Yukon
Public Interest
Disclosure
Commissioner

Allegations of Wrongdoing in the Delivery of Group Home Care

FINAL

Special Investigation Report
under the
Public Interest Disclosure of Wrongdoing Act

Diane McLeod-McKay
Public Interest Disclosure Commissioner

April 10, 2019

This page is intentionally blank.

TABLE OF CONTENTS

The total pages in the Special Investigation Report, inclusive of the Appendix, is 151.

DISCLOSURES

In May of 2018, my office received, from Yukon government employees, disclosures of a number of alleged wrongdoings regarding seven children who were in the care of the Department of Health and Social Services, Social Services Division (Department) or who were otherwise involved with the Department related to their care. The disclosers alleged that employees in the Department committed wrongdoings under subsection 3 (a) and paragraph 3 (b)(i) of the *Public Interest Disclosure of Wrongdoing Act* (PIDWA)[1] because of their decisions, actions or omissions as it pertained to these children.

To summarize, the allegations were as follows.

1. A child[2] was refused entry to a group home at night when it was cold because of his behaviour. This was a contravention of the *Child and Family Services Act* (CFSA) [PIDWA subsection 3 (a)] and created a substantial and specific danger to the life, health or safety of the youth [PIDWA paragraph 3 (b)(i)].

2. A youth[3] in care was evicted from a group home without suitable alternative accommodation. This was a contravention of the CFSA [PIDWA subsection 3 (a)] and created a substantial and specific danger to the life, health or safety of the youth [PIDWA paragraph 3 (b)(i)].

3. Four youth in care were not provided a group home resource in a timely manner. This was a contravention of the CFSA [PIDWA subsection 3 (a)] and created a substantial and specific danger to the life, health or safety of the youth [PIDWA paragraph 3 (b)(i)].

4. Employees at a group home failed to provide adequate supervision, jeopardizing the safety of two youth[4] who were involved in an altercation. This was a contravention of the CFSA [PIDWA subsection 3 (a)] and created a substantial and specific danger to the life, health or safety of the youth [PIDWA paragraph 3 (b)(i)].

5. An employee threatened to withdraw services for a youth in care if the youth took their concerns to the media. This was a contravention of the CFSA [PIDWA subsection 3 (a)] and created a substantial and specific danger to the life, health or safety of the youth [PIDWA paragraph 3 (b)(i)].

---

[1] S.Y. 2014, c.19

[2] "Child" is defined in the *Child and Family Services Act* as "a person who is under 19 years of age". Any reference to child or children in this Report has the same meaning.

[3] "Youth" is defined in the *Child and Family Services Act* as "a person who is 16 years of age or over but is under 19 years of age. Any reference to youth in this Report has the same meaning.

[4] The age of one youth is unknown. For the purposes of this Report, both will be referred to as "youth".

6. The Department sought to terminate continuing care orders for youth who were difficult to serve. This was a contravention of the CFSA [PIDWA subsection 3 (a)] and created a substantial and specific danger to the life, health or safety of the youth [PIDWA paragraph 3 (b)(i)].

EXPLANATORY NOTE

All section references in this Special Investigation Report (Report) are to PIDWA unless otherwise stated.

JURISDICTION

Section 18 authorizes me to investigate a disclosure of wrongdoing received, subject to sections 19 and 20. Having considered sections 19 and 20, I decided to investigate the allegations of wrongdoing made therein.

Section 17 identifies the purposes of an investigation conducted by the Public Interest Disclosure Commissioner (PIDC) into a disclosure. This section states as follows.

> *17 The purpose of an investigation by the* [PIDC] *into a disclosure is to*
>
> *(a) bring the wrongdoing to the attention of the affected public entity;*
>
> *(b) recommend corrective measures that should be taken; and*
>
> *(c) promote public confidence in the administration of public entities.*

I am required by subsection 17 (a) to bring a finding of wrongdoing during an investigation to the attention of the chief executive of the Department,[5] which I have done through this Report. My authority in respect of a finding of wrongdoing is remedial. To remedy the wrongdoings I found during this investigation, I have made recommendations to the Department.

INVESTIGATIVE PROCESS

I assigned investigation of the allegations of wrongdoing to an investigator in my office. The investigative process undertaken is set out below.

[5] The "chief executive "of the Department of Health and Social Services under PIDWA is the Deputy Minister.

The following documents were reviewed:

- legislation, regulations, policy, procedure and practice manuals of the Department;
- documents from the Department files specific to the children;
- Group Home Incident Reports Review: Observations and Recommendations (June 2018);
- Report of the Auditor General of Canada to the Yukon Legislative Assembly – 2014, Yukon Family and Children's Services – Department of Health and Social Services;[6] and
- Investigation Report authored by Pamela Costanzo, June 20, 2018 (Costanzo Report).[7]

Interviews with the following individuals occurred:

- senior management employees and other Department employees;
- First Nations representatives and social workers;
- an RCMP representative;
- the Yukon Child and Youth Advocate and her employees;
- two children who were the subject of the wrongdoing allegations; and
- a mother of one of the children.

Draft Investigation Report

- On January 30, 2019, a draft of the Report was provided to the Department for representations.
- On February 15, 2019, a letter was received from legal counsel for the Department raising legal issues and citing additional evidence.
- On February 26, 2019, a letter was provided to legal counsel for the Department responding to the legal issues and requesting additional evidence.
- On March 11, 2019, a letter was received from legal counsel for the Department responding to the legal issues and additional evidence was received.

The Department's representations in respect of the draft Report have been considered and incorporated, as applicable, into this final Report.

<u>Note about interviews with the youth</u>

One of the key articles in the UN Convention on the Rights of the Child, and repeated in the CFSA, is the right of the child to be heard and considered in matters that affect them. Of the seven children involved with this investigation, only two were interviewed, despite numerous efforts to

[6] Located on the Office of the Auditor General of Canada's website at http://www.oag-bvg.gc.ca/internet/docs/yuk_201402_e.pdf.

[7] The Costanzo Report was written by Pamela Costanzo who was retained by the Department to investigate a number of allegations made in respect of several youth.

contact the others. The Child and Youth Advocate and her employees explained that media coverage concerning their situations, while not naming individuals, identified to them and those who knew them, their stories, which they did not wish to share; hence, their reluctance to be interviewed as part of this investigation. Respecting their confidence and conforming to the confidentiality requirements of the CFSA, I have included limited information about the children and their respective circumstances in the body of this Report.

RELEVANT LAW

PIDWA

One of the purposes of PIDWA is as follows.

> *1 (a) to facilitate the disclosure and investigation of significant and serious matters in or relating to public entities, that an employee believes may be unlawful, dangerous to the public or injurious to the public interest;*

Under PIDWA, 'wrongdoing' is defined in section 3.

> *3 This Act applies to the following wrongdoings in or relating to public entities*
>
> *(a) a contravention of an Act, a regulation made under an Act, an Act of Parliament, or a regulation made under an Act of Parliament;*
>
> *(b) an act or omission that creates a substantial and specific danger*
>
> *(i) to the life, health or safety of individuals, other than a danger that is inherent in the performance of the duties or functions of an employee….*

In a prior investigation into an allegation of wrongdoing under PIDWA, I stated the following about how subsection 3 (a) is to be interpreted.

> *Subsection 3 (a) states that [t]his Act applies to the following wrongdoings in or relating to public entities*
>
> *(a) a contravention of an Act, a regulation made under an Act, an Act of Parliament, or a regulation made under an Act of Parliament.*
>
> *The specific wrongdoings set out in section 3 makes it clear that they are not meant to capture any behaviour that is wrong in that such behaviour, at the low end of the spectrum, is incorrect or somewhat imprudent; rather, it is behaviour at the high end that*

deserves the weight of strong sanction if proven out on a balance of probabilities. In that sense, subsection 3 (a) is about a fundamental breach of statute (or regulation), as opposed to something less. This interpretation is supported by the first purpose set out in subsection 1 (a); namely, to facilitate the disclosure and investigation of significant and serious matters in or relating to public entities, that an employee believes may be unlawful, dangerous to the public or injurious to the public interest.

I have not yet interpreted the meaning of paragraph 3 (b)(i) and, therefore, will do so now.

The modern approach to statutory interpretation is that the words of an Act are to be read in their entire context and in their grammatical and ordinary sense harmoniously with the scheme of the Act, the object of the Act and the intention of Parliament.[8]

In Yukon's *Interpretation Act*,[9] it states that [e]very enactment and every provision thereof shall be deemed remedial and shall be given the fair, large, and liberal interpretation that best ensures the attainment of its objects.

The purposes of PIDWA are set out in section 1.

The purposes of this Act are

(a) to facilitate the disclosure and investigation of significant and serious matters in or relating to public entities, that an employee believes may be unlawful, dangerous to the public or injurious to the public interest;

(b) to protect employees who make those disclosures; and

(c) to promote public confidence in the administration of public entities.

As previously indicated, the purpose set out in subsection 1 (a) makes it clear that the wrongdoings in subsection 3 "are not meant to capture any behaviour that is wrong in that such behaviour, at the low end of the spectrum, is incorrect or somewhat imprudent; rather, it is behaviour at the high end that deserves the weight of strong sanction if proven out on a balance of probabilities."

The purpose of subsection 1 (a) and the wording in paragraph 3 (b)(i) make it clear that, for this type of wrongdoing to occur, the alleged act or omission must create a danger to the life, health or safety of individuals that is both substantial and specific.

[8] *Rizzo & Rizzo Shoes Ltd. (Re)*, [1998] 1 SCR 27, 1998 CanLII 837 (SCC), at para. 21.
[9] R.S.Y. 2002, c.125, at section 10.

The online Oxford dictionary defines 'danger' as the possibility of suffering harm or injury. However, the mere possibility of danger is not enough to qualify as a wrongdoing.[10] For purposes of paragraph 3 (b)(i), the substantial and specific danger created by an act or omission must be real or probable.

A 'substantial' danger is a risk or situation that a reasonable person would consider to be serious in nature, including the outcomes. It would result or would likely result from a real harm to the life, health or safety of a person. A 'specific' danger is one that is clearly identifiable, is an actual threat (as opposed to a speculative one), and has a reasonable expectation of occurrence within a foreseeable time that can be consistently described. Both types are required to establish the danger at hand. One or the other is not sufficient.

If both are established such that a substantial and specific danger to the life, health or safety of an individual is found to exist, wrongdoing under paragraph 3 (b)(i) will not be present if the danger created is inherent in the performance of the duties or functions of an employee responsible for creating the danger.

'Inherent' is defined in the online Oxford Dictionary as "existing in something as a permanent, essential or characteristic attribute." Based on this definition, danger to the life, health or safety of an individual that is substantial and specific will be inherent in a duty or function if the danger is an essential or a permanent aspect of the duty or function or a characteristic attribute. Plus, the act or omission that created the danger must be inherent in the specific duty or function performed by the employee.

CFSA

Section 2 of the CFSA is clear and unequivocal. It states that the CFSA 'shall' be interpreted and administered in accordance with the principle that the best interests of the child shall be given paramount consideration "in making decisions or taking any action under this Act."

A list of non-exhaustive factors that the designated director (Director) must consider in determining the best interests of the child are set out section 4 of the CFSA.[11]

> *4(1) In determining the best interests of the child all relevant factors shall be considered, including*
>
> *(a) the child's safety, health and well-being;*

[10] 'Possibility' is akin to speculation but 'probable' is sufficient if supported by the facts.
[11] Paragraph 173 (1)(a) of the CFSA enables the Commissioner in Executive Council to designate a member of the public service as the director of family and children's services. This position is within the Social Services Division.

(b) the attachment and emotional ties between the child and significant individuals in the child's life;

(c) the views and preferences of the child;

(d) the child's physical, cognitive and emotional needs and level of development;

(e) the importance of continuity and the resulting stability to the child, and the effect of any disruption in that continuity;

(f) the child's cultural, linguistic, religious and spiritual upbringing and heritage;

(g) the importance to the child of an on-going, positive relationship with their parents and with members of their extended family;

(h) the ability of a proposed care provider for the child to fulfill parental responsibilities;

(i) the role assumed by a proposed care provider during the child's life; and

(j) any history of family violence or child maltreatment perpetrated by a prospective care provider, and the effect on the child of any past experiences of family violence or maltreatment.

(2) If a child is a member of a First Nation, the importance of preserving the child's cultural identity shall also be considered in determining the best interests of the child.

Subsection 88 (1) establishes the rights of a child in the care or custody of the Director.

88 (1) A child in the care or custody of a director has the following rights

(a) to be free from corporal punishment in the course of receiving services from the director;

(b) to be fed, clothed and nurtured according to community child rearing standards;

(c) to receive medical and dental care, when needed;

(d) if it is not inconsistent with the best interests of the child to

(i) visit and receive visits from members of the child's extended family, and

(ii) regularly speak in private with members of the child's extended family;

(e) to participate in, and express their views according to their abilities about, significant decisions affecting them, including development and review of their case plan;

(f) to be informed of the standard of behaviour expected by their caregivers and of the consequences of not meeting the caregiver's expectations;

(g) to participate in community, social and recreational activities according to their abilities and interests, if available and appropriate;

(h) to pursue spiritual development, receive religious instruction and participate in spiritual or religious activities, according to their abilities and interests, if available and appropriate;

(i) to receive guidance and encouragement to maintain their cultural heritage;

(j) to privacy during discussions with a lawyer, the Ombudsman, a member of the Legislative Assembly, a member of Parliament, and, if the child is a member of a First Nation, an authorized representative of the child's First Nation;

(k) to reasonable privacy and possession of their personal belongings; and

(l) to be informed, in language suitable for their level of understanding, of these rights and the internal complaint procedures or other procedures available for them to enforce their rights.

Subsection 89 (1) requires that the Director only place a child in their care or custody "with a caregiver in a residential facility established by, or operated on behalf of the Minister under section 165."

Subsection 174 (1) requires the Director to "ensure that the provisions of this Act for which the director is responsible are carried out." According to subsection (2) of this section, the Director has "general superintendence over all matters pertaining to the care or custody of children who come into the [D]irector's care or custody." Any decision-making by the Director under the CFSA would require they make decisions in accordance with the principles in section 2, including decision-making about whether a child should be brought into care or custody.

'Care' is defined as "physical care and control of the child." The definition of 'custody' goes further and is defined to include "the right to the care and nurturing of the child, the right to consent to medical treatment for the child, the right to consent to the adoption or the marriage of the child, and the responsibilities associated with those rights, including the duty of supporting the child and of ensuring that the child is appropriately clothed, fed, educated and disciplined, and supplied with the other necessities of life."

Paragraph 165 (1)(b) authorizes the Minister to establish, operate and provide residential group homes, for children. Subsection 165 (4) charges the Director with responsibility to supervise them.

Child and Family Services Policy Manual[12]

Chapter 1 of the Child and Family Services Policy Manual (CFS Manual) sets out the philosophy and principles for Family and Children's Services' (FCS)[13] service delivery.[14] In this regard, it states as follows.

> *The Child and Family Services Act (CFSA) (R.S.Y. 2008 c.1) provides the legislative framework within which Health and Social Services delivers services to children, youth and families in Yukon*[.]
>
> *The CFSA opens with a preamble that provides context for the legislation. The preamble states that Canada has signed the UN Convention on the Rights of the Child…which recognizes that children deserve and need full protection of state laws. The Preamble also reaffirms these fundamental beliefs:*
>
> - *Every child is entitled to safety, health and well-being.*
> - *Supporting the integrity of families promotes the well-being of children.*
> - *All families are unique and have value, integrity and dignity.*
> - *Members of society and communities have a responsibility to promote the well-being of children.*

Under the heading 'Guiding and Service Delivery Principles', it states as follows.

> *Sections 2 and 3 of the CFSA contain Guiding and Service Delivery Principles, upon which the entire Act is based.*
>
> *These principles articulate the philosophy that is the basis for service delivery and program development in Yukon. They strongly reflect the beliefs identified in the UN Convention on the Rights of the Child.*
>
> *These principles also guide the implementation and interpretation of the CFSA. They give us direction on how the law is to be applied and are considered in all areas of our planning and decision-making with children and families.*
>
> *The Guiding and Service Delivery Principles are also an integral part of the accountability framework for the CFSA. Meaningful accountability requires benchmarks or standards*

[12] This manual indicates it was last updated in July of 2013.
[13] FCS is a branch within the Social Services Division.
[14] CFS Manual at p. 2.

against which our performance will be measured. The principles are the starting point for these benchmarks.

[These] *Principles will guide decision-making by all users of the Child and Family Services Act, families, social workers, and other professionals, directors, and the courts.*

BACKGROUND AND ANALYSIS

This portion of the Report is contained in the Appendix. The reason for structuring my Report in this manner is to protect the confidentiality of the children who were involved in this investigation to the degree possible. As such, I will only provide the Appendix to the Department. It will not be made public.

FINDINGS

First Allegation

For the first allegation, I found that the child was refused entry into the group home by Department employees. However, I also found that in the circumstances surrounding this event, the decisions and actions of these employees did not amount to wrongdoing under subsection 3 (a) or paragraph 3 (b)(i). I made this finding on the basis of determining that the decisions and actions of the employees involved were not contrary to the requirements of the CFSA. I also determined that the harm suffered by the child as a result of the decisions and actions of these employees did not create a danger to the child's life, health or safety.

Second Allegation

For the second allegation, I found that the youth, who was in the care of the Director, was evicted from the group home without suitable alternate accommodation and that the decisions, actions or omissions of Department employees involved amounted to wrongdoing under subsection 3 (a) and paragraph 3 (b)(i).

I found that wrongdoing under subsection 3 (a) occurred on the basis of determining that the decisions, actions or omissions by Department employees involved amounted to fundamental contraventions of subsections 2 (a) and (b), subsections 4 (a), (c), (d) and (e), paragraphs 88 (1)(b) and (e), and subsection 174 (2) of the CFSA that were significant and serious.

I also found that wrongdoing under paragraph 3 (b)(i) occurred on the basis of determining that the decisions, actions or omissions by these employees created a substantial and specific danger to the youth's health and safety. I also determined that the danger created for this youth was not inherent in the duties or functions performed by these employees given that, in these circumstances, they were contrary to the CFSA.

Third Allegation

For the third allegation, the circumstances involving four youth were investigated. I found that wrongdoing under subsection 3 (a) and paragraph 3 (b)(i) did not occur. The reasons for my findings follow.

For the first youth, I found no wrongdoing on the basis of determining that the decisions made and actions taken by Department employees involved in providing this youth suitable accommodation met the requirements of the CFSA and that there was no danger to the life, health or safety of the youth.

For the second youth, I found no wrongdoing after determining that the decisions, actions or omissions by Department employees involved in providing this youth with suitable accommodation did not contravene the CFSA. While the youth suffered some harm due to a delay in locating the youth suitable accommodation, there was no danger to the life, health or safety of the youth.

For the third youth, I found no wrongdoing after determining that the decisions, actions or omissions by Department employees involved in providing this youth with suitable accommodation were in contravention of paragraph 4 (1)(e) and subsection 89 (1) of the CFSA. This contravention was significant but not serious. While the youth suffered some harm as a result of the decisions, actions or omissions by these employees, I determined that there was no danger to the life, health or safety of the youth.

For the fourth youth, I found no wrongdoing on the basis of determining that the decisions and actions by Department employees involved in providing this youth with suitable accommodation met the requirements of the CFSA and that there was no danger to the life, health or safety of the youth.

Fourth Allegation

There were two allegations made. For the first, I found no wrongdoing occurred on the basis of determining that the decisions and actions by Department employees responsible for supervising these youth were done so in accordance with the CFSA and that there was no danger to the life,

health or safety of either youth caused by these decisions or actions. For the second, I found no wrongdoing occurred on the basis of determining there was no risk of harm to the employees.

Fifth Allegation

For the fifth allegation, I determined that information relayed to the youth could have been perceived by the youth as a threat in regards to their care but in the specific context was not a threat. Based on this, I found no wrongdoing occurred.

Sixth Allegation

For the sixth allegation, I found no evidence to support the allegation that the Department sought to terminate continuing care orders for youth who were difficult to serve.

RECOMMENDATIONS

I made eight recommendations to remedy the wrongdoing found as a result of my investigation of the second allegation. Subsection 23 (1) authorizes me to make any recommendations about the wrongdoing. These recommendations are summarized below.

Investigation to Identify the Cause of the Wrongdoing

I recommended the Department thoroughly investigate the underlying cause of the wrongdoings and detail its findings in a report, together with:

- the investigation process, including who was interviewed and what documents were reviewed;
- the applicable law, policy, procedures or other documents reviewed;
- who was involved in the decision-making and what led to the decisions; and
- the steps it will take to ensure wrongdoings of this nature will not recur.

Policy and Procedure Review

I recommended the Department review its transition and discharge planning policies, and ensure that:

- employees are clear as to the rules they must follow when discharging and transitioning a youth from a group home placement to independent living;

- employees are clear that they cannot discharge a child in the custody of the Director from a group home placement without ensuring that the child has suitable alternate accommodation;

- employees are clear as to their respective responsibilities and involvement when it comes to managing children transitioning from group home care to other types of care; and

- there is a mechanism therein to address, in a timely manner, any discrepancies that may arise in respect of these responsibilities, plus risk-based criteria to inform employees about what constitutes 'timely' in any given situation.

In respect of any modification to policy and procedure as result of the Department's review of them, I recommended that Department employees be sufficiently trained, such that they are informed about any new or modified policy and procedures or other documents developed following the review.

Accommodation of Children When Group Home Beds Unavailable

I also recommended that the Department evaluate whether it is necessary to establish a plan to accommodate children in an alternate location that ensures their safety and well-being when there is a group home bed shortage.

Timelines

Included in the recommendations are timelines. I requested that the Department provide me with a copy of the investigation report generated as a result of investigating the underlying cause of the wrongdoings within six months of receiving this Report.[15] For all the other recommendations, I requested that the Department provide me with evidence that it met these recommendations within 12 or 18 months as set out in the Appendix.

Additionally, in accordance with my authority under subsection 24 (1), I requested the Department notify me about the steps it has taken or proposes to take to give effect to the recommendations within 60 days from the date it received this Report.

[15] For clarity, "this Report" refers to this Special Investigation Report.

OBSERVATIONS STEMMING FROM INVESTIGATION OF ALLEGATIONS

I made a number of observations about issues that came to my attention during investigation of the first, third (*i.e.* second, third and fourth child) and fourth allegations. These observations are made for the Department's consideration and are as follows.[16]

First Allegation

Incident reporting

During the investigation, I observed that the incident report detailing what occurred in respect of this child was missing crucial information about the refused entry. I suggested that the Department evaluates its incident reporting policies and procedures to ensure that incident reporting is done properly. In this regard, I stated:

> *One of the main objectives of incident management is to ensure incidents are properly identified, documented, communicated and reviewed so that the cause of the incident is learned, risks are identified and addressed, and service quality improved. This purpose can only be achieved if employees properly document incidents. Similarly, reviewers need to be trained to question the information provided where the facts may be unclear or the information provided suggests something may have occurred that was not documented. Incidents of a significant nature should be brought to the attention of senior management for further investigation and action as necessary.*

To improve incident reporting and management, I suggested that the Department:

1. *determines whether it is necessary to review its policies and procedures on incident reporting to ensure that the purpose of incident reporting, not just critical incident reporting, is properly conveyed therein;*
2. *trains employees responsible for completing incident reports to ensure that they understand the purpose and importance of including all the facts that led to an incident and that all employees and children involved are identified in the incident report;*
3. *trains supervisors responsible for reviewing incident reports to look for issues that may require further review and establish a process of communicating incidents to management that may reveal a service quality issue;*

[16] Observations are not recommendations under PIDWA. The Department is not required to accept them or to report to the PIDC on them.

4. *trains managers responsible for reviewing incident reports forwarded to them by supervisors or others on the steps to take concerning an incident to ensure that it is properly reviewed and, where warranted, improvements are made to address any service quality issues;*

5. *trains those employees responsible for reviewing incident reports, as identified in the incident management policy and procedure, to sign the incident report as evidence of their review;*

6. *incorporates into policy and procedure a requirement that senior management employees who become involved in a review of an incident report document their review and any actions taken in respect of the incident;*

7. *establishes an audit process to review the incident reporting system, annually preferably, to ensure that it is working as intended and that modifications are made where necessary for improvement; and*

8. *reports the audit information to the Deputy Minister to ensure they are informed of any risks to the incident reporting system so that they can take action as necessary for improvement.*

I also suggested that the Department explores ways to facilitate a child's participation in incident reporting to ensure that their version of events is included, such as by providing a document to the child in which to relay their version of events. This document could then be appended to the incident report provided to the supervisor for review. Facilitating participation in this manner will alleviate the privacy concerns raised by the Department.

Deficient Investigations

During the investigation, I observed that the investigations undertaken by the Department in respect of the allegation made by the child were deficient. I suggested that the Department establishes policies and procedures to ensure that investigations conducted as a result of an allegation made by a child about their care are done properly. My comments in respect of this suggestion follow.

> *The evidence demonstrated that the investigations undertaken by the Department in respect of the allegation reported by the child were deficient. One of the reasons this occurred is, in my view, attributable to a faulty incident report and review in the first instance. However, the follow up by management to the allegation beyond the first line of review demonstrates that the processes utilized by the Department for follow up may be flawed.*

The evidence showed that all the reviews by management and senior management, up to the Director level, relied on the findings made by the first line investigation, which was found for a number of reasons to be of poor quality. The Department then appeared to rely on the results of this investigation to make decisions in respect of the allegation.

To improve investigation processes, the Department should consider establishing investigation procedures to guide employees on how to properly conduct investigations where incidents, that may be service quality issues, are alleged. The Department should consider including a requirement that investigations concerning these types of allegations are to be investigated thoroughly and neutrally. For clarity, the Department should consider defining the term 'service quality incident' and provide explanation on what it means for an investigation to be conducted 'thoroughly and neutrally'.

Practice of Refusing Children Entry to Group Homes

During the investigation, I observed that there is a practice used by group home employees that involves refusing children entry into their group homes in certain circumstances that Department management may not know about. My suggestion in respect of this observation follows.

..the Department should identify whether this practice is occurring in group homes. If the practice is occurring and the Department determines that the practice is acceptable, then it should provide guidance to group home employees about when the practice may be utilized and instruction about what group home employees are to do once refusal occurs. The guidance should also address where children who are refused entry to their group home are to go as an alternative. The written guidance, if developed, should be shared with children in group home care so they are informed about the practice, as well as their options and recourse, should they be refused entry into their group home.

Training

During the investigation, there was evidence that group home employees may require additional training to manage challenging youth. I suggested that there might be a need to review whether more training is necessary to improve outcomes. I suggested that the Department consider whether a review of this nature is warranted.

Third Allegation – Second Child

During the investigation, I observed that a lengthy delay occurred in finding suitable accommodation for this child. I suggested that the Department consider reviewing the delay to determine whether service quality needs to be improved.

Third Allegation – Third Child

During the investigation, I observed the following.

I observed that the Department might not have taken adequate steps to locate suitable accommodation for the youth upon learning that they would require it. I suggested that it evaluates whether this occurred.

I observed that Department employees may not be adequately balancing the interests of children whose beds are reserved in group homes during a period of transition out of group home care against those who require placement because they do not have one. I suggested that the Department consider whether these interests are being properly balanced. I also suggested that it more clearly define what constitutes an emergency placement to access group home beds.

I also observed that Department employees are significantly reluctant to place children in care in private accommodation, such as hotels and bed and breakfasts, even when there are no other placement options available. I noted that, in one case, a child without a placement was refused this option. I suggested that the Department revisit this policy to ensure that children who require this type of care, because there are no other options, are provided with this resource if available.

Third Allegation – Fourth Child

During the investigation, I observed that there was a delay in providing the youth with accommodation in a private group home. I suggested that the Department review the delay to determine if placement procedures contributed to it.

Fourth Allegation

During the investigation, I observed that a critical incident report was not completed in respect of the altercation between the youth. The Department's policies and procedures indicate that this type of incident may qualify as critical. I suggested that the Department consider whether a critical incident review in respect of the altercation is warranted.

OBSERVATIONS ABOUT MATTERS OF ADMINISTRATION

Internal and External Complaint Procedures: Independent Oversight

During the investigation, I observed that there were circumstances where children may not have been aware about how to make a complaint and to whom.

Both the CFS Manual (policy 19.2) and the Transitional Services Support Manual[17] (policy 4.2) contain complaint mechanisms for children. They provide a vehicle for the child's voice to be heard and considered, as required by the UN Convention on the Rights of the Child, as well as subsections 4 (c) and 88 (e) of the CFSA. Under the policy manuals, the right to be heard and the procedures to complain are to be provided to a child on intake.

To ensure that children are clear on what is available to them to address concerns, the Department should consider reviewing its policy and procedures. In so doing, the Department should consider including the following requirements:

- employees are to remind children about these avenues of redress on at least an annual basis and when an incident occurs that they are involved in; and
- employees assist children to navigate the complaints process.

The Department should also consider evaluating the materials describing the complaints process to ensure that the information is accurate. In the material describing the complaint process accessible to children in group home care,[18] the Office of the Ombudsman is mentioned. The material identifies that children can access the services of the Ombudsman only after exhausting internal processes. This is not entirely accurate.

Under the *Ombudsman Act*, subsection 14 (c) authorizes the Ombudsman to exercise discretion about whether to investigate a complaint, if the Ombudsman is of the opinion that:

> *the law or existing administrative procedure provides a remedy adequate in the circumstances for the person aggrieved, and if the person aggrieved has not availed themselves of the remedy, there is no reasonable justification for their failure to do so;*

In other words, the Ombudsman may still investigate a complaint if a child has not availed themselves of the Department's complaint mechanism. Given this, the Department should consider amending its policy manuals and any materials mentioning the Ombudsman to ensure that they properly reflect the Ombudsman's authority to receive and investigate complaints from children in care.

[17] Formerly called the "Residential Youth Treatment Services Manual".
[18] TSS Manual (Residential Youth Treatment Services Policy and Procedures Manual).

Record Keeping

The investigation of the first allegation of wrongdoing was hampered by a faulty incident report and difficult-to-read log book notes. Of equal concern were the documents provided by the Department in response to the request for the 'child in care' files.

Instead of a succinct and chronological file containing incidents, case plans, reviews, and other relevant documentation about the child, the Department produced a collection of emails and memos from various employees and others involved in the lives of these children. There was much redundancy and repetition of information. Having reviewed these records, it would be difficult, in my view, for a worker or management to get an overall sense of a child's care by examining this collection of information without having first to spend a significant amount of time organizing and reviewing it in order to piece together the full picture. The Department indicated that it is in the process of automating its file and documentation procedures.

In the document 'Group Home Incident Reports Review: Observations and Recommendations' (June 2018), the Department made a recommendation to "introduce an electronic system for managing Incident Reports". The Department should consider expanding this initiative to alleviate the problem with its records keeping about children. In the interim, the Department should take steps to ensure that the child in care files contain proper documentation.

OBSERVATIONS ABOUT PIDWA AND THE *OMBUDSMAN ACT*

PIDWA – Procedures and PIDC's Investigative Powers

Disclosure procedures

The Legislature has included in PIDWA the ability of a Department to adopt its own procedures for managing disclosures.

> *5 (1) A chief executive may establish procedures to manage disclosures by employees of the public entity for which the chief executive is responsible.*

During the second reading of Bill No. 75, *Public Interest Disclosure of Wrongdoing Act*, Mr. Silver (now Premier), as recorded in *Hansard*, stated when referring to section 5 (1), "the fact that adopting procedures are not required will likely result in many departments or organizations not adopting such procedures as it will not likely be a priority for them. So we're looking for the Minister to explain why these are not mandatory."

Communications by the Department about the procedures under PIDWA demonstrated confusion about the protections afforded to employees thereunder, including that a disclosure must follow the process set out in PIDWA. A failure to have proper disclosure procedures in place puts employees at risk who are courageous enough to bring a matter forward. Proper procedures ensure confidentiality and anonymity for the discloser, which is critically important for reprisal protection. Additionally, an employee who fails to follow proper procedure in reporting wrongdoing may not be afforded the protection of PIDWA. In my view, this is serious.

Given the foregoing, the Department should consider working with the PIDC to develop disclosure procedures.[19] If disclosure procedures are developed, the Department should ensure that its employees are sufficiently trained on them.

PIDC's Authority to Obtain Information

It became abundantly clear during this investigation that there is a significant difference of opinion between my office and the Yukon government as to the powers of the PIDC to obtain records and interview witnesses.

During the investigation, requests for the production of records and requests for employee witness interviews were vigorously met with numerous legal challenges by Yukon government lawyers. The Department refused access to certain records and insisted on having legal counsel present during interviews of some employees, both of which are problematic. While I understand the importance of the Yukon government protecting its legal rights, the exercise of these rights must not, in my view, be an obstacle to the ability of the PIDC to conduct a thorough investigation under PIDWA. This is particularly so given that the PIDC is charged under PIDWA with the responsibility to conduct investigations into allegations of wrongdoing that soundly are in the public interest.

What occurred in this investigation clearly identifies the need for the authority of the PIDC in PIDWA to be reviewed and clarified. I note that section 55 requires the Minister to begin a review of PIDWA within five years of it coming into force. PIDWA was proclaimed in force on June 15, 2015.

[19] At the writing of this Report, the Public Service Commission announced that it is preparing guidelines on disclosure procedures that a public entity could follow to ensure that its employees are protected by PIDWA and that disclosures made to the public entity by its employees are done in accordance with PIDWA.

Ombudsman Act **– Own Motion Investigations**

During the course of this investigation, although wrongdoings were found for one of the allegations made, many of the issues identified by the disclosers, as well as those that came to light during the investigation, were more about policy, procedure, and the availability of resources. These types of issues are, in my view, much better dealt with under the provisions of the *Ombudsman Act,* which is focused on 'matters of administration'.

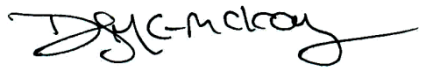
The persons who brought the issues to our attention could not, however, make a complaint under the *Ombudsman Act* as they were not directly affected by the wrongdoing; that is, they were not an affected person in their personal capacity, pursuant to section 11. The Ombudsman, on their own motion, could not examine these issues.

In other jurisdictions with Ombudsman legislation, this does not present a problem as the Ombudsman can commence an investigation on their own initiative. For instance, in British Columbia's *Ombudsperson Act,* section 10 states as follows.

> *10 (1) The Ombudsperson, with respect to a matter of administration, on a complaint* ***or on the Ombudsperson's own initiative****, may investigate…*[My emphasis]

This power is especially important in circumstances in which the aggrieved party, because of tender age, developmental disability, lack of freedom, or other reason, may not be able to complain on their own behalf. I intend to raise this issue with the Speaker of the Legislative Assembly, as they are responsible for the *Ombudsman Act*.

This concludes my Report as presented to the Speaker for tabling in the Yukon Legislative Assembly.



_____

Diane McLeod-McKay, B.A., J.D.,
Public Interest Disclosure Commissioner