



# Manitoba Ombudsman

## 2012 Report under Section 16.1 of *The Ombudsman Act*

### *The Ombudsman Act*

Monitoring children's advocate's recommendations

16.1(1) The Ombudsman must monitor the implementation of recommendations contained in the reports provided to the Ombudsman by the children's advocate under section 8.2.3 of *The Child and Family Services Act*.

Report to assembly

16.1(2) In the annual report to the assembly under section 42, the Ombudsman must report on the implementation of the children's advocate's recommendations.

### Aggregate Investigations

In 2011 – 2012, the Office of the Children's Advocate began grouping some special investigation reviews together thematically into one Special Investigation Report. Called an aggregate report, this type of SIR encompasses a number of child deaths into one report to address systemic issues. This type of report groups together a number of child death investigations according to service delivery from particular agencies, or examinations of certain issues linking multiple agencies. Some of the systemic themes explored involve staff training, record-keeping, inter-organizational communication, the ability of agencies to respond to the needs of older youth, and gang interference in the lives of children.

### Implementation of Recommendations Resulting from Special Investigations of Child Deaths by the Office of the Children's Advocate

As part of our mandate, Manitoba Ombudsman has responsibility for monitoring and reporting annually on the implementation of recommendations resulting from special investigations of child deaths by the Office of the Children's Advocate (OCA).

When a child dies in Manitoba, the Office of the Chief Medical Examiner (OCME) determines the manner of death according to an established protocol. Child deaths that meet the criteria for Special Investigation Reviews by the OCA include those cases where the child, or the child's family, had an open file with a child welfare agency or a file was closed within one year preceding the child's death.

The OCA investigates child deaths that meet the criteria and may make recommendations in their Special Investigation Reports (SIRs) to improve services and enhance the safety and well-being of children and prevent deaths in similar circumstances in the future.

After a reasonable period of time, our office follows up with the entity or entities to which the recommendations have been made to determine what action has been taken in response to the recommendations, and to report publicly on those actions to ensure accountability.

Since the OCA received its mandate to perform Special Investigation Reviews on September 15, 2008, to the end of our reporting period December 31, 2012, the office has reviewed 271 child deaths, produced 250 Special Investigation Reports, and made recommendations in 75 of those reports, for a total of 347 recommendations. In total, thirty percent of the child death reports by the OCA resulted in recommendations.

Through our mandate to track and monitor the implementation of the OCA's recommendations, we have noted that while all the recommendations within the SIRs are intended to improve services and enhance the safety and well-being of children and prevent future similar deaths, the recommendations range from specific, single-agency improvements to complex, multi-organizational system changes, even legislative changes. It is clear that some recommendations lend themselves to immediate implementation; others may require intensive consultation, coordination and collaboration. Still others may pose significant challenges and the entity to which the recommendation was made may develop an alternate solution which addresses the concern.

We have also noted that most child deaths in the province of Manitoba occur naturally – whether a child has received services from a child welfare agency or not.

The child welfare system in Manitoba is a large and complex network of entities that has evolved over time. Recommendations made by the OCA resulting from special investigations of child deaths often reflect this complexity, providing an avenue to examine the larger issues that underpin and impact the child welfare system, and make administrative improvements to help the complex system work together to implement larger systemic, planned changes. The identification, monitoring and tracking of larger and systemic issues in the delivery of child welfare services is paramount for the continued development of improved services for children, youth and their families in the province of Manitoba.

Many of the 347 Special Investigation Report recommendations made by the OCA since it received its mandate September 15, 2008, relate to challenges that are significant, long-standing and systemic in nature. Our office has identified that a recurring area of concern in recommendations made by the OCA is case management as it pertains to risk assessment, case planning and service delivery. According to the Manitoba Child and Family Services Standards, assessment begins at the first contact with a case and is ongoing. It includes information on the strengths, needs and resources of a person or family and could include family and community resources. Assessment becomes the basis for case management and effective service delivery. Part of the case management is planning, which ensures that risk factors identified in the assessment are addressed to keep children safe and strengthen family functioning.

A great deal of work has been done, however, to implement the many recommendations to improve these concerns. Many of the recommendations that have been implemented by each authority relate directly to staff training, and we are hopeful that both mandatory and authority-specific training that has occurred in the Province of Manitoba will positively impact the skill level of caseworkers in the area of case management.

The following Table 1 illustrates the number of Special Investigation Reports received by our office from the OCA by fiscal year from September 15, 2008 to December 31, 2012. Table 2 illustrates the number of Special Investigation Reports received by our office from the OCA by calendar year from September 15, 2008 to December 31, 2012. For Status Definitions, please see page 2 of this report.

Tables 1 and 2 encompass the Special Investigation Reports received by the Ombudsman from the Office of the Children's Advocate from September 15, 2008 to December 31, 2012. Table 1 is by fiscal year and Table 2 is by calendar year.

Fiscal Year	Child Death Investigations	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008 - 2009	7	7	7	40
2009 - 2010	21	21	19	141
2010 - 2011	27	26	16	63
2011 - 2012	154*	147	15	44
2012 - Dec 31, 2012	62	49	18	59
<b>Total</b>	<b>271*</b>	<b>250*</b>	<b>75</b>	<b>347</b>

\* Notes: The number of child deaths investigated in 2011-2012 is significantly higher than other years due to cases carried from previous years, and is not reflective of the number of child deaths referred to the OCA by the OCME in that fiscal year. The number of Child Deaths Investigated and the number of Special Investigation Reports Received differ because some Special Investigation Reports, called Aggregate Reports, group together a number of child death investigations into one Special Investigation Report to address systemic issues.

Calendar Year	Child Death Investigations	Special Investigation Reports Received	SIRS Received with Recommendations	Recommendations Received
2008	3	3	3	17
2009	19	19	17	83
2010	23	22	18	135
2011	148*	141	17	43
2012	78	65	20	69
<b>Total</b>	<b>271*</b>	<b>250*</b>	<b>75</b>	<b>347</b>

\* Notes: The number of child deaths investigated in 2011 is significantly higher than other years due to cases carried from previous years, and is not reflective of the number of child deaths referred to the OCA by the OCME in that calendar year. The number of Child Deaths Investigated and the number of Special Investigation Reports Received differ because some Special Investigation Reports, called Aggregate Reports, group together a number of child death investigations into one Special Investigation Report to address systemic issues.

**Glossary of Acronyms**

- AJI-CWI – The Aboriginal Justice Inquiry – Child Welfare Initiative
- CEO – Chief Executive Officer of one of the four Child and Family Service Authorities
- CFS – Child and Family Services
- CFSIS – Child and Family Services Information System
- CFSSC – Child and Family Services Standing Committee
- CFS Act – *Child and Family Services Act*
- CPB – Child Protection Branch
- FSCA – Family Services and Consumer Affairs, former name of the Department of Family Services and Labour
- FSL – Family Services and Labour
- GA – General Child and Family Services Authority
- MA – Metis Child and Family Services Authority
- NA – First Nations of Northern Manitoba Child and Family Services Authority
- OCA – Office of the Children’s Advocate
- OCME – Office of the Chief Medical Examiner
- SA – Southern First Nations Network of Care Child and Family Services Authority
- SIR – Special Investigation Report

**Status Definitions**

In 2012, CFS Standing Committee, the advisory body comprised of the CEOs from the four Authorities and the Director of CFS, agreed upon common status definitions with regard to recommendations made in Special Investigation Reports. Each respective recommendation referenced in this report is delineated as one of the following:

**Complete** – The organization to which the recommendation is directed accepts the recommendation and has demonstrated that it has taken all necessary steps to respond to the recommendation.

**Complete: Alternate Solution** – The organization to which the recommendation is directed disagrees with the recommendation but accepts the general concern raised in the report and has developed an alternate solution which addresses the concern. The organization has formulated an implementation plan to fully respond to the issue underlying the recommendation. The organization has demonstrated that it has taken all necessary steps to respond to the recommendation.

**In Progress** – The organization to which the recommendation is directed accepts the recommendation. The organization has formulated an implementation plan to fully respond to the recommendation.

**Pending** – The organization to which the recommendation is directed accepts the recommendation. The organization has not yet completed an implementation plan to fully respond to the recommendation.

**Not Accepted (unachievable)** – The organization to which the recommendation is directed agrees with the recommendation but cannot implement the recommendation based on existing resources, legislation, or governance structure.

**Rejected** – The organization to which the recommendation is directed disagrees with both the foundation and substance of the recommendation.

The Ombudsman’s office has created two additional Status Definitions for the purposes of our report:

**Recommendations “Response Under Review”** – The Manitoba Ombudsman has received information from the entity to which the recommendation is directed and is currently reviewing the information.

**No Status Reported** – The organization to which the recommendation is directed has not yet reported to the Manitoba Ombudsman. Note that because our reporting period includes recommendations made within SIRs released up to December 31, 2012, it is expected that entities would not yet have any information to report on recently released recommendations.

Table 3 below encompasses the recommendations within the Special Investigation Reports received by the Ombudsman from the Office of the Children’s Advocate in Special Investigation Reports by calendar year since the enactment of the *Children’s Advocate’s Enhanced Mandate Act* on September 15, 2008. The table illustrates the status of the recommendations as reported to the Ombudsman’s office by the entities to which the recommendations were made using the Status Definitions as per Standing Committee (see Status Definitions for further information).

Table 3: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity September 15, 2008 - December 31, 2012							
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA September 15, 2008 to December 31, 2008 by Entity							
Authority/Agency/Entity to which the recommendation was directed	NUMBER OF RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NO STATUS REPORTED TO THE OMBUDSMAN	Status of Recommendations	
Child Protection Branch	1	0	1	0	0		
CFS Standing Committee	1	0	1	0	0		
CBP & CFS Standing Committee	3	2	1	0	0		
Family Services & Labour*	0	0	0	0	0		
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	0	0	0	0	0		
Southern Authority	6	5	0	1	0		
Northern Authority	1	1	0	0	0		
General Authority	0	0	0	0	0		
Metis Authority	5	5	0	0	0		
External Organizations (other departments, private service providers)	0	0	0	0	0		
<b>TOTAL NUMBER</b>	<b>17</b>	<b>13</b>	<b>3</b>	<b>1</b>	<b>0</b>		
<b>TOTAL PERCENTAGE</b>		<b>76%</b>	<b>18%</b>	<b>6%</b>	<b>0%</b>		
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2009 to December 31, 2009 by Entity							
Child Protection Branch	14	7	7	0	0		
CFS Standing Committee	0	0	0	0	0		
CBP & CFS Standing Committee	1	1	0	0	0		
Family Services & Labour*	1	1	0	0	0		
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	3	2	1	0	0		
Southern Authority	39	26	7	6	0		
Northern Authority	19	12	3	4	0		
General Authority	6	6	0	0	0		
Metis Authority	0	0	0	0	0		
External Organizations (other departments, private service providers)	0	0	0	0	0		
<b>TOTAL NUMBER</b>	<b>83</b>	<b>55</b>	<b>18</b>	<b>10</b>	<b>0</b>		
<b>TOTAL PERCENTAGE</b>		<b>66%</b>	<b>22%</b>	<b>12%</b>	<b>0%</b>		
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2010 to December 31, 2010 by Entity							
Child Protection Branch	14	8	6	0	0		
CFS Standing Committee	0	0	0	0	0		
CBP & CFS Standing Committee	0	0	0	0	0		
Family Services & Labour*	11	7	4	0	0		
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	5	2	2	1	0		
Southern Authority	36	12	14	10	0		
Northern Authority	41	16	8	17	0		
General Authority	9	9	0	0	0		
Metis Authority	0	0	0	0	0		
External Organizations (other departments, private service providers)	19	17	2	0	0		
<b>TOTAL NUMBER</b>	<b>135</b>	<b>71</b>	<b>36</b>	<b>28</b>	<b>0</b>		
<b>TOTAL PERCENTAGE</b>		<b>52%</b>	<b>27%</b>	<b>21%</b>	<b>0%</b>		
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2011 to December 31, 2011 by Entity							
Child Protection Branch	11	9	2	0	0		
CFS Standing Committee	0	0	0	0	0		
CBP & CFS Standing Committee	0	0	0	0	0		
Family Services & Labour*	4	3	1	0	0		
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	2	2	0	0	0		
Southern Authority	8	2	5	1	0		
Northern Authority	14	6	3	5	0		
General Authority	2	2	0	0	0		
Metis Authority	1	1	0	0	0		
External Organizations (other departments, private service providers)	1	0	1	0	0		
<b>TOTAL NUMBER</b>	<b>43</b>	<b>25</b>	<b>12</b>	<b>6</b>	<b>0</b>		
<b>TOTAL PERCENTAGE</b>		<b>58%</b>	<b>28%</b>	<b>14%</b>	<b>0%</b>		
Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA January 1, 2012 to December 31, 2012 by Entity							
Child Protection Branch	4	0	4	0	0		
CFS Standing Committee	0	0	0	0	0		
CBP & CFS Standing Committee	0	0	0	0	0		
Family Services & Labour*	0	0	0	0	0		
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	6	1	1	0	4		
Southern Authority	29	2	17	1	9		
Northern Authority	22	13	8	0	1		
General Authority	4	4	0	0	0		
Metis Authority	3	0	0	0	3		
External Organizations (other departments, private service providers)	1	0	1	0	0		
<b>TOTAL NUMBER</b>	<b>69</b>	<b>20</b>	<b>31</b>	<b>1</b>	<b>17</b>		
<b>TOTAL PERCENTAGE</b>		<b>29%</b>	<b>45%</b>	<b>1%</b>	<b>25%</b>		

Table 4: Status of Special Investigation Report Recommendations Received by the Ombudsman from the OCA by Entity September 15, 2008 - December 31, 2012

Authority/Agency/Entity to which the recommendation was directed	RECOMMENDATIONS	RECOMMENDATIONS "COMPLETE" OR "COMPLETE-ALTERNATE SOLUTION"	RECOMMENDATIONS "IN PROGRESS" OR "PENDING"	RECOMMENDATIONS "RESPONSE UNDER REVIEW"	NO STATUS REPORTED TO THE OMBUDSMAN
Child Protection Branch	44	24	20	0	0
CFS Standing Committee	1	0	1	0	0
CBP & CFS Standing Committee	4	3	1	0	0
Family Services & Labour*	16	11	5	0	0
Multiples - FSL, CPB, NA, MA, SA, GA (more than one authority/agency/entity)	16	7	4	1	4
Southern Authority	118	47	43	19	9
Northern Authority	97	48	22	26	1
General Authority	21	21	0	0	0
Metis Authority	9	6	0	0	3
External Organizations (other departments, private service providers)	21	17	4	0	0
<b>TOTAL NUMBER</b>	<b>347</b>	<b>184</b>	<b>100</b>	<b>46</b>	<b>17</b>
<b>TOTAL PERCENTAGE</b>		<b>53%</b>	<b>29%</b>	<b>13%</b>	<b>5%</b>

\* Note: Family Services & Labour includes former department name Family Services & Consumer Affairs.

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