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Office of the Provincial Advocate  
for Children and Youth

Investigation Report:  
“Alex”

Office of the Provincial Advocate for Children and Youth  
April 2011

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## I. EXECUTIVE SUMMARY

This investigation was initiated based on the complaint of a foster parent, (“Renee”), who felt pressured into accepting a young person into her home, despite her objections that the child’s needs were beyond what she felt she could handle at that particular time. The ensuing placement was short, but disastrous. “Alex” moved into the foster home on a Friday, and was removed by police two days later, after holding the foster parent at knifepoint, threatening to stab her, and setting a fire on the porch. As this incident started to escalate, two foster children and an adult with a developmental delay were ushered out of the home for their own safety and waited in a truck for the police to arrive. Alex was arrested by police and taken to a local hospital for assessment. The foster parent and a youth worker who was assisting in the home were unable to return to work in the aftermath of the incident.

The scope of this investigation covers events that took place between January 29 – 31, 2016 when Alex was placed in Renee’s home, as well as the circumstances surrounding the decision of CAS Algoma to place Alex with Summit (“Summit Human Services”), and the decisions made regarding the appropriateness of the placement. During the course of the investigation, Investigators from the Office of the Provincial Advocate for Children and Youth (“Advocate’s Office”) interviewed 15 witnesses and reviewed over 5,100 pages of documentation (including information from the then Ministry of Children and Youth Services, now the Ministry of Children, Community and Social Services, [“the Ministry”]; Summit Human Services, the Children’s Aid Society of Algoma; the police; and a hospital).

This report contains a detailed account of the investigation. Broadly speaking, the findings can be broken down into three major themes: (1) The events in question; (2) Ensuring appropriate support to children and staff in residential placements; (3) Oversight and Documentation practices.

Renee agreed to accept Alex into her home after refusing four earlier requests. Two of these requests were made in separate calls by staff at Summit Human Services Inc., where Renee worked as a foster parent. The third call was from a worker from Algoma Children’s Aid Society, who spoke directly to Renee at the suggestion of Renee’s supervisor. During that third call, Renee refused again to accept Alex, but eventually agreed to accept the placement.

Renee’s initial reasons for refusing to accept Alex had very little to do with Alex: two other foster children were just settling into the home after recently moving in, and Renee was about to go on a long-planned overseas vacation. After receiving more information about Alex, Renee gave an additional reason for refusing the placement — she could not accept young people whose behaviour required physical intervention. Nevertheless, by the end of that call, Renee changed her mind and agreed to accept Alex into her home.

Both CAS Algoma and Summit advised Investigators from the Advocate’s Office that there was no intention on their part to pressure or coerce the foster parent into accepting a placement that she did not feel able to accept. The Advocate’s Office accepts the positions of both agencies at face value. From the point of view of CAS Algoma, the society’s priority was to find a safe placement for a child in an emergency situation. They did not intend to coerce a foster parent into accepting a placement she did not want to take, but they desperately needed somewhere for Alex to stay. Similarly, Summit advised the Advocate’s Office that because of Renee’s extensive background and expertise in fostering, as well as her confident demeanour, they had not anticipated she would feel unduly pressured in this situation. There is no evidence to

suggest that anyone involved in these events was motivated by anything other than doing what they thought was best in difficult circumstances. Yet the foster parent, despite her credentials, her confidence, and many years of experience, did indeed feel pressured into accepting the placement of Alex into her care.

At the conclusion of the Investigation, it was determined that placement protocols were not followed and the report makes a number of recommendations for both agencies to review protocols, clarify the meaning of certain policies and documents, and to meet with each other to debrief about the incident.

Another finding from the investigation was that Alex's placement with Renee warranted additional support. In their initial response to a draft version of this investigation report, the Algoma Children's Aid Society expressed their view that Summit was best placed to assess whether additional resources were needed and that if a request for resources had been made by Summit, CAS Algoma would have approved it. While the Advocate's Office understands the logic behind this point of view, in cases such as these (where, for example: the children's aid society had "very limited information" about Alex at the time of placement; both agencies were aware that Alex had a mental health treatment plan that was not being followed; children's aid had not been able to confirm a mental health diagnosis but was aware Alex had not been taking the medication prescribed by a psychiatrist for at least a couple of weeks; Alex had exhibited aggressive and violent behaviours, including damage to property at a local hospital days earlier; and both agencies were aware Alex had made a threat against another Summit foster parent), it seems more prudent, especially when the foster parent has expressed hesitancy about the placement, to proactively and explicitly assess the adequacy of the resources in place to support the placement. The Advocate's Office views the obligation to have this type of explicit discussion in high-risk cases as a shared responsibility between the children's aid society, the residential services provider, and, in some complex cases, the respective provincial ministry.

An additional finding relates to expectations about note taking. While there are extensive standards regarding note-taking and documentation imposed upon children's aid societies, Investigators discovered no such standards for government staff or residential service providers. The absence of consistent and standardized best practices for documentation by residential service providers and the Ministry resulted in several recommendations. It also became evident during the course of this investigation that there are no protocols to guide Ministry representatives when they conduct reviews related to complaints about the actions of children's aid societies or residential licensees, or to track outstanding terms when conditions are imposed on a residential license. Further, the Ministry advised that an agency's response to their inquiries is accepted at face value; there is no requirement that agencies provide documentation to support their responses to complaints.

Finally, the report highlights the ongoing concern about the availability of resources in northern Ontario for children and youth in care, particularly those with mental health needs, and Indigenous youth.

A copy of the draft investigation report was provided to the Children's Aid Society of Algoma, Summit Human Services, and the Ministry for response.

Summit accepted all recommendations made to them.

The Algoma Children’s Aid Society agreed to amend Alex’s child protection record, continue working to ensure their staff meet expectations with respect to documentation, and meet with Summit to discuss pre-placement communication protocols.

In their formal reply, the Ministry advised that they have developed a serious occurrence risk analysis program to identify children in residential care who are at risk, and that Ministry staff follow up with the placement agencies and the residential care providers to confirm that the proper supports are in place so that children are receiving the quality of care to which they are entitled. The Ministry also advised it is in the process of developing a standardized screening tool to identify children at high risk who may be vulnerable and/or require more intensive service provision as recommended by the Ontario Chief Coroner’s expert panel. The standard screening tool will facilitate the collection, documentation and sharing of information so that children who have been identified as high risk are placed in residences that can meet their needs.

Additionally, the Ministry indicated it had provided training to Ministry Licensing staff in 2017 on documentation requirements, business practices, and that Ministry staff will receive training on note taking and interview techniques to ensure licensed files are fully documented in a standardized format, that compliance with the conditions will be fully documented in a new database (which is expected to be operational in 2019), that documentation must include a date when compliance was achieved and a note indicating where supporting evidence is stored, and they are conducting unannounced inspections to verify compliance with legislative requirements, including conditions on a license. The new database system will track and document Ministry communications with the placing agency and the licensee along with the responses, actions and any additional documents that are required to be uploaded into the system and resolution of the complaint will be fully documented in the SOR-RL system and will be reviewed by a licensing manager as part of the inspection process.

## II. INTRODUCTION

### A. OVERVIEW

“Alex,”<sup>1</sup> a bright, creative and talented First Nations<sup>2</sup> youth, was 15 years old and seeking mental health support and a safe place to live at the end of January 2016. When Alex needed services that were beyond the ability of Alex’s First Nation and family to provide, Alex’s Band reached out to the Children’s Aid Society of Algoma (“CAS Algoma”) for help.

On the morning of January 29, 2016, CAS Algoma brought Alex into its care, on an emergency basis, through a Temporary Care Agreement (“TCA”)<sup>3</sup> for a period of two months. By the end of

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<sup>1</sup> Alex is a pseudonym (fictitious name). Alex’s real name, gender and Band membership are not used in this report to protect Alex’s privacy. The reasons for this are explained later in this report.

<sup>2</sup> The term “First Nations” as used in this report refers to the collective name for Indigenous peoples, who are neither Inuit or Métis, currently living in the geographical boundaries of what is now known as Canada. Alex was identified as a First Nations youth by the First Nation Band and the foster parent with whom Alex was eventually placed.

<sup>3</sup> A Temporary Care Agreement is a written agreement between a person who is temporarily unable to care adequately for a child in her or his custody and a children’s aid society. It transfers the child’s care and custody to the children’s aid society for the term of the agreement.

that day, CAS Algoma had placed Alex with a foster parent named Renee<sup>4</sup> who worked for an organization then known as Summit Human Services Inc. (“Summit”). A Residential Youth Worker (“Youth Worker”) assisted Renee in the home on a regular basis.

Alex’s placement with Renee collapsed soon afterwards. On the evening of January 31, 2016, Alex appeared anxious to leave the placement and Alex’s behaviour became increasingly concerning to Renee and the Youth Worker. It culminated in Alex repeatedly threatening to stab Renee with a knife, and later threatening to self-harm.

Under Renee’s direction, the Youth Worker called 9-1-1. Renee continued to attempt to defuse Alex’s behaviour. Within 40 minutes of the 9-1-1 call, police attended Renee’s home and arrested Alex. Alex never returned to the home.

## **B. THE REQUEST FOR AN INVESTIGATION**

On May 2, 2016 a lawyer contacted the Office of the Provincial Advocate for Children and Youth (“Advocate’s Office”) on behalf of Renee (the foster parent) and requested an investigation.

The written request for an investigation described an incident on January 31, 2016, in which Renee “was threatened with death while being held at knifepoint in her home,” characterizing it as a “trauma” that “could have been prevented”. The letter also contained allegations that: (1) CAS Algoma and Summit failed to follow proper procedures and ensure full disclosure of all relevant information about Alex to Renee before placement; (2) Renee was pressured into accepting Alex into her home despite previously indicating she was not willing to accept any new placements; and (3) Alex did not get the help that was needed.

## **III. MANDATE AND AUTHORITY OF THE ADVOCATE’S OFFICE**

### **A. MANDATE**

The Advocate’s Office is an independent office of the Legislative Assembly of Ontario with the legal authority to advocate for children and youth. The purpose of the Advocate’s Office is explained in section 1 of *The Provincial Advocate for Children and Youth Act, 2007*.<sup>5</sup>

- a) Provide an independent voice for children and youth, including First Nations children and youth and children with special needs, by partnering with them to bring issues forward
- b) Encourage communication and understanding between children and their families and those who provide them with services
- c) Educate children, youth and their caregivers regarding the rights of children and youth
- d) Conduct investigations and make recommendations to improve children’s aid society services and services provided by residential licensees where a children’s aid society is the placing agency

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<sup>4</sup> Renee is a pseudonym chosen by the foster parent. The foster parent’s real name is not used in this report to protect the foster parent’s privacy.

<sup>5</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 1.



## B AUTHORITY

Investigators from the Advocate's Office have the power to:<sup>6</sup>

- Hear or obtain information from anyone the Provincial Advocate thinks may be relevant to the investigation and make inquiries the Provincial Advocate thinks may be relevant to the investigation
- Compel information and the production of documents from anyone who is able to give information relating to any matter being investigated by the Provincial Advocate, including the government, a children's aid society, or a residential licensee
- Summon for an examination under oath anyone who, in the Provincial Advocate's opinion, is able to give any information relevant to the investigation, including individuals from the government, a children's aid society, or a residential licensee
- Obtain information that would ordinarily be subject to various privacy Acts

## C. INVESTIGATIVE FOCUS

Under the *Provincial Advocate for Children and Youth Act, 2007*, investigations undertaken by the Advocate's Office are focused on making recommendations to improve the children's service system.<sup>7</sup>

When conducting its work, the Investigations Unit is also required to take into account the:

- Paramount purpose of the *Child and Family Services Act ("CFSA")* to promote the best interests, protection and well-being of children<sup>8</sup>
- Principles expressed in the United Nations Convention on the Rights of the Child<sup>9</sup>
- Canadian Charter of Rights and Freedoms<sup>10</sup>

## D. PUBLIC REPORTS, PRIVACY, AND FAIRNESS

The *Provincial Advocate for Children and Youth Act, 2007* requires the Provincial Advocate to create a report, and to make it available to the public, each time an investigation is completed.<sup>11</sup> A final report must explain the reasons for the investigation and include any recommendations the Provincial Advocate considers necessary to improve services for children and youth within the Office's mandate.<sup>12</sup>

The legislation that governs the work of the Advocate's Office also contains specific privacy provisions that prevent the disclosure of the name or other identifying information of a young person in an investigative report.<sup>13</sup>

In addition to protecting the privacy of young persons, the Advocate's Office is not permitted to reveal the name or identifying information of any adult in a public report, unless the adult

<sup>6</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 16.1.

<sup>7</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 1(d).

<sup>8</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 15(4).

<sup>9</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 15(4).

<sup>10</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982 (UK)*, 1982, c 11.

<sup>11</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, ss 21.1(1), (4).

<sup>12</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 21.1(1).

<sup>13</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 21.1(2).

consents to be identified.<sup>14</sup> Accordingly, this report does not name the individuals who provided information or were interviewed. Individuals are referenced by a general title (eg, as a “Supervisor,” “Director,” “Worker” or “Employee”).

In its public reports, the Advocate’s Office explains how the investigation was conducted, the analysis upon which the findings are based, and the rules or standards to which organizations are held accountable. The Advocate’s Office carefully considers the impact of including sensitive information in a public report and does so only when it is necessary to advance the overall objective of making recommendations to improve services for the children and youth in its mandate.

Any organization or individual who will be the subject of recommendations from the Advocate’s Office must be made aware of these recommendations before the public report is released and be provided with the opportunity to respond in a manner that is consistent with section 16.1(3) of the *Provincial Advocate for Children and Youth Act, 2017*.

## IV. WHO WAS INVOLVED IN THIS INVESTIGATION

### A. THE YOUNG PERSON AT THE CENTRE OF THE INVESTIGATION

Investigators were unable to speak directly with Alex during this investigation despite many attempts to do so. During part of the investigation, Alex was living away from family and First Nation, and Alex’s direct contact information was unknown. Because Investigators were not able to speak directly to Alex, they paid close attention to the documentary record of statements made by Alex to others, both during and after Alex’s placement with Renee.

On the morning that Alex came into care, a CAS Algoma Intake Worker first met with Alex and a Band Representative and then separately met with Alex and Alex’s father. The CAS Algoma Intake Worker’s case notes and information she provided to Investigators indicates Alex told her:

- Alex would like to leave town and start fresh
- There were many people who wanted to fight [Alex] and did not like [Alex]
- Staff at the hospital had spoken to Alex previously about an out of town placement or facility where Alex could get help
- Alex wanted to get help

Ideally, in addition to hearing the young person’s versions of events, the Advocate’s Office prefers that young people at the centre of investigations choose names for themselves that can be used as aliases to protect their identities. Since this was not possible in this investigation, Investigators reached out to Alex’s Band for suggestions for a pseudonym. In the end, Investigators chose the name “Alex” and the Band Representative was content with this pseudonym.

In order to protect Alex’s privacy, the youth’s gender and specific Band membership are not identified in this report. While this might make it more cumbersome to read, the Advocate’s Office felt these extraordinary steps were necessary to protect Alex’s privacy.

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<sup>14</sup> *Provincial Advocate for Children and Youth Act, 2007*, SO 2007, c 9, s 20(10).

## B. THE FOSTER PARENT

“Renee”, the pseudonym chosen by the foster parent who requested this investigation, was employed by Summit to provide foster care services in her home. Renee had also worked for Summit in a supervisory capacity.

## C. AGENCIES INVOLVED IN THIS INVESTIGATION

At the time that the Advocate’s Office received the request for an investigation, CAS Algoma was the child welfare service designated by the Ontario government to provide child protection services to Alex’s First Nation and six other North Shore First Nations.<sup>15</sup> CAS Algoma is one of 49 children’s aid and Indigenous children’s aid societies<sup>16</sup> across Ontario required by law to provide the following services: (a) investigate allegations or evidence that children may be in need of protection; (b) protect children where necessary; (c) provide guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children; (d) provide care for children assigned or committed to its care; (e) supervise children assigned to its supervision; (f) place children for adoption; (g) other duties assigned by legislation or regulations.<sup>17</sup>

Children’s aid societies often enter into contracts with residential service providers, known as Outside Paid Resources (“OPR”), to provide residential placements for the children in their care. In this case, these contracts are known as Resource Service Agreements (“RSA”). The RSA explains the obligations of both parties regarding the placement and care of the children involved. The OPR is responsible for ensuring that children placed in its care, including in foster homes, receive appropriate care. The branch of government responsible for licensing and monitoring all of Ontario’s children’s aid societies and residential service providers is now known as the Ministry of Children, Community and Social Services. At the time of Alex’s placement, it was known as the Ministry of Children and Youth Services (“the Ministry”). The function of the Ministry includes a general oversight and supervisory role with respect to the children’s aid societies. The Ministry is also responsible for assessing a licensee’s compliance with licensing requirements under the *Child, Youth and Family Services Act* (“CYFSA”)<sup>18</sup> and licensing residential service providers providing residential services to children and youth in accordance with the CYFSA and its regulations.

The OPR, as the licensed residential service provider, and the CAS, as the placing agency, are both accountable to the Ministry based on the provisions of the CYFSA for any services that

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<sup>15</sup> Effective April 1, 2017, Nogdawindamin Family and Community Services, achieved full designation as a children’s aid society. Since that time, it has assumed full responsibility as the child welfare authority for the seven members of the North Shore First Nations that formerly had protocols with CAS Algoma related to the provision of child protection services.

<sup>16</sup> There were 49 children’s aid and Indigenous children’s aid societies in Ontario at the time of writing this report. For a current list of these societies, see the First Nations Child and Family Services at: <<https://fncaringociety.com/child-and-family-service-agencies-canada>> and the Ontario Association of Children’s Aid Societies at: <<http://www.oacas.org/childrens-aid-child-protection/locate-a-childrens-aid-society/>>.

<sup>17</sup> See *Child and Family Services Act*, RSO 1990, c C11, s 15(3) and *Child, Youth and Family Services Act, 2017*, SO 2017, c 14, Schedule 1, s 35(1). In 2016, the legislation that was in force was the *Child and Family Services Act*, RSO 1990, c C11 (“CFSA”). On April 1, 2018, the CFSA was replaced with the *Child, Youth and Family Services Act, 2017*, SO 2017, c 14, Schedule 1 (“CYFSA”).

<sup>18</sup> *Child, Youth and Family Services Act, 2017*, SO 2017, c 14, Schedule 1.

they deliver. Children's aid societies are also accountable to meet the Ontario Child Protection Standards.<sup>19</sup>

Summit is an Outside Paid Resource ("OPR")<sup>20</sup> which, according to its Program Outline, provides a system of parent-model, therapeutic foster care homes for children and youth aged six to eighteen years. At the time of the investigation, Summit was licensed by the government under the *Child and Family Services Act* to operate foster and group homes. Each foster home operated by Summit is headed by at least one live-in foster parent. Youth Workers provide weekly support and relief in the homes.

In Alex's case, Summit entered into an RSA with CAS Algoma, and then entered into its own sub-contracts with the foster parent Renee to provide care and services to Alex.

## V. METHODOLOGY

### A. INVESTIGATIVE ISSUES

The following questions framed the main issues in this investigation:

1. What were the applicable pre-placement policies and protocols relevant to the placement of Alex with Renee, and were they followed by CAS Algoma and Summit?
2. Did CAS Algoma and Summit provide Renee with all of the relevant information known about Alex prior to Alex's placement with Renee?
3. What impact did Alex's placement with Renee have on Alex, and others?
4. During the course of the investigation, were there any other concerns that came to the attention of Investigators?

The methodology for addressing these issues is explained below. The analysis and discussion of the issues within each question, and the related recommendations, follows.

### B. SCOPE

The scope of the investigation covers events that took place between January 29 – 31, 2016 when Alex was placed in Renee's home, as well as the circumstances surrounding the decision of CAS Algoma to place Alex with Summit and the decisions made regarding the appropriateness of the placement.

Some of allegations made by Renee were not included in the investigative scope, as they did not fit within the Provincial Advocate's mandate. For example, allegations that did not "concern

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<sup>19</sup> The *Child Protection Standards in Ontario* (February 2007) were in effect during the time of Alex's placement with Renee. In June 2016, these were replaced by the *Ontario Child Protection Standards* (2016). Both documents can be located on the Ministry website: <<http://www.children.gov.on.ca/htdocs/English/professionals/childwelfare/protection-standards/index.aspx>>.

<sup>20</sup> When a children's aid society is unable to provide foster care to a child or youth from within its own foster homes/resources (ie, through the foster parents the children's aid society recruits, trains and supervises directly), it may need to rely on another outside agency, an Outside Paid Resource (OPR), to provide the foster care services it needs for a child or youth. Ontario OPRs are licensed by the Ministry under the CYFSA and are subject to an annual licensing review.

a child or group of children,” or did not relate to “services” could not be considered by the Provincial Advocate and were therefore excluded from the investigation.<sup>21</sup>

Renee advised Investigators that following Alex’s departure from her home, three separate reviews were undertaken by two separate governmental authorities. As required by the *Provincial Advocate for Children and Youth Act, 2017*, Investigators confirmed these reviews had been completed and that the Provincial Advocate’s intended investigation was within its jurisdiction.<sup>22</sup>

## C. DOCUMENTS, MEETINGS AND INTERVIEWS

Investigators made formal requests for documents from the following individuals and organizations:

- CAS Algoma
- Another children’s aid society that had placed a child with Summit
- Summit
- The Ministry
- Ontario Provincial Police
- A local Police Service
- A local Hospital
- Psychiatrist

Renee provided Investigators with several documents that she had in her possession.

In total, Investigators received and reviewed over 5,100 pages of documentation from all sources.

Investigators also reviewed relevant legislation, international conventions and treaties, the Ontario Child Protection Standards (2007) and (2016), and several published reports relating to the experiences of young people living in care.

Investigators held several consultations over the course of the investigation:

- Two Investigators and the Director of Investigations met with over 20 staff at CAS Algoma to provide an overview of the investigation process and address any questions and concerns;
- Two Investigators met with four Band Members from Alex’s First Nation to provide an overview of the investigation and consult with Band Representatives about the best way to reach out to Alex and obtain Alex’s perspective on the events under investigation;

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<sup>21</sup> As set out above in the Introduction, the Provincial Advocate may only investigate matters “concerning a child or group of children” with respect to “a children’s aid society service” or “a service provided by a residential licensee where a children’s aid society is the placing agency.” Any of Renee’s allegations that related to matters involving only adults or to services that were outside the Provincial Advocate’s jurisdiction were excluded from the investigation scope.

<sup>22</sup> Under subsection 16.4(1)3, the Provincial Advocate may not commence an investigation if the Director of the Ministry believes that it would interfere with an inspection or review by the Ministry. Under subsection 16.4(1)5, the Provincial Advocate cannot commence an investigation until other investigative authorities conducting investigations have completed their investigations.

- Two Investigators met with an officer from a local Ontario Provincial Police (“OPP”) Detachment. During the meeting, Investigators sought to clarify certain information contained in the documents provided by the OPP under a formal document request.
- The Lead Investigator had several telephone meetings to seek clarification of information provided in response to formal document requests, including with Alex’s psychiatrist at a local hospital, managers at another children’s aid society that had involvement with Summit at the relevant time, and all three agencies involved in this investigation.

This investigation also included fifteen examinations under oath (“interviews”).<sup>23</sup> Investigators conducted audio-recorded interviews with the following individuals:

- Renee
- Two adults who observed portions of the interactions between Renee and Alex on the evening of January 31, 2016
- Band Representative (one individual)
- CAS Algoma staff (four individuals including a child protection intake worker, a supervisor, a member of the foster care program and a Director)
- Summit staff (four individuals including a Residential Youth Worker, a worker, a supervisor and a Director)<sup>24</sup>
- Ministry staff (two Ministry Representatives)

## **D. OTHER INFORMATION**

In addition to the information received from documents, meetings and interviews, Investigators took photographs of Renee’s home and text messages that were contained on Renee’s cellular phone. These text messages included contemporaneous communications that Renee had with Summit and CAS Algoma staff. The preserved text messages helped to corroborate the timing and/or content of some communication exchanges between Renee and Summit staff and Renee and the CAS Algoma Child Protection Intake Worker. Photographs of the home assisted the Investigators to better understand the events described by interviewees at Renee’s home.

## **E. CHALLENGES IN OBTAINING ALEX’S PERSPECTIVE**

Investigators made repeated and ongoing attempts at all stages of the investigation (up to the report’s release) to reach Alex and hear Alex’s perspective. Investigators stayed in frequent contact with a representative of Alex’s Band, attempted to meet with Alex during a trip to Alex’s First Nation and a nearby city where interviews were held, and also provided documentation to the Band Representative to provide to or review with Alex, if and when Alex made contact. Alex’s contact with the Band was infrequent and unpredictable. Despite this, the Band

<sup>23</sup> Investigators did not interview an adult and two youth who were present in Renee’s home during part of the evening of January 31, 2016. Neither the adult nor the youth witnessed any events that were relevant to the key issues under investigation. Moreover, Investigators determined it would not be in the best interests of these potential interviewees to conduct formal interviews with them. Investigators reached this decision in consideration of several factors. These included the limited communication skills of the adult due to disabilities, the circumstances of the youth as communicated to Investigators by agencies involved with them and the likelihood that these interviewees would be unable to provide additional information meaningful to the investigation (beyond what was already collected through documents and other interviewees).

<sup>24</sup> Two of the four individuals interviewed were employed by Summit at the time of Alex’s placement, but were not employed at the time of their respective interviews.



Representative was able to provide Alex the documents from Investigators which included: information about the investigation, reasons why Alex's perspective was being requested, a list of proposed questions from the Investigators for Alex, and suggestions of other ways that Alex could provide input.

The Band Representative informed the lead Investigator that Alex considered, but ultimately declined to participate in the investigation. The Band Representative told the lead Investigator that while Alex did not object to the investigation, Alex was not interested in reviewing these events and wanted to move on.

Accordingly, Alex's perspective can only be drawn from statements that Alex made to others during and after being placed with Renee. At that time, Alex spoke with a CAS Algoma worker, Summit staff members, Renee, police officers, physicians, and the Band Representative, all of whom recorded or said that they remembered the statements that Alex made to them. Some documented Alex's statements at the time or soon after Alex made the statements. Others recalled Alex's statements to Investigators during their interviews.

## VI. CHRONOLOGY

This section provides a detailed review of the main events at the centre of this investigation. Except where otherwise indicated, the facts presented below emerge from information that has been corroborated through interviews and/or reliable documentary sources.

### A. JANUARY 27 AND 28, 2016: EVENTS BEFORE ALEX'S PLACEMENT WITH RENEE

Investigators reviewed documentation from CAS Algoma, a police service and a hospital that contained information about events prior to Alex's placement with Renee, including:

- Prior to January 27, 2016, CAS Algoma had received several child protection referrals<sup>25</sup> regarding Alex. Alex's Band repeatedly requested that CAS Algoma close these child protection referrals on the basis that the Band was addressing the concerns through its own resources. CAS Algoma agreed.
- Early in the morning on January 27, 2016, officers with a local police service observed Alex, who appeared to be intoxicated, engaging in self-harming behaviours on a road. Alex requested to attend a local hospital to see someone in the crisis unit for self-harm issues. Police officers took Alex to a local hospital.
- At the hospital, a Constable with the police service telephoned CAS Algoma seeking the agency's assistance in locating contact information for Alex's parents because Alex had refused to provide it to police officers. A CAS Algoma child protection worker provided the contact information for Alex's father and the Constable successfully contacted him.
- Alex left the hospital after a couple of hours. Medical staff were concerned for Alex's safety and requested police assistance to locate and bring Alex back to the hospital. Police located Alex who agreed to return to the hospital with them. Alex was assessed

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<sup>25</sup> A referral is "any report or information received by a CAS from any source (eg, a child, a community member, the police) and through any method (eg, by phone, in person, in writing) that a child is or may be in need of protection. Ministry of Children and Youth Services, *Ontario Child Protection Standards* (2016) (Toronto: Province of Ontario, 2016) at 133.

under mental health legislation,<sup>26</sup> which authorized the hospital to admit Alex involuntarily for a period of 72 hours.

- In the evening of January 27, 2016, staff at the hospital contacted police for assistance. According to staff, Alex was very upset, pulled fire alarms, and caused “a large amount of damage” within the hospital.
- Police arrested Alex at the hospital and took Alex to the police station to be “booked” and await bail the next morning. Police charged Alex with two offences under the *Youth Criminal Justice Act*.<sup>27</sup>
- After overhearing Alex’s conversation with Alex’s father, another Constable contacted a CAS Algoma child protection worker due to a concern that Alex’s father may not allow Alex to return home after Alex’s attendance at bail court on January 28, leaving Alex in a “homeless situation.” The Constable advised her of the events involving Alex at the hospital that night and that Alex was on several medications and had a mental health treatment plan that was not being followed.
- Alex was unable to return to Alex’s father’s home on January 28, 2016 due to conflict between Alex and Alex’s father. CAS Algoma, Alex’s Band, a local police service and an Indigenous agency spoke about where Alex could stay once released from police custody. Eventually, a Band Representative agreed that Alex could spend the night of January 28 with her while other placement options were being explored.

## **B. FRIDAY, JANUARY 29, 2016: THE DAY OF ALEX’S PLACEMENT WITH RENEE**

### **Friday Morning**

- At approximately 9:35 am on the morning of January 29, 2016, a Band Representative contacted a CAS Algoma Intake Supervisor on Alex’s behalf to request residential care. The Band Representative informed the CAS Algoma Intake Supervisor that Alex could not go back home, the Band did not have any other options for Alex, and the Band requested that Alex be placed in CAS Algoma’s care.
- At approximately 10:00 am, the CAS Algoma Intake Worker first met with the Band Representative and Alex and then later, separately with Alex and Alex’s father. A two-month Temporary Care Agreement (“TCA”) was signed by Alex, Alex’s father, a Band Representative, the Intake Worker, and the Intake Worker’s Supervisor. The TCA identified that Alex’s father was unable to care adequately for Alex at that time “due to high needs of child”. During the meeting, Alex advised the Intake Worker that Alex would like to “leave town and start fresh” and that someone at the local hospital talked to Alex about an out of town placement or facility where Alex “could get better.”
- During the morning and early afternoon of January 29, an employee at the CAS Algoma Foster Care Program (“Placement Office Employee”) attempted to locate a placement for Alex through an Indigenous agency that provides foster care and other services. The Indigenous agency did not have any placement options for Alex at that time.
- Around 10:00 am on January 29, a CAS Algoma Placement Office Employee called staff at the Summit office seeking a placement for Alex. The Placement Office Employee

<sup>26</sup> Form 1 under the Mental Health Act: Application by Physician for Psychiatric Assessment (see *Mental Health Act*, RSO 1990, c M7, ss 15(1), 15(1.1); RRO 1990, Reg 741, s 13(1)).

<sup>27</sup> *Youth Criminal Justice Act*, SC 2002, c 1.



informed the Summit staff member: CAS Algoma needed a placement for Alex that day, they were “stuck” finding somewhere to place Alex, Alex required placement due to conflict between Alex and Alex’s father, and Alex was not attending school.

- Shortly after the Placement Office Employee’s telephone call, a Summit worker made separate calls to Renee and one other foster parent. The Summit worker presented the limited information CAS Algoma had provided about Alex and asked each foster parent whether they would accept the placement of Alex into their respective homes. Both of the foster parents declined the placement. The Summit worker provided this information to the Summit Supervisor.
- Later that morning, the CAS Algoma Placement Office Employee provided the Summit Supervisor with some additional information about Alex, including the fact that Alex had recently caused property damage at a local hospital and Alex’s father was refusing to provide care to Alex.
- Shortly after her call with the CAS Algoma Placement Office Employee, the Summit Supervisor called Renee, with the additional information she obtained about Alex and also shared her own past interactions with Alex. She asked Renee whether she would consider the placement of Alex. Renee refused the placement. Renee advised the Summit Supervisor that she was not open to any new placements for two main reasons. First, Renee already had two youth residing with her that had been placed relatively recently with her (one within a month and the other only two weeks longer) and the youth were still getting comfortable in her home. Renee was particularly concerned about the impact of an additional youth in the home upon one of the youth who had “a rocky start and was just settling into a good routine.” Renee wanted to ensure stability for both youth and was concerned the placement of another youth might be disruptive. Second, Renee was leaving within 12 days for an overseas vacation that had been planned for months. Renee felt this disruption alone would not be in any of the youths’ interests, including a newly placed youth. Renee advised the Summit Supervisor that she would be open to considering another placement after her vacation.
- The Summit Supervisor acknowledged Renee’s refusal to accept another youth into her home and thereafter advised the CAS Algoma Placement Office Employee that Renee’s home was not an option for Alex’s placement.
- The Summit Supervisor continued to explore options with other foster parents. She identified another Summit foster home as a potential placement for Alex and began arrangements for Alex’s placement there.<sup>28</sup> At that time, CAS Algoma foster care program staff believed this was the only available placement for Alex within the Algoma district.

## Friday Afternoon

### *CAS Algoma Placement Office Employee’s Call with the Summit Supervisor*

- Around 1:00 pm, Renee, the Summit Supervisor, and another youth placed in Renee’s foster home attended the Summit office for a Plan of Care<sup>29</sup> meeting.

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<sup>28</sup> This placement was also not ideal and some CAS Algoma staff had questioned its appropriateness for Alex as there was another youth living in the home with whom Alex had been involved in a physical altercation. Summit staff assured CAS Algoma staff that they would be able to address any issues that arose as a result of the previous conflict.

<sup>29</sup> A Plan of Care meeting brings together a child in the care of a children’s aid society (where the child is 12 years of age or over), a representative from the agency that placed the child into the care of the children’s aid society, the foster parent(s), and the child’s parent(s) where appropriate, to, among other

- The meeting also involved teleconferencing with the youth's worker from another CAS. The Plan of Care meeting was a very important meeting for the youth.
- The Summit Supervisor was also Summit's On-Call Supervisor<sup>30</sup> that day, and consequently, several minutes into the Plan of Care meeting at the Summit office, answered a call from a CAS Algoma Placement Office Employee. The telephone call was disruptive to the youth's Plan of Care meeting, and so the Summit Supervisor stepped outside of the meeting room to speak with the CAS Algoma Placement Office Employee.
- The CAS Algoma Placement Office Employee discussed the placement arrangements that were in progress for Alex, and advised the Summit Supervisor that Alex had threatened to stab the foster parent that Summit was planning to place Alex with. (The CAS Algoma Intake Worker had also been provided with this information, as it is recorded in her case notes.)
- The Summit Supervisor advised the CAS Algoma Placement Office Employee that Summit did not have any other placement options for Alex at that time. The Summit Supervisor then ended the call and returned to the Plan of Care meeting.

#### *CAS Algoma Intake Worker's Call with the Summit Supervisor<sup>31</sup>*

- Around 2:00 pm, the CAS Algoma Intake Worker again telephoned the Summit Supervisor, interrupting the meeting for a second time. According to the Summit Supervisor, the Intake Worker wanted to discuss placement possibilities for Alex.
- The Summit Supervisor informed Renee and the youth that "CAS" was on the phone, then left the Plan of Care meeting and went into another room.
- The Summit Supervisor informed the CAS Algoma Intake Worker that Summit had "a bed available" on February 6, 2016, but nothing was available before that date and suggested the possibility that Renee could be asked to "take" Alex until February 6.
- The Summit Supervisor asked the CAS Algoma Intake Worker if she wanted to speak with Renee directly about the possibility of Alex's placement with Renee until February 6, 2016. The Intake Worker informed the Summit Supervisor that she did.
- The Summit Supervisor returned to the room and asked Renee to take the telephone and speak with the CAS Algoma Intake Worker. Renee initially refused to take the telephone call. Renee told Investigators that she then felt she had to take the telephone call because the interruption caused by the telephone call during the youth's Plan of Care meeting appeared to be creating frustration for the youth.
- The Summit Director recorded Renee's contemporaneous report of that telephone call during a meeting between the Summit Director and Renee on February 3, 2016. The Summit Director recorded that Renee described being "forced to take a call from CAS." The Summit Director did not identify the reasons Renee shared for feeling "forced" to take that call.

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things, identify outcomes for the child and the plan for meeting those outcomes. Sections 111 and 115 of RRO 1990, Reg 70 under the CFSA set out that a Plan of Care meeting must be held within 30 days, three months, six months and every six months after a child is in foster care.

<sup>30</sup> Summit's On-Call Services Policy sets out its on-call services for program support and expectations of the "On-Call Supervisor."

<sup>31</sup> During her interview with Investigators from the Advocate's Office, the CAS Algoma Intake Worker could not recall details about the timing and content of this call and her subsequent calls with Renee. Accordingly, information related to this call is drawn from the interviews of Renee and the Summit Supervisor, supporting documentation, information provided during those interviews, and the CAS Algoma Intake Worker's January 29, 2016, 2:00 pm case note.

### *CAS Algoma Intake Worker's First Call with Renee<sup>32</sup>*

- Renee took the phone from the Summit Supervisor to speak with the CAS Algoma Intake Worker and left the room.
- Renee told Investigators that during the telephone call, she and the CAS Algoma Intake Worker discussed several things,<sup>33</sup> including the following:
  - The CAS Algoma Intake Worker told Renee that with only two youth in her home she could “take another;”
  - Renee explained why she was unwilling to take another youth into her home, most importantly that she was still “stabilizing” the youth already in her home;
  - The CAS Algoma Intake Worker suggested that Alex be placed with Renee for just six days and Renee advised the CAS Algoma Intake Worker that it was not a good idea;
  - The CAS Algoma Intake Worker informed Renee that Alex is “a really nice kid” and that Alex was scheduled to go to another foster home, but that “something came up;”
  - Renee informed the CAS Algoma Intake Worker that she does not take placements of youth that require physical intervention;
  - The CAS Algoma Intake Worker described to Renee some of Alex’s history known to CAS Algoma including: information about Alex’s mental health, that Alex was not taking medication as prescribed, some of Alex’s behaviours and that Alex had recently started to fight back with Alex’s father; and
  - The CAS Algoma Intake Worker specifically asked Renee, “Will you take [Alex]?” and Renee agreed to take Alex for six days only (until February 6, 2016).
- In her 2:00 pm case note, the CAS Algoma Intake Worker noted, “I spoke to [Renee] and [the Summit Supervisor]. [Renee] agreed to keep the child, and when space becomes available at [the Summit Supervisor’s], the child may go there. I provided information regarding the child in [*sic*] [Alex’s] difficult behaviors ... I will fill out placement form and place child at [Renee’s].” The CAS Algoma Intake Worker’s case note did not specify the timing or location of the placement admission meeting<sup>34</sup> for Alex.
- Both the Summit Supervisor and another Summit worker present at the Summit office who observed Renee on the telephone during her conversation with the CAS Algoma Intake Worker informed Investigators during their interviews that the call between the CAS Algoma Intake Worker and Renee was about 20 minutes long.
- By the time Renee had finished speaking with the CAS Algoma Intake Worker, the Plan of Care meeting had ended in her absence. Renee quickly left the Summit office, as she needed to pick up another youth who was waiting for her at school.
- As Renee was leaving the Summit office, she had a brief conversation with the Summit Supervisor and told her that she would accept the placement of Alex until February 6, 2016. The Summit Supervisor advised Renee that she would tell the CAS Algoma Placement Office Employee that Renee had accepted Alex’s placement.
- At 2:29 pm, the CAS Algoma Placement Office Employee sent an email to the Intake Worker and the Intake Worker’s Supervisor confirming that Alex would be placed at Renee’s home.

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<sup>32</sup> In addition, another Summit worker provided information during his interview related to his observations at the Summit office of this telephone call between the CAS Algoma Intake Worker and Renee.

<sup>33</sup> This is Renee’s recollection of the events only.

<sup>34</sup> The “placement admission meeting” (sometimes called a “placement meeting” or “admission meeting”) is the meeting at which the child is formally “admitted” into the care of the foster parent. Normally this occurs at the foster home.

### *CAS Algoma Intake Worker's Second Call with Renee*

- The time for Alex's placement admission meeting was not set before Renee left the Summit office. The Summit Supervisor informed Investigators that she made at least two telephone calls to the CAS Algoma Intake Worker to confirm the time of the meeting, but was unable to reach her directly.<sup>35</sup>
- While Renee was doing errands after leaving the Summit office, the CAS Algoma Intake Worker called Renee directly on her cell phone to confirm the time of the Alex's placement admission meeting at Renee's home. The meeting was set for 4:40 pm
- After Renee spoke with the CAS Algoma Intake Worker about the timing of the placement admission meeting, she sent a text to the Summit Supervisor to advise her of the meeting time.
- The CAS Algoma Intake Worker did not document her second call with Renee nor did she make a case note about the time and location of Alex's placement admission meeting.
- After the CAS Algoma Intake Worker's telephone conversations with Renee on January 29, 2016 and prior to Alex's placement admission meeting, the CAS Algoma Intake Worker had a "Safety Consult" with her supervisor. In a 3:38 pm Supervision case note, the Supervisor noted: "Worker Safety — [child protection worker] and [children's services worker] will use caution when alone with the child due to child's mental health and child's statement that [Alex] carries a knife to ensure [Alex's] personal safety."
- CAS Algoma also created a Family Risk Assessment, dated January 29, 2016,<sup>36</sup> that provided an "override risk level" of "very high" for the following reasons: "Child's mental health needs are severe at this time and father has been unable to meet the child's needs. The child is at high risk for requiring further mental health intervention...and for risk to self and others."

## **Friday Evening**

### *Alex's Placement Admission Meeting at Renee's Home*

- Alex's placement admission meeting, held from approximately 4:45–5:45 pm at Renee's home, was attended by: Renee, the Summit Supervisor, an On-Call Supervisor,<sup>37</sup> the CAS Algoma Intake Worker and Alex.
- During the meeting, the CAS Algoma Intake Worker told everyone present that Alex had carried a knife for protection while hitchhiking, but that Alex was no longer carrying it. The Band Representative confirmed during her interview that Alex had given the Band Representative a knife prior to going into the care of CAS Algoma on January 29, 2016.
- At one point during the meeting, Alex's behavior escalated aggressively and Alex became upset and threatened to "F—ng kill" anyone who touched Alex or Alex's belongings. Alex's behaviour de-escalated within a few minutes. The Summit

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<sup>35</sup> Investigators were unable to confirm the Summit Supervisor's efforts to reach the CAS Algoma Intake Worker as neither the Summit Supervisor nor the CAS Algoma Intake Worker had documented the attempted calls.

<sup>36</sup> During her interview, the CAS Algoma Supervisor informed Investigators that despite the Family Risk Assessment reflecting a "Date of Approval" of January 29, 2016, and that the document was approved by her, this document was likely created after January 29, 2016, and by another CAS Algoma Supervisor.

<sup>37</sup> Both the Summit Supervisor who had been "on-call" during the day on January 29, 2016, as well as the Supervisor who was "on-call" as of 5:00 pm on January 29, 2016 attended the meeting.

Supervisor, the Summit On-Call Supervisor, CAS Algoma Intake Worker, Renee and others present at the meeting noted this behaviour.

- Renee told Investigators that immediately after Alex made this statement during the placement admission meeting, Renee turned to the Summit Supervisor and told her the placement “isn’t going to work.” The Summit Supervisor told Investigators that she did not hear Renee say this.
- Renee was not informed, at any time before or during Alex’s placement admission meeting, of Alex’s threat to stab the other Summit foster parent with whom Alex was originally to be placed.
- The CAS Algoma Intake Worker brought the Summit Referral Form<sup>38</sup> to the placement admission meeting but it was not complete. She added information to this form during the meeting and provided it to Renee at the end of the meeting.
- After the meeting, the CAS Algoma Intake Worker stressed to the Summit Supervisor that she needed to ensure that Alex met with Alex’s psychiatrist as soon as possible on Monday. The CAS Algoma Intake Worker reiterated the importance of this, as Alex was not taking medication as prescribed. Renee was present for this interaction.
- The Youth Worker arrived shortly after the placement admission meeting ended. Renee had contacted the Youth Worker before the meeting and requested that she attend Renee’s home to provide support due to Alex’s placement.
- Renee informed Investigators that after the CAS Algoma Intake Worker provided the information to the Summit Supervisor about Alex’s urgent need to see a psychiatrist and Alex’s failure to take prescribed medication, Renee told the Summit Supervisor that she needed support staff that weekend. Renee also informed the Summit Supervisor that she did not have any extra support hours available to her for this purpose. The Youth Worker overheard this interaction and informed Renee in the presence of the Summit Supervisor that she was unavailable on Saturday, but could work on Sunday. Renee and the Youth Worker both informed Investigators that the Summit Supervisor did not respond to these comments. The Summit Supervisor told Investigators that she did not recall Renee raising any issues about support at that time.
- Once the placement admission meeting was over and Alex was settled, Renee reviewed the Referral Form. Renee was concerned about some of the content, including a statement that Alex “can be aggressive”, particularly in light of the information previously provided to her, and her observations of Alex during the placement admission meeting.
- Around 6:16 pm, Renee sent a text to the Summit Supervisor which stated, “I think we should put in a support staff for the weekend. To ensure safety.” The Summit Supervisor was no longer “on call” after 5:00 pm and did not respond to this text.
- Renee sent another text to the Summit Supervisor at approximately 6:56 pm that evening in which she asked, “Do you know what Lind [*sic*] of knife [Alex] normally carries?” The Summit Supervisor did respond to this text at approximately 6:57 pm and stated, “No I don’t.”

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<sup>38</sup> Summit’s 10-page Referral Form is the primary source of documentary information about a child shared between Summit and a children’s aid society when that society proposes to place a child with Summit. It provides information under many headings including the reason for referral, risk indicators, special behavioural concerns/issues, child’s personality/strengths/aptitudes, concerns, and medical history. The Referral Form also includes a two-page “Risk Factors – Child Information Form” Checklist.



## C. SATURDAY JANUARY 30–SUNDAY, JANUARY 31, 2016: EVENTS DURING ALEX’S PLACEMENT WITH RENEE

### Saturday

- On the morning of Saturday, January 30, 2016, the CAS Algoma Intake Worker contacted a CAS Algoma on-call supervisor to ask whether there were any reports to CAS Algoma about Alex on January 29, 2016. The Intake Worker advised investigators that it is not typical for her to call and make inquiries relating to the placement of a youth, but that in this case she was concerned about the “personality” fit between Renee and Alex and the possibility that Alex might run from the foster home.
- On January 30 and throughout the day on January 31, 2016, Renee became increasingly concerned about Alex’s behaviour. Renee informed Investigators that Alex attempted to break into the staff office, Alex became extremely upset when Alex’s behaviour was redirected by Renee, Alex continually climbed over staircase railings after Renee advised Alex not to do so due to safety concerns, and Alex’s behaviour was erratic and alternated between being confrontational and profane and being friendly, within a short period of time.

### Sunday

- Because of Renee’s concerns, in the early morning of January 31, 2016, she telephoned the Youth Worker who provided support in her home. Renee requested a change in the Youth Worker’s weekly Sunday morning shift at Renee’s home. The Youth Worker ordinarily worked a day-shift in Renee’s home on Sundays, commencing at 9:30 am, so Renee could leave the home and attend to personal errands. Renee told investigators that she was fearful of leaving the home on Sunday, January 31 due to Alex’s behaviour and so postponed her errands and requested that the Youth Worker come later that day as an additional support to Renee in the afternoon and evening instead. The Youth Worker agreed to change her shift to the afternoon.
- Renee and the Youth Worker both informed Investigators that by the mid-afternoon of January 31, 2016, Alex’s behaviour was increasingly erratic and unstable.
- At approximately 6:44 pm on January 31, 2016, Renee telephoned the Summit On-Call Supervisor<sup>39</sup> to request additional support in her home or for Alex to be removed. The Summit On-Call Supervisor who answered Renee’s call was the foster parent with whom Alex was originally to be placed. During their conversation, he advised Renee that Alex had threatened to stab him if Alex was placed in his home. When she heard this information Renee told Investigators that she asked for Alex to be removed from her home immediately. The On-Call Supervisor told Renee that he needed to speak to Summit management, discuss options and would call Renee back at 8:00 pm
- At approximately 7:08 pm, Renee called the Summit On-Call Supervisor again and suggested another Summit home as a placement for Alex. The Summit On-Call Supervisor told Renee that Alex could not be placed at the home Renee was suggesting.
- Renee and the Youth Worker told Investigators that after Renee’s call with the Summit On-Call Supervisor, Alex’s mood changed suddenly from lively laughter to anger and destructive behaviour. Renee and the Youth Worker witnessed Alex swearing and

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<sup>39</sup> Summit has a three-page “On-Call Services” Policy that sets out its on-call services for program support and during emergency situations, and includes expectations of the on-call supervisor and response times.

yelling and heard sounds like furniture being knocked over and glass breaking near Alex's basement bedroom. Alex appeared very upset and informed Renee that Alex wanted to call Alex's father and leave the home.

- Renee asked the Youth Worker to call 9-1-1 and the Youth Worker made the call from the home's telephone. Renee's home is at least a 30-minute drive, in ideal conditions, from the nearest community with emergency medical response services.
- At approximately 8:00 pm, Renee telephoned the Summit On-Call Supervisor on her cellular phone, informed him that Alex was "out of control" and requested that the On-Call Supervisor attend at her home as soon as possible. Renee also informed the On-Call Supervisor that Alex had threatened the Youth Worker while she was on the phone with 9-1-1. The telephone call between Renee and the Summit On-Call Supervisor was disconnected when Renee dropped the telephone while attending to the Youth Worker in the bathroom. Alex was upset and trying to take the telephone from the Youth Worker.
- Shortly after Renee's telephone call with the Summit On-Call Supervisor, Alex pulled out a knife from underneath Alex's shirt and pointed it at Renee.<sup>40</sup> Renee attempted to de-escalate the behaviour of Alex, who appeared agitated and erratic at that time. Alex also became increasingly angry, as Alex was unable to call Alex's father from Renee's home telephone. After the Youth Worker had called 9-1-1, the 9-1-1 operator maintained exclusive control of the telephone line and prevented any further outgoing or incoming calls.
- Alex began running up and down the stairs between Renee in her kitchen and Alex's bedroom in the basement. The Youth Worker and Renee became increasingly concerned about the safety of others in the home and decided that the others should leave the home. While Alex was in the basement, the Youth Worker ushered two other youth, an adult with developmental disabilities who had been placed in Renee's home by the Ministry of Community and Social Services, and Renee's dog, outside and into the Youth Worker's truck.
- At approximately 8:03 pm, while Alex was continuing to threaten Renee, Renee answered a telephone call from her adult daughter. Renee's daughter told investigators that she overheard Renee pleading with Alex not to stab her and Alex threatening to stab Renee.
- At approximately 8:06 pm, Renee's daughter called the Summit On-Call Supervisor to advise him to attend immediately at Renee's home.
- At approximately 8:19 pm, Renee sent a text to the Summit On-Call Supervisor, "9-1-1 get here now."
- Over the next several minutes, Alex continued to threaten to stab Renee with a knife and also threatened to self-harm and cut Alex's own wrists. Alex pressed the knife hard into Alex's arm and caused indentations, but did not draw blood. Renee continued to try to de-escalate Alex's behaviour.
- While Renee was attempting to calm Alex, Renee's adult son came out of his room and stood near Renee. Renee didn't know that her son was home at that time. Alex stopped threatening Renee with the knife after Alex noticed Renee's son standing beside her.
- A few minutes later, Alex went outside of the home and set fire to a plastic bag of salt on the front porch. Renee and her son were able to extinguish it.
- At approximately 8:40 pm, OPP officers arrived at Renee's home and arrested Alex. An officer located a knife in Alex's basement bedroom at Renee's home. Officers took the

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<sup>40</sup> Investigators were unable to confirm where and when Alex obtained this knife.

statements of Renee and the Youth Worker and then drove Alex to a local hospital for an assessment by a doctor.

- At approximately 8:55 pm, the Summit On-Call Supervisor arrived at Renee’s home, along with the Summit Supervisor.
- Police drove Alex to a local hospital for an assessment by a doctor. Alex was later committed to the hospital for a mental health assessment under Form 1 of the *Mental Health Act*.<sup>41</sup>
- The Summit On-Call Supervisor and Summit Supervisor left Renee’s home after the police left with Alex. The Youth Worker remained at Renee’s home until early the next morning to provide support to Renee and the other youth in the home.
- The Summit On-Call Supervisor returned in the early hours the next day.

#### D. EVENTS AFTER ALEX WAS REMOVED FROM RENEE’S HOME

- On Monday, February 1, 2016, Alex was charged under the *Youth Criminal Justice Act* with two offences related to the events on January 31, 2016. Alex was later convicted and sentenced in respect of one of the charges.
- Alex was discharged from the care of CAS Algoma on February 1, 2016, prior to the expiry of the two-month Temporary Care Agreement.
- In early February, the two other youth who had been placed with Renee, one by CAS Algoma and the other by another children’s aid society, were moved to other foster homes.
- The Summit Director was out of the country January 15–February 2, 2016, inclusive.
- On February 3, 2016, at Renee’s request, Renee and the Summit Director met to discuss Renee’s concerns about Alex’s placement.
- Alex was also hospitalized as an in-patient in February 2016 for mental health support.
- Alex turned 16 years old in the summer of 2016. Under section 37(1) of the old *CFSA*,<sup>42</sup> a children’s aid society could not intervene to provide child protection services to a young person once they turned 16, unless the matter was already before a family court.
- Alex moved away from Alex’s home and Band. Alex’s specific whereabouts were unknown to Alex’s Band for several months.
- Renee was off work on medical leave and, at the time of writing this report, has been unable to work as a foster parent since the incident.
- The Youth Worker working with Renee on January 31, 2016 was also on medical leave for a time, and is no longer working for Summit.

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<sup>41</sup> *Mental Health Act*, RSO 1990, c M7.

<sup>42</sup> In January 2016, under section 37(1) of the *CFSA*, a children’s aid society could not provide child protection services to a person who was “actually or apparently sixteen years of age or older” unless the child was already the subject of a child protection order; however, under section 3(1) of the *CFSA* at that time, a children’s aid society was still able to provide other (non-child protection) services to children aged 16 and 17 years. In the new *CYFSA*, a children’s aid society is able to provide all services, including child protection services, to children up to the age of 18.



## E. THE MINISTRY'S RESPONSES TO CONCERNS ABOUT ALEX'S PLACEMENT AND PLACEMENT BREAKDOWN

### The Ministry's Review of the February 1, 2016 Serious Occurrence Report

- On February 1, Summit submitted a Serious Occurrence Report ("SOR")<sup>43</sup> to the Ministry regarding the events involving Alex's placement.
- On February 1, after reviewing the SOR, a Ministry Representative contacted Summit Management and requested that someone contact her to discuss the events.
- On February 5, Summit submitted an Incident Report Update to the Ministry.
- On February 8, a Ministry Representative reviewed the SOR and Incident Report Update and spoke with the Summit Supervisor. The Summit Supervisor did not keep any notes of the conversation. The Ministry Representative documented a conversation with the Summit Supervisor on that date and noted "no further action [was] required."

### The Ministry's Review of Alex's Placement: April 2016

- On March 22, 2016, Renee's lawyer sent a letter to two Ministry Representatives "Ministry Representative A" who provided an oversight role with regard to CAS Algoma, and "Ministry Representative B" who provided an oversight role with regard to Summit. In the letter, Renee's lawyer suggested that Summit and CAS Algoma failed to follow proper procedure and had not fully disclosed all relevant information regarding Alex prior to Alex's placement with Renee. Renee's lawyer requested a formal investigation by the Ministry into Alex's placement with Renee.
- On March 22 or 23, 2016, Ministry Representative A telephoned a CAS Algoma Director to discuss Renee's lawyer's letter. The Advocate's Office asked the Ministry to disclose any notes or other documentation related to conversations between Ministry Representative A and CAS Algoma Director.<sup>44</sup> No documentation was provided to the Advocate's Office that confirms either party documented this conversation. Subsequent email communication between the CAS Algoma Director and Ministry Representative A on March 23 and 24, 2016 mentioned this telephone call.
- On April 1, 2016, Ministry Representative A sent an email to a CAS Algoma Director requesting a response to three specific issues:
  1. Whether full information about Alex was provided to Summit prior to the placement of Alex with Renee;
  2. Whether a CAS Algoma staff spoke directly to Renee to convince her to accept Alex;
  3. Whether CAS Algoma staff discussed the situation involving Alex with Summit Management.
- In early April 2016, the CAS Algoma Director conducted an internal review of the events and responded by email to Ministry Representative A on April 5, 2016. The CAS Algoma Director advised Ministry Representative A, among other things, that:
  1. CAS Algoma had "very limited information" about Alex at the time of placement;

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<sup>43</sup> A Serious Occurrence Report (SOR) is a formal notification to the Ministry, as well as others, about serious incidences involving children and youth in the care of a foster home or children's residence.

<sup>44</sup> The Advocate's Office specifically requested the Ministry of Child and Youth Services to disclose, "Copies of any notes or other documentation relating to the content of the conversation that occurred between [Ministry Representative A], and [CAS Algoma Director], CAS Algoma, on or before April 1, 2016, related to the placement of [Alex]."

2. That “all placement arrangements were made with Summit manager in accordance to our placement protocol;” and
  3. That “[d]ebriefing of the circumstances occurred between [the CAS Algoma Placement Office Employee] and [Summit Director] on February 1, 2016.”
- Investigators noted that the information contained in the CAS Algoma Director’s email response to Ministry Representative A, as they relate to the second and third issues, was inconsistent with information obtained from several other sources during this investigation.
  - Ministry Representative A did not ask the CAS Algoma Director to provide any supporting documentation as part of the response.
  - Ministry Representative A did not document at least two conversations she had with two different CAS Algoma Directors about the letter from Renee’s lawyer.
  - On April 26, 2016, Ministry Representative A provided a copy of the CAS Algoma Director’s April 5, 2016 email response to Ministry Representative B.

### **The Ministry’s Annual Licensing Review with Summit: April and May 2016**

- On April 1, 2016, Ministry Representative B sent an email to the Summit Director requesting a written report outlining what Summit knew about Alex before the placement, when Summit obtained that information, and what support and assistance was requested and received by Renee related to Alex’s placement.
- Over the next few days, there was some telephone and email communication between the Summit Director and Ministry Representative B in relation to the Ministry’s requests. Neither the Summit Director nor the Ministry Representative B documented their telephone conversations.
- Prior to the letter from Renee’s lawyer, Ministry staff had planned to conduct its Annual Licensing Review<sup>45</sup> of Summit in April 2016. The Ministry’s review of the circumstances relating to Alex’s placement with Renee continued within that Annual Licensing Review process, held between April 18 and 20, 2016.
- As part of its review, the Ministry reviewed the circumstances surrounding the Serious Occurrence Report Summit submitted to the Ministry on February 1, the Incident Report Update submitted by Summit on February 5, 2016 relating to Alex’s placement with Renee, and the allegations made by Renee’s lawyer in her letter dated March 22, 2016.
- Based on the findings of its review, the Ministry was prepared to renew Summit’s licence allowing it to continue its residential foster care program during the period May 1, 2016 to April 30, 2017 with a specific “Term and Condition”:

“[Summit] shall submit written confirmation outlining the measures taken by the agency to ensure all areas identified in the Licensing Summary Report dated April 2016 have been addressed as required. The written response must be submitted to the accountable Ministry [Representative] on or by May 31, 2016.”

- The required areas for follow up as per the specific Term and Condition included the need for Summit to take action on six items.

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<sup>45</sup> Foster care agencies in Ontario may be licensed by the Ministry. A licence is required where a person is providing residential care directly or indirectly, to 3 or more children, not of common parentage, in places that are not children residences and must be renewed at least annually. See the CYFSA and the Ministry’s, *Foster Care Licensing Manual* (Toronto, ON: Ministry of Children and Youth Services, 2012). The Ministry’s previous licensing review with Summit was completed in June 2015.

- On May 10, 2016, the Summit Director provided documentation to Ministry Representative B in response to the first five items required by the Ministry. Summit's actions included: (1) amending its Admission Policies and Emergency Placement Policy; (2) holding meetings with all staff to review the Summit Supervisor's breaches in policies, as they related to Alex's placement; and (3) ensuring all staff reviewed Summit policies and confirmed in writing their understanding of and agreement to future compliance with them.
- After receiving the Summit Director's May 10, 2016 letter, Ministry Representative B did not have any further communication with the Summit Director. The following sixth required item, which was part of the specific Term and Condition of Summit's Licence, was never addressed.
  - Review and strengthen, as necessary, existing protocols related to the referral and placement process of children and youth in the foster care program with the Children's Aid Society of Algoma. [emphasis added]

## VII. ANALYSIS AND RECOMMENDATIONS

### A. INVESTIGATIVE ISSUE ONE: ALEX'S PLACEMENT WITH RENEE

Investigators found that CAS Algoma and Summit did not follow all placement policies and protocols when Alex was placed with Renee. Three documents were particularly relevant in coming to this conclusion: the Resource Service Agreement between Summit and CAS Algoma and two of Summit's internal policies: its Service Area and Referrals Policy and Emergency Placement Policy.

#### **Resource Service Agreement between Summit and CAS Algoma**

The Resource Service Agreement between Summit and CAS Algoma ("RSA") describes the obligations of both agencies when CAS Algoma places children in its care with Summit, including pre-placement procedures and the admission process.<sup>46</sup>

The protocol that exists under the RSA allows for pre-admission communication only between the "Placement Office" (defined as "that unit of the CAS which is responsible for the placement of children in CAS care") and the "Resource Licensee" (Summit).

The RSA does not explicitly prohibit communication between a prospective Summit foster parent and CAS Algoma staff; however, both CAS Algoma and Summit staff acknowledged during interviews that the agencies share an interpretation of the RSA that there should not be any direct communication between a Summit foster parent and CAS Algoma staff members during a foster parent's consideration of whether to accept or refuse a placement of a child.

#### **Summit's Internal Policies**

Summit's Service Area and Referrals Policy and its Emergency Placement Policy both outline the steps to be taken by Summit staff prior to the placement of a child in an emergency situation

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<sup>46</sup> The Resource Service Agreement between Summit Human Services Inc. and CAS Algoma was signed by both agencies on August 12, 2013 and was effective at the time of Alex's placement with Renee.

(eg, when a child needs a foster care placement on the same day that child comes into the care of a children's aid society).<sup>47</sup>

In Summit's Service Area and Referrals Policy, the "Protocol for Referrals" requires that all pre-admission communication with a referring agency (eg, a children's aid society) must be between that agency and a Summit supervisor or Summit's Executive Director. This policy further stipulates Summit's Management Team decides whether to accept or refuse the potential placement of a child and that when a decision has been made to accept a placement, "the Executive Director or her designate" is the individual who contacts the referring agency (eg, a children's aid society) to accept the placement and arrange admission.

Summit's "Emergency Placement Protocol" outlines the steps to be taken during an emergency referral. The first five steps of this protocol are as follows:

1. The (Summit) Supervisor/On Call Supervisor will identify which beds are available in the program by consulting the management resident list, which is updated as changes occur.
2. The Supervisor will call the referring CAS worker to gather information prior to deciding on an appropriate placement.
3. The Supervisor will contact the foster/group home to determine program feasibility of receiving an emergency placement.
4. The Supervisor will inform CAS, by telephone, of the decision regarding accepting or refusing the referral, then follow-up with the admission/refusal form.
5. The Supervisor will make arrangements with CAS regarding the time and place for the admission and proceed to bring a child's binder if the home does not have an extra/empty one.

## **Discussion**

During their respective interviews with Investigators, a CAS Algoma Director, and a Summit Supervisor and Director each confirmed that a CAS Algoma child protection worker should not have direct contact with a foster parent until after a child's placement with that foster parent was finalized.

The CAS Algoma Placement Office Employee advised Investigators during his interview that any contact between a CAS Algoma child protection worker and a foster parent prior to the placement admission meeting at the foster home is merely to confirm details of the placement meeting (eg, time and location of the meeting).

Contrary to the RSA, and contrary to Summit's internal policies, the Investigators concluded that the Summit Supervisor initiated a telephone conversation between Renee and the CAS Algoma Intake Worker for the purpose of discussing Alex's possible placement directly with Renee. The Summit Supervisor initiated this conversation after Renee had already refused to accept the placement of Alex, or any another youth, in her home.<sup>48</sup>

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<sup>47</sup> References are made here to Summit's policies in effect at the time of Alex's placement in January 2016. As discussed below, Summit revised its Emergency Placement Policy, as well as other policies in May 2016.

<sup>48</sup> Information obtained during interviews with Renee, a Summit Supervisor, a Summit Director and another Summit employee who observed Renee on the telephone, as well as from documents created at

The Summit Supervisor and a Summit Director were both very candid in their interviews about this issue. They advised that following its Annual Licensing Review,<sup>49</sup> Summit took several steps in April and May 2016 to ensure that Summit staff complied with its policies in the future. For example, in May 2016, the Summit Director required all Summit staff to review Summit's relevant policies with their supervisors and sign a written acknowledgment confirming their understanding of, and agreement to comply with them.

When Investigators asked the CAS Algoma Director, during her interview, what could have been done differently when Alex was placed, the CAS Algoma Director said that she was not sure if anything could have been done differently because "protocols were followed." When the CAS Director was asked whether circumstances surrounding the placement of Alex resulted in any changes at CAS Algoma, she stated, "Not that I am aware of."

As set out in the Chronology above, on April 1, 2016, a Ministry Representative sent an email to a CAS Algoma Director requesting a response to three issues related to Alex's placement. One of the questions was, "[t]he foster parent indicated that the CAS Algoma staff spoke to her directly to convince to accept the child in the home. Is this correct [*sic*]." The response to this question, provided by the CAS Algoma Director to the Ministry at that time, was, "[t]his information is not correct, all placement arrangements were made with Summit manager in accordance to our placement protocol. The CPW [CAS Algoma Intake Worker] did have direct communication to coordinate the time of the placement. CPW and the child met with [Summit supervisor] and foster parent to review the limited information that we had at the time of [Alex's] placement. This meeting only occurred after Summit had accepted [Alex] and identified the placement."

During her interview, the CAS Algoma Director told Investigators that CAS Algoma's response to the Ministry's April 1, 2016 inquiry was based on its own internal review, including discussion with the CAS Algoma Intake Worker and a review of documents. The CAS Algoma Director and the CAS Placement Office Employee both advised Investigators that CAS Algoma procedures do not permit communication between front line child protection workers and potential foster parents until after Summit confirms a placement.

However, the content of CAS Algoma's response to the Ministry on April 5, 2016 did not address the (first) approximately 20-minute telephone call between the CAS Algoma Intake Worker and Renee while Renee was at the Summit office on January 29, 2016. The Advocate's Office Investigators concluded that the CAS Algoma Intake Worker spoke directly to Renee about issues unrelated to the timing or location of the placement admission meeting, and asked her to reconsider her refusal to accept the placement of Alex into her home.

In reaching this conclusion, Investigators considered several sources of information, including: (1) the Summit Supervisor's statement that she initiated the call between Renee and the CAS Algoma Intake worker for the specific purpose of having them discuss Alex and the option of a short-term placement of Alex at Renee's home; (2) Renee's detailed and consistent recollection of her first telephone call with the Intake Worker on January 29, 2016 during interviews and as recorded in documents created shortly after Alex left Renee's home and (3) the estimates by the Summit Supervisor and another Summit employee who observed the telephone call between

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or around the time of Alex's placement at the end of January and early February 2016, support this conclusion.

<sup>49</sup> See Chronology above, "The Ministry's Annual Licensing Review with Summit: April and May 2016."

Renee and the CAS Algoma Intake Worker as about 20 minutes in duration — seemingly much longer than would have been needed to confirm the timing and location of a placement admission meeting.

During her interview, the CAS Algoma Intake Worker could not recall the timing and content of her calls with Renee on January 29, 2016. She also could not recall how the calls with Renee or the Summit Supervisor were initiated and to whom they were made (Renee, the Summit Supervisor or both). The CAS Algoma Intake Worker was only able to provide the limited information set out in her January 29, 2016, 2:00 pm case note.

The one case note that the CAS Algoma Intake Worker made about these conversations does not clearly set out the content of each call, or other relevant details of the discussions.

However, even without those details, the January 29, 2016 2:00 pm case note supports some of the key information that Renee and the Summit Supervisor provided. In her case note, the CAS Algoma Intake Worker wrote, “I spoke to [Renee] and [the Summit Supervisor]. [Renee] agreed to keep the child, and when space becomes available at [the Summit Supervisor’s], the child may go there. I provided information regarding the child[’s] ... difficult behaviors. I will fill out placement form and place child at [Renee’s].”

The Investigators noted that the CAS Algoma Intake Worker confirmed Alex’s placement with Renee in her January 29, 2016, 2:00 pm case note; however, the CAS Algoma Placement Office Employee did not inform the CAS Algoma Intake Worker and her Supervisor that Alex would be placed in Renee’s home until 2:29 pm. Consequently, CAS Algoma’s own documentation supports that the CAS Algoma Intake Worker spoke directly with Renee prior to receiving confirmation of the placement from the CAS Algoma Placement Office.

The CAS Algoma Intake Worker informed Investigators that perhaps the 2:00 pm time recorded in her January 29, 2016 case note was not accurate and her telephone call with Renee was later that day; however, the timing of an approximately 20-minute discussion between Renee and the CAS Algoma Intake Worker commencing around 2:00 pm is consistent with other information obtained during the investigation, including the time Renee left the Summit office and when the Summit Supervisor confirmed with the CAS Algoma Placement Office Employee that Alex could be placed with Renee.

Further, the CAS Algoma Intake Worker’s January 29, 2016, 2:00 pm case note did not include any information about the timing or location of the placement admission meeting for Alex. The information obtained during the investigation, including text message exchanges between Renee and the Summit Supervisor, shows that it was only during a subsequent (second) direct telephone call between the CAS Algoma Intake Worker and Renee that the time of the meeting was confirmed. This second call was initiated by the CAS Algoma Intake Worker who called Renee directly on her cell phone to confirm the time of the placement admission meeting as 4:40 pm. That call occurred after 3:00 pm and after Renee had left the Summit office. After Renee’s second telephone call with the CAS Algoma Intake Worker, Renee texted the Summit Supervisor to advise her of the 4:40 pm placement admission meeting time.

There were three important consequences resulting from the Summit Supervisor initiating the telephone conversation between the CAS Algoma Intake Worker and Renee.

- First, Renee advised Investigators that she felt pressured by Summit and CAS Algoma staff to accept a placement that she had already refused.
- Second, telephone calls between Summit and CAS Algoma staff and then between the CAS Algoma Intake Worker and Renee significantly disrupted an unrelated youth's Plan of Care meeting.
- Third, the Summit Supervisor did not hear what, if any, information the CAS Algoma Intake Worker provided to Renee during their private telephone call and was therefore unable to confirm whether all relevant information had been shared. The first two consequences are discussed below. The third consequence is discussed separately under "Investigative Issue Two".

## Consequences

### 1. Renee Felt Pressured by Summit and CAS Algoma Staff to Accept a Placement She Had Already Refused

During her interview, the Summit Supervisor informed Investigators that she thought that having Renee speak directly with the CAS Algoma Intake Worker about the option for a shorter-term placement of Alex at Renee's (ie, until February 6, 2016 only) would be helpful and allow Renee to have her questions answered directly by the CAS Algoma Intake Worker.

Renee told Investigators that she felt pressured during her first call with the CAS Algoma Intake Worker to accept a placement that she had already refused twice (once to the Summit Supervisor and first to another Summit worker). She explained she had refused to consider taking another youth into her home at that time because she was concerned about the stability of two other youth in her home, particularly in light of her upcoming vacation.

Regardless of the Summit Supervisor's intentions, it was her responsibility to ensure that she alone was communicating separately with the CAS Algoma Intake Worker and Renee prior to the placement admission meeting (including about the time and location for the placement admission meeting). However, the CAS Algoma Intake Worker also shares some responsibility and should have been aware that her communication with Renee prior to Renee accepting a placement was contrary to expected protocol about not directly communicating with a prospective foster parent. One consequence of the direct telephone call between the CAS Algoma Intake Worker and Renee is that Renee felt pressured to take a placement that she had already refused.

#### **CAS Algoma & Summit: Revise the RSA re: Communication with Foster Parents**

**RECOMMENDATION ONE:** CAS Algoma and Summit should revise the RSA to explicitly outline the circumstances, if any, under which it is acceptable for CAS Algoma staff to communicate directly with prospective Summit foster parents before a placement admission meeting has been arranged.

#### **Summit: Review Protocols on Communication with Foster Parents**

**RECOMMENDATION TWO:** Summit should review and revise, where needed, its protocols with other children's aid and Indigenous children's aid societies to explicitly outline the circumstances, if any, under which it is acceptable for staff at those societies to communicate directly with prospective Summit foster parents.



**CAS Algoma: Ensure staff Follow Pre-admission Protocol on Communication**

**RECOMMENDATION THREE:** CAS Algoma should ensure that all of its staff involved in the placement of children review, understand and comply with the pre-admission protocol on communication between CAS Algoma staff and prospective foster parents.

**Summit: Staff Awareness of RSA and Changes to it**

**RECOMMENDATION FOUR:** Summit should ensure that its staff review, understand and comply with any revisions made to the RSA.

*Summit Response to Recommendations*

Summit advised that their agency has accepted and implemented all recommendations directed toward their organization. Summit provided copies of internal forms that had been revised in response to these recommendations. The revised Referral Form specifically includes the following statement in bold type on its front page: “Foster Parents are NOT to have any conversation with the placing agency in regard to a potential placement until the youth has been formally placed in their home.” The Advocate’s Office notes that the version of the Referral Form in use at the time of Alex’s placement did not contain a similar caution.

*CAS Algoma Response to Recommendations*

The formal response from CAS Algoma notes that the Resource Services Agreement (“RSA”) does not preclude communication between other employees of the Society and Summit when communication is believed to be beneficial to the child’s placement. However, CAS Algoma acknowledged that, “best practice sets out that placement requests be managed by the Society’s placement staff, including initial requests to Summit.”

CAS Algoma has agreed to meet with Summit to discuss the RSA and pre-placement communication protocols, while at the same time taking the position that “in urgent situations there may be occasions when it is in the child’s best interests for the Child Protection Worker to communicate with Summit directly.”

**2. Telephone Calls Disrupted Another Youth’s Plan of Care Meeting**

A second consequence of the Summit Supervisor initiating the first telephone call between the CAS Algoma Intake Worker and Renee during an unrelated youth’s Plan of Care meeting is its effect on the integrity of the meeting itself, and the lack of respect that was shown toward the other youth, who was engaged in a process intended to create a plan that would address his needs while he was in care.

The meeting of the youth, his/ her children’s aid society worker, Renee, and the Summit Supervisor was required under subsection 111(4) of Ontario Regulation 70 of the old CFSA.<sup>50</sup> It was mandatory for Renee as a foster parent, and the Summit Supervisor as the licensee to participate in the meeting to finalize the youth’s foster plan of care.

Plan of Care meetings are significant events for children living in care and require at least the same attention and freedom from interruption as should be expected in any other important meeting. The importance of the unrelated youth’s Plan of Care meeting on January 29, 2016 was not afforded the respect it deserved.

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<sup>50</sup> Subsection 111(4) of RRO 1990, Reg 70 also requires the child’s parents, where appropriate, to be part of this plan of care.



The Summit Supervisor disrupted the youth's Plan of Care meeting three times. The first two disruptions occurred when the Summit Supervisor took two separate telephone calls during the meeting then left the meeting to further engage in conversation with each caller (first with the CAS Algoma Placement Office Employee and later with the CAS Algoma Intake Worker). The youth's Plan of Care meeting was disrupted a third time by the Summit Supervisor when she returned to the meeting after speaking with the CAS Algoma Intake Worker and began a conversation with Renee, during the meeting, and asked her to speak with the CAS Algoma Intake worker.

Renee provided Investigators with detailed information regarding the third disruption. In her interview, Renee described the disruption as follows: the Summit Supervisor asked Renee to speak with the CAS Algoma Intake Worker in the presence of the unrelated youth, Renee initially refused to take the phone call. When Renee saw that the youth was becoming frustrated by the interruption to the plan of care meeting, she felt pressured to take the phone.

Because the Summit Supervisor was also the On-Call Supervisor for Summit that day, she may have felt compelled to answer her "on-call" phone during the youth's Plan of Care meeting, despite the impact of such disruptions on the youth and the meeting. However, the Summit Supervisor could have ensured that she was free from interruptions during that meeting. One option may have been for the Summit Supervisor to arrange for another Summit staff to be "on-call" during that meeting. This would have eliminated the Summit Supervisor's need to engage in any telephone calls and prevented the three separate disruptions to an important meeting for that youth.

#### **Summit: Limit Interruptions to Plan of Care Meetings**

**RECOMMENDATION FIVE:** Summit should ensure that all Plan of Care meetings for children living in its foster homes proceed without interruption, except in extraordinary circumstances.

#### *Summit Response to Recommendation*

As noted earlier, Summit has accepted all recommendations.

## **B. INVESTIGATIVE ISSUE TWO: SHARING OF INFORMATION**

### **Disclosure of Relevant Information**

The Investigation also explored Renee's allegations that CAS Algoma and Summit did not fully disclose all relevant information concerning Alex prior to Alex's placement with Renee.

Investigators concluded that Summit and CAS Algoma failed to provide at least one key piece of information to Renee: staff at both agencies specifically failed to inform Renee about the threat Alex had made to stab another foster parent with whom Alex was to be placed.

Three separate sources outline the requirement to provide relevant information to a foster parent and/or the way in which that information is to be provided: (1) Subsection 112(b) of the former *CFSA* Regulation 70, which was in force at the time; (2) two of Summit's internal policies; and (3) the *RSA*.

### *Subsection 112(b) of Regulation 70 under the old CFSA<sup>51</sup>*

Subsection 112(b) of the former Regulation 70 states,

112. No licensee shall select a placement for a child in a foster home or place a child in a foster home unless the licensee... (b) discloses to the foster parents all information known to the licensee about the child that is relevant to the care of the child...

### *Summit's Internal Policies*

In Summit's internal Admission Policies,<sup>52</sup> the Referral Form is described as being "required prior to placement and is used in determining both planned and emergency placements and the particular needs of both the referring agency and the client."

In the Emergency Placement Protocol contained within Summit's Emergency Placement Policy, step two of the Protocol identifies that a Summit supervisor will call the referring CAS worker to gather information prior to deciding on an appropriate placement. Step three of that Protocol sets out that a Summit supervisor will contact the foster home to "determine program feasibility of receiving an emergency placement."

### *The Resource Service Agreement*

Under the RSA, a CAS Algoma foster care program staff member is responsible for providing Summit staff with relevant information about the child after a Summit staff member advises a CAS Algoma foster care program staff member of its willingness to receive information about a child. A CAS child protection worker completes Summit's "Referral Form" to provide information about a child ("Referral Information").<sup>53</sup> The 10-page form—the primary source of documentary information about a child—is used by CAS Algoma and Summit when CAS when a placement is proposed and provides information under many headings including: the reason for referral, risk indicators, behavioural concerns/issues, child's personality/strengths/aptitudes, and medical history along with a checklist for risk factors and child information. The RSA sets out that the "[CAS] Placement Office shall endeavour to forward the Referral Information to [Summit] in a timely manner."

## **Discussion**

On January 29, 2016, the CAS Algoma Placement Office Employee advised the Summit Supervisor that the Referral Form would not be completed prior to Alex's placement admission meeting because of the emergency nature of Alex's same-day placement. The Referral Form was completed at the meeting instead.<sup>54</sup>

It was only after the placement admission meeting and before the CAS Algoma Intake Worker left Renee's home that she provided the referral form to Renee. There was nothing on the referral form that indicated Alex had threatened to stab another foster parent. Therefore, the

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<sup>51</sup> RRO 1990, Reg 70.

<sup>52</sup> Reference is made here to Summit's Admission Policies that were in effect at the time of Alex's placement. This policy was revised in May 2016, as described further below.

<sup>53</sup> CAS Algoma completes a "Placement Request/Child Information Form" when it places children within in its own foster homes; however, when CAS Algoma requests the placement of a child or youth with a licensed foster care provider like Summit, CAS Algoma completes that licensee's version of the Placement Request/Child Information Form.

<sup>54</sup> In his January 29, 2016, 1:04 pm case note, the CAS Algoma Placement Office Employee advised the CAS Algoma Intake Worker, among other things, "you will need to complete admission paperwork including the referral package at the time of the admission. Typically, they want the referral in advance; however, I explained that the situation today will not allow you to do so in advance."

only information Renee had about Alex prior to accepting the placement was what was provided during three telephone conversations on January 29, 2016. Two of these conversations were with Summit staff and one was with the CAS Algoma Intake Worker.

Renee also told Investigators that she believed Summit withheld information about Alex's involvement in a violent 2015 altercation involving another youth placed with Summit. The Summit Supervisor had discussed the incident with Renee prior to January 2016, but had not identified Alex by name. It is unclear if Summit knew Alex was involved in the incident. The Summit Supervisor told Investigators that she did not know if Alex was one of the youth involved but another youth had alleged Alex was present. Summit staff did not confirm whether Alex was present, nor the extent of Alex's involvement, if any. Alex was not in Summit's care at the time of the 2015 incident, unlike the other youth involved. The Summit Supervisor confirmed to Investigators she was aware of the rumour prior to Alex's placement with Renee, but did not share the information with Renee. Investigators were unable to conclude that this information should have been provided to Renee.

Renee told Investigators that the CAS Algoma Intake Worker provided her with some information about Alex during their first telephone call. This included information about Alex's history of abuse, that Alex was fighting with Alex's father, the suggestion that Alex received a specific diagnosis of significant mental health problems,<sup>55</sup> but was not taking medication as prescribed, and that Alex could not be placed in the original foster home as planned. The CAS Algoma Intake Worker knew about of the threat Alex made against the other foster parent before having this conversation with Renee, but did not disclose this information. Renee told investigators during her interview that she specifically asked the CAS Algoma Intake Worker why Alex was not being placed with the other foster parent, and the CAS Algoma Intake Worker responded that "something came up" and Renee did not ask anything further about it.

After the CAS Algoma Intake Worker's telephone conversation with Renee on January 29, 2016 and prior to Alex's placement admission meeting, the CAS Algoma Intake Worker had a "Safety Consult" with her supervisor. In a 3:38 pm Supervision case note, the Supervisor noted, "Worker Safety — [child protection worker] and [children's services worker] will use caution when alone with the child due to child's mental health and child's statement that [Alex] carries a knife to ensure [Alex's] personal safety."

### **Summit Supervisor Did Not Ensure Renee Had All Relevant Information**

Renee did not have the opportunity to discuss with the Summit Supervisor what she had heard from the CAS Algoma Intake Worker as she had to leave the Summit office immediately after the plan of care meeting (when the first call with the CAS Algoma Intake Worker occurred). The Summit Supervisor was not aware of the information that had been provided directly to Renee.

Shortly after 1:00 pm on January 29, 2016 the Summit Supervisor was told by the CAS Algoma Placement Office Employee that Alex had made a threatening statement about another foster

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<sup>55</sup> Renee advised Investigators that the CAS Algoma Intake Worker informed her about one apparently significant mental health problem that Alex "had". Under the category of "Medical Condition" in Summit's Referral Form for Alex, the CAS Algoma Intake Worker included the name of this disorder, as well as two others, each diagnosable by a psychiatrist, however, information obtained during this Investigation, including information received from the psychiatrist who saw Alex at a local hospital and documentation produced by that hospital and CAS Algoma, did not support the assertion that Alex had ever been diagnosed with any of those three disorders.

parent; however, the Summit Supervisor did not make any attempt thereafter to ensure that Renee was made aware of this information.

The Summit Supervisor also was aware that Renee would not have an opportunity to review the Referral Form until sometime during or after the placement admission meeting at Renee's home, at which Alex would be present. Further, the Summit Supervisor did not review the Referral Form that was provided to Renee at the placement admission meeting and did not ensure that it contained all relevant and required information known to her. This was particularly warranted given Alex's additional threats during the placement admission meeting to "f—ng kill" anyone who touched Alex or Alex's "stuff." Had the Summit Supervisor reviewed the written information the CAS Algoma Intake Worker provided to Renee, she would have noted that information about Alex's threat to stab another foster parent was missing.

The Summit Supervisor did not make any inquiries about what information had been provided to Renee until after Alex was removed from Renee's home. In early February 2016, the Summit Supervisor contacted the CAS Algoma Intake Worker and specifically asked her whether she had informed Renee about Alex's threat toward another foster parent on January 29, 2016. The CAS Algoma Intake Worker informed the Summit Supervisor that she had not provided this information to Renee. The Intake Worker and the Summit Supervisor had each assumed that the other had given Renee this information.

This information was particularly important for Renee. According to Renee, she has physical limitations that prevent her from engaging in physical interventions with children placed in her home and she has young grandchildren that visit regularly. Renee told Investigators that she specifically advised the CAS Algoma Intake Worker on January 29, 2016, and had advised the Summit Supervisor previously, that youth who were at risk of being physically violent could not be placed in her home. In her interview, the CAS Algoma Intake Worker could not recall details of her telephone call with Renee on January 29, 2016. Summit's position was that Renee was never expected to engage in physical interventions with Alex and that Summit expected Renee to contact the police immediately in any situation that required physical intervention.

Investigators confirmed, through interviews and the documentary record, that Summit and CAS Algoma each failed to follow the expected protocols for communication between a foster parent and CAS Algoma staff, which contributed to the fact that relevant information about Alex was not shared with Renee. The CAS Algoma Intake Worker did not provide the relevant information about Alex's threat toward another foster parent to Renee during either of her calls with Renee on January 29, 2016 or on the Summit Referral Form, and the Summit Supervisor did not ensure that all relevant information was communicated to Renee.

In response to the actions required after the Ministry's Annual Licensing Review, Summit has taken steps to ensure that its staff provide all relevant information to its foster parents in the future. In May 2016, Summit revised its Admission Policies and Emergency Placement Policy to specify that a Summit supervisor must ensure that she/he provides all relevant information to a foster parent to enable the foster parent to make an informed decision whether to accept or refuse a youth into their home. All Summit staff were required to review the amended policies with their supervisors and confirm in writing their understanding of and agreement to comply with them.

However, Investigators note that the revised Admission Policies and the RSA remain inconsistent in the requirements for delivering written "Referral Information" (ie, the Referral

Form). The RSA states that CAS Algoma “shall endeavour to forward the Referral Information to [Summit] in a timely manner;” however, Summit’s Admission Policies set out that the Referral Form is “required prior to a placement.”

Clarity and consistency about the expected delivery of the Referral Forms is important, particularly in cases of emergency or same-day placements. A potential foster parent should be made aware of all significant information about a child prior to the placement admission meeting to ensure that a potential foster parent is able to make an informed decision and remains willing to accept and appropriately support the placement of a child. CAS Algoma should only transport a child to a foster home after a foster parent has formally accepted a placement based on all the significant information related to a child.

Finally, in the Ministry Representative’s April 1, 2016 inquiry to CAS Algoma, she asked a CAS Algoma Director to confirm whether “full information about [Alex] was provided to Summit prior to placement.” In response to the inquiry, CAS Algoma provided an overview of Alex’s involvement with CAS Algoma and advised that it had very limited information about Alex’s current needs at the time of Alex’s placement. In the course of this investigation, Investigators were able to confirm that the specific information known to CAS Algoma was shared with the Summit Supervisor by the time of Alex’s placement with Renee. Aside from Alex’s threat to stab another foster parent, Investigators were unable to conclude that there was other relevant information known to Summit at the time of Alex’s placement that Summit failed to share with Renee.

**CAS Algoma & Summit: Amend RSA to Allow Foster Parents Time to Review Information**  
**RECOMMENDATION SIX:** CAS Algoma and Summit should amend the RSA to clarify when CAS Algoma must provide the Referral Form to Summit prior to a child’s placement with a potential foster parent. The RSA should specify that a foster parent must have the opportunity to review all significant information about a child prior to the child attending at her or his foster home.

**Summit: Amend Policies to Reflect Changes to RSA**  
**RECOMMENDATION SEVEN:** Summit should amend its Admission Policies and Emergency Placement Policy to be consistent with any changes made to the RSA.

**Summit: Communicate Threats Made by Children/ Youth to Foster Parents**  
**RECOMMENDATION EIGHT:** Summit should ensure that any threats made by children or youth to self-harm and/or harm another person, are communicated clearly to foster parents who are considering having those children or youth placed with them.

**CAS Algoma: Record Threats Made by Children/ Youth on Necessary Forms**  
**RECOMMENDATION NINE:** CAS Algoma should ensure that any threats made by children or youth to self-harm and/or harm another person, are recorded clearly on its Placement Request/Child Information Form or the equivalent of this form used by residential licensees providing foster care services to children in CAS Algoma’s care.

#### *Summit Response to Recommendations*

As noted earlier, Summit has accepted all recommendations. The agency has provided the Advocate’s Office with a copy of a Referral Form marked “revised January 2018” which includes

questions and additional space for answers that did not appear in the Referral Form filled out at the time of Alex's placement. In particular, the new Referral Form includes the following questions with space for responses: Does the child or youth self-harm; Has the child harmed another person; Information requested by the Summit Management representative; Youth's wishes as it relates to placement; That the Foster Parent was given the opportunity to ask necessary questions to their Summit Supervisor prior to youth's placement; and Foster parent has agreed to the placement of the youth in their home.

### *CAS Algoma Response to Recommendations*

The response of CAS Algoma noted that Summit had been provided all of the information known to them about Alex and CAS Algoma believes that by the end of the admission meeting, Renee had the necessary information necessary to make an "informed decision" about whether Alex was an appropriate candidate for placement in her home.

## **C. INVESTIGATIVE ISSUE THREE: IMPACT OF PLACEMENT ON ALEX AND OTHERS**

### **Impact of Alex's Placement on Alex**

Investigators were unable to hear directly from Alex on issues related to Alex's placement with Renee. Therefore, the information below was obtained from documents and interviews with others. Investigators did not solicit responses to Alex's comments from Renee or others living in Renee's home at the time of Alex's placement with Renee. It may be that others would suggest alternative perspectives to some of those provided by Alex; however, these comments are the only fragments of Alex's voice relating to Alex's experiences in the foster care placement. As such, they are set out as reportedly conveyed to others, without comment, to give voice to Alex's views:

- The Youth Worker who was working in Renee's home on January 31, 2016 informed Investigators during her interview that Alex became upset around dinnertime that evening when the Youth Worker referred to Alex's regalia<sup>56</sup> as "a costume." Alex was working on the regalia at Renee's home. The Youth Worker recalled that Alex was very upset by the comment and told the Youth Worker that it was "so disrespectful." The Youth Worker informed investigators that Renee intervened and was able to de-escalate Alex's anger and assist Alex. The Youth Worker also informed investigators that she felt badly that she was "ignorant" about the meaning of Alex's regalia and, in hindsight, realized that her comment was "disrespectful."
- Renee advised Investigators during her interview that Alex informed Renee about Alex's desire to go to a "Native treatment place down south"<sup>57</sup> that Alex's sibling had attended and "had done well at." Renee and Alex together looked up information about the treatment facility. Renee informed Alex that they would speak with Alex's CAS Algoma worker on Monday and hopefully start the process for Alex to go there. Alex informed Renee that Alex wanted treatment in a "traditional" or "Native environment."

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<sup>56</sup> Regalia are meaningful traditional creations and a powerful symbol of one's First Nation identity. See for example, one link that explains the significance of regalia: <https://www.aboriginalbc.com/blog/culture-not-costumes-the-art-of-regalia/>. It appeared from information obtained from Renee and the Youth Worker that Alex's work on Alex's regalia was meaningful to Alex.

<sup>57</sup> Alex told Renee the name of the facility; however, Renee could not recall the name at the time of Renee's interview.

- A Band Representative informed Investigators during an interview that Alex sent a private message on social media while Alex was at Renee’s home to inform the Band Representative that Alex was unhappy with the placement. The Band Representative told Investigators that after Alex left Renee’s home, Alex spoke with the Band Representative more specifically about Alex’s concerns at Renee’s home. Alex’s concerns included Alex’s unhappiness with Alex’s bed and bedroom, the fact that Alex could not smoke or use the telephone as Alex wanted to, complaints about some of the food Renee served, and some comments that Renee made to Alex. The Band Representative recalled that Alex had expectations of certain standards in foster care that Alex felt were unmet and that Alex “just wanted out.”
- One of the OPP officers who attended Renee’s home on the evening of January 31, 2016 recorded information provided by Alex that night in a formal Witness Statement. The OPP officer noted that during his attendance at Renee’s home, Alex informed him that Alex did not want to be at Renee’s, did not like the food Renee served, and was upset that Renee did not let Alex call Alex’s father.
- A psychiatrist who assessed Alex on February 1, 2016, recorded that Alex informed him that Alex was upset that Renee would not let Alex call Alex’s father, Alex did not like the way Renee spoke to Alex, and did not like the food that Renee served. Alex also told the psychiatrist that Alex had “been thinking about a cultural treatment centre in Ottawa, London or Alberta.” The psychiatrist noted that Alex “admitted snapping” [while at Renee’s] and that Alex told the psychiatrist that Alex “just wanted to call my dad and go home.”
- The CAS Algoma Intake Worker informed Investigators during her interview that she met with Alex while Alex was an inpatient at a hospital sometime in February 2016. The CAS Algoma Intake Worker informed Investigators that Alex told her that Renee “set [Alex] off,” Alex did not like the way Renee spoke with Alex, and Renee would not let Alex make the telephone calls Alex wanted to make.

The extent to which the above issues, raised in Alex’s comments to others, contributed to Alex’s behaviour toward Renee on January 31, 2016 is unclear. At that time, Alex was a 15-year old First Nation youth, who was seeking help for mental health issues (with a hope to attend a mental health treatment program in the “south” with a “Native or traditional” format). In Renee’s home Alex was placed with a non-Indigenous foster parent, and at least one staff working in the home acknowledged that she was not aware of an important First Nation tradition.

The breakdown of Alex’s placement with Renee contributed to a chain of events that likely had a negative impact on Alex:

- On February 1, 2016, Alex was charged under the *Youth Criminal Justice Act*<sup>58</sup> for offences related to Alex’s behaviour at Renee’s home on January 31, 2016.<sup>59</sup> Alex was later found guilty of one of the offences and sentenced accordingly.
- In February 2016, Alex was further hospitalized as an inpatient to support Alex’s mental health needs. By that time, Alex was resisting treatment and was eventually discharged.
- From the spring of 2016 and into 2017, Alex’s specific whereabouts were often unknown to the Band. The Band Representative informed Investigators during an interview in

<sup>58</sup> Youth Criminal Justice Act, SC 2002, c 1.

<sup>59</sup> See Chronology above for Alex’s specific behaviour on the evening of January 31, 2016.



December 2016, that the Band believed that Alex was living in a precarious relationship at that time.

It is important to note that the Temporary Care Agreement was terminated early, and that during the summer of 2016, Alex turned 16 years old. As set out in the “Chronology” above, Alex then ceased to be a “child” under Part III of the old *CFSA* and, at that time, a children’s aid society could no longer intervene to provide child protection services (including mental health services and referrals) to Alex.

### **Impact of Alex’s Placement on Renee**

As described earlier in the “Chronology” section, Renee experienced Alex’s behaviour as increasingly erratic, unstable, destructive and ultimately very threatening. Renee recounted to Investigators her efforts to de-escalate Alex’s behaviour for over an hour, all the while worried that Alex was going to “gut” and kill her. Renee informed Investigators that after Alex was removed from her home, she felt unable to continue fostering youth. Renee went on medical leave shortly after.

### **Impact of Alex’s Placement on the Youth Worker**

The Youth Worker who was providing support to Renee in the home during the afternoon and evening of January 31, 2016 was also significantly affected by Alex’s behaviour. As directed by Renee, the Youth Worker called 9-1-1 after Alex’s behaviour had become destructive and erratic. During her interview, the Youth Worker recounted her experience of feeling threatened by Alex when Alex broke into the washroom in which the Youth Worker was speaking to a 9-1-1 operator. The Youth Worker also informed Investigators of her traumatic experience of facilitating the evacuation of the two other youth, an adult with developmental disabilities, and Renee’s dog from Renee’s home on a freezing night. They waited in her truck until police attended. The Youth Worker informed Investigators that the incident that night “ruined” and affected all aspects of her life. Shortly after her experience on January 31, 2016, the Youth Worker went on medical leave and resigned from Summit.

### **Impact of Alex’s Placement on the Other Youth Placed in Renee’s Foster Home**

The two other youth placed with Renee were present in Renee’s home on the evening of January 31, 2016. While they were in other rooms in Renee’s home while Renee and the Youth Worker were responding to Alex’s behaviours, the youth were still impacted by the events of that evening. The information obtained during the investigation supports that both youth negatively experienced being ushered, shoeless, out of Renee’s home into freezing, snowy weather and crammed into the Youth Worker’s truck with the others.

The Youth Worker advised Investigators that the youth “were really upset” about what was happening inside the home while they waited in the Youth Worker’s truck for police to attend. The Summit Supervisor informed Investigators that she spoke to both youth after Alex left Renee’s home in an attempt to debrief their experiences of the January 31, 2016 events. On February 1, 2016, the Summit Supervisor “debriefed” the events with both youth. According to the Summit Supervisor, one youth was “more upset” by the incident than the other. The Summit Supervisor advised that youth’s CAS worker about the incident and suggested that the worker continue to monitor and debrief with the youth about her experiences given the impact of the incident upon that youth. The Summit Supervisor attempted to debrief the incident at least twice with the second youth. That youth informed the Summit Supervisor that he “is used to this kind of thing.”



Perhaps most significantly, as a result of Renee's inability to continue working as a foster parent after the incident, both youth were forced to leave Renee's home on an urgent basis on February 4, 2016. Both youth experienced unplanned moves and transitions to new homes.<sup>60</sup> This also meant an unplanned transition to a new school for one youth.

### **Impact of Alex's Placement on the Adult Placed with Renee**

Like the youth in the home, the adult placed with Renee was in another room while Renee and the Youth Worker were responding to Alex's behaviours. This adult also negatively experienced being ushered, shoeless, out of Renee's home into freezing, snowy weather and crammed into the Youth Worker's truck with the others. While the adult demonstrated some unusual behaviour upon her initial return to the home, Renee reported that the adult did not appear to be impacted further by the incident.

## **D. INVESTIGATIVE ISSUE NUMBER FOUR: OTHER CONCERNS**

During the course of the investigation, several significant concerns came to the attention of Investigators. First, Alex's placement required additional support within the foster home, at least until Alex's mental health needs were confirmed. Second, CAS Algoma failed to debrief with Summit to develop a full understanding of the circumstances surrounding Alex's placement with Renee and the reasons for its breakdown. Third, there was a systemic lack of attention to documentation, and a failure to follow accepted standards and best practices. Fourth, there was a pervasive lack of appropriate residential services (including intensive mental health treatment services in a residential setting) and Indigenous-specific residential services in Alex's home community.

### **Additional Needs and Supports**

Renee informed Investigators that she became increasingly concerned about Alex's placement during the admission meeting and told the Summit Supervisor that Alex's placement "isn't going to work" after Alex displayed aggressive behaviour and made threats during the meeting; however, the Summit Supervisor informed Investigators that she did not hear Renee say this and the Youth Worker, who was nearby at the time, did not observe the interaction.

Renee also informed Investigators that she attempted to tell the Summit Supervisor she felt she needed additional support staff for the weekend beyond her regular allotment of support hours immediately after the placement admission meeting. The Youth Worker observed and confirmed Renee's communication to the Summit Supervisor. Renee and the Youth Worker informed Investigators that the Summit Supervisor did not respond to Renee or the Youth Worker's comments about the need for additional support. In her interview, the Summit Supervisor did not recall Renee raising any issues about support for Alex's placement.

As outlined earlier, Renee did not have complete information and the first opportunity she had to review the Referral Form was after the placement admission meeting when the CAS Algoma Intake Worker and Summit staff had already left her home. Renee informed Investigators that she became more concerned about Alex's placement with her after reading Alex "can be

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<sup>60</sup> Although it appeared at the end of January 2016 that discussions had been held between Summit and a children's aid society to move one youth to a foster home closer to that youth's family, this had not been shared with Renee. Further, a moving date and a transitional plan for a future move had not been confirmed with Renee or the youth.

aggressive” on the Referral Form. This information, along with hearing Alex threaten to “F—ng kill” anyone who touched Alex or Alex’s belongings, increased Renee’s concerns about the safety of herself and others in the home.

### *Summit’s On-Call Services Policy*

Summit’s three-page On-Call Services Policy<sup>61</sup> sets out its on-call services for program support and expectations of the “On-Call Supervisor,” including expected response times. The Policy includes the following provisions:

- Summit “provides 24/7 On-Call services for program support and emergency situations.”
- An On-Call Supervisor is “to attend a home when a Foster parent or staff feel this level of support is needed.”
- The Summit On-Call Supervisor “can be reached by phone and the response time for a call back is 30 minutes. If the On-Call Supervisor needs to attend a home, the intent is to arrive safely and as quickly as possible. There are many factors that may affect the amount of time it takes to attend a home. Summit is committed to have the On-Call Supervisor attend within one hour.”
- On-Call Supervisors are “required to uphold Summit’s policies and procedures, utilize professional judgment when assessing each situation and at times, may have to remind front-line staff of our protocols and systems.” Foster parents are expected to communicate directly with the On-Call Supervisor according to schedules provided to them and via the designated on-call telephone line.

### *Renee’s First Request for Support: January 29, 2016 Text*

Renee did not contact the scheduled Summit On-Call Supervisor about her safety concerns after Alex’s placement admission meeting at Renee’s home on January 29, 2016. Instead, Renee tried to connect with the Summit Supervisor who had recently left Renee’s home and with whom she had other communication about Alex’s placement that day. Renee texted the Summit Supervisor at approximately 6:16 pm stating, “I think we should put in a support staff for the weekend. To ensure safety.”

The Summit Supervisor was not “on-call” as of 5:00 pm on the evening of Friday, January 29, 2016 and did not respond to Renee’s 6:16 pm text (although she did respond to other texts Renee sent to her that evening and weekend, including one Renee sent to her about 40 minutes later).<sup>62</sup> Renee did not contact a Summit On-Call Supervisor with another request for support until Sunday, January 31, 2016.<sup>63</sup>

The Summit Supervisor and Director informed Investigators that it was Renee’s responsibility to notify Summit’s “on-call” service if she had concerns about Alex’s placement Renee had worked with Summit for many years, including in a previous supervisory role and was aware of the protocols and policies.

While it is clear that Renee did not contact “on-call” on the evening of January 29, 2016, as per Summit’s protocol, the Summit Supervisor did not remind Renee to follow up directly with the

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<sup>61</sup> Reference here is to the On-Call Services Policy in effect at the time of Alex’s placement with Renee. Summit made some minor amendments to this policy in April 2016.

<sup>62</sup> See the “Chronology” above.

<sup>63</sup> However, Renee did contact Summit’s on-call supervisor on Saturday, January 30, 2016 to report another issue about Alex unrelated to safety or support.

appropriate “On-Call Supervisor” about options for additional support, and indeed responded to other text messages from Renee throughout the weekend.

### *Renee’s Second Request for Support: January 31, 2016 Telephone Calls*

Renee told Investigators when she did reach out to the appropriate On-Call Supervisor, she did not feel that she received the needed support. Renee called the On-Call Supervisor three times that evening, at approximately 6:44 pm, 7:08 pm and 8:00 pm.

Renee informed Investigators that she requested that the On-Call Supervisor put additional staff support in her home, remove Alex or “come out” to Renee’s home during her first call to the On-Call Supervisor at about 6:44 pm. The On-Call Supervisor told Investigators that he specifically asked Renee during that telephone call if she needed him to attend at that time and Renee said that she did not. The On-Call Supervisor recalled that Renee stated that she wanted Alex moved from her home and he had documented in the On-Call log book that Renee informed him that “she didn’t feel safe.”

On the evening of January 31, 2016 the Summit On-Call Supervisor was, coincidentally, the foster parent with whom Alex was originally scheduled to be placed. During their 6:44 pm telephone call, Renee asked the On-Call Supervisor why Alex was not placed with him as originally planned. The On-Call Supervisor advised Renee that Alex had threatened to stab him if placed there. Renee informed Investigators that, upon hearing this information, she told the On-Call Supervisor that Alex needed to be removed from her home that day. Both Renee and the On-Call Supervisor recalled that the On-Call Supervisor then advised Renee that he needed to speak to Summit management about options and he would call Renee back by 8:00 pm.

Renee called the On-Call Supervisor back around 7:08 pm to suggest another Summit foster home to which she believed Alex could be moved. The On-Call Supervisor informed Renee that this home was not an option for Alex.

At approximately 8:00 pm, Renee spoke with the On-Call Supervisor again. Summit did not yet have any alternative plan for Alex at that time. Renee informed the On-Call Supervisor that Alex was out of control, the Youth Worker had to call 9-1-1 and he needed to attend at Renee’s home as soon as possible. Renee also texted the On-Call Supervisor at approximately 8:19 pm with the message, “911 get here now.”

The On-Call Supervisor informed Investigators that Renee was clear in her 8:00 pm telephone call that she wanted him to attend her home. His log notes of that call recorded, “[Renee] called and requested on-call to attend.” The On-Call Supervisor informed Investigators that he could not have arrived at Renee’s much earlier than he did that night due to the distance between his and Renee’s homes and the snowy driving conditions that night. He also informed Investigators that he picked up the Summit Supervisor for additional support on his way to Renee’s. At 8:55 pm the Summit On-Call Supervisor arrived at Renee’s home, along with the Summit Supervisor.

Summit’s On-Call Services policy directs the On-Call Supervisor to attend a foster home “when a Foster Parent or staff feel this level of support is needed.” The policy further provides that “[i]f the On-Call Supervisor needs to attend a home ... Summit is committed to have the On-Call Supervisor attend within one hour.” On January 31, 2016, the On-Call Supervisor attended Renee’s home within one hour of the 8:00 pm telephone call, during which Renee clearly communicated that she wanted him to attend at her home as soon as possible.

On April 28, 2016, two Ministry Representatives spoke with the Summit Director as part of the Ministry's Annual Licensing Review with Summit. During that conversation, the Ministry Representatives reviewed the Serious Occurrence Report and Incident Report that Summit submitted to the Ministry on February 1, 2016. The Incident Report notes that Renee contacted Summit On-Call "at 6:44 pm to inform on call that the Foster Parent did not feel safe with [Alex] and request support."

The Ministry Representatives advised the Summit Director that the On-Call Services policy left some ambiguity related to expectations about when the On-Call Supervisor needs to attend a foster parent's home. The Ministry included in its specific Term and Condition attached to Summit's Licence, a requirement that Summit "review the policy related to On-Call and specifically the length of the response and the type of response that foster parents can expect in emergency and other situations."<sup>64</sup> Summit reviewed and revised its On-Call Services policy in April 2016 and has clarified that it "is committed to have the On-Call Supervisor attend within one hour of the phone conversation requesting attendance." [emphasis added]

### **Support at the Start of Alex's Placement Was Warranted**

In reviewing the circumstances surrounding Alex's placement with Renee, it is possible that more resources and support to Alex at the onset of Alex's placement with Renee could have altered the course of events that unfolded on January 31, 2016.

The RSA between Summit and CAS Algoma contemplates situations in which children will require additional services that are not covered in the typical funding for services contract, or "Days in Care Agreement,"<sup>65</sup> between Summit and CAS Algoma. Summit may request, through a "Special Rate Agreement,"<sup>66</sup> additional funds from CAS Algoma to support non-routine services or interventions needed for reasons including "safety" and/or to support children's particular medical or behavioural needs.

CAS Algoma specifically contemplates in its Emergency OPR Within District of Algoma Policy,<sup>67</sup> that in support of a placement, additional resources might be required. The policy provides that: "[p]lacement in a foster home is always the preferred option, even if this requires building in an enhancement package to help support the placement."

Renee informed Investigators that in the past Summit had provided her with additional staffing assistance when needed to support the placements of other children in Renee's home. She explained that ordinarily, Summit and a children's aid society complete an agreement for extra services in advance of a placement. However, Renee informed Investigators that in past urgent situations, Summit had provided additional staffing support upfront and afterward requested that a children's aid society cover the cost of the special services required.

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<sup>64</sup> See "Chronology" above, "The Ministry's Annual Licensing Review with Summit: April and May 2016."

<sup>65</sup> The Days in Care Agreement between CAS Algoma and Summit sets out a *per diem* (ie, daily) amount that CAS Algoma agrees to pay to Summit for providing services to each child being placed with Summit. Services include, among other things, food, shelter, transportation and activities. The agreement also sets out other responsibilities of both Summit and CAS Algoma related to the provision of services and the agreement itself. Summit then further contracts with each of its foster parents for the provision of the services set out in the Days in Care Agreement.

<sup>66</sup> This is set out on pages 19–20 of the RSA. A Special Rate Agreement provides for funds above the regular amounts when a child requires certain services that are not covered in the Days in Care Agreement.

<sup>67</sup> Ministry of Children and Youth Services, *Policy AC-CIC-OPR.1* (February 28, 2007).

Renee told Investigators that Summit should have provided additional support to Alex from the onset of Alex's placement given what was both known and unknown about Alex's needs and behaviours. Because Summit did not provide additional support that weekend, Renee scheduled some additional hours of Youth Worker assistance on her own initiative. The additional Youth Worker assistance that Renee herself organized for the weekend was insufficient to prevent the events from unfolding as they did on the evening of January 31, 2016.

### *Discussion*

The circumstances of Alex's placement suggest that additional support was necessary at the onset of the placement to ensure the safety of Alex and others in Renee's home, and to support Alex appropriately. CAS Algoma has stated that it had "very limited information" about Alex at the time of placement. However, CAS Algoma and Summit were aware that Alex had a mental health treatment plan that was not being followed, Alex had not been taking prescribed medication, and Alex had exhibited aggressive behaviour, including damage to property at a local hospital a few days earlier. CAS Algoma and Summit were also aware that Alex had been carrying a knife before placement, had previously attempted self-harm, had directed a threat toward another Summit foster parent, and had made threatening statements during the placement admission meeting on Friday, January 29, 2016.

Although, CAS Algoma was unable to confirm Alex's mental health diagnoses or needs with Alex's health professionals at the time of placement, and was unable to do so for another three days,<sup>68</sup> Investigators noted that the CAS Algoma Intake Worker and her Supervisor had a "Safety Consult" before the CAS Algoma Intake Worker attended Alex's placement admission meeting on January 29, 2016, because of concerns about working alone with Alex. In her 3:38 pm Supervision case note, the CAS Supervisor wrote: "Worker Safety – [child protection worker] and [children's services worker] will use caution when alone with the child due to child's mental health and child's statement that [Alex] carries a knife to ensure [Alex's] personal safety."

Both CAS Algoma and Summit knew that Renee had refused another youth being placed with her and was concerned about stabilizing the placements of two other youth in the home. CAS Algoma and Summit were also clearly aware that Renee lived at least 30 minutes (in ideal conditions) from emergency medical response services.

It is therefore surprising, in these circumstances that CAS Algoma and Summit did not arrange additional support for Alex as a condition of the placement, regardless of whether or not this was requested by a foster parent.

In its Annual Licensing Review with Summit in April 2016, the Ministry required Summit to "review the system in place, which provides support to foster parents to ensure they have the necessary support and relief and that children/youth placed in the foster homes are supervised as necessary."

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<sup>68</sup> The CAS Algoma Intake Worker tried to obtain this information before placement. She called Alex's psychiatrist on January 29, 2016 at approximately 3:00 pm, hoping to schedule an appointment for Alex. The CAS Algoma Intake Worker was advised that the psychiatrist was unavailable until the following week.

**Summit: Provide Individualized Support When Harm/ Self-Harm is Possible**

**RECOMMENDATION TEN:** Summit should seek and provide individualized support to foster care placements to support children with significant, but unknown mental health issues who have made threats of harm to self and/or others until such time as those children’s mental health needs can be confirmed by, and a safety plan can be developed with, the children’s mental health professionals.

**Ministry and CAS Algoma: Facilitate Individualized Support Until Needs Are Assessed**

**RECOMMENDATION ELEVEN:** The Ministry and CAS Algoma should facilitate the provision of resources to Summit and other residential licensees to ensure foster placements of children with significant, but unknown mental health issues who have made threats of harm to self and/or others are sufficiently supported until such time as those children’s mental health needs can be confirmed by, and a safety plan can be developed with, the children’s mental health professionals.

*Summit Response to Recommendations*

As noted earlier, Summit has advised the Advocate’s Office that it has accepted and implemented all recommendations pertaining to their organization.

*CAS Algoma Response to Recommendations*

In their written response, CAS Algoma advised that Summit had not requested any additional resources while Alex was in their care, and if Summit had done so, CAS Algoma would have approved the request.

*Ministry Response to Recommendations*

In a formal reply to a draft version of this report, the Ministry advised that they have developed a serious occurrence risk analysis program to identify children in residential care who are at risk. Ministry staff follow up with the placement agency and the residential care provider to confirm that the proper supports are in place so that children are receiving the quality of care to which they are entitled.

The Ministry also advised it is in the process of developing a standardized screening tool to identify children at high risk who may be vulnerable and/or require more intensive service provision as recommended by the Ontario Chief Coroner’s expert panel. The standard screening tool will facilitate the collection, documentation and sharing of information so that children who have been identified as high risk are placed in residences that can meet their needs.

The Ministry’s comments further advised, that in an effort to support improved capacity to respond to the needs of children in licensed residential care, the Child and Parent Resource Institute (“CPRI”) (based on their clinical expertise in supporting children and youth in residential care who have experienced trauma) is offering free webinar training to all licensees. Additional training modules are being developed and will be made accessible through the new Serious Occurrence Reporting — Residential Licensing (SOR-RL) IT system to assist licensees and placing agencies.



## **Debriefing**

On April 1, 2016, Ministry Representative A sent an email to a CAS Algoma Director and requested a review of Alex's placement at Summit. Ministry Representative A sought a response from CAS Algoma about three issues.

One of the issues about which the Ministry Representative sought confirmation, "whether CAS Algoma staff have discussed this situation with Summit Management." In response to Ministry Representative A's question, the CAS Algoma Director responded by email on April 5, 2016, "[d]ebriefing of the circumstances occurred between [the Placement Office Employee] and [Summit Director] on February 1, 2016." The Ministry did not follow up with CAS Algoma after CAS Algoma's April 5, 2016 email response.

In their interviews with Investigators, neither the CAS Algoma placement office employee nor the Summit Director recalled participating in a "debrief" or any purposeful communication related to the circumstances of Alex's placement at Renee's home. The Summit Director advised Investigators that she was out of the country on February 1, 2016, the date on which CAS Algoma advised the Ministry that the "debriefing" occurred. The Summit Director also advised that she did not recall participating in a "debrief" or formal discussion with the CAS Algoma Placement Office Employee or any other CAS Algoma staff member about the circumstances surrounding Alex's placement after her return to work on February 3, 2016.

The CAS Algoma Placement Office Employee could not recall "debriefing" Alex's placement with the Summit Director. He informed Investigators during his interview that in the event there had been a "debrief" or discussion, he would have recorded this in a case note. Investigators specifically requested that CAS Algoma provide all documentation created by the Placement Office Employee related to Alex's placement and CAS Algoma did not produce any documents pertaining to a "debrief" between the Placement Office Employee and the Summit Director, or any other discussion with between CAS Algoma and Summit staff about any issues related to Alex's placement with Renee.

## **Discussion**

Ministry Representative A relied solely on the CAS Algoma Director's email responses to her inquiries. She neither requested supporting documentation nor sought further information about how the CAS Algoma Director arrived at the facts presented in her April 5, 2016 email response to the Ministry.

If Ministry Representative A had requested documentation from the CAS Algoma Director to support the responses to her inquiries, the Ministry may have taken action at an earlier time to ensure CAS Algoma and Summit met to formally "debrief" and review the circumstances surrounding Alex's placement with Renee.

Investigators found that CAS Algoma staff did not engage in any "debriefing" with Summit Management on or after February 1, 2016, contrary to what was stated in CAS Algoma's response to the Ministry on April 5, 2016. A formal debriefing between Summit and CAS Algoma related to the pre-placement communication surrounding Alex's placement would provide both agencies the opportunity to share information and fully review the circumstances surrounding Alex's placement with Renee. It would also enable both agencies to clarify the responsibilities of and restrictions upon staff from both agencies involved in the placement of children and youth prior to the pre-placement admission meeting.



According to the Summit Director's interview with Investigators, Summit held meetings with its staff to review the failure of the Summit Supervisor to adhere to Summit's internal policies during the placement of Alex on January 29, 2016 and encouraged staff to learn from the Summit Supervisor's mistakes. Summit also took steps to revise its internal policies and ensure future compliance in response to the actions initially taken by the Ministry during its Annual Licensing Review in April 2016. Summit amended and further strengthened its internal policies related to the placement of children in its homes and ensured that all staff were familiar with them through a formal review and sign-off process. Summit has not had the opportunity to share what it has learned with CAS Algoma.

#### **Summit and CAS Algoma: Debrief Circumstances of January 31 Events**

**RECOMMENDATION TWELVE:** Summit and CAS Algoma staff should meet to formally debrief together the pre-placement communications that occurred prior to Alex's placement with Renee. Summit and CAS Algoma should amend the RSA, to ensure that it aligns with Summit's expectations regarding pre-placement procedures and the use of Summit's Referral Form, including during emergency placements of youth and that it clearly sets out each agency's staff's responsibilities and restrictions related to pre-placement communication between the agencies and with foster parents.

#### *Summit Response to Recommendations*

Summit has notified the Advocate's Office that it accepts all recommendations made to their agency.

#### *CAS Algoma Response to Recommendations*

CAS Algoma advised the Advocate's Office that "debriefing" should occur among Summit management and their own employees and that CAS Algoma has no role in this meeting. The position of the CAS is that the identified concerns relate to actions and interactions between Summit staff. However, CAS Algoma did indicate a willingness to meet with Summit to discuss pre-placement communication and protocols to be included in the Resource Service Agreement.

#### **CAS Algoma Documentation Practices**

Documentation by child protection workers must be prepared in accordance with legislated standards and the internal policies of the children's aid society in which those workers provide services to children, youth and families. For child protection workers at CAS Algoma, this means adhering not only to the Ontario Child Protection Standards, but also to CAS Algoma's internal policies and procedures relating to documentation.

#### *Child Protection Standards*

Ontario Regulation 206/00 under the old *CFSA* requires children's aid societies to provide services in accordance with the Ministry's Child Protection Standards. These Standards provide the mandatory framework within which child protection services are to be delivered and set out the minimum level of performance required of child protection workers, supervisors and children's aid societies.<sup>69</sup>

The Child Protection Standards in Ontario (February 2007) were still in effect in January 2016. Standard #12 of those Standards sets out "the minimum requirements with respect to

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<sup>69</sup> Ministry of Children and Youth Services, *Child Protection Standards in Ontario* (February 2007) at 4.

supervisory review and approval of casework decisions.”<sup>70</sup> A child protection supervisor is responsible for ensuring the “quality of written documentation” produced by child protection workers as part of Standard #12.

Children’s aid societies must achieve four outcomes as part of Standard #12. The fourth outcome relates specifically to documentation and requires that “[c]ase documentation is timely, thorough and accurate. Documentation accurately reflects information obtained about families, assessments and decisions (including the rationale).”<sup>71</sup>

In June 2016 the Ontario Child Protection Standards (2016) replaced the earlier Child Protection Standards in Ontario (February 2007). In these revised Standards, a new first Standard outlines practice standards relevant to all areas of child protection services, including the preparation of case notes. Standard G of the new Standards, “Contemporaneous Case Notes” sets out the requirements related to that Standard:

The child protection worker documents detailed information about the child and his or her family that is relevant to the delivery of child protection services and which is obtained through any contact, either internal or external to the CAS in contemporaneous case notes. At minimum, contemporaneous case notes must contain:

- The date and time of contact, method of contact and the names of the individuals involved in the contact;
- Significant events, discussions and observations related to the particular contact; and the name of the author and date of the case note.<sup>72</sup>

Like the 2007 Standards, the 2016 Standards also set out the supervisor’s role as “one of accountability and quality assurance,” including ensuring “the quality of written documentation.”<sup>73</sup> Finally, the 2016 Standards specify that case notes are to be completed within 24 hours.

### *CAS Algoma’s Internal Policies*

In addition to the Child Protection Standards, CAS Algoma’s internal policies provide additional direction to its employees relating to documentation practices. Three of its policies in effect at the time of Alex’s placement with Renee are particularly relevant to documentation reviewed during this Investigation. Each of these three policies were approved in July 2012, more than three years prior to Alex’s placement with Renee.

First, in its Collection of Client Identifying Information Policy,<sup>74</sup> CAS Algoma sets out that it “has an obligation to ensure the accurate collection and maintenance of client-related data to enable timely intervention, worker safety and excellence of service to families.”

Second, CAS Algoma sets out in its Electronic Case Notes Policy,<sup>75</sup> that “[a]ll documentation must be comprehensive, clear, concise and contemporaneous...Case notes must be completed within twenty-four (24) hours as per [the Ministry’s ] Standards.” The procedures set out within this policy provide additional guidance. Procedure two requires that, “[a]ll [child protection

<sup>70</sup> Ministry of Children and Youth Services, *Child Protection Standards in Ontario* (February 2007) at 81.

<sup>71</sup> Ministry of Children and Youth Services, *Ontario Child Protection Standards* (2016) at 83.

<sup>72</sup> Ministry of Children and Youth Services, *Ontario Child Protection Standards* (2016) at 16–17.

<sup>73</sup> Ministry of Children and Youth Services, *Ontario Child Protection Standards* (2016) at 119.

<sup>74</sup> Ministry of Children and Youth Services, *Policy CP-DOC.1* (July 30, 2012).

<sup>75</sup> Ministry of Children and Youth Services, *Policy CP-DOC.2* (July 30, 2012).

worker] communication and/or observational contacts with clients and collaterals such as face-to-face meetings, telephone calls, attempts to contact, sightings, missed appointments, messages left, etc. are to be documented.” Procedure six lists several best practices, including to “document significant comments as close to word-for-word as possible; using quotation marks around exact quotes.”

Third, CAS Algoma sets out procedures related to the “Status and Quality of Recordings” in its Documentation of Supervision – Case Related (Documentation/Records Section).<sup>76</sup> This includes the following requirement:

[T]he Supervisor will review the quality of the worker’s recordings. It is expected that all recordings are comprehensive, current and reflective of the circumstances that occurred with the children and family. Any inconsistencies in this practice will be addressed by the Supervisor, who will set out a plan to have them revised to an acceptable level.”

### *Training Related to Documentation Standards*

Child protection workers are expected to attend training relating to their obligations under the Child Protection Standards and the policies of the children’s aid society in which they work.

In 2012, CAS Algoma offered case note training to its child protection workers. The training reviewed best practices related to documentation and electronic case notes and included a mandatory quiz.

The Ontario Association of Children’s Aid Societies (“OACAS”) provides a curriculum for child welfare professionals in Ontario. Children’s aid societies used OACAS’s *Foundations of Child Welfare Practice* between 2008 and 2016 to train its child protection workers. Course 2: Protecting Children and Strengthening Families, Part 1, includes a section on the importance of case notes. It sets out that case notes must be contemporaneous (ie, “made at the time or shortly after something occurs that requires documentation”) and “should refresh the memory of the child protection worker who recorded them and inform a reader of the key facts and circumstances of a particular event.”<sup>77</sup> It also sets out that case notes should “create a picture that another person could understand or that would clearly remind you of the scene if you read these notes five years later.”<sup>78</sup>

In 2016, OACAS updated its child protection worker training materials. Its *Facilitation Guide – Module Two: Legal Authority of Child Protection Services (CWP2)*,<sup>79</sup> sets out that “good documentation” is “contemporaneous, complete, accurate, balanced and fair, based on factual first-hand evidence, professional and objective.” It further describes that in order to be “accurate,” child protection workers must “[e]nsure that information recorded is correct. There is no guessing or assuming.” It must be “clear and concise” and “well presented...[w]ritten in clear language, checked for grammar and spelling and thoroughly reviewed and edited.”

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<sup>76</sup> Ministry of Children and Youth Services, *Policy CP-DOC.3* (July 30, 2012).

<sup>77</sup> Ontario Association of Children’s Aid Societies, *Foundations of Child Welfare Practice: Child Welfare Profession Training Series – Course 2 Protecting Children and Strengthening Families, Part 1* (Toronto, ON: Ontario Association of Children’s Aid Societies, 2016) at 84.

<sup>78</sup> Ontario Association of Children’s Aid Societies, *Foundations of Child Welfare Practice: Child Welfare Profession Training Series – Course 2 Protecting Children and Strengthening Families, Part 1* (Toronto, ON: Ontario Association of Children’s Aid Societies, 2016) at 85.

<sup>79</sup> Ontario Association of Children’s Aid Societies, *Facilitation Guide – Module Two: Legal Authority of Child Protection Services (CWP2)* (Toronto: Ontario Association of Children’s Aid Societies, 2016) at 16.

In its *Facilitation Guide – Module Five: Providing Child Welfare Services (CPW1)*, it explains that “the effective use of documentation is a key component of being an effective Child Welfare Professional. Professional documentation supports effective collaborative work with families. It aids the development of helpful case plans and it covers the requirement that our work can be held fully accountable. It is very important that all documentation is clear, legible, accurate, factual and objective.”<sup>80</sup>

### *Discussion*

Alex went into the care of CAS Algoma under a TCA on January 29, 2016. The CAS Algoma Intake Worker assigned to Alex generated several documents related to Alex and Alex’s placement that day. There were issues with several of these documents. These are discussed according to three categories below: (1) Accuracy; (2) failure to document; and (3) lack of clarity and comprehensiveness.

#### *Accuracy*

First and perhaps the most significant issue was the CAS Algoma Intake Worker’s inaccurate description of Alex’s medical diagnoses on the placement Referral Form she provided to Summit. The CAS Algoma Intake Worker listed three separate mental health problems, diagnosable by a psychiatrist<sup>81</sup> under the category of “Medical Condition” in Summit’s Referral Form; however, information obtained during this Investigation, including from a psychiatrist who had seen Alex at a local hospital, documentation produced by that hospital and documentation by CAS Algoma, does not support that Alex had been diagnosed with any of the three mental health problems noted by the CAS Algoma Intake Worker.

Only those qualified to make medical diagnoses (eg, physicians) may do so.<sup>82</sup> Child protection workers should not record a medical diagnosis without that diagnosis being confirmed by a qualified health professional.

The CAS Algoma Intake Worker recorded in her case note dated January 29, 2016, 10:00 am, that Alex’s father advised her that a doctor had “indicated” that Alex had certain mental health diagnoses, but the CAS Algoma Intake Worker had not confirmed these with a qualified health professional. The CAS Algoma Intake Worker did not document the source and circumstances under which specific medical diagnoses were brought to her attention, nor did she record that she had not yet confirmed any diagnosis on Summit’s Referral Form.

The CAS Algoma Intake Worker therefore recorded inaccurate information on the Referral Form, and provided that information to Summit. Subsequent inaccurate records were created in both agencies relating to Alex and Alex’s mental health. If left uncorrected, these records will be retained by CAS Algoma for 25 years, at which point Alex would be 40 years old.<sup>83</sup>

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<sup>80</sup> Ontario Association of Children’s Aid Societies, *Facilitation Guide – Module Five: Providing Child Welfare Services (CPW1)* (Toronto, ON: Ontario Association of Children’s Aid Societies, 2016) at 27.

<sup>81</sup> CAS Algoma completes a “Placement Request/Child Information Form” when it places children within its own foster homes; however, when CAS Algoma requests the placement of a child or youth with a licensed foster care provider like Summit, CAS Algoma completes that licensee’s version of the Placement Request/Child Information Form.

<sup>82</sup> See *Regulated Health Professions Act, 1991*, SO 1991, c 18, s 27.

<sup>83</sup> CAS Algoma’s *Record Retention and Destruction Policy (A-OP.17)*, approved February 21, 1994, provides the times after which various CAS Records will be destroyed. Child Care and Family Services files are destroyed 25 years after closure.

In addition to the inaccurate reference to medical diagnoses, the CAS Algoma Intake Worker did not accurately record a key statement Alex made to her. In one of her January 29, 2016, 1:00 pm case notes, the CAS Algoma Intake Worker recorded, “[a] place that was found at summit human services on ... road, and [Alex] indicated if it is [the male foster parent] [Alex] will stop [sic] him if [Alex] has to go there.” The CAS Algoma Intake Worker informed Investigators during her interview that the threat was to “stab” not “stop” the male foster parent.

The CAS Algoma Intake Worker’s Supervisor advised Investigators during her interview that the CAS Algoma Intake Worker and some other child protection workers at CAS Algoma use speech recognition software to create case notes and that errors may arise during the use of this software. She also informed Investigators that speech recognition software is often used by workers who have developed workplace injuries due to the volume of documents (ie, paperwork) they are required to produce. Further, the CAS Algoma Intake Worker’s Supervisor informed Investigators that workers, “don’t have the time to go back and proofread all the time” given their workloads.

In August 2016, CAS Algoma approved a new policy relating to expectations of case notetaking when such software is used.

CAS Algoma’s Use of Voice Activated Devices or Software for Documentation Policy<sup>84</sup> provides that:

Each employee of the Society has a responsibility to ensure that all documentation is proof read for accuracy when using voice activated devices or software. This includes, but is not limited to documentation completed with the assistance of a voice recorder, cell phone, speech recognition software (Dragon), and all other electronic devices.

Moreover, the “Procedure” as part of the Policy sets out:

Employees who use voice activated devices or software for documentation must:

1. Proofread each document to ensure they are comprehensive, clear and concise.
2. Ensure spelling and grammar are correct.
3. Ensure all information is accurate, appropriate and respectful to the client.

This new Policy further and clearly reinforces CAS Algoma’s expectations of its workers when they use voice activated devices or software for documentation.

The CAS Algoma Intake Worker also informed Investigators during her interview that the time of two of her case notes on January 29, 2016 (ie, both 1:00 pm case notes and one timed at 2:00 pm) and the Safety Assessment timed at 11:30 am on January 29, 2016, were not accurately recorded. The CAS Algoma Intake Worker advised that the Safety Assessment dated January 29, 2016 would likely have been completed on or after January 30, 2016, as some of the events described in that document did not occur until the late afternoon of January 29, 2016.

Other CAS Algoma employees also inaccurately recorded information related to Alex, as indicated above. CAS Algoma created a Family Risk Assessment reflecting a “Date of Approval” of January 29, 2016 by the CAS Algoma Intake Worker’s Supervisor; however, the CAS Algoma Intake Worker’s Supervisor informed Investigators during her interview that the document was not approved by her and likely not on that date. The Supervisor explained that another CAS

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<sup>84</sup> Ministry of Children and Youth Services, *Policy AR-HR-ADM.7* (August 2, 2016).

Algoma Supervisor “who wanted to be helpful” completed the document “prematurely.” She explained that this document and the information collected as part of the Family Risk Assessment typically takes 30–45 days to complete.

#### Failure to Document

Child protection workers are required to document all contact with external parties (eg, Summit staff members, foster parents); however, the CAS Algoma Intake Worker did not document her second telephone call with Renee on January 29, 2016, during which time she confirmed the time of Alex’s Placement Admission Meeting at Renee’s home. The CAS Algoma Intake Worker did not record that she had confirmed Alex’s Placement Admission Meeting with Renee and the time of that meeting in any case note on January 29, 2016.

#### Lack of Clarity and Comprehensiveness

Finally, case notes must be created with sufficient clarity to refresh the memory of the author and be comprehensive enough for a reader to understand the chain of events captured in those case notes. The case note made by the CAS Algoma Intake Worker at 2:00 pm on January 29, 2016 does not provide sufficient clarity and is not comprehensive.

The CAS Algoma Intake Worker wrote in that case note that “I spoke to [Renee] and [Summit Supervisor]. [Renee] agreed to keep the child, and when space becomes available at [Summit Supervisor’s], the child may go there. I provided information regarding the child[’s] ...difficult behaviours.” As set out earlier in this report, this case note confusingly relates to two separate telephone conversations. The CAS Algoma Intake Worker telephoned the Summit Supervisor and spoke with her for a few minutes. The Summit Supervisor then directed Renee to take the telephone and the CAS Algoma Intake Worker had a separate telephone conversation with Renee for approximately 20 minutes. The January 29, 2016, 2:00 pm case note does not set out the content of each separate call nor other relevant details of the interactions during the two distinct conversations (eg, who provided the information contained in the case note to the CAS Algoma Intake Worker, to whom the CAS Algoma Intake Worker provided information about Alex’s behaviours and what “difficult behaviours” the CAS Algoma Intake Worker specifically disclosed). It is not surprising that the CAS Algoma Intake Worker was unable to recall the chain of events surrounding two telephone calls captured by this case note during an interview.

The CAS Algoma Intake Worker’s burden of work on January 29, 2016 was clearly significant given the nature of Alex’s emergency placement that day, the volume of documents that were required and the short period of time. The significance of some of the documentation issues and the errors made by the CAS Algoma Intake Worker on January 29, 2016 highlight the importance of following Child Protection Standards and CAS Algoma policies.



**CAS Algoma: Correct Alex’s Child Protection Record**

**RECOMMENDATION THIRTEEN:** CAS Algoma should immediately correct Alex’s child protection record to accurately record Alex’s mental health status as of January 29, 2016 in accordance with section 315 of the *Child, Youth and Family Services Act, 2017* (not yet in force), including by adding information to make the record accurate and complete.<sup>85</sup>

**CAS Algoma: Staff Documentation requirements**

**RECOMMENDATION FOURTEEN:** CAS Algoma should take steps to ensure that all of its child protection workers and supervisors fully understand and respond accordingly to their documentation obligations under the Child Protection Standards and CAS Algoma policies.

**CAS Algoma: Strengthen Quality Control for Documentation**

**RECOMMENDATION FIFTEEN:** CAS Algoma Directors should ensure that they provide CAS Algoma Supervisors with sufficient opportunities to review and provide feedback to child protection workers relating to documentation expectations set out in the Child Protection Standards and CAS Algoma policies.

***CAS Algoma Response to Recommendations***

CAS Algoma indicated that it will continue working to ensure their staff meet expectations with respect to documentation. CAS Algoma confirmed that it is prepared to amend Alex’s child protection record. The amendment will consist of the inclusion of a “Special Caution” in CPIN. The category will be “Record Alert” and the Type would be “Significant Error Identified”. The narrative description will state the following:

The Children’s Aid Society of Algoma has documented information about statements made to the Society by the father and the youth about disorders both of them believed the youth to have. The Children’s Aid Society of Algoma possesses no information or documentation that indicates this individual has been diagnosed by a psychiatrist with any disorder.

**Summit Documentation Practices**

Investigators also identified some troubling issues with documentation practices at Summit, including the Summit Supervisor’s failure to take and/or maintain notes relating to her contacts with Renee and CAS Algoma staff between January 29 and 31, 2016.

Despite the fact that residential licensees (and its foster parents) are required to prepare documents that become part of a record for children and youth, there appear to be no specific requirements for residential licensees to comply with standards relating to the documentation of communications with external parties, such as children’s aid societies and foster parents.

Residential licensees that provide foster care were statutorily obligated to generate certain documents under Part IX of Regulation 70 under the *CFSA* (eg, foster plans of care, daily logs). The Ministry establishes standards and has an oversight role to assess compliance with these

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<sup>85</sup> CAS Algoma does not have a formal policy related to the correction of inaccuracies in a record; however, a CAS Algoma Supervisor advised Investigators that the agency has an established practice that when such action is required, CAS Algoma will add information to an existing record related to the inaccuracy. Section 315 of the *Child, Youth and Family Services Act, 2017* contains several other provisions related to the correction of a record, including the manner in which inaccuracies must be corrected [s 315(11)].



standards. The Ministry's *Foster Care Licensing Manual*<sup>86</sup> contains, among other things, processes and procedures governing foster care in Ontario. Section E of this Manual sets out the record keeping and reporting obligations of licensees operating foster homes, including the mandatory Standard Foster Care Terms and Conditions<sup>87</sup> that all licensees must fulfill but does not contain any standards related to note taking. Term and Condition 24 requires that licensees maintain a written case file for each foster child. Documentation from a variety of sources is maintained in this file, some of which is generated by the licensee and/or foster parents (eg, reviews, plans of care, and complaints).

Investigators observed the varied and individual note-taking practices by Summit office and on-call staff. The Summit Supervisor did not consistently make contemporaneous notes relating to her contacts with CAS Algoma staff between January 29 to January 31, 2016. This was acknowledged by the Summit Supervisor and a Summit Director during interviews and as part of their responses to document requests. The Summit Supervisor did not retain any notes that she made.

The Summit Director informed Investigators in writing and during her interview that Summit expects its management staff to create phone logs and case notes related to all contacts, including with CAS Algoma staff. For example, the On-Call Services policy requires the On-Call Supervisor to “[d]ocument in the On-Call book date, time, caller, home and nature of the call. Document in the On-Call book all directives/course of action given to Youth Worker’s and Foster Parents.” The Summit Director advised that she provides staff with log books for this purpose. She also advised that she was aware that some Summit staff had not completed documentation as diligently as expected and in some cases, not at all, in the year prior to her interview in October 2016.<sup>88</sup> At the time of her interview, the Summit Director also informed Investigators that she had directed all Summit staff to ensure they were documenting all contacts diligently, and that she was reviewing staff documentation regularly.

### *Discussion*

Residential licensees ought to be held to the same standards of accountability for records they produce related to children and youth in their care, as those imposed on children’s aid societies. At the very least, there should be an expectation that residential licensees will complete contemporaneous case notes in accordance with expectations set out in the Child Protection Standards (ie, that such notes include the date and time of contact, method of contact, names of individuals involved in the contact, the significant observations, events and discussions related to each contact and the author’s name and date of the case note).<sup>89</sup> Residential licensees should be required to take steps to ensure that all documentation created by its staff is accurate, clear and comprehensive.

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<sup>86</sup> Ministry of Children and Youth Services, *Foster Care Licensing Manual* (Toronto: Province of Ontario, 2012).

<sup>87</sup> There are 27 Standard Foster Care Terms and Conditions attached to all foster care licenses in Ontario. In addition, Ministry licensors sometimes add specific terms and conditions to a licence, such as that attached to Summit’s licence for the period of May 1, 2016 to April 30, 2017.

<sup>88</sup> Investigators did observe the presence of clear and concise notes (including dates and times) recorded by some On-Call Supervisors during the period Alex was placed with Renee.

<sup>89</sup> These are expectations as set out in Ministry’s Standards for all Phases of Child Protection Service Delivery, Standard G: Contemporaneous Case Notes. See Ministry of Children and Youth Services, *Ontario Child Protection Standards* (2016) at 16–17.

**Ministry: Documentation Standards for Residential Licensees**

**RECOMMENDATION SIXTEEN:** The Ministry should establish standards for the documentation created by residential licensees during their communications with external parties and related to children and youth to whom they are providing care. These standards should be comparable to those expected of children’s aid societies as set out in the Child Protection Standards.

**Ministry: Establish Documentation Standards for Licensees**

**RECOMMENDATION SEVENTEEN:** The Ministry should work with residential licensees and the associations that support residential licensees to ensure that all staff at residential licensees, including foster parents, obtain the training necessary to ensure compliance best practices for documentation and any new standards set by the Ministry.

***Ministry Response to Recommendations***

In its reply, the Ministry indicated that it recognizes the need for accurate documentation related to meeting the unique needs of children and youth, as well as the appropriate sharing of information to support effective decisions related to the placement of children and youth in residential care settings.

The Ministry’s comments further informed the Advocate’s Office that Licensee training on filing and documenting a Serious Occurrence Report will be provided through a training module in SOR-RL. Training modules will be incorporated into the SOR-RL system to assist staff in placing agencies and at licensed premises in completing and properly documenting reports that are to be submitted in SOR-RL.

**Ministry Documentation Practices**

Investigators noted three specific issues with the Ministry’s documentation practices during the course of the Investigation: (1) lack of Ministry standards relating to documentation of external contacts with children’s aid societies and residential licensees; (2) lack of a Ministry protocol for following up on outstanding terms and conditions on licences,<sup>90</sup> and (3) lack of standardized review process for complaints made to the Ministry about a residential licensee or children’s aid society.

The Ontario Public Service Common Service Standards apply to Ministry staff. These standards set out general expectations for response times, wait times and the way in which Ministry employees are expected to communicate with “customers” (eg, telephone calls “will be returned within one business day,” “be courteous and helpful” while providing service in person). The only substantive documentary best practice in these Standards is a directive to “[k]eep your response simple and easy to understand” when responding to an email.

***Absence of Documentation Standards***

Upon the request of Investigators, the Ministry was unable to locate any directives or standards specifically relating to documentation best practices that govern Ministry staff. The two Ministry Representatives interviewed during the investigation informed Investigators that they were unaware of any directives or standards beyond the Ontario Public Service Common Standards that applied to documentation, including any that relate to the Ministry’s contact with external parties such as children’s aid societies or residential licensees. The two Ministry

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<sup>90</sup> The Ministry tracks terms and conditions through the use of the Field Worker tool and the SMIS system.

Representatives interviewed described their documentation practices as unique and acquired through their own experiences, including in other positions in the Ministry over the years.

Investigators found that not only are there no standards set for Ministry Representatives related to the type of details that should be recorded during in-person and telephone contact between a Ministry Representative and a children's aid society or a residential licensee, but there are no requirements that these contacts be documented at all. One Ministry Representative named in Renee's lawyer's letter dated March 22, 2016, failed to maintain notes of all telephone calls she had at the end of March and early April 2016 with CAS Algoma Directors. The other Ministry Representative inconsistently documented her telephone calls, recording some, but not others with a Summit Director.<sup>91</sup>

The Ministry requires that children's aid societies meet documentary best practices through their required adherence to the Ontario Child Protection Standards. These Standards help to ensure transparency and accountability in the actions taken by those working within children's aid societies. It seems reasonable to expect that the Ministry should be required to adhere to similar standards, as the oversight body for children's aid societies. Ministry staff should be required to document all contact with children's aid and Indigenous children's aid societies and residential licensees. At a minimum, these notes should include the date and time of contact, method of contact, names of individuals involved in the contact, the significant observations, events and discussions related to each contact and the author's name and date of the case note.

#### **Ministry: Documentation Standards for Ministry Staff**

**RECOMMENDATION EIGHTEEN:** The Ministry should establish documentation standards for its staff who supervise and have contact with residential licensees and children's aid societies. These should be comparable to those expected of children's aid societies and as set out in the Child Protection Standards.

#### ***Ministry Response to Recommendations***

In its reply, the Ministry commented that in 2017 Ministry licensing staff received training in on regulations under the *CFSA* that included a core component focusing on documentation requirements and business processes. Subsequent training also occurred in the spring of 2018 on regulations under the *CYFSA*.

In addition to training on inspection processes, Ministry staff will receive training on note-taking and interview techniques to help ensure that licensed files are fully documented in a standard format.

#### **No Protocols for Tracking Licensees' Outstanding Terms and Conditions**

Investigators also learned during interviews with the two Ministry Representatives that the Ministry does not have any protocol in place to track outstanding terms and conditions on a licence. Like the documentation of communication with external parties, Ministry Representatives follow up with licensees according to their own systems.

As part of its annual review of Summit's licence, the Ministry required Summit to take action on six items as per the specific Term and Condition:

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<sup>91</sup> This Ministry Representative did take handwritten notes of a telephone conversation that she, another Ministry Representative and the Summit Director had on April 28, 2016 related to the outcome of Ministry's licensing review of Summit.

The Ministry was prepared to renew Summit's Licence provided the following criteria were met:

1. Review and revise the policies and processes related to emergency and planned placements to ensure that prospective foster parents have all available information related to the child/youth that is being considered for placement in their home. Included in the revisions will be definitions of 'emergency placement' and 'planned placement,' as well as the different processes required for both;
2. Review how child/youth background information is communicated to foster parents when a placement is being considered. Foster parents must have the opportunity to make an informed decision and access to all sources of information about the child/youth that is available to the Licensee;
3. Review the policy related to "On-call," specifically the amount time it may take to receive a response, and the type of response that foster parents can expect in emergency and other situations;
4. Ensure that the policies and processes are strictly adhered to by the agency;
5. Review the system in place, which provides support to foster parents to ensure they have the necessary support and relief and that children/youth placed in the foster homes are supervised as necessary; and
6. Review and strengthen, as necessary, existing protocols related to the referral and placement process of children and youth in the foster care program with the Children's Aid Society of Algoma. [emphasis added]

This was the final of six actions required to fulfill the specific Term and Condition attached to Summit's residential foster care licence issued for the period May 1, 2016 to April 30, 2017.

Summit was required to complete all six actions and provide written confirmation of their completion prior to May 31, 2016. However, Investigators found that Summit had only taken action and responded to the Ministry in respect of the first five of the six required items. The Summit Director did not provide, nor did the Ministry request, written confirmation relating to the sixth item. It was Summit's responsibility to take action on all items required by the Ministry, and it was the Ministry's obligation to ensure that Summit complied with the Term and Condition of its licence.

On May 10, 2016, the Summit Director sent the Ministry Representative documents to support Summit's fulfilment of the first five conditions set out in the specific term and condition, as well as a letter in which the Summit Director stated, "I have concluded that I have met the [Specific] Term and Condition." The Ministry Representative responsible for ensuring all items were completed as part of the specific term and condition candidly informed Investigators during her interview that she mistakenly believed that the sixth item had been met. The Ministry Representative did not follow up further with Summit about the sixth item.

If there had been a follow up system in place related to outstanding terms and conditions on licences, the Ministry may have been alerted to the outstanding item required of Summit prior to May 31, 2016 and may have taken steps to address it with Summit accordingly.

It appeared to Investigators during their interviews with the Summit Director and the Ministry Representative that the lack of follow up on the sixth item as part of specific Term and Condition was unintentional. Nevertheless, as a result of the failure by Summit and the Ministry to address the incomplete sixth item, Summit and CAS Algoma have not had the opportunity to meet to review the RSA and the relevant protocols between the agencies.

**Ministry: Ensure Each Term and Condition is Met and Documentation is Obtained**

**RECOMMENDATION NINETEEN:** As part of its licensing reviews, Ministry staff should ensure that all actions required as part of a specific Term and Condition placed upon a residential licensee are fulfilled and accompanied by adequate written supporting documentation.

**Ministry: Track Outstanding Specific Terms and Conditions**

**RECOMMENDATION TWENTY:** The Ministry should establish a system for its licensing staff to track outstanding specific terms and conditions. This system should include a mechanism to alert Ministry staff when a residential licensee has failed to meet any specific term and condition within the time prescribed for it.

***Ministry Response to Recommendations***

The Ministry's reply explained that expectations for documentation related to conditions were confirmed with all licensing staff through training in May and June 2017 and with follow up written materials. The Ministry is working towards a new IT solution for licensing that will strengthen oversight and accountability including ongoing assessments for compliance with licence conditions. A review of the current business processes that underpin the IT development is underway.

The Ministry further advised, that compliance with the conditions will be fully documented in the new SOR-RL (which is expected to be operational in 2019) and will be reviewed by a licensing manager as part of the inspection process. Documentation must include a date when compliance was achieved and a note indicating where supporting evidence is stored.

The Ministry is improving oversight and accountability of licensees and are conducting unannounced inspections to verify compliance with legislative requirements, including conditions on a licence.

The Ministry's also confirmed that the tracking of terms and conditions is currently done in the Ministry's "Fieldworker" tool, and that the training which took place in May/June 2017 outlined a provincially consistent method of tracking non-compliance related to any requirements under legislation and regulations. The Ministry advised that documentation must include a date when compliance was achieved and a note indicating where any supporting evidence is stored.

**Lack of Standardized Review Process for Complaints**

Ministry Representatives acknowledged in their interviews that there is no protocol to guide them when they conduct reviews related to complaints about the actions of children's aid societies or residential licensees.<sup>92</sup> There is no requirement that children's aid societies or residential licensees provide documentation to support their responses to Ministry inquiries about events described in complaints.

When a Ministry Representative made inquiries of CAS Algoma in relation to a complaint made to the Ministry by Renee's lawyer, she did not seek any documentation in support of CAS Algoma's responses. Instead, the Ministry Representative relied solely on the CAS Algoma Director's email response. Some of the information provided by the CAS Algoma Director to the

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<sup>92</sup> Investigators asked the Ministry for information related to any reviews apart from the legislated complaint and review procedures related to alleged violations of the rights of children in care under sections 109 – 110 and Part V of RRO 1990, Reg 70 under the CFSA.

Ministry Representative was inaccurate. Had the CAS Algoma Director been required to furnish documentation to support her responses to the Ministry Representative, the CAS Algoma Director would have needed to investigate issues further and realized earlier some of the issues surrounding Alex's placement with Renee.

In their response to this report, the Ministry advised the Advocate's Office that, "historically, it has not been the Ministry's practice to request supporting documentation from CASs as there is an expectation that the Executive Director who speaks on behalf of the organization is providing factual information to the ministry".<sup>93</sup> The Ministry should therefore establish processes to help ensure that the information it receives is indeed factual, and supported by documentary evidence.

**Ministry: Create Standardized Review Process for Complaints**

**RECOMMENDATION TWENTY-ONE:** The Ministry should establish a standardized review process for Ministry staff involved in responding to complaints about a children's aid society or a residential licensee. This process should include a requirement that children's aid societies and residential licensees provide supporting documentation to the Ministry as part of any children's aid societies and residential licensees' responses to the Ministry's reviews of complaints.

*The Ministry's Response to Recommendations*

The new SOR-RL system is being designed to fully capture and document reports, updates, responses, the resolution of licensee complaints and Serious Occurrence Reports. The SOR-RL system will track and document Ministry communications with the placing agency and the licensee along with the responses, actions and any additional documents that are required to be uploaded into the system. Resolution of the complaint will be fully documented in the SOR-RL system and will be reviewed by a licensing manager as part of the inspection process.

With respect to the lack of standardized review processes for complaints made to the Ministry about a residential licensee or children's aid society, the Ministry advised that a body known as the Provincial Regional Residential Committee is working to harmonize documentation tools provincially<sup>94</sup> and that one of the tools being created is a standardized "CYFSA Complaint Form". According to the Ministry, "the standardization of a single complaint mechanism will serve to generate a standardized review process for complaints made to the Ministry, as the Ministry has similar processes in place for other formal complaint/information request mechanisms".

**Availability of Resources in the North**

As highlighted by CAS Algoma in their response to the draft report, Sault Ste. Marie is hundreds of kilometers from any other major community. In responding to the need for emergency placement for Alex, CAS Algoma did not consider out of district options that may have provided enhanced mental health services and treatment. Instead, CAS Algoma prioritized the placement of Alex "within district". As reflected in CAS Algoma's Criteria for Placement, it is a well-accepted presumption that children and youth should be "placed within their own community whenever possible." This enables children and youth to more easily maintain connections with

<sup>93</sup> In February 2018, the Ministry advised the Advocate's Office of this expectation in its response to a draft version of this report.

<sup>94</sup> In February 2018, the Ministry advised the Advocate's Office in its response to the draft version of this report that this process is underway.



their families, Bands and communities. Most children and youth would also prefer to receive supports and services near their home community. Some Indigenous children and youth who leave their communities experience fear and anxiety, face racism and discrimination, and are without the support of families and friends nearby.<sup>95</sup>

Given Alex's initial comments to the CAS Algoma Intake Worker ("Alex wanted to leave town and start fresh"), to Renee (Alex told her about wanting to go to a "Native treatment place down south"), as well as similar information Alex provided to the psychiatrist at the local hospital, it is unclear whether Alex would have prioritized a placement "within district". However, in Alex's case, there was an urgent need to locate an immediate placement. According to CAS Algoma, once Alex had "settled", the children's aid society intended to meet with Alex to explore Alex's wishes about placement, including an out of town placement. As Alex did not remain in care, this process did not occur.

It is an unfortunate reality that children and youth in the north<sup>96</sup> often must consider leaving their communities and regions to obtain enhanced mental health services. Further, enhanced mental health services that are culturally appropriate for First Nations, Inuit and Métis children and youth are scarce. Even when such services are available, they do not necessarily provide a range of supports and services reflective of the varied Indigenous communities from which those children and youth come.<sup>97</sup> In Alex's case, information from witnesses interviewed during the course of the investigation indicated there were few resources for teenagers living in the Sault Ste. Marie area, and that residential services for adolescents who required mental health supports were even less available.

The Ontario government, under the Ontario Indigenous Children and Youth Strategy, has committed to "work with Indigenous partners to co-develop strategies and approaches to meet the needs of Indigenous children and youth in residential care, and their families and communities."<sup>98</sup> The Ministry has set the goal, by 2025, to achieve a consistent quality of care across the province and have a child and youth-centred service system in which "the needs of all children and youth are met and supported, including those of Black, racialized, First Nations, Métis and Inuit children and youth."<sup>99</sup> In the meantime, Indigenous children and youth, like Alex, have limited residential treatment options.

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<sup>95</sup> Office of the Provincial Advocate for Children and Youth, *Feathers of Hope: A First Nations Youth Action Plan* (Toronto, ON: Office of the Provincial Advocate for Children and Youth, 2014). Youth from Alex's Band participated in this report.

<sup>96</sup> "North," as it is used here, is defined as one of the Ministry's five service regions, which includes communities north of Parry Sound.

<sup>97</sup> The Band Representative who was interviewed reinforced with Investigators that even facilities that employ Indigenous staff or that have cultural components may not be familiar with the teachings and laws relevant to the Indigenous children who are placed at those facilities.

<sup>98</sup> Ministry of Children and Youth Services, *Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services* (Toronto: Province of Ontario, 2017) at 14.

<sup>99</sup> Ministry of Children and Youth Services, *Safe and Caring Places for Children and Youth: Ontario's Blueprint for Building a New System of Licensed Residential Services* (Toronto: Province of Ontario, 2017) at 20.



**MCCSS: Ensure Children/ Youth in Residential Care can Access Local Services**

**RECOMMENDATION TWENTY-TWO:** First Nations, Métis and Inuit children and youth in residential care should be able to access the services they need within their own communities wherever possible. MCYS and its successor Ministry should continue to work with First Nations, Métis and Inuit partners to develop the resources to meet the shared vision outlined in the Ontario Indigenous Children and Youth strategy.

*The Ministry's Response to Recommendations*

Working collaboratively across child and youth-serving sectors, including with First Nations, Inuit and Metis communities, the Ministry is making fundamental changes so that services are more responsive to the unique needs of their children and youth, and improve the quality of their everyday experiences.

The Ministry works with First Nations, Inuit and Metis partners to support the delivery of culturally appropriate child welfare services, including residential care services. The *CYFSA* acknowledges that First Nations, Inuit, and Metis people should be entitled to provide their own child and family services wherever possible and a majority of First Nations reserve communities in Ontario are currently receiving or in the planning stages to receive services from Indigenous children's aid societies.

## VIII. CONCLUDING REMARKS

This report represents the investigation by the Advocate's Office into the concerns raised by a foster parent about the circumstances surrounding the placement of a young person in her care. Earlier sections of the report dealt with specific details of this case: what was looked into, what conclusions were drawn (and why), and what recommendations were made to the agencies involved. The purpose of these conclusory remarks is not to highlight a shortcoming of a particular agency, but to provide explanatory information about why the Advocate's recommendations have significance to the wider system.

The centre of this story is Alex — a First Nations young person who was experiencing a mental health crisis and needed support from the residential service system. The few days that constitute the focus of this investigation represented a point-in-time opportunity to get Alex help that was desperately needed. Yet, just days after being taken into care, Alex was facing criminal charges and was quickly disconnected from family and community; a worse situation, arguably, than when Alex was taken into care and more in line with the type of outcome that such an intervention was intended to avoid. As a province, we must continue to work towards a residential service system where such opportunities are not missed, and young people like Alex can get the support they need.

As this case demonstrates, the best intentions of service workers will always fall short if they are not given the tools and resources they need to succeed. From the point of view of CAS Algoma, the society's priority was to find a safe placement for a child in an emergency situation. There was no intention on their part to coerce a foster parent into accepting a placement she did not want to take, but they desperately needed somewhere for Alex to stay. Similarly, Summit advised the Advocate's Office that because of Renee's extensive background and expertise in fostering, as well as her confident demeanour, they had not anticipated she would feel unduly pressured in this situation. Both CAS Algoma and Summit stated that there was no intention on their part to pressure or coerce the foster parent into accepting a placement that she did not feel able to accept. The Advocate's Office accepts the positions of both agencies at face value. There is no evidence to suggest that anyone involved in these events was motivated by anything other than doing what they thought was best in difficult circumstances. Yet the foster parent, despite her credentials, her confidence, and many years of experience, did indeed feel pressured into accepting the placement of Alex into her care — something she strongly believes she did against her better judgment.

As confirmed in the investigation, the foster parent had already turned down the placement twice and initially refused to accept a subsequent phone call about the same request. Eventually, however, the foster parent, Renee, accepted the phone call and agreed to the placement. The investigation found that the number of requests to Renee did not seem to raise red flags with anyone, perhaps because within the human services sector, it is not unusual to resort to strategies that involve pleading and cajoling in pursuit of urgent services for clients.

Because of this, and the paramount purpose of ensuring a child's safety, it is important to consider how best to safeguard foster parents from feeling pressured into accepting children whose needs they don't feel equipped to handle.

As well, it should be recognized that the capacity of any person is not something that is static — there may be times that a person, including an experienced foster parent, may feel less able to cope with risk or complexity. This could depend on many factors or a combination of factors

including physical health, energy level, personal stressors, stressors affecting others in the family/extended family, or the complexity of the needs of other children in the home.

Another finding of this investigation was that additional support for the placement was warranted. In their initial response, CAS Algoma expressed their view that Summit was best placed to assess whether additional resources were needed and that if a request for resources had been made by Summit, CAS Algoma would have approved it. While the Advocate's Office understands the logic behind this point of view, in cases such as these (where, for example: the children's aid society had "very limited information" about Alex at the time of placement; both agencies were aware that Alex had a mental health treatment plan that was not being followed; children's aid had not been able to confirm a mental health diagnosis but was aware Alex had not been taking the medication prescribed by a psychiatrist for at least a couple of weeks; Alex had exhibited aggressive and violent behaviours, including damage to property at a local hospital days earlier; and both agencies were aware Alex had made a threat against another Summit foster parent), it seems more prudent, especially when the foster parent has expressed hesitancy about the placement, to proactively and explicitly assess the adequacy of the resources in place to support the placement. The Advocate's Office views the obligation to have this type of explicit discussion in high-risk cases as a shared responsibility between the children's aid society, the residential services provider, and, in some complex cases, the respective provincial ministry.

It became evident during the course of this investigation that there are no protocols to guide Ministry representatives when they conduct reviews related to complaints about the actions of children's aid societies or residential licensees, to require independent documentation from agencies in support of responses, or to track outstanding terms when conditions are imposed on a residential licence. Recommendations in this report also address these issues in order to strengthen the capacity of the government to exercise their ultimate oversight responsibilities for children's aid society and residential service providers providing care to children in the Province of Ontario.

It is also recommended that the government establish documentation standards that would apply to residential service providers and also to the Ministry. Currently, these standards do not exist for either group although there are clear standards in place that apply to the documentation practices of children's aid society workers. The Advocate's Office suggests that the same set of standards be applied to all.

Finally, this investigation highlighted the ongoing concern about the availability of resources for children and youth in care, particularly those with mental health needs, and Indigenous youth. Investigators believed that one of the reasons there were multiple requests made to Renee to consider taking Alex was because, aside from CAS Algoma's own internal resources (ie, foster parents working directly with CAS Algoma), the only other 'game' in town was Summit.

According to a list provided by the Ministry in June 2018, there are three licensed residential service providers operating in Sault Ste. Marie: CAS Algoma, Summit, and Community Living Algoma. A cursory review of Community Living Algoma's website indicates that at present, the agency does not provide residential services to children. Another publicly available database of resources, known as "ConnexOntario", which is funded by the Ontario government, includes information about alcohol, drug, gambling, and mental health services available in the province. According to this database, residential services available to someone Alex's age and living in

Algoma is limited to the Sault Area Hospital Child and Adolescent Inpatient Unit<sup>100</sup> — the place where this story begins.

Two recommendations in this report attempt to address the problem of resource availability for youth in care, Indigenous youth, and youth with mental health issues in Northern Ontario. The first recommendation suggests that the Ministry should be included as a potential source of funding when a children's aid society and placement agency agree that additional support is warranted to safeguard the placement. The second recommendation suggests that the government continue to work with Indigenous partners to develop resources that would allow children to receive services within their own community.

Summit, CAS Algoma and the Ministry were extremely co-operative during the investigative process and all responded to the Advocate's Office in a manner that reflected a similar focus on enhancing and strengthening standards and best practices within the child welfare system.

A copy of the draft investigation report was provided to the Children's Aid Society of Algoma, Summit Human Services, and the Ministry for response.

Summit accepted all recommendations made to them.

The Algoma Children's Aid Society agreed to amend Alex's child protection record, continue working to ensure their staff meet expectations with respect to documentation, and meet with Summit to discuss pre-placement communication protocols.

In their formal reply, the Ministry advised that they have developed a serious occurrence risk analysis program to identify children in residential care who are at risk, and that Ministry staff follow up with the placement agencies and the residential care providers to confirm that the proper supports are in place so that children are receiving the quality of care to which they are entitled. The Ministry also advised it is in the process of developing a standardized screening tool to identify children at high risk who may be vulnerable and/or require more intensive service provision as recommended by the Ontario Chief Coroner's expert panel. The standard screening tool will facilitate the collection, documentation and sharing of information so that children who have been identified as high risk are placed in residences that can meet their needs.

Additionally, the Ministry indicated it had provided training to Ministry Licensing staff in 2017 on documentation requirements, business practices, and that Ministry staff will receive training on note taking and interview techniques to ensure licensed files are fully documented in a standardized format, that compliance with the conditions will be fully documented in a new database (which is expected to be operational in 2019), that documentation must include a date when compliance was achieved and a note indicating where supporting evidence is stored, and they are conducting unannounced inspections to verify compliance with legislative requirements, including conditions on a license. The new database system will track and document Ministry communications with the placing agency and the licensee along with the responses, actions and any additional documents that are required to be uploaded into the system and resolution of the complaint will be fully documented in the SOR-RL system and will be reviewed by a licensing manager as part of the inspection process.

Recommendations to all parties and their responses are integrated throughout this report.

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<sup>100</sup> ConnexOntario, online:<<https://Connexontario.ca>>.

## IX. APPENDIX A: RECOMMENDATIONS

### **CAS Algoma & Summit: Revise the RSA re: Communication with Foster Parents**

**RECOMMENDATION ONE:** CAS Algoma and Summit should revise the RSA to explicitly outline the circumstances, if any, under which it is acceptable for CAS Algoma staff to communicate directly with prospective Summit foster parents before a placement admission meeting has been arranged.

### **Summit: Review Protocols on Communication with Foster Parents**

**RECOMMENDATION TWO:** Summit should review and revise, where needed, its protocols with other children's aid and Indigenous children's aid societies to explicitly outline the circumstances, if any, under which it is acceptable for staff at those societies to communicate directly with prospective Summit foster parents.

### **CAS Algoma: Ensure staff Follow Pre-admission Protocol on Communication**

**RECOMMENDATION THREE:** CAS Algoma should ensure that all of its staff involved in the placement of children review, understand and comply with the pre-admission protocol on communication between CAS Algoma staff and prospective foster parents.

### **Summit: Staff Awareness of RSA and Changes to it**

**RECOMMENDATION FOUR:** Summit should ensure that its staff review, understand and comply with any revisions made to the RSA.

### **Summit: Limit Interruptions to Plan of Care Meetings**

**RECOMMENDATION FIVE:** Summit should ensure that all Plan of Care meetings for children living in its foster homes proceed without interruption, except in extraordinary circumstances.

### **CAS Algoma & Summit: Amend RSA to Allow Foster Parents Time to Review Information**

**RECOMMENDATION SIX:** CAS Algoma and Summit should amend the RSA to clarify when CAS Algoma must provide the Referral Form to Summit prior to a child's placement with a potential foster parent. The RSA should specify that a foster parent must have the opportunity to review all significant information about a child prior to the child attending at her or his foster home.

### **Summit: Amend Policies to Reflect Changes to RSA**

**RECOMMENDATION SEVEN:** Summit should amend its Admission Policies and Emergency Placement Policy to be consistent with any changes made to the RSA.

### **Summit: Communicate Threats Made by Children/ Youth to Foster Parents**

**RECOMMENDATION EIGHT:** Summit should ensure that any threats made by children or youth to self-harm and/or harm another person, are communicated clearly to foster parents who are considering having those children or youth placed with them.

### **CAS Algoma: Record Threats Made by Children/ Youth on Necessary Forms**

**RECOMMENDATION NINE:** CAS Algoma should ensure that any threats made by children or youth to self-harm and/or harm another person, are recorded clearly on its Placement Request/Child Information Form or the equivalent of this form used by residential licensees providing foster care services to children in CAS Algoma's care.

**Summit: Provide Individualized Support When Harm/ Self-Harm is Possible**

**RECOMMENDATION TEN:** Summit should seek and provide individualized support to foster care placements to support children with significant, but unknown mental health issues who have made threats of harm to self and/or others until such time as those children’s mental health needs can be confirmed by, and a safety plan can be developed with, the children’s mental health professionals.

**Ministry and CAS Algoma: Facilitate Individualized Support Until Needs Are Assessed**

**RECOMMENDATION ELEVEN:** The Ministry and CAS Algoma should facilitate the provision of resources to Summit and other residential licensees to ensure foster placements of children with significant, but unknown mental health issues who have made threats of harm to self and/or others are sufficiently supported until such time as those children’s mental health needs can be confirmed by, and a safety plan can be developed with, the children’s mental health professionals.

**Summit and CAS Algoma: Debrief Circumstances of January 31 Events**

**RECOMMENDATION TWELVE:** Summit and CAS Algoma staff should meet to formally debrief together the pre-placement communications that occurred prior to Alex’s placement with Renee. Summit and CAS Algoma should amend the RSA, to ensure that it aligns with Summit’s expectations regarding pre-placement procedures and the use of Summit’s Referral Form, including during emergency placements of youth and that it clearly sets out each agency’s staff’s responsibilities and restrictions related to pre-placement communication between the agencies and with foster parents.

**CAS Algoma: Correct Alex’s Child Protection Record**

**RECOMMENDATION THIRTEEN:** CAS Algoma should immediately correct Alex’s child protection record to accurately record Alex’s mental health status as of January 29, 2016 in accordance with section 315 of the *Child, Youth and Family Services Act, 2017* (not yet in force), including by adding information to make the record accurate and complete.

**CAS Algoma: Documentation requirements**

**RECOMMENDATION FOURTEEN:** CAS Algoma should take steps to ensure that all of its child protection workers and supervisors fully understand and respond accordingly to their documentation obligations under the Child Protection Standards and CAS Algoma policies.

**CAS Algoma: Strengthen Quality Control for Documentation**

**RECOMMENDATION FIFTEEN:** CAS Algoma Directors should ensure that they provide CAS Algoma Supervisors with sufficient opportunities to review and provide feedback to child protection workers relating to documentation expectations set out in the Child Protection Standards and CAS Algoma policies.

**Ministry: Documentation Standards for Residential Licensees**

**RECOMMENDATION SIXTEEN:** The Ministry should establish standards for the documentation created by residential licensees during their communications with external parties and related to children and youth to whom they are providing care. These standards should be comparable to those expected of children’s aid societies as set out in the Child Protection Standards.

**Ministry: Establish Documentation Standards for Licensees**

**RECOMMENDATION SEVENTEEN:** The Ministry should work with residential licensees and the associations that support residential licensees to ensure that all staff at residential licensees, including foster parents, obtain the training necessary to ensure compliance best practices for documentation and any new standards set by the Ministry.

**Ministry: Documentation Standards for Ministry Staff**

**RECOMMENDATION EIGHTEEN:** The Ministry should establish documentation standards for its staff who supervise and have contact with residential licensees and children's aid societies. These should be comparable to those expected of children's aid societies and as set out in the Child Protection Standards.

**Ministry: Ensure Each Term and Condition is Met and Documentation is Obtained**

**RECOMMENDATION NINETEEN:** As part of its licensing reviews, Ministry staff should ensure that all actions required as part of a specific Term and Condition placed upon a residential licensee are fulfilled and accompanied by adequate written supporting documentation.

**Ministry: Track Outstanding Specific Terms and Conditions**

**RECOMMENDATION TWENTY:** The Ministry should establish a system for its licensing staff to track outstanding specific terms and conditions. This system should include a mechanism to alert Ministry staff when a residential licensee has failed to meet any specific term and condition within the time prescribed for it.

**Ministry: Create Standardized Review Process for Complaints**

**RECOMMENDATION TWENTY-ONE:** The Ministry should establish a standardized review process for Ministry staff involved in responding to complaints about a children's aid society or a residential licensee. This process should include a requirement that children's aid societies and residential licensees provide supporting documentation to the Ministry as part of any children's aid societies and residential licensees' responses to the Ministry's reviews of complaints.

**Ministry: Ensure Children/ Youth in Residential Care can Access Local Services**

**RECOMMENDATION TWENTY-TWO:** First Nations, Métis and Inuit children and youth in residential care should be able to access the services they need within their own communities wherever possible. MCYS and its successor Ministry should continue to work with First Nations, Métis and Inuit partners to develop the resources to meet the shared vision outlined in the Ontario Indigenous Children and Youth strategy.



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