility for the child.

Case Breakdown of CFS Agencies: (n=836)

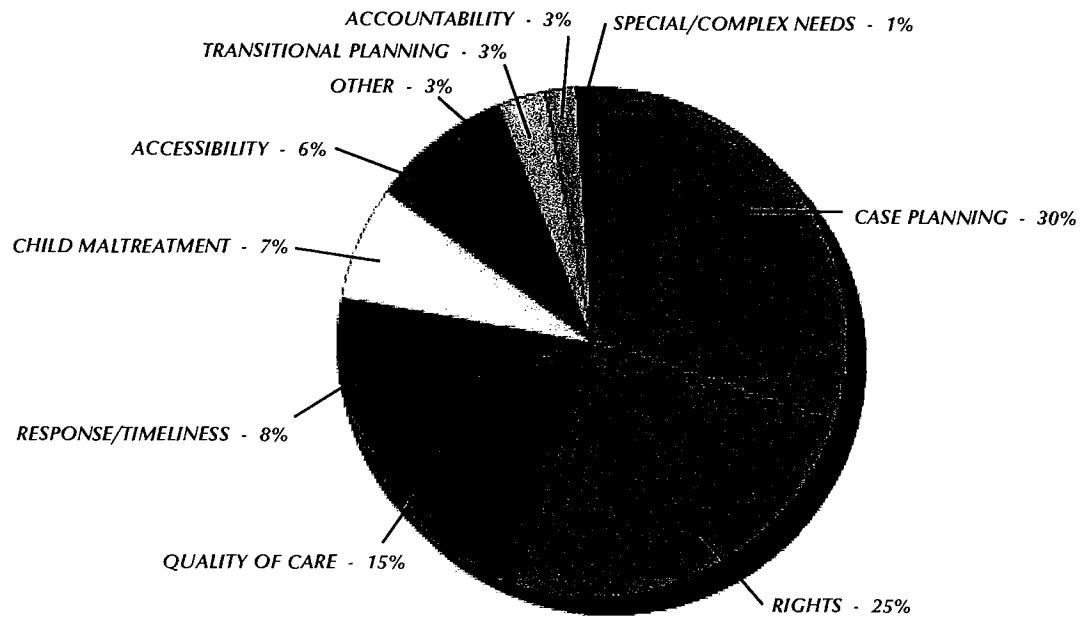


Of the 836 case files, 35 had no CFS involvement at the time contact was made with the OCA. The remaining 801 did have CFS involvement with agencies under the following authorities:

**(While the Southern Authority oversees ANCR, it is listed separately in this report as it provides crisis and intake service for Winnipeg and the surrounding area on behalf of all four authorities.)*

Top CFS Related Concerns: (n=2321*)

OCA Cases may have multiple concerns. This year, our case work yielded 2321 concerns.



- Case planning, youth rights and quality of care issues were the top concerns of 2009-10.
- Year over year, the top concerns have been youth rights, and quality of care issues related to case planning and remain the number one concern consistently since 2001.

Total CFS Related Concerns by Age by Category: (n=2321)

ISSUE	0-2	3-5	6-10	11-12	13-15	16-18	18+	TOTAL	%
Case Planning	163	85	115	62	130	135	0	690	30%
Rights	128	73	82	53	129	99	4	568	25%
Quality of Care	54	39	68	30	90	68	0	349	15%
Responsiveness/Timeliness	25	23	31	20	45	35	0	179	8%
Child Maltreatment	36	22	42	15	26	15	0	156	7%
Accessibility	18	9	27	8	29	38	1	130	6%
Other	11	4	11	2	16	33	1	78	3%
Transitional Planning	0	0	3	0	5	65	5	78	3%
Accountability	18	8	15	3	9	8	0	61	2%
Special/Complex Needs	0	1	3	2	11	4	0	21	1%
Devolution	2	2	2	0	0	0	0	6	-
Adoption	0	2	0	0	2	1	0	5	-
Total	455	268	399	195	492	501	11	2321	100%

Total Issues (CFS Related): 2009-2010

Case Planning remains the primary issue identified by our office. Case planning is further broken down as noted below.

Category	Number	Percentage
Case Planning		
Disagree/Refusal of/with CFS	312	45%
Lack of case planning	77	11%
Lack of planning for family	66	10%
Lack of appropriate protection plan	66	10%
Lack of child participation	50	7%
Poor reunification planning	40	6%
Lack of service standards	27	4%
Other	22	3%
Lack of permanency planning	19	2%
Change of worker	11	2%
Lack of parental/family participation	0	-
Lack of worker contact	0	-
	690	100%
Rights		
Lack of information	238	42%
Lack of consideration	130	23%
Lack of participation	130	23%
Lack of knowledge of advocacy	54	10%
Lack of legal advocacy	16	2%
	568	100%
Quality of Care: Child in Care		
Access/visitation to CIC	144	41%
Lack of appropriate care resources	34	10%
Other	34	10%
Mental health intervention/treatment	22	6%
Inappropriate use of intrusive measures	17	5%
Too many placement moves	20	6%
Lack of education program	11	3%
Child AWOL	12	3%
Lack of health care	11	3%
Lack of clothing	21	6%
Inappropriate discipline acts	8	2%
Lack of recreation	7	2%
Lack of food	4	1%
Lack of privacy	3	1%
No contact with peers	1	1%
	349	100%
Response/Timeliness		
Unresponsive	97	54%
Service delays	35	20%
Over response	32	18%
Administrative delays	15	8%
	179	100%



Year-end Statistical Analysis Special Investigation Reviews

April 1, 2009 to March 31, 2010

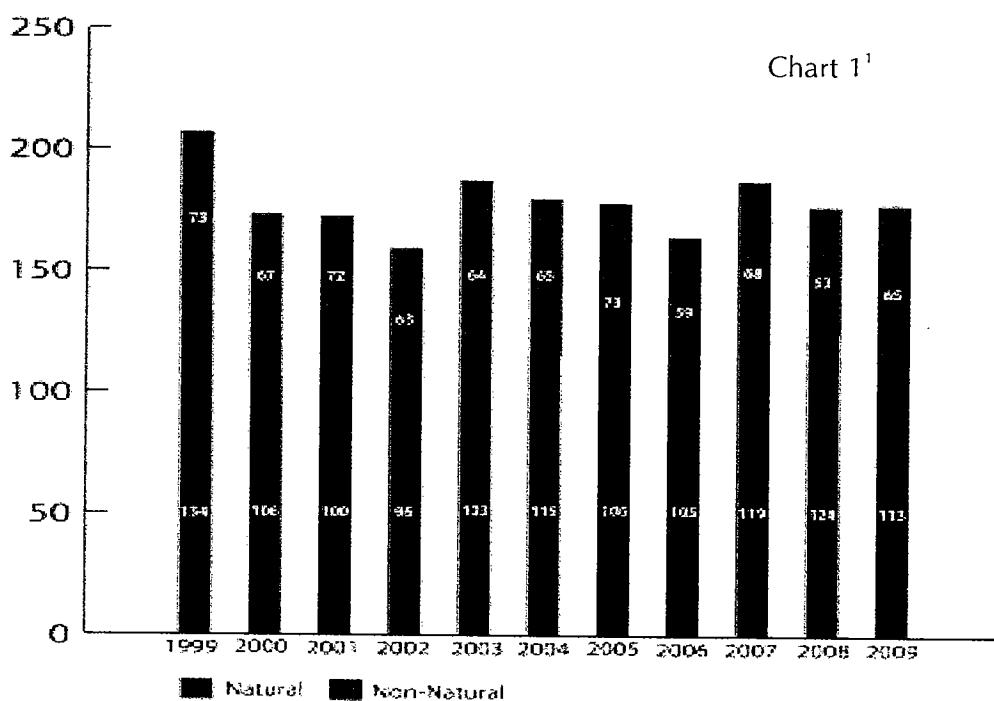
SPECIAL INVESTIGATION REVIEWS

An Overview

Child Deaths in Manitoba 2009-2010

The Office of the Children's Advocate is responsible for reviewing services provided to a child in receipt of services from a child and family service agency within 12 months of his/her death.

In the 2009-2010 fiscal year, our office was notified of the deaths of 177 Manitoba children. The Office of the Chief Medical Examiner (OCMA) determines the manner of death of each child according to an established protocol. Manner of death is described as natural, accidental, suicide, homicide or undetermined. The majority of child deaths are determined to be natural (See Chart 1). In the chart below, all deaths not known to be the result of natural causes are counted as non-natural deaths.



As demonstrated by this chart, the total number of deaths of children in Manitoba has remained reasonably consistent over the past 10 years with an average of 179 child deaths occurring each year and an average of 113 of those being due to natural causes.

¹ The data used in this chart is directly from the Office of the Chief Medical Examiner (OCME). The OCME reports on data by calendar year. The OCA reports its data based on the fiscal year. Therefore there are slight differences in the numbers reported by the OCME and the OCA.

Further detail on the manner of death for children in Manitoba is provided in Table 1. This table is based on the fiscal year as reported by the OCA and is therefore slightly different from the numbers reported by the OCME for the calendar year. However, it is clear that most child deaths fall into the natural category. Deaths are declared undetermined when there is insufficient information to clearly specify a manner. This may include the deaths of children who die from unknown causes (e.g. sudden infant death syndrome) or deaths where the cause may be known but other factors are unclear (e.g. self-inflicted or inflicted by another).

Manner of Death - Manitoba Child Death Notification: (n=177)

Table 1

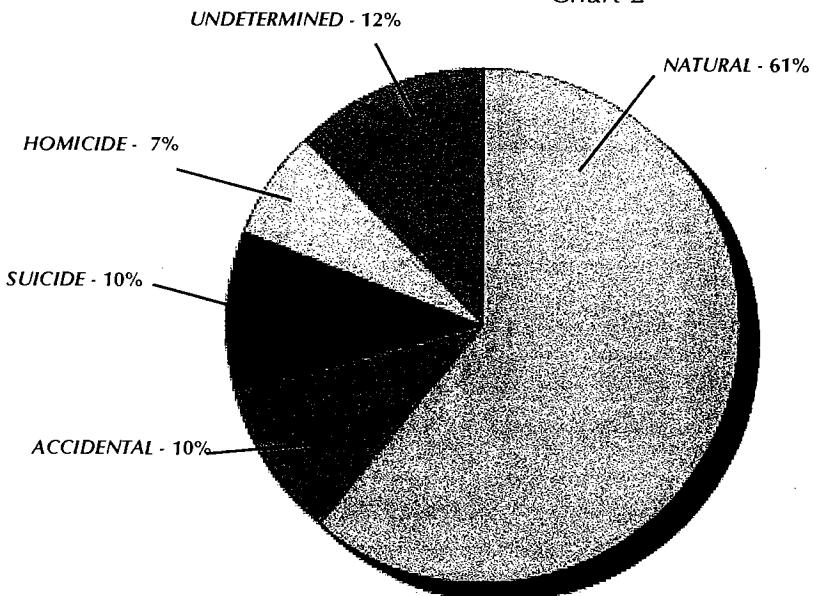
Manner	Number	Percentage
Natural	108	61%
Medically fragile	44	
Prematurity	45	
Disease	15	
Other	4	
Accidental	17	10%
Other	3	
Drowning	4	
In the home	3	
Motor vehicle	7	
Suicide	18	10%
Homicide	13	7%
Undetermined	21	12%
Total deaths	177	100%

Manner of Death - Manitoba Child Death Notification: (n=177)

A more detailed review of the child deaths indicates the following:

- The majority of deaths (104 or 59%) occurred in children between 0 and 2 years of age.
- In that age group, prematurity accounted for 45 of 104 or 43% of the deaths.
- Youth between 16 and 18 years accounted for 16% or the next largest proportion of deaths.
- Suicide was the manner of death for 13 young teens in the 13 to 15 year age group

Chart 2



Reviewable Child Deaths

Special Investigation Reviews 2009-2010

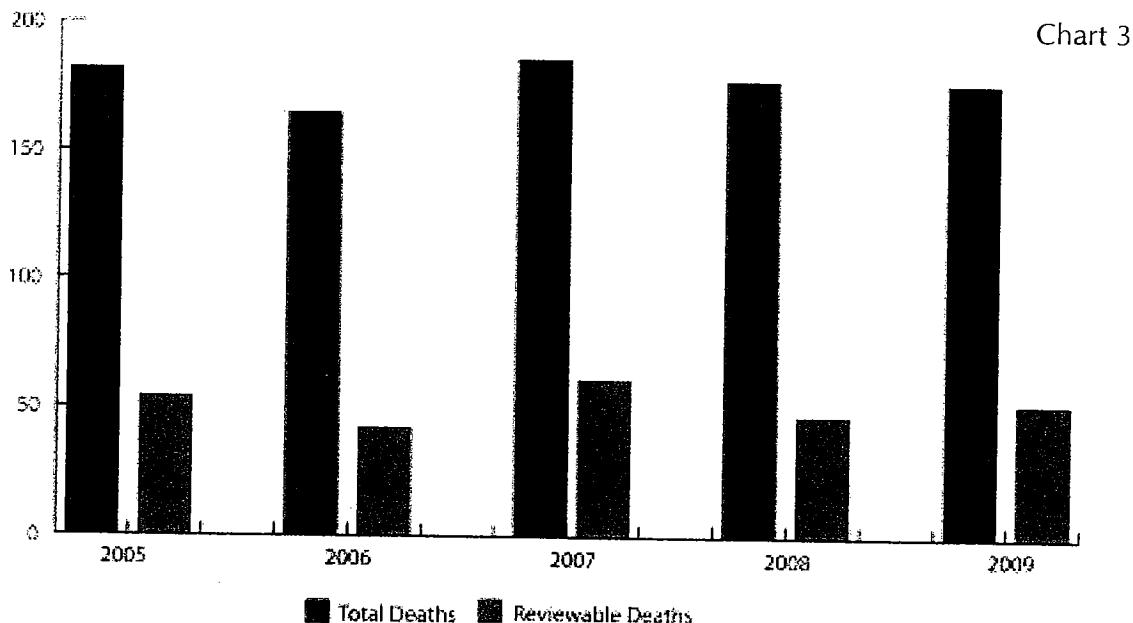
As shown in Table 2, the number of child deaths requiring a special investigation review totaled 52 (child welfare cases closed within one year and open cases). Note that of all the child deaths in Manitoba, 50% occurred in families that were not known to child welfare, and 25% occurred in families that were currently involved with the child welfare system.

Manitoba Child Deaths: Nature of CFS Involvement: (n=177)

Table 2

Manner	Number	Percentage
CFS Involvement		
No record of CFS involvement	88	50%
No record of CFS involvement last year	37	21%
Closed case within one year	7	4%
Open case	45	25%
Total cases	177	100%

The number of deaths that fall under our office for review can be compared over the past five years as shown in Chart 3. In that time period, the average number of child deaths per year was 177, the average number of reviewable deaths was 51 or 28.8% of all deaths. At 177 deaths and 52 or 29.2% reviewable deaths, the numbers for 2009-2010 are reflective of the past five years.



The activity of the Special Investigation Review Unit is summarized in Table 3. Of the 177 deaths, 52 were identified for review and 21 reports were completed and forwarded to the Minister of Family Services and Consumer Affairs. Of those completed reports, 15 were investigations of files that were transferred from the Office of the Chief Medical Examiner following the proclamation of the enhanced mandate of the Children's Advocate September 15, 2008 and six were reviews related to deaths following proclamation.

Table 3 includes the number of files remaining of the backlog of cases that was transferred from the OCME following proclamation. Those files are referred to in the table as pre-proclamation cases. The Department of Family Services and Consumer Affairs continues to support the staff who are working to complete those reviews.

Table 3

Special Investigation Review		2009-2010
Child Death Notifications (April 1/09-March 31/10)		
Non-resident deaths		1
Manitoba child deaths		177
Total child deaths		178
Open Files (April 1/09-March 31/10)		
Carried over Pre-proclamation cases		99
Carried Over SIR (29) and Pending (13)		42
Total carried over from 2008-09		141
Files Closed (April 1/09-March 31/10)		
Pre-proclamation cases with reports		15
SIR reports not necessary (closed no report Apr1-Mar31)		140
SIR with reports		6
Total closed files		161
Files Carried Over to April/10		
Pre-proclamation transferred cases		84
SIR reports required		75
SIR determination pending		0
Total files carried over		159

The following charts and tables provide detailed information on the group of 52 child deaths identified for special investigation review. Table 4 outlines the manner of death of each child in the reviewable group.

Note that reviewable deaths mirror the deaths in Manitoba in that the greatest proportion of deaths are considered to have occurred naturally. Compared to the general population, the reviewable group has a lower proportion of accidental deaths but a higher proportion of deaths by suicide. Of all the suicide deaths in Manitoba in 2009-2010, two-thirds involved youth who were or had been receiving services from an agency. Because suicide deaths are of great concern to this office and to the child welfare system, this report will examine those deaths more closely in a later section.

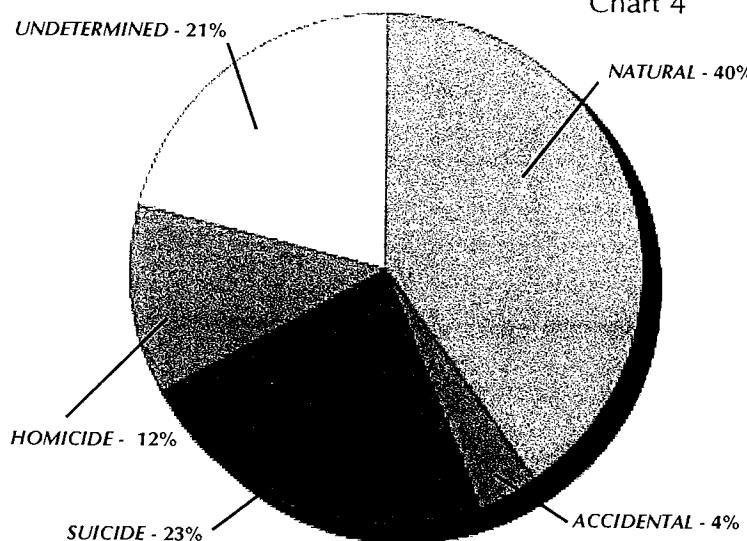
Manner of Child Death – SIR: (n=52)

Table 4

Manner	Number	Percentage
Natural	21	40%
Medically fragile	11	
Prematurity	9	
Disease	1	
Other	0	
Accidental	2	4%
Other	1	
Drowning	0	
In the home	0	
Motor vehicle	1	
Suicide	12	23%
Homicide	6	12%
Undetermined	11	21%
Total deaths	52	100%

Manner of Child Death – SIR: (n=52)

Chart 4



As with general Manitoba child deaths, the largest proportion (44%) of reviewable deaths occurred among children 0-2 years of age with prematurity being a leading cause. Teens in the 13-15 year group and the 16-18 year group each accounted for 19% of the total reviewable deaths. This was somewhat higher than the proportion of teen deaths in the general population where those deaths represented 12% and 16% respectively of all deaths. The greatest differences, however, are noted in the proportion of suicides, where suicides were the manner of death for 23% of the reviewable deaths but only 10% of all deaths.

Table 5 below indicates which agency and authority was providing services that will be the subject of a review. Reflecting on the number of deaths occurring within the agencies of each authority, it is important to also consider as context the number of families served by each authority. A summary of the of number of children and families served by authorities reported in the 2008-2009 Annual Report of the Minister of Family Services and Consumer Affairs follows in Table 6.²

SIR Child Deaths: By Agency and Authority 2009-2010: (n=52)

Table 5

Manner	Number	Percentage
General Authority		
WCFS	4	
Eastman	1	
CFS Western	1	
Subtotal	6	12%
Métis Authority		
Métis	6	
Subtotal	6	12%
First Nations Northern Authority		
Awasis	9	
Island Lake	2	
Cree Nation	7	
Nisichawayasihk	2	
KSMA	1	
Undetermined	1	
Subtotal	22	42%
First Nations Southern Authority		
ANCR	3	
ACFS	2	
Southeast	5	
Peguis	1	
DOCFS	1	
West Region	3	
Sandy Bay	3	
Subtotal	18	35%
Total Cases with CFS Involvement	52	*100%

*Totals affected by rounding numbers

²The 2008-2009 Annual Report provides numbers of cases as of March 31, 2009. The report is on line:
http://www.gov.mb.ca/fs/about/annual_reports/2008-09/FSH_Annual_Report_08_09_en.pdf

Table 6

Authority	Children in Care	Percent	Families Served	Unmarried Teen Parents	Total	Percent
FN South	4,194	49%	3,121	101	7,416	40%
FN North	2,079	24%	2,239	199	4,517	24%
General	1,639	19%	3,407	77	5,123	28%
Métis	717	8%	743	11	1,471	8%
Total	8,629	100%	9,510	388	18,527	100%

Given the number of children in care and the number of families served, it would be reasonable to expect that the greatest proportion of child deaths would be experienced by the Southern First Nations Child and Family Services Authority and their agencies. However, it appears that with 49% of children in care, the Southern Authority experiences 35% of the deaths, while the Northern First Nations Authority with 24% of the children in care and providing 24% of overall services, experiences 42% of the reviewable child deaths. This raises questions about factors that are affecting child health and safety in regions served by the Northern Authority agencies. One factor for example may be related to technical difficulty affecting data entry into the child and family services information system. As connectivity issues and technical training needs are resolved this difference may lessen. However, the differences do highlight an area that needs to be explored further.

Children in Care

Each year, a small proportion of child deaths occur in children who are in care. In 2009-2010, 14 of the 177 child deaths involved children in care of an agency at the time of their death.

Child in Care Deaths: (n=177)

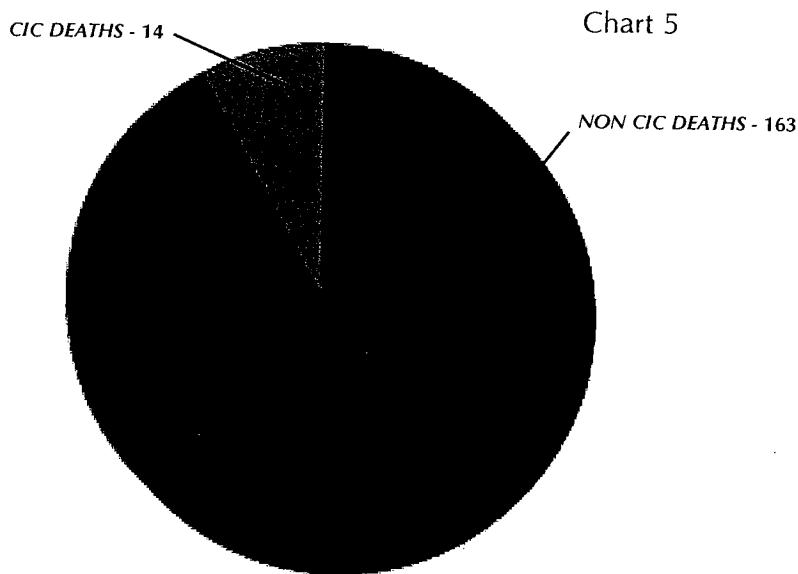


Table 7 outlines the nature of the association with an agency of each child who is the subject of a review. Only seven of those children had a closed file at the time of their death. The greatest numbers of children who are part of a review were family members where there was an open family file. A small number were actually in care and Table 7 identifies their legal status at the time of their death.

SIR Child Deaths: Nature of CFS Involvement 2009-2010: (n=52)

Table 7

CFS Involvement	Number	Percentage
Closed Case within One Year	7	12%
Open Case	45	
Legal Status in Open cases		
Permanent ward	3	
Temporary ward	3	
VPA	5	
Apprehension	3	
Total CIC	14	27%
Non-Care	31	61%
Sub-total	45	88%
Total Cases with CFS Involvement	52	*100%

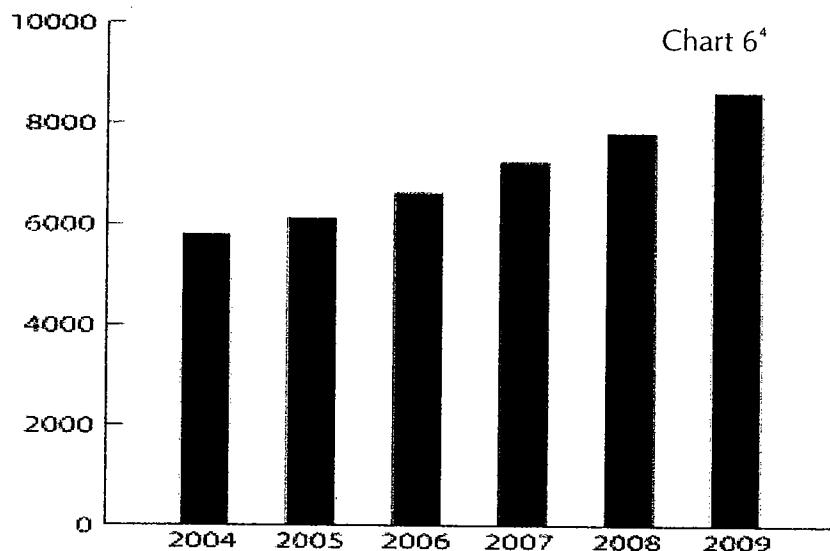
As was shown in Chart 3, there has been no identifiable trend or increase in the number of reviewable deaths over the past five years. Earlier comparisons are limited by the availability of data.

However, there has been a demonstrable increase in the number of children in care over that same time period (Chart 6).

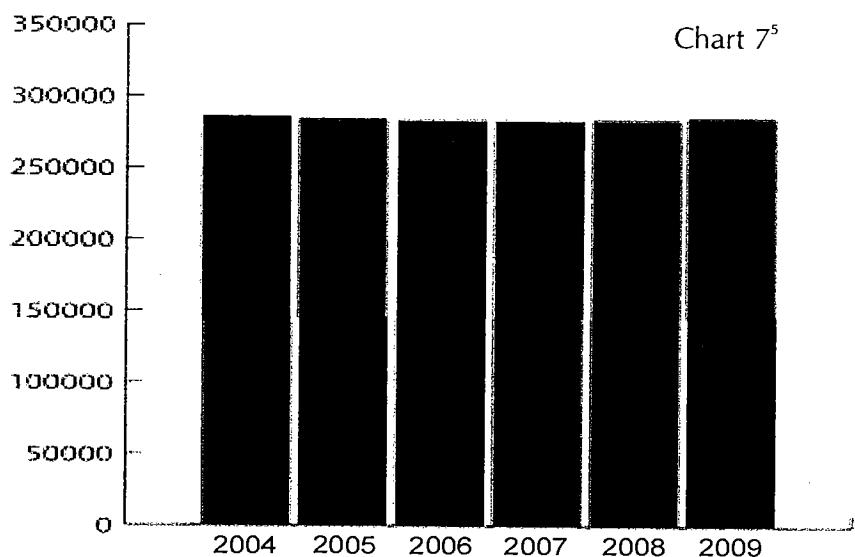
- The number of children in care has increased by almost 3,000 in steady increments of approximately 10% per year from 5,782 in 2004 to 8,629 in 2009³.
- Although there has been a marked increase in children in care, the population of children in Manitoba has not shown a parallel increase over that same time period (Chart 7).
- This means that the proportion of children in Manitoba who are in the care of an agency has increased significantly over the past five years from 2% of the population in 2004 to 3% of the population in 2009 (Chart 6).

³ Manitoba Family Services and Consumer Affairs reports annually on the number of children in care at March 31 of their reporting year. Annual reports are available on line: http://www.gov.mb.ca/fs/about/annual_reports.html

Number of Children in Care



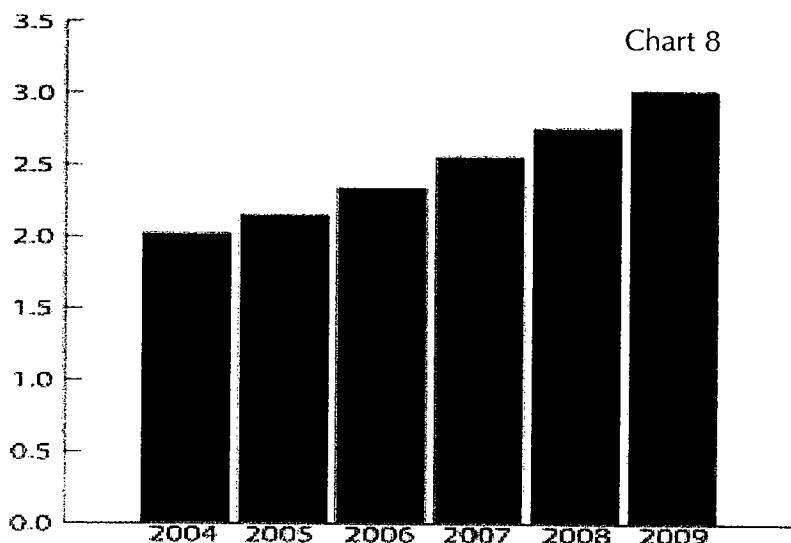
Manitoba Child Population (0 - 17 Years)



⁴ Manitoba Family Services and Consumer Affairs reports annually on the number of children in care at March 31 of their reporting year. Annual reports are available on line: http://www.gov.mb.ca/fs/about/annual_reports.html

⁵ Manitoba Health reports annually on the child population of Manitoba. Their report is based on the records of residents registered with Manitoba Health as of June 1 of the reporting year. The population reports are available on line: <http://www.gov.mb.ca/health/population/index.html>

Number of Children in Care as a Proportion of Children in Manitoba



The reasons for this increase in the number of children in care are not clear. It may reflect an increase in the number of families in crisis. Economic downturn places increased stress on families and may account for some of the increase. It is also possible that the agencies working under the authorities are able to follow families more effectively and are more aware of children who may be at risk. Another factor may be the changing population demographic. Although the number of children in Manitoba is not increasing, the birthrate among aboriginal Manitobans is significantly higher than that of the general population. As more than 80% of the children in care are Aboriginal, part of the increase in children in care may be simply a reflection of an increased population at risk.

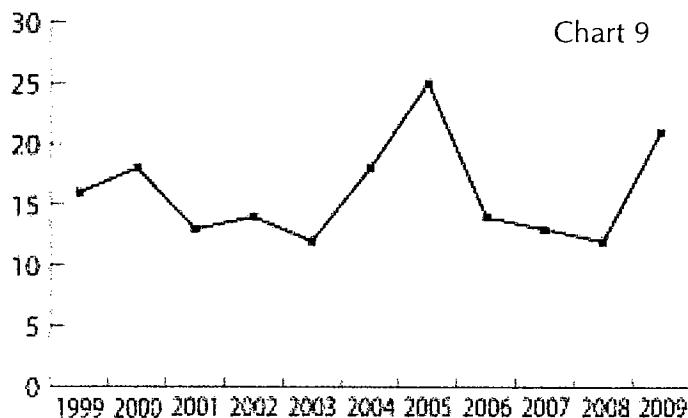
Youth Suicide

The loss of life through suicide stirs a deep response in families and caregivers alike. Preventing the death of a child is a priority for all. However, the continuing loss of young life to suicide, a preventable death, cries out for increased efforts to understand and address the causes of hopelessness among young people. It requires us to explore what makes some youth resilient and how to build that resiliency.

The following section looks at youth suicide throughout Manitoba and, in particular, among youth involved with the child welfare system. The purpose of including this examination of suicide is to describe its occurrence and raise awareness as a first step in the exploration of best practices in meeting the needs of youth at risk of suicide.

Since 1999 the number of suicides occurring annually in those under 18 years of age ranged from a low of 12 in 2003 to a high of 25 in 2005.⁶ The average number for that time period was 16. See chart 9. In 2009, the OCME reported 21 suicides which approached the highest annual number in the past 11 years.

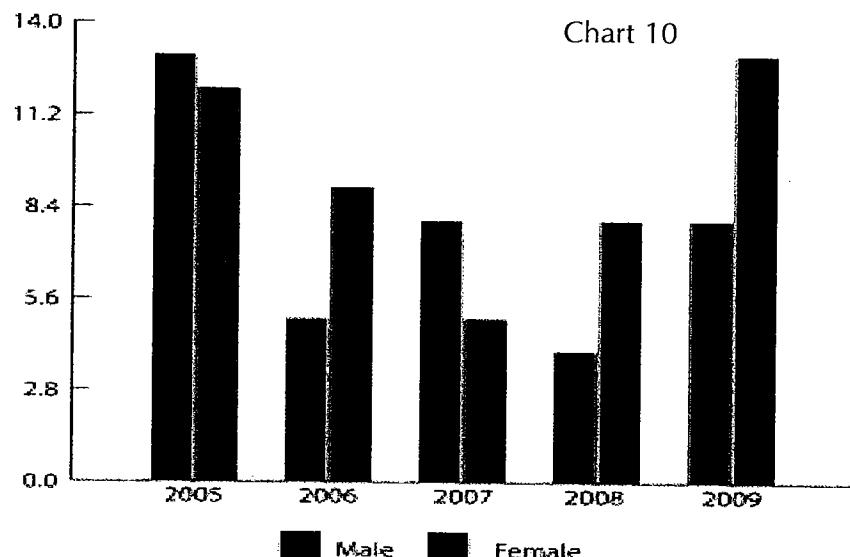
Youth Suicide Deaths in Manitoba



In the past, death by suicide has been noted to occur six times more often among young men than young women and 50-64% died by gunshot in the period 1950-1990 (Cutler, Glaeser, & Norberg 2001).⁷ This has changed, at least in Manitoba, where young women dying by suicide often outnumber the young men. In the past five years, the average number of male deaths was 7.6 while 9.4 was the average number of female deaths. (See chart 10) Most commonly, death was caused by hanging regardless of gender.

⁶ The Office of the Chief Medical Examiner is the source of this data on suicide. Therefore, it reflects a calendar year and will differ slightly from numbers reported based on OCA data collection. This diversity in reporting is necessary until the OCA has sufficient historical data.

⁷ Cutler, D., Glaeser, E., Norberg, K. (2001). Explaining the rise in youth suicide. Harvard Institute of Economic Research, Discussion Paper 1917. Available on line: http://www.canadiancrc.com/PDFs/Harvard_discussion_paper_No_1917.pdf



The number of suicide deaths in the 2009-2010 fiscal year was 18 and, as reported earlier, 12 of those deaths occurred in youth who had involvement with the child welfare system. Special investigation reviews will be conducted related to each of those deaths. Only three of the youth were in care at the time of their deaths. One was in care under a voluntary placement agreement; one under apprehension and one was a temporary ward.

The age of all those who died by suicide in 2009 is summarized in Chart 11. The age distribution of reviewable deaths in 2009-2010 follows a similar profile with the greatest number of deaths occurring in those aged 15. It is particularly disturbing to note the number of deaths occurring in children age 13 to 15 years.

In summary, 2009 saw a high number of deaths by suicide among youth with the greatest number dying in the 13 to 15 year age group. The death of girls appears to be increasing in relation to the death of boys. Hanging deaths are common.



SIR Themes Arising from the Special Investigation Reviews

In 2009-2010, the Special Investigations Unit completed 21 reports and forwarded them to the Minister of Family Services and Consumer Affairs. We noted many instances of good practice. We saw many examples of workers who provided exemplary service and agencies that were able to assess and address family needs in spite of resource limitation.

Of the reports we submitted, 19 contained recommendations. The number of recommendations totaled 217. Recommendations were made to Child and Family Service agencies, Authorities and the Child Protection Branch. We directed some recommendations, 13 in total, to other service providers including mental health, addictions and other publicly funded social services.

We identify three main themes in the recommendations to the child welfare system: case management, accountability and training.

Case Management

The most frequently cited area for improvement was case management, which was the focus in 65 recommendations. Case management is well outlined in provincial standards and speaks to the process of providing service in a series of defined steps moving from intake through assessment and planning to service delivery and evaluation. The special investigation reviews noted that assessment and risk assessment were particularly troubling areas as were issues related to both service delivery and planning.

Accountability

We made 52 recommendations in the area of accountability. Almost half of those recommendations spoke to shortcomings in the areas of documentation and reporting practices. Some files were found to be inadequate in both the amount and quality of recording. This is especially troubling where children or families are changing placements, changing workers and/or changing agencies. Without solid recording, history is lost, assessments are wasted and planning must continually be repeated. The areas of funding, caseload size, staffing and staffing resources jointly speak to stress within a system that expects more than can possibly be delivered with its current resource base. Caseload size continues to be a barrier to best practice service delivery and we can see the impact in case management and accountability as noted above.

Training

We repeatedly note the necessity of increased or improved training for workers, supervisors, and service providers. The four Authorities and the Child Protection Branch continue to strive to increase the quality and availability of training opportunities. However, the breadth and depth of knowledge demanded in the current service delivery milieu is remarkable. Workers need to master the core competencies but that foundational piece is only the beginning. In addition to keeping up-to-date in areas of expanding knowledge such as post-traumatic stress and fetal alcohol spectrum disorder, agencies and service providers are stretched to learn better ways of delivering service to children and families increasingly troubled by addictions, gang involvement, and sexual exploitation. Increasing numbers of agency workers and service providers further increases the pressure on training resources as new untrained people enter the field.

In addition to the largest themes, we also noted issues related to placements and service providers with some frequency. It is troubling to discover that children have been placed in situations that have not always been carefully assessed for safety and that may not be adequately supported. At least that much is owed to the children who enter agency care.

Advisory Council

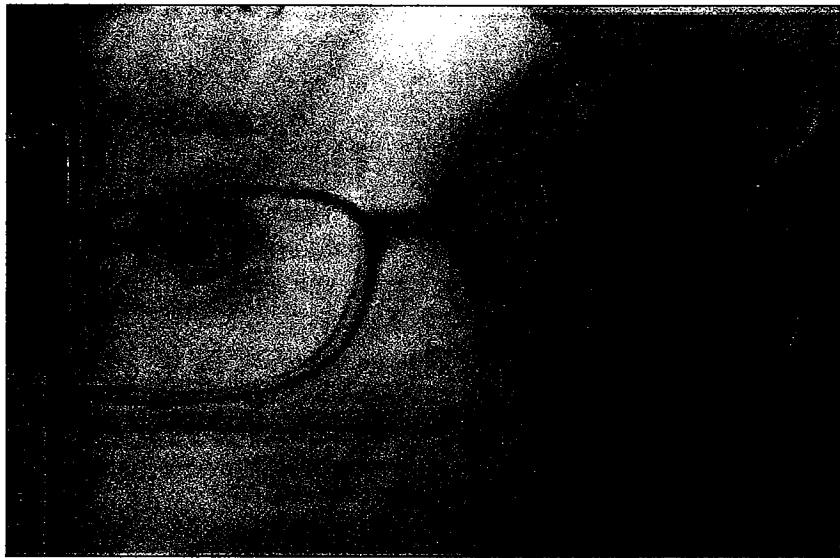
Following the transfer of responsibility for the review of child deaths to the Office of the Children's Advocate in 2008, the OCA determined that a multi-disciplinary advisory team would be beneficial. It was hoped that this team could provide timely, expert feedback on Special Investigation Review recommendations. Towards that end, the OCA assembled a group of (approximately) 15 professionals who would meet four times a year to hear case review summaries, providing feedback to the team of investigators regarding specific practice or policy issues. These are experts in Manitoba who work in specific areas affecting children, youth or families, who can speak to best practice in their area of expertise.

*Advisory Council Members for Special Investigations 2009-2010

Dr. Charles Ferguson	Director, Child Protection Unit
Ms. Marie Christian	Director, Voices-Youth in Care
Dr. Peter Markestyn	Former Chief Medical Examiner
Ms. Margaret Lavallee	Elder, University of Manitoba
Dr. Don Fuchs	Dean, Faculty of Social Work
Ms. Cheryl Fontaine	Therapist, FNIHB
Mr. Peter Rogers	Senior Advisor, Heath Canada
Mr. Cecil Sveinson	Program Manager, Aboriginal Diversity-WPS
Ms. Doris Young	Assistant to the President on Aboriginal Affairs University College of the North
Ms. Myra Laramee	MB First Nation Education Resource Center
Sgt. Chris Ballard	RCMP Criminal Operations Branch
Judge Arnold Connor	Retired Justice
Ms. Anna Fontaine	Director Indian & Northern Affairs
Mr. Selamawi Ezez	Services to Newcomers/Immigrants

We gratefully acknowledge their dedication to the children of Manitoba.

*Complete biographies of Council Members are available on the OCA website at www.childrensadvocate.mb.ca



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The Fiscal Year Budgets for The Office of the Children's Advocate

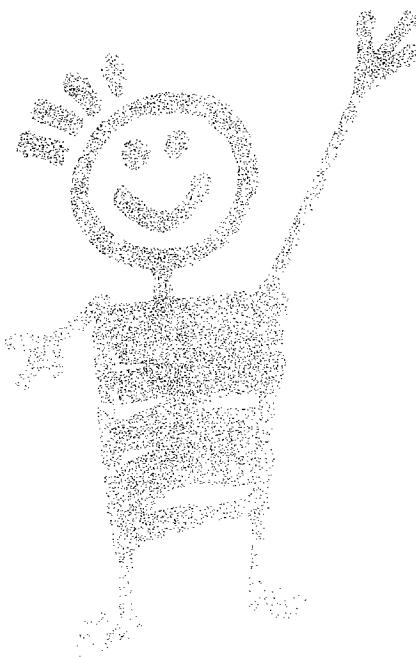
Expenditures	\$(000)	FTE
2009-2010		
Total Salaries and Employee Benefits	\$1,605.0	18
Total Operating Expenses	\$ 779.0	

The Office of the Children's Advocate Staff List

Billie Schibler, Children's Advocate
Bonnie Kocsis, Deputy Children's Advocate
Patty Sansregret, Manager, Administration & Finance
Patsy Addis Brown, Manager, Special Projects (Contract)
Debra Swampy, Administrative Secretary

Advocacy Services Unit:

Angie Balan, Program Manager
Thelma Morrisseau, Children's Advocacy Officer
Gerald Krosney, Children's Advocacy Officer
Kevin Barkman, Children's Advocacy Officer
Rosie O'Connor, Children's Advocacy Officer
Carolyn Parsons, Children's Advocacy Officer
Kirstin Magnusson, Children's Advocacy Officer
Debra Babey, Intake Assessment Officer
Dawn Gair, Intake Assessment Officer
Sarah Arnal, Intake Assessment Officer (mat leave)
Michelle Hykawy, Intake Assessment Officer (to July 2009)
Paula Zimrose, Advocacy Assessment Officer - Intake



Special Investigations Unit, including contract and seconded staff

Shelagh Marchenski, Special Investigator & Program Manager
Ainsley Krone, Special Investigator
Lynda Schellenberg, Special Investigator
Doug Ingram, Special Investigator
Justine Grain, Special Investigator
Barb Tobin, Special Investigator
Cathy Hudek, Special Investigator
Joanne Lysak, Special Investigator
Don Wells, Special Investigator
Bob Christle, Special Investigator
TANIS HUDSON, Special Investigator
Don Wells, Special Investigator
Reji Thomas, Administrative Assistant
James Turk, Program Manager (to August 2009)
Angie Balan, Special Investigator (to July 2009)
Aaron Klein, Special Investigator (to August 2009)



*We all have a hand
in it!*

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