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A Voice Unheard: Brandon's Story

Investigation into the Children's Aid Society of Toronto's response to child protection concerns involving "Brandon" between December 31, 2015 and October 26, 2018

OMBUDSMAN REPORT

Paul Dubé, Ombudsman of Ontario

December 2022

A Voice Unheard: Brandon's Story

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Ombudsman Report

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Executive Summary

1 On Monday, October 22, 2018, 10-year old "Brandon"[1] lay on a urine-soiled futon on the filthy and bug-infested living room floor of the apartment he shared with his great-uncle, "Frank." He had not gone to school, as he was in too much pain from bowel impaction and an undiagnosed and untreated kidney infection.

2 The Children's Aid Society of Toronto (the CAS) had been involved with Brandon's family throughout his life, and court supervision orders placing him in the care of his great-uncle had been in place for a year and a half. In mid-October 2018, a judge expressed concern about the latest information on the state of Brandon's health, school attendance, and the cleanliness of the family home. Brandon suffered from chronic urinary and mental health issues, and his family had not followed through on getting him necessary care. He had been late 34 times since the start of the school year and had already missed 9.5 days. The family apartment was infested with bedbugs. It was cluttered and dirty, and Frank and Brandon were sleeping on a futon together on the floor. Frank, who is legally blind, was struggling to keep the apartment clean.

3 That Monday, Frank had failed to arrive for a scheduled meeting at the school with Brandon's principal and a CAS worker. When they spoke to Frank over the phone, he said that Brandon was having stomach pains. He seemed frantic and hung up on them. They decided to visit the family home. When they arrived at the apartment, they noticed a strong odour. There were feces, unclean cat litter, and urine-soaked pull-up diapers scattered on the floor. Brandon was curled up on a stained futon in the main living area in what the principal later described as a "catatonic" state. Emergency services were called and two paramedics and two police officers soon arrived.

4 The police officers were horrified by Brandon's living conditions, including the permeating stench from cigarettes and cat litter, the filthy state of the floors and walls, the urine-streaked futon without sheets where Brandon lay wrapped in a dirty blanket, and the live and dead cockroaches littering the floor.

[1] The names of the child and his family members have been anonymized in this report for reasons of confidentiality.

5 After some difficulty in calming and controlling Brandon, the paramedics took him by ambulance to hospital.

6 Based on her observations, the CAS worker believed that Brandon was at immediate risk of harm. She called a supervisor to request permission to apprehend him. The supervisor denied the request, noting that the CAS had been working co-operatively with the family, Brandon already had court-ordered supervision, and there was a concern about apprehending him prematurely before the court had weighed in,

7 The police officers assumed that the CAS would remove Brandon from the home for his own safety. After they learned the CAS had no intention of doing so, the Toronto Police Service formally apprehended him, and he was taken to a foster home.

8 The hospital found that Brandon was malnourished and almost anemic, with a low red blood cell count and low hemoglobin. He was 15 pounds underweight for his age and height, had an enlarged kidney and was suffering from a kidney infection. One of Brandon's doctors credited the intervention as saving Brandon's life.

9 The CAS initially maintained that Brandon should be returned to his family. The police contacted the Provincial Advocate for Children and Youth (the Child Advocate) about the situation. The Child Advocate's office – which at the time was responsible for investigating such complaints – commenced an investigation into the Children's Aid Society of Toronto's provision of services and its response to information about child protection concerns regarding Brandon between December 30, 2015 and October 26, 2018. After the Child Advocate's office was closed and its investigative authority transferred to my Office in May 2019, we continued the investigation under the authority of the *Ombudsman Act*.[2]

10 Brandon had a long history of urinary tract infections, painful urination, constipation, mental health issues, and persistent school absences, which had not been effectively addressed by his family. Since entering and remaining in CAS care, his health and school attendance have improved considerably. On November 18, 2020, a court order placed him in the extended care of the CAS. His mother and great-uncle continue to have access rights.

[2] *Ombudsman Act*, RSO 1990, c O.6, s 14(1.1).

11 Our investigation revealed numerous gaps in the CAS's service provision and response to concerns about Brandon's welfare. The CAS failed on many occasions to comply with the Ontario Child Protection Standards. At times it disregarded the regulatory requirements relating to the timing of safety assessments. Reports from professionals and others concerned about Brandon's welfare were not always given careful consideration, and several investigations were delayed – one of them more than twice as long as the standards permit.

12 The CAS did not ensure that timely and meaningful service plans were prepared, reviewed and revised, compromising its ability to monitor whether Brandon's needs were being met. There were also frequent delays in meeting with the family, contrary to the requirements of the standards, leading to significant periods when there was no line of sight into Brandon's circumstances. One visit was delayed for almost a month, and at another point, the CAS neglected to conduct visits for more than six months.

13 The CAS was responsible for ensuring that Brandon was interviewed privately, both during its investigations and at least once a month while he was receiving ongoing services. Instead, successive CAS workers over several years routinely failed to meet with him in private, leaving his voice unheard and ignored.

14 CAS supervisors regularly approved departures from the provincial standards as a matter of convenience, rather than based on Brandon's best interests. Supervisory reviews were at times delayed, leaving supervisors with limited insight into the family's changing circumstances. And yet, CAS managers gave little credence to the eyewitness accounts of the horrific state of Brandon's living environment on October 22, 2018.

15 Brandon's story is not one of deliberate caregiver neglect, but of failure of his family to meet his needs, given their own significant challenges. Brandon's situation degraded over time to the point of crisis. Unfortunately, during the period in question, the CAS was distracted by the assurances of Brandon's family. It lost sight of its responsibility to act in his best interests, leaving him to suffer in silence in a situation of chronic neglect.

16 Based on the evidence gathered in our investigation, I have concluded that the services provided by the CAS and its response to information received about child protection concerns relating to Brandon were contrary to law, unreasonable, and wrong under subsections 21(1)(a), (b) and (d) of the *Ombudsman Act*.

17 I have made 18 recommendations addressed at improving the CAS's compliance with regulatory requirements and the Ontario Child Protection Standards, and enhancing its child protection services. The CAS has accepted and committed to implement all of my recommendations, and I will monitor its efforts to address the gaps and failures outlined in this report.

18 Children's voices are too often silenced in the presence of the adults who surround them. It is the responsibility of children's aid societies to make sure that children are heard, in order to properly fulfil their protection role. History has shown that when they fail to do so, the consequences can be devastating. Brandon's case serves as a reminder that children's aid societies must remain vigilant in ensuring compliance with regulatory requirements and prescribed standards, which promote consistency and rigour in their provision of services and direct their focus to the best interests of children.

Investigative Process

19 On October 26, 2018, a Toronto Police Service officer contacted Ontario's Provincial Advocate for Children and Youth (the Child Advocate) to report the disturbing circumstances of Brandon's apprehension. Based on the information provided by police, the Child Advocate determined that an investigation was warranted.

20 The Child Advocate notified the Children's Aid Society of Toronto of his intention to conduct an investigation on October 31, 2018, covering the period from December 30, 2015 through October 26, 2018.

21 As of May 1, 2019, as a result of the *Restoring Trust, Transparency and Accountability Act, 2018* (Bill 57), the Child Advocate's office was eliminated and its investigative responsibilities transferred to the Ontario Ombudsman. This investigation – along with others initiated by the Advocate that were pending at that time – continued under my authority.

22 This investigation was undertaken by the Child Advocate's Investigation Unit, whose functions are now part of the work of the Children and Youth Unit within the Ombudsman's Office. A number of factors have affected the investigation timeline since then, including the transfer of the Advocate's investigative role and personnel to my Office, and the transition to remote work – by our staff and many of those we contacted in the course of this investigation – due to the COVID-19 pandemic.

23 The team conducted 21 interviews, including with the Toronto Police officers and paramedics who visited Brandon's home, frontline workers and supervisors with the Children's Aid Society of Toronto, the principal and vice-principal at Brandon's school, Brandon's pediatrician and a Toronto Public Health worker familiar with his case, and the foster parents who took Brandon in.

24 Our investigation team also reviewed numerous documents from various agencies connected with the case, including the Children's Aid Society of Toronto, the Toronto Police Service, Toronto Paramedic Services, Toronto Public Health, and Brandon's pediatrician.

25 The CAS co-operated fully with our investigation.

Law and Policy

26 The Children's Aid Society of Toronto's conduct in this case unfolded during a period of legislative transition. The *Child and Family Services Act* applied until April 30, 2018, when a new Act, the *Child, Youth and Family Services Act, 2017*, came into effect.

27 The paramount purpose of the *Child and Family Services Act* was to promote the best interests, protection and well-being of children (s.1(1)). The purpose of the new Act remains unchanged (s.1(1)). However, there is a now a preamble to the *Child, Youth and Family Services Act, 2017*, which contains several government commitments, including that services provided to children and families should be "child-centered."

28 For the purposes of this report, the information summarized reflects the provisions of the *Child, Youth and Family Services Act, 2017*. There is no material difference between the two pieces of legislation relevant to the issues identified in this investigation.

The *Child, Youth and Family Services Act, 2017*

29 According to the Act, the function of a children's aid society is, among other things, to:

- Investigate allegations or evidence that children may be in need of protection;

- Protect children where necessary;
- Provide guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children;
- Provide care for children assigned or committed to its care under the Act;
- Supervise children assigned to its supervision under the Act;
- Place children for adoption under Part VIII (Adoption and Adoption Licensing); and
- Perform any other duties given to it by the Act or the regulations or any other Act.

Regulations and Ontario Child Protection Standards

30 Regulations made under the Act set out additional requirements for children's aid societies[3]. The province has also issued Ontario Child Protection Standards[4] to promote consistently high quality service delivery to children, youth and their families receiving child protection services. The standards create a mandatory framework for service delivery and establish performance expectations for child protection workers, supervisors and children's aid societies.

31 The standards recognize that some flexibility is required to address the unique and complex needs of children, and accordingly allow for "departures" from the standards in certain circumstances. However, the primary focus of child protection service is always the safety and well-being of the child. Departures from the standards are also acceptable for reasons beyond the control of the worker (e.g., the child and family are unavailable for interviews) provided a supervisor reviews, and approves

[3] New regulations were issued when the *Child, Youth and Family Services Act, 2017* came into effect. In this report, the relevant provisions from both the former and current regulations are cited in corresponding footnotes.

[4] The most recent Ontario Child Protection Standards were issued June 11, 2016, and cover much of the period under consideration in this investigation. This report references the latest standards, as they do not differ in any material respect from the former standards with regard to the issues identified in this report: Ministry of Children and Youth Services, "*Ontario Child Protection Standards*" (Updated: 22 February 2022) [Ontario Child Protection Standards], online.

them. Departures must be documented in contemporaneous case notes by the worker or the supervisor.[5]

32 The eight standards cover each phase of service delivery, from intake to closing of a case when a child is no longer in need of protection or eligible to receive services.

33 Each standard includes "practice notes" that provide best practice suggestions and factors to be taken into consideration when making clinical or case-specific decisions. However, unlike the standards, the notes are not intended to be used to measure the performance of children's aid societies.

34 Several of the requirements of the provincial standards are relevant to Brandon's case, and it is useful to discuss these in some detail.

35 Under **Standard 1**, when a children's aid society receives information that a child may be in need of protection (a "referral"), it must determine a response time based on the circumstances.[6] The options range from within 12 hours – if there is an imminent threat to the safety of the child, or when physical evidence could be lost due to delay – to seven days for family-based investigations where no immediate threat is identified.

36 **Standard 2** sets out the expectations for planning and conducting a child protection investigation including that all investigations require face-to-face contact with the child and individual interviews of family members.[7] The practice notes to the standard also indicate that interviews of family members should take place in private.

37 Under the regulations to the Act, a safety assessment must take place at the point of first contact with the child and family.[8] **Standard 3** requires that the assessment occur within the response time set by the CAS, e.g., seven days.[9] It also provides that a safety plan must be prepared if a safety threat is identified.

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[5] Supervision Standards: *Ibid* at 114.

[6] Ontario Child Protection Standards, *supra* note 2 at 24.

[7] *Ibid* at 37.

[8] O Reg 206/00, s 3; O Reg 156/18, s 31.

[9] Ontario Child Protection Standards, *supra* note 2 at 48.

38 The regulations require a risk assessment prior to the end of an investigation.[10] **Standard 4** provides guidance for conducting these assessments,[11] which result in rating of risks on a scale from "low" to "very high."

39 At the conclusion of a child protection investigation, children's aid societies must determine whether protection concerns are "verified," "not verified," or "inconclusive," in accordance with **Standard 5**.[12] Investigations must conclude within 45 days, unless a supervisor approves and documents reasons for an extension, which can be up to 60 days.

40 **Standard 6** outlines the steps that must be undertaken when a CAS transfers a case between workers, including that the transferring and receiving worker must visit the family within 10 days of submission of the transfer documentation to the supervisor.[13] The transfer is complete on the day of the visit.

41 **Standard 7** establishes the expectations for ongoing service when an investigation determines that a child is in need of protection.[14] It requires an assessment of the family and child's strengths and needs, and development of a service plan within 30 days after the investigation concludes. The service plan is intended to reduce the risk of future harm, and, at a minimum, it must contain specific goals, objectives and activities, including the persons responsible and timeframes for completion, and the specific level of contact between the worker and the child.

42 Standard 7 requires a family receiving ongoing services have a visit from a worker at least once a month. The worker must meet privately with the child, in the child's home or another setting. Unannounced visits may occur in certain circumstances, for example, if the worker is unable to contact the family to arrange a visit, or it is necessary to assess living conditions without the family having the opportunity to alter the environment.

43 Standard 7 also provides direction for situations when a CAS receives a referral regarding a child who is receiving ongoing services: If the referral relates to a known condition or incident, no investigation is necessary; if

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[10] O Reg 206/00, s 3; O Reg 156/18, s 31.
[11] Ontario Child Protection Standards, *supra* note 2 at 56.
[12] Ontario Child Protection Standards, *supra* note 2 at 62.
[13] *Ibid* at 72.
[14] *Ibid* at 80.

the concern is "new," the CAS must follow the steps outlined in Standard 1 to determine the appropriate disposition.

44 The regulations require that risk assessments take place every six months.[15] Standard 7 also outlines what reviews are required during ongoing service provision: Informal supervisory reviews must be done at least every six weeks; a formal case review and evaluation must be done every six months; and the service plan and the family and child's strengths and needs must be reassessed every six months. (**Standard 8** relates to closing cases and is not particularly applicable in this case.)

Children's Aid Society of Toronto policies

45 The Children's Aid Society of Toronto's policies supplement or elaborate upon the Ontario Child Protection Standards. During the period covered by our investigation, the CAS's policy for its child protection investigations required them to be completed within 30 days, rather than the 45-day period set out in provincial Standard 5. However, the policy has since been changed, as of June 22, 2020, and now aligns with the 45-day provincial standard.

46 Still, the policy in place during this critical time in the CAS's involvement with Brandon required investigations to be completed and documented within 30 days. As with the provincial standards, extensions could be granted if the quality and thoroughness of the investigation might be compromised by the timeline, and only in "exceptional circumstances." Any reasons for delay also had to be documented.

Brandon's story: Chronology

47 Brandon was born in Toronto in April 2008. His mother, "Cindy," had a challenging childhood. She was a victim of neglect and abuse, and had spent time in the CAS's care. She also lives with cognitive and developmental issues. The CAS's involvement with Brandon began before his birth, when Cindy received services on a voluntary basis during her pregnancy.

[15] O. Reg. 206/00 s.4(3); O. Reg 156/18 s.32(3).

Birth to age 7 – 2008 to 2015

First supervision order

48 Shortly after Brandon's birth, the CAS became concerned about Cindy's ability to care for him, particularly after she accidentally dropped him twice. In July 2008, the CAS filed a child protection application and in August, a court issued the first of a series of temporary supervision orders. Brandon was placed into the care of his paternal grandmother, who lived in Brampton. Conditions of the order included that his mother's access was to be supervised.

49 In early 2009, the CAS reviewed and approved Cindy's maternal uncle, Frank, with whom she sometimes lived, to supervise weekend access visits with Brandon.

50 In the spring of 2009, during proceedings initiated by the CAS, a court-ordered assessment of Cindy's parenting capacity concluded that without full-time, live-in support, placing Brandon in Cindy's care would set them both up for failure. In September of that year, during two unannounced visits by a CAS worker, it was revealed that Frank had left Brandon with Cindy unsupervised. The CAS also received reports about Cindy's using alcohol.

51 The CAS continued to monitor Brandon's living arrangements in 2010, both with his grandmother in Brampton and during his supervised visits with his mother in Toronto.

52 In November 2010, a child and youth mental health centre assessed Frank as a caregiver (as opposed to a supervisor), and the results were positive. However, the CAS did not approve Frank's home as a "kinship service home" due to his overall caregiving capability, including consideration of his historical struggles with alcohol.

Second supervision order

53 In April 2011, a new temporary supervision order provided that Brandon would be in the care of his grandmother on weekends and in Frank's care on weekdays. At the time, Cindy lived a block away from Frank.

54 In August 2011, police reported to the CAS that Cindy, Frank and Brandon were staying at Cindy's apartment while Frank's apartment was being treated for bedbugs. They described Cindy's home as "unclean," littered

with cigarette butts and a bong, and said Brandon was sleeping in a playpen inappropriate for his age. The CAS scheduled a visit to inquire into the situation, and continued to work with the family.

55 By the end of September 2011, a court had issued a custody order placing Brandon in the care of his grandmother and his great-uncle Frank, with his mother's access at Frank's discretion. This marked the end of the supervision order and the CAS closed its file.

First CAS investigation – 2014

56 After almost three years without recorded involvement with the family, in 2014 the CAS received a series of referrals from Brandon's teachers, one in May, four in October and two in November. The teachers reported concerns about Brandon's hygiene and aggressive behavior, and Frank's alcohol use and verbal confrontations with school staff. An anonymous caller also reported concerns in November about the dirty condition of Frank's home, and Cindy's conduct towards Brandon while he was frequently alone in her care. The CAS opened an investigation in October. It was closed in December after Frank expressed he was not interested in having the CAS involved in his life.

57 In closing its file, the CAS recorded that school staff were unaware of Frank's vision impairment and had mistaken "the appearance of his eyes" for intoxication. The CAS noted Frank was doing the best that he could, and that he would likely come back to their attention again because of his personality and appearance, and Brandon's behaviours and hygiene concerns. In a rather prophetic note, one CAS staffer wrote that their intervention "may never impact any change for this family."

Second CAS investigation – 2015

58 In March 2015, the CAS received a referral from Brandon's pediatrician, who was concerned because Cindy had disclosed hitting Brandon, and he smelled of urine. The worker did not privately interview Brandon, but he was present when the worker discussed the importance of hygiene and spanking laws with Cindy.

59 In May and October 2015, officials from Brandon's school contacted the CAS to report concerns about Brandon's inappropriate and violent behavior, as well as his hygiene. It was noted that he reeked of cigarette smoke, appeared dirty and tended to wear the same clothes for days. The

worker twice tried to see Brandon at school, but he was absent both times. The worker discussed the situation with Frank, who explained that he was working with Brandon's pediatrician and doing the best he could. Frank expressed frustration with the school and committed to trying to get Brandon to take regular baths. The CAS closed its investigation in late October 2015, verifying allegations made by the pediatrician and school, but noting that the school had connected the family to various support resources, including children's mental health programs and a Big Brothers Big Sisters program.

Period covered by this investigation: December 30, 2015 – October 26, 2018

60 The Children's Aid Society of Toronto had become increasingly involved with Brandon's family during the two years prior to the period covered by our investigation. It had received more than a dozen reports about the family, and opened and closed two investigations, in which several concerns about Brandon's situation had been verified. It is useful to consider this history when assessing the adequacy of the CAS's conduct from December 30 onward.

61 On the night of December 30, 2015, police responded to a report that people could be heard screaming in Cindy's apartment. When they arrived, the officers became concerned about Brandon's care and the conditions of his mother's home, where it appeared he had been staying for the holidays. Cindy told police that she hadn't taken her medication so she could drink alcohol.

62 The police contacted the CAS and expressed their belief that Cindy's apartment was not a suitable place for a child. The CAS provided them with Frank's contact information, and they brought Brandon to him. They observed that Frank had been drinking but appeared fine. They suggested that the CAS should be involved with the family.

63 At this point, the CAS opened its third protection investigation and set the response time at seven days.

Third CAS investigation – January 2016

64 On January 4, 2016, the CAS assigned the investigation file to a worker who had not previously dealt with the family. On January 7, the worker made several unsuccessful attempts to reach Frank. She was also

unsuccessful in contacting Cindy. The same day, the vice-principal of Brandon's school contacted the CAS, and told the worker Frank had had a heart attack and was in hospital. He said Brandon was staying with Cindy, and described her as being involved in Brandon's life in a good way.

65 Brandon's pediatrician also contacted the CAS on January 7 and told the worker the family was in therapy at the Centre for Addiction and Mental Health (CAMH), and that Brandon had Attention Deficit Hyperactivity Disorder (ADHD), as well as possible attachment and anxiety issues. The pediatrician also expressed concern about bedbugs in the home and Brandon's urinary issues.

66 Over the next few days, the worker confirmed that Brandon had returned to school, and reached Frank, who maintained that he did not need any support for his own care or for Brandon's. However, they arranged to meet.

67 On January 14, the worker visited Frank's apartment. Cindy and Brandon were also there. The worker found the home to be tidy but unclean and that Brandon was eating and appeared clean. Frank explained Brandon was still staying with his paternal grandmother on weekends. At Frank's request, the worker discussed the December 30 incident with the family as a group. Cindy said she had argued with Brandon about him playing video games. The worker interacted with Brandon throughout the visit, but did not interview him privately. When asked about this by our investigators, the worker said she understood that each family member should be interviewed privately when there is an allegation of direct harm to a child. However, she saw this situation as involving all of the family and felt there was no reason to push for a private meeting.

68 The family visit took place two weeks after the initial call from the police. The worker told us that although CAS workers are expected to make efforts to see the family within seven days, she had to balance this with the demands of her own timelines. She noted that she had initially not been able to confirm where Brandon was living, and that was why she contacted others such as the pediatrician and vice-principal.

69 On January 16, the worker completed a safety assessment determining that Brandon was safe, and a risk assessment scoring the situation as high risk (although she incorrectly indicated that Frank had no history of alcohol use).

70 A CAS case note dated January 28 observed that Frank was blind and his home was "not 100%," but that he was managing well with his family.

71 The worker also met with her supervisor on January 28. They determined that the concerns raised by the police report were verified, but that the file could be closed. The worker told our investigators she was reassured by such things as the family's community supports, Brandon's grandmother's active participation in his care, and the principal's efforts in referring the family to programs and services.

March 2016 referral

72 In mid-February, Brandon's pediatrician recommended he be taken for emergency psychiatric care and counselling, after an appointment when he acted defiant and uncooperative. The family failed to follow through with the recommendation and missed Brandon's next appointment, and on March 30, a pediatric nurse reported this to the CAS.

73 The CAS worker followed up with Frank the next day. He said he had forgotten the latest appointment, but told her the family was "finished" with CAMH, as Brandon was connected well at school and didn't need any more counselling. The worker determined that no investigation was warranted.

Fourth CAS investigation – June-September 2016

74 After several months with little interaction with the family, the CAS received a series of reports in June 2016 about Brandon, who was now eight years old.

75 On June 2, a teacher reported concerns about Brandon's irregular attendance, behaviour and hygiene. She said he often wet his pants, smelled of urine, and came to school with dirt caked on his hands and face. He was far behind academically and his behaviour ranged from unresponsive to out of control. She observed that his family were doing the best they could, but that Brandon's mother had no control over him, and his great-uncle gave him whatever he wanted.

76 The CAS initiated its fourth investigation based on this referral, and set a seven-day response time.

77 Four days later, the vice-principal of Brandon's school called the CAS with similar concerns. He also said Brandon's pediatrician wanted to see him to

address his urinary issues. The vice-principal requested to speak with the assigned worker.

78 The CAS did not assign the case to a worker until June 14. Its records note that this was "beyond the seven-day response time and is not compliant with the standards."

79 On June 16, another teacher reported to the CAS that Brandon had come in the day before filthy and with a bag smelling of old food. The teacher said that he looked undernourished.

80 Although there had been three reports, the worker assigned to the file did not escalate the matter, as they all addressed the same primary concern. A week after the last report, she began to take steps to contact Brandon. She called the school on June 23, 28 and 29, to arrange to meet him, but he was absent each time. She did not speak with the vice-principal, despite his request that she do so.

July 2016

81 On July 7, the CAS worker made an unannounced visit to Brandon's home. Frank was there, but he said Brandon had gone to his grandmother's house for two weeks because he was behind in cleaning and laundry. The worker noted layers of dirt and a strong smell of urine in the home, and a laundry hamper filled with clothing that smelled. Frank talked to her about Brandon's struggles with incontinence. They also spoke about the school's concerns about Brandon's hygiene and attendance. He commented that Brandon had ADHD and Oppositional Defiance Disorder, and sometimes urinated on the floor and spilled drinks. He said he and Cindy had worked with doctors and teachers, "but nothing changes."

82 The worker attempted to visit Cindy on July 14, but she was not home. The worker left a card.

83 On July 26, the worker spoke to a nurse from Brandon's community medical team. The nurse explained that over the years Brandon had refused to go to school, follow rules, and take medication that might have addressed some of these behaviours. She expressed concern about the lack of follow-through by Brandon's caregivers, and questioned whether they had limited cognitive ability. She noted that they attended a one-day parenting program, but did not follow up on a psychiatric referral for

Brandon. She noted that the medical team was also considering a referral to a mental health care agency.

84 The nurse also spoke of Brandon's incontinence and refusal to bathe, and observed that his odour affected his ability to interact with peers and teachers. She said a psycho-educational assessment for Brandon had not been completed because of his sporadic school attendance. She asked the worker to attend a medical follow-up appointment with Brandon on August 10.

85 The same day, the worker also spoke to a community mental health nurse, who suggested Brandon's psycho-educational assessment could be completed when school resumed in the fall. This nurse also mentioned the pending referral to a mental health care agency and encouraged the CAS to remain involved with the family.

86 On July 27, the worker tried unsuccessfully to reach the family by phone. Her call to Frank went to voicemail, and the numbers she had for Brandon's mother and grandmother were no longer in service.

August 2016

87 The worker wasn't able to connect with Brandon's medical team to arrange to go to his August 10 appointment, but she asked the pediatrician to call her afterwards.

88 On August 12, the worker met with her supervisor for the first consultation since she received the file almost two months earlier. Under the CAS's policy at the time, the timeline for an investigation was 30 days. Under the provincial standards, it is 45 days, or 60 days with supervisor approval. The investigation had been pending for 59 days and the worker had not even seen Brandon. At the meeting, the supervisor approved a departure from the provincial standard for completion of a safety assessment.

89 The worker was finally able to arrange a home visit for August 16, 75 days after the CAS had received the first call from the concerned teacher. It was her first encounter with Brandon, and she observed him to be clean. However, he wouldn't make eye contact or speak to her, and stayed in the living room with his mother and great-uncle. The worker noted that the home was still dirty and smelly, but in better condition than during her last visit. As for the August 10 medical appointment, the family told her they had missed it because they were delayed on a streetcar, and it had to be rescheduled. During a discussion of Brandon's incontinence issues,

Brandon got angry, swore at his mother, ran into the bathroom and slammed the door. Frank also expressed anger about the CAS's involvement in his life.

90 The worker completed a safety assessment after the visit. She scored the situation as "safe" with no interventions required. She also met again with her supervisor and discussed her observations about Brandon and his home environment.

September 2016

91 On September 5, Brandon's paternal grandmother died. He began living full-time with Frank, but the CAS did not learn of this until September 19, when the CAS worker spoke with a nurse from Brandon's medical team. The nurse also reported that the team had finally met with the family and collected a urine sample from Brandon. She said Brandon was clean and co-operative, but Frank expressed feeling overwhelmed by the CAS's involvement. The nurse told the worker that she felt the situation was manageable between the school and the medical team.

92 The worker completed a risk assessment coding the family as high risk, and did not identify any discretionary or overriding considerations mitigating the risks. When our investigators spoke to her, she explained that she rated the risk as "high" because of Brandon's previous involvement with the CAS, his behavioural and developmental challenges, his mother's cognitive challenges and his great-uncle's poverty struggles.

93 On September 20, service providers decided to convert Brandon's behavioural treatment program into sessions for his caregivers, as Brandon had suffered a panic attack during one session and then had refused outright to attend.

94 That same day, the investigation file into Brandon's welfare was closed – 110 days after it was opened, and substantially beyond the provincial standard. The CAS had determined that the allegations of neglect of basic physical needs and risk of harm were not verified. When we interviewed the worker, she told us there were several mitigating factors at the time, including that the family was connected to a medical team and a mental health nurse at Brandon's school. She also observed that the medical team felt that they could adequately manage Brandon's needs with the family, without CAS involvement, and the family was unwilling to work co-operatively with the CAS.

95 When we asked about the delay in completing the investigation, the worker told us that the situation described by those who initially expressed concerns to the CAS in June had improved over the summer.

Fifth CAS investigation – October 2016-March 2017

96 On October 7, just 17 days after it had closed its fourth investigation, a teacher called the CAS reporting concerns about Brandon's hygiene. He smelled of urine and had been wearing the same clothing for a week. She noted that he looked undernourished and refused to participate in class. The CAS launched its fifth investigation to assess whether Brandon's caregivers were neglecting his basic physical needs.

97 On October 14, the file was assigned back to the worker who had most recently dealt with the family. She waited two weeks before taking steps to address the allegation.

98 On October 31, the worker left voicemails with Frank and Cindy. After receiving no responses, she attempted to conduct an unannounced visit, but no one was home. She left a card asking them to call her, then went to Brandon's school. He wouldn't speak with her, but she observed him to be clean. This was only the second time she had seen Brandon in a year. She also talked to the principal, who said there were still concerns about Brandon's behaviour and attendance, but things were better than the year before.

99 The worker completed a safety assessment without interviewing Brandon's caregivers, or seeing his home environment. She scored the situation as "safe" with no intervention required. She reported to her supervisor that Brandon would not speak with her but was clean. She also noted that the school had reported improvements, and that Brandon was taking his medication.

100 The worker later told us that she understood that the safety assessment requires meeting with the child and family and is to be completed within seven days of a case being assigned. This meeting occurred 24 days after the initial call about Brandon was received. She could not explain to us why she waited so long to see Brandon.

November-December 2016

101 On November 7, the CAS received an anonymous report that, the previous day, Frank had fallen in his home and emergency services were called. The caller described Frank and his home as unkempt and expressed concerns about child neglect.

102 The next day, the same CAS worker who had recently assessed the home as safe made an unannounced visit, but found no one at Frank's or Cindy's apartments. She could not reach any of the family for several days. On November 11, her supervisor suggested she contact Brandon's school.

103 On November 14, the worker spoke to the vice-principal, who confirmed Frank had been in hospital for one night but had been home since then. He said Brandon had been upset and worried about his great-uncle.

104 Two weeks later, on November 28, the worker sent letters to Frank and Cindy, asking them to contact her. She received no response.

105 After several weeks without any contact with Brandon's family, the worker spoke with her supervisor on January 6, 2017. They decided to consult with CAS legal staff about applying for a supervision order that would allow them to complete the investigation or apprehend Brandon – whichever would be the least intrusive avenue for the family.

January-February 2017

106 On January 30, the worker consulted with the mental health nurse at the school, who said he was working with Brandon on an individualized behavioural treatment program, but Brandon's poor attendance and his lack of attention and co-operation had prevented them from completing it. He also said he was trying to connect the family with CAMH for counselling and Brandon with the mental health care agency for an assessment. He said Brandon had attended one counselling session at CAMH.

107 On January 31, the worker called both Frank and Cindy. She left a voice mail message for Frank, but was unable to leave one on Cindy's phone. The message to Frank went unreturned. The worker had no contact with the family for the next month. During this time, Brandon also missed two appointments with his pediatrician.

March 2017

108 On March 6, the worker met with her supervisor to discuss the results of the fifth investigation, which had been open for 150 days at that point – more than twice the length established by the provincial standard, and five times the length permitted by the CAS's policy at the time. Even with supervisory approval, the standards only contemplate an extension up to a maximum of 60 days from the date of the referral. The worker and her supervisor determined that the allegation was verified, as both Frank and Cindy had repeatedly demonstrated a lack of follow-through in meeting Brandon's basic physical needs. They decided to apply for a supervision order and the file was transferred for "ongoing service."

Application for supervision order – March-May 2017

109 On March 9, the worker completed a risk assessment, finding Brandon at high risk. Four days later, she spoke with Brandon's pediatrician and a nurse from his community medical team. They told her Brandon's great-uncle and mother had reported that he was still refusing to go to school, follow rules and take his medication. They had attended a one-day parenting program, but frequently forgot medical appointments and missed parent support group meetings.

110 They also said CAMH had seen Brandon two or three times and had made recommendations for him, but there was no evidence of follow-through by the family. When our investigators interviewed the pediatrician, she said her main concern was that Brandon was making no progress on any of his medical, behavioural or mental health issues.

111 On March 20, the worker spoke with the community nurse who had been working with Brandon through his school, who told her he had scheduled assessments for Brandon at a mental health care program, but that the family was unwilling to follow up with counselling at CAMH or with behavioural treatment for Brandon, and that his involvement with the family would end in April.

April 2017

112 On April 26, the vice-principal at Brandon's school reported to the CAS that Brandon, now nine years old, had come into the office, began rocking on a bench and holding his hands towards his genitals, and said: "If you want to help me, get me a knife so I can kill myself, just leave me alone."

He described Brandon as sweating, screaming, and acting out. The vice-principal called Frank, Cindy and emergency medical services, but Brandon was calm by the time they arrived. He also reported similar concerns to the medical professionals about Brandon's lack of progress.

113 The next day the police reported to the CAS that during this incident, Brandon had told the Mobile Crisis Intervention Team that he didn't want to die, but was in pain due to an infection.

May 2017

114 The CAS filed its request for a six-month supervision order in court on May 2, on the basis that Frank had failed to provide adequate care for Brandon and was neglecting him. The application noted Frank's failure to follow through on recommendations to deal with Brandon's behaviour, urinary issues, hygiene, and school attendance. It pointed out that the CAS had not been able to engage the family on a voluntary basis to address these issues.

115 The CAS began the process of transferring the case to a "family service worker" – its normal practice when a child is found in need a protection and ongoing service is required. The primary role of these workers is to support parents to ensure they are making progress and work with them to mitigate identified risks.

116 On May 4, the existing worker spoke with the vice-principal, who had left several messages with the CAS, requesting a case conference. The vice-principal reported that Brandon was struggling in school, and had again made comments about wanting to die.

Supervision order granted – May 2017

117 Frank contested the CAS's application. However, on May 8, the court issued a temporary supervision order, placing Brandon in Frank's care subject to three conditions: Frank had to permit the CAS to meet with him and Brandon twice before the next court date, Brandon had to attend school every day, and Frank had to notify the CAS of any address or phone number change within 24 hours.

118 Despite continuing concerns about Brandon's welfare, the CAS worker had not attempted to meet with him privately for more than six months after her initial visit to his school on October 31. She acknowledged to our

investigators that she understood her role was to try to engage him during that time.

119 On May 15, Brandon's case was assigned to a family service worker. Both the new and previous worker attended a case conference arranged by Brandon's school on May 18. During the conference, it was noted that Brandon had a good relationship with his teacher and the vice-principal; he often went to the vice-principal's office to "unwind." It was also observed that he was connected with a mentor from the Big Brothers Big Sisters program, and always came to school on Fridays to see her.

120 On May 25, Brandon's pediatrician reported to the CAS that Brandon needed urgent mental health support, had kidney damage from withholding his urine, and his family hadn't provided a urine sample in more than six months. She said she was "very concerned" and expressed the opinion that Brandon needed to be placed in a new home. She described his relationship with his mother as destructive – they swore at and hit each other – and causing Brandon emotional damage. She said when Brandon's mother left him alone with her, he "comes out of his shell and is a chatty little boy." The pediatrician also observed that Frank struggled to take care of himself, had been slurring his words in a way that might indicate an issue with alcohol or prescription drugs, and couldn't adequately care for Brandon. She noted that the initial conclusion of the urology department at the Hospital for Sick Children had been that Brandon's problems were emotional, but she had asked them to take another look at his file.

121 After consulting with her supervisor about this report, the new family service worker on the case asked the pediatrician to put her concerns in writing. The family service worker also sought information about CAMH and other programs for Brandon. She also tried unsuccessfully to obtain Frank's consent to attend a mental health care agency appointment with the family.

122 Despite the pediatrician's concerns, however, it was noted in the CAS file on May 31 that Frank was "complying with the supervision order." The family service worker told us that this was because Frank was trying his best to get Brandon to school.

Under supervision – June 2017 to October 2018

123 The new worker's first scheduled visit to Brandon's home took place on June 1. Frank and Cindy were at the apartment, but Brandon was at

school. The worker observed that the apartment was dim and the walls were filthy and covered with fingerprints. There were dirty dishes and food debris in the kitchen. The floors were worn and dirty, and a bed was leaning up against the entrance to the living room. Frank and Cindy said Brandon sometimes slept in his room – the only bedroom – on a mattress, and sometimes on a pull-out couch in the living room. The worker said she was there to introduce herself and discuss the pediatrician's concerns and setting up a school meeting. Frank said he did not see the need for CAS involvement.

124 The new worker did not attempt to meet with Brandon that day. (The previous worker had also not attempted to meet with him privately for the past six months.) When interviewed by our investigators, she told us she never met privately with Brandon, because he refused to talk to her. She noted she had concerns about the apartment immediately. However, given Brandon's age – he was then nine – she considered that this was his environment, and how the family was functioning. She decided to see what she could do to make the environment better, and to help Brandon meet his mental and medical needs. She acknowledged that had he been closer to three years old, she likely would not have left him in the home.

125 After the visit, the worker let her supervisor know the home should be cleaned up, and the family needed to make sure that Brandon's medical and mental health needs were met. The supervisor advised her to contact Brandon's doctors to make sure that he attended appointments.

126 On June 15, the worker had a second visit with the family. Brandon was present, but she did not speak to him. She noted that he was pale and thin, but didn't smell. Frank told her Brandon's medication affected his appetite, and although there was no set routine for dinner, he would snack on whatever he wanted. He also said he couldn't force Brandon to go to school and suggested that he be home-schooled in the mornings.

127 The next day, the worker spoke with Brandon's pediatrician who reiterated her concerns, provided medical notes dating back to 2014, and asked the worker to attend an upcoming urology appointment with Brandon and the family.

128 On June 22, the court extended the supervision order.

July 2017

129 The worker made her third scheduled visit to Brandon's home on July 7. She noted that the apartment was cleaner than before. Brandon was lying on the couch, covered by a blanket and wearing a pull-up, while playing on a tablet and eating noodles from a plastic container. The worker did not speak to him privately. Frank blamed Brandon's poor school attendance on his medication. He asked Brandon during the visit if he would go to school every day, and Brandon said no. The worker emphasized to Frank that structure and routine were important, especially with respect to school.

130 The worker did not attend the Hospital for Sick Children urology appointment scheduled for July 13. When she mentioned it during her visit, Frank became defensive and said he felt monitored by the CAS. The worker told our investigators that she and her supervisor discussed this at length and decided it would not be in Brandon's best interests for her to show up at the appointment, as he might not go through with the scheduled testing. She never spoke directly with anyone at the hospital about Brandon's urological issues.

August 2017

131 Prior to her next visit, the worker discussed with her supervisor the importance of Frank following through with taking Brandon to school in September and with attending medical appointments.

132 On August 11, the worker visited Brandon, Frank and Cindy. Frank said the Hospital for Sick Children urology department had told him "it was all in Brandon's head," and another appointment was scheduled for September. Frank continued to maintain that the CAS's involvement was unwarranted, and he refused to schedule another home visit until after the next court date. He was angry in the worker's presence, raised his voice and talked over her. Cindy also became upset during the visit after the worker referred to Frank as Brandon's parent.

133 Brandon, meanwhile, was lying on the couch in pull-ups, playing a video game on a tablet and eating small icing-sugar-covered donuts from a plastic container. He refused to speak to the worker in private, but would repeat comments she and Frank made in a sarcastic manner. At the end of the visit, Brandon announced that he wanted to say something. He told the worker: "CAS does not need to come to see me – I am fine."

134 On August 21, the court once again extended the supervision order.

September-October 2017

135 On September 1, the family service worker attempted to schedule her fifth home visit. She was unsuccessful and ultimately did not visit again until September 28. She requested a departure from the 30-day standard required by the provincial standard on September 14, citing jury duty as the reason.

136 At the September 28 visit, Brandon did not respond to most of the worker's questions, except when Frank told him to. Frank said Brandon had attended school every day and had no counselling appointments scheduled.

137 On October 18, the worker confirmed with the vice-principal that Brandon was attending school. The vice-principal said Brandon had trouble connecting with peers, and they were considering engaging an education consultant about managing his behaviour.

138 The worker made her sixth home visit on October 27, and noted that the apartment smelled stale and needed a thorough scrubbing. Brandon again refused to speak with her.

November-December 2017

139 On November 13, a school psychologist left a message for the worker, inquiring about supports and saying Brandon was having difficulty managing his behaviour. The next day, the worker confirmed the family was starting counselling at CAMH.

140 Two days later, the CAS received an anonymous report that Frank smelled of alcohol, the family home was filthy, and that Brandon's mother screamed and swore at him. The caller stated that if something wasn't done, they would inform the media.

141 The worker consulted with her supervisor and they agreed that these allegations were similar to those they were already addressing and did not require an investigation. The worker was going on holidays, and her supervisor agreed to assign another worker to follow up with the family. However, this did not happen – no follow-up was done until the assigned worker returned from vacation at the end of the month.

142 In the interim, the anonymous caller contacted the CAS again. He said he had been told there would be an investigation, but the child was still living in the apartment. He threatened to go to his Member of Provincial Parliament and speak publicly on social media.

143 On November 29, the worker conducted her seventh home visit. She again observed that the home needed cleaning. Brandon was present but refused to come out of the bedroom and talk to her. Frank denied the anonymous caller's allegations. He said Brandon had been attending school, but had a hard time going back after lunch. There was no further follow-up on the anonymous call.

144 When we spoke to this worker, she said she was aware there were frequent allegations about Frank having a drinking problem, but she never found him to seem intoxicated or smell of liquor, and she saw no evidence of excess drinking in the home. She noted that she never considered making an unannounced visit. While she observed that she would usually also speak to the child rather than rely on family assurances, she explained that she knew Brandon would not speak with her. Her supervisor told us the drinking allegation didn't seem to worry the family service worker, so it didn't worry him.

145 No formal home visit took place in December, although on December 8, the worker dropped off a Christmas gift for Brandon and food vouchers for the family. Her supervisor also approved payment for a new bed for Brandon.

January 2018

146 At her eighth home visit on January 5, the worker noted that Brandon's home was "significantly dirty." She found Brandon sitting on a table in the bedroom, naked and covered in a blanket, playing a video game. There were used pull-ups strewn about the room. Brandon would not talk to her, but Frank explained that they hadn't cleaned because they all had the flu.

147 That same day, the worker asked her supervisor to approve a departure from the standard requiring that she meet privately with Brandon, as he had repeatedly refused to speak with her.

148 On January 8, the court issued a final supervision order, finding that Brandon was a child in need of protection and placing him with Frank. There were several conditions attached to the order, including:

- Frank and Cindy had to work co-operatively with the CAS, including meetings at least once a month;
- Frank had to permit the CAS worker to visit his home both on an announced and unannounced basis and to meet privately with Brandon;
- Frank had to make best efforts to ensure Brandon's daily and timely attendance at school, address his hygiene needs (including working with the CAS to establish a hygiene routine), and ensure that Brandon took his medication; and
- Frank had to make sure that Brandon attended scheduled medical or therapeutic appointments, and to follow the reasonable recommendations of service providers.

149 On January 11, the vice-principal of Brandon's school told the worker Brandon's performance was suffering because of his frequent lateness. He also said Brandon was engaging in destructive behavior, and required constant one-on-one supervision. The worker said she would speak with Frank.

150 When she reached Frank, he said the apartment was scheduled to be fumigated for a bedbug infestation, and asked that the CAS not deliver Brandon's new bed until February.

151 On January 22, the worker went to a meeting at Brandon's school with teachers, two vice-principals, consultants, the board psychologist and a social worker. Frank did not attend, as he had taken Brandon to a urology appointment. At the meeting, it was noted that Brandon was disruptive when his teacher wasn't present, had made no improvement academically, and was working at a Grade 1 level in Grade 4. As for mental health services, it was noted that Brandon would not engage with CAMH or the services of a mental health care provider.

152 After the meeting, the worker made several inquiries and learned that the family had begun attending sessions at CAMH in January, however, when Brandon attended the parenting sessions, he was disruptive and refused to leave.

February 2018

153 When the worker made her ninth home visit on February 1, the apartment was being prepared for fumigation. She observed that it needed cleaning.

She greeted Brandon and asked if he wanted to talk in private, but he did not acknowledge her. He had pinkeye, which was being treated. Frank acknowledged forgetting a CAMH appointment in January, and noted that he had been updated on the school meeting and had signed papers relating to Brandon's learning.

154 On February 5, the worker's supervisor approved another departure from the standard requiring a private interview with Brandon, and on February 6, after discussing the case with the worker, the supervisor noted on the file: "While there remain many challenges with Brandon's behaviour…, Frank is working hard with CAMH, CAS and the school to ensure that his needs are met."

155 Over the next few days, a counsellor from the CAMH program told the worker that it was not working out, because Brandon was refusing to engage. Their weekly meetings had turned into monthly meetings, and there were none at all from August to October. The counsellor referred the worker to another program at a community children's mental health centre. As well, Brandon's pediatrician reported that she was still waiting for the urine sample she had been asking for since November.

156 The worker conducted a tenth home visit on February 20. Brandon did not acknowledge her.

March-April 2018

157 In early March, the worker requested an update from Brandon's pediatrician. She responded that she was concerned about Brandon and the family had not made much "headway." Several days later, the worker visited the home for the 11th time. Brandon refused to meet with her privately. Frank responded to her questions about the pediatrician's repeated request for a urine sample by saying it was unnecessary, because the Hospital for Sick Children urology department had deemed Brandon's problems behavioural. The worker emphasized that the pediatrician needed the sample. However, she took no additional steps on this matter. Her supervisor later approved her request for another departure from the standard requiring a private interview with Brandon.

158 On March 28, the worker made her 12th visit to Frank's apartment, this time with a representative from a cleaning program, who provided an estimate for cleaning services. She also raised concerns about Brandon's school attendance, to which Cindy responded that he thought school was

boring. Frank consented to having Brandon attend a treatment program at a community mental health centre in the fall.

159 In early April, the court extended the CAS's supervision order. The worker visited again on April 5, and again Brandon did not acknowledge her. A few weeks later, Brandon's vice-principal told her he was concerned that Frank had not agreed to place Brandon in a specialized classroom for the upcoming school year.

160 On April 27, the worker's supervisor granted a departure from the monthly in-home visit standard, as the worker was going on vacation. They agreed not to send a substitute during her absence, as Brandon wasn't prepared to talk to anyone.

May-June 2018

161 In mid-May, Brandon's pediatrician alerted the CAS to her concerns about Brandon's still-outstanding urine sample and potential damage to his kidneys. She said she was ordering an ultrasound test for Brandon and also requested the worker's help in getting Brandon and his family into programs at CAMH. The vice-principal also expressed concern to the worker about a lack of progress on Brandon's issues.

162 The next home visit was delayed (and a departure from the standard approved) because the worker had a personal appointment, but she and her supervisor met to discuss Brandon's case on May 28. The supervisor wrote in his notes after the meeting: "Despite the challenges, Brandon is best in the care of his uncle. At least with Frank he's able to maintain a relationship with his family. We will continue to try to encourage Frank to access as much service and support for Brandon both at school and at home."

163 The family service worker made her 14th visit to the home on May 31. She described it as "unkempt." Brandon refused to talk with her, and although the urine sample was discussed, no plan was created to ensure that Frank followed up. The worker later commented to our investigators that, in retrospect, this was "a huge oversight on my part."

164 In early June, the worker's supervisor again approved the now-routine request for a departure from the standard requiring a private meeting with Brandon. The worker spoke to the vice-principal about Frank's objection to sending Brandon to a specialized class (he felt busing him away from his regular school would be too difficult). She noted that Frank did agree for

Brandon to attend a mental health program – but it is not clear if she ever sent in an application for that program.

165 The worker's 15th home visit was on June 28. She noted that it was dusty and dirty. Brandon refused to speak with her, and Frank again refused the offer of a bed for Brandon, saying the home had to be fumigated once more for a bedbug infestation.

July-August 2018

166 On July 9, a public health inspector received an urgent request from Toronto Community Housing regarding Frank's apartment. The inspector and other officials visited the home that day. The inspector's findings included a litany of filthy conditions in every room, as well as the presence of bedbugs. The inspection report noted that the clutter – including garbage, unwashed dishes, dirty laundry, food waste, soiled cat litter and pull-up diapers – would have to be removed before they could deal with the bedbugs.

167 The inspector told the worker the infestation was due to the poor maintenance of the home, which she observed bordered on a health hazard for Brandon. She said she would have issued a health hazard order if Frank and the landlord had not co-operated about getting the unit cleaned up. She stressed there would have to be follow-up at Cindy's home to stop re-infestation, since bedbugs were being transported between the two apartments.

168 The inspector also noted to the worker that Brandon had asthma and his mother smoked in the apartment, he slept with Frank, and he looked malnourished.

169 Concerned by the inspector's comments, the worker spoke with Frank that day. Frank responded that things "just got away" from him, and that the real problem was that the family was underhoused. He also said Brandon was upset, angry, and felt no one loved him. The worker told Frank that Brandon needed counselling.

170 On July 17, the worker, public health inspector and the cleaning vendor went to Frank's home, and found him defensive. The home was cluttered and dirty, but Frank was unwilling to dispose of any items. Brandon hadn't bathed for a week. The worker said she would request approval to pay for the cost of cleaning the apartment. Frank said they needed a larger

apartment, but they had been on a waiting list for a transfer to a two-bedroom unit for seven years.

171 Brandon again refused to talk to the worker, which she described as "typical," and her supervisor agreed to another departure from the standard. When asked about this by our investigators, the worker explained that she was well aware of the standard, but Brandon always refused to speak with her. She acknowledged that she did not attempt to see him at school and that she and her supervisor never discussed strategies to engage him.

172 The CAS had agreed to purchase a bed for Brandon in February, but the bedbug situation hampered that effort. In August, Brandon was sleeping on two couch cushions. The CAS again agreed to purchase a bed.

173 In mid-August, the worker requested a departure from the monthly visit requirement. The supervisor told us this was granted because the home environment appeared to be improving and plans were in place to assist the family in keeping their home safe and clean. However, on August 16, a public health inspector reported to the worker that she had gone to the apartment – believing they had a scheduled meeting there – and Frank refused to let her in. She reported that she could see from the hallway that the home was filthy and the family hadn't followed the strict instructions regarding pest control. In her view, the living conditions were unacceptable and it was her duty to report this to the CAS.

174 The worker called Frank, who denied the inspector's observations. Ultimately, there was no follow-up, as the worker went on an extended leave on August 21. The public health inspector emailed the worker for an update on August 27. She closed her file in November, having received no response.

September 2018

175 The worker's supervisor approved a departure from the monthly visit standard in early September, noting that it didn't make sense to send a replacement while she was on leave. No one was officially assigned the file again for almost a month. However, in mid-September, a new worker was advised that she would be taking over the file. As she familiarized herself with the case, the new worker had some challenges. For instance, the formal six-month reviews hadn't been completed for 11 months.

176 On September 28, she called Brandon's school for an update prior to her official assignment. The principal told her Brandon was attending school, but usually arrived late, regularly wore the same clothes to school, and recently came to her office complaining that his stomach hurt. She observed that Frank appeared very loving and caring towards Brandon, but she believed Brandon worried about his home situation. She questioned whether Brandon had enough to eat at lunch, and agreed with the worker to enroll him in the school's hot lunch program free of charge.

177 The worker also left an introductory voicemail message for Frank and contacted community housing. She learned his unit had been treated for bedbugs on August 15, 22, and September 26, and a follow-up inspection was pending. A cleaning service had been contracted, but the cleaning had not yet been done because the home was still not pest-free. There was concern that Brandon's mother might be bringing bedbugs into the home from her own apartment. It was also noted that a public health nurse felt the home was "unlivable."

October 2018

178 On October 1, the new worker was officially assigned to Brandon's file, and she spoke to Frank that day. He said Brandon had slept in and hadn't yet gone to school. When she told him she had arranged for Brandon to be enrolled in the hot lunch program, Frank responded that Brandon didn't like to eat at school, and his medication for his ADHD interfered with his appetite. Frank also said he was recovering from surgery and that Brandon's mother had been helping out. He confirmed that the unit had been sprayed for bugs a few times and needed to be done again.

179 The worker also checked with the community children's mental health program that had been suggested for Brandon (it was ultimately determined not to be a good fit), and spoke with the Canadian National Institute for the Blind (CNIB) about its parenting programs. The CNIB said it had already sent information to the CAS but received no response; the worker completed a referral for the program that day.

180 On October 4, the worker paid her first visit to the family's apartment. She noted that the volume on the television was very loud and she had to knock three times before Frank answered the door. She noted a strong odour. When Brandon arrived with his mother, the worker attempted to speak alone with him, but he refused. He appeared clean and dressed in appropriate clothing, and seemed shy, small for his age, and very thin. She gave him a model helicopter to make over the weekend.

181 The worker also observed that the home smelled musty and smoky, the walls and floors were dirty, the kitchen was cluttered and there were dirty dishes in the sink, and there were small dead bugs on the coffee table. There were also garbage bags full of household items, and the sheets on the futon were stained and extremely dirty. The only bedroom was being used as a storage area and Brandon and Frank were sleeping together on the futon in the living room. Frank said that public health had put his items in bags and never returned to pick them up. He again rejected the offer of a new bed, saying he would have to throw it away because of the bedbugs. The worker offered to find someone who could pick Brandon up for school in the mornings.

182 On October 10, the worker spoke to a supervisor at CAMH, who told her the family had attended seven sessions from January to June, and then one in September, but Brandon was not participating. The CAMH supervisor felt the family wasn't making progress, as Brandon would not participate and Frank seemed overwhelmed. However, she suggested ongoing grief counselling for the death of Brandon's grandmother.

183 On October 15, the worker discussed her concerns about Brandon's nutrition and the condition of Brandon's home with a CAS supervisor. The supervisor instructed her to continue to work with the family, and suggested she buy Brandon a "bed in a bag" (bedding and pillows) and some canned nutritional drinks.

184 Brandon's school principal spoke to the worker on October 17, raising numerous concerns. Brandon had been late 34 times since the start of school on September 4, and absent 9.5 days. Frank had refused consent to get Brandon a psychological assessment. Because he wasn't at school during the hot lunch program and complained of stomach pains, the principal worried he was not getting enough to eat. He habitually wore the same clothes every day, and smelled of body odour. Although he was in Grade 5, he was still working at a Grade 1 level in all subjects. The worker and the principal decided the principal should meet with Frank to relay her concerns firsthand.

185 The worker also spoke with community housing officials about the condition of Frank's apartment, and discussed possibly relocating Frank to another building with more supports.

186 The CAS and the family returned to court on October 17, where the judge expressed concern about Brandon's health, school, and the cleanliness of the home. He asked Frank to follow through, and the CAS to demonstrate

that progress had been made on the identified issues. The worker also spoke with Frank and Cindy about her concerns, and reminded Frank that he needed to ensure that Brandon attended school on time and for the full day, every day.

187 On October 19, Brandon's principal told the worker Brandon had been to her office several times, complaining of stomach pain, and was arriving at school in clothing inappropriate for the weather. They decided to schedule a meeting with Frank at the school for the following Monday, October 22. The worker also left a voicemail for Brandon's pediatrician, inquiring about his overall health.

Monday, October 22 – The Apprehension

188 On Monday, October 22, the worker met with the principal in the morning at Brandon's school. Frank did not show up for the scheduled meeting. When the worker and principal called him on speakerphone, he sounded frantic. Brandon was refusing to get up and complaining of stomach pains. Frank didn't know if he had eaten the night before. The principal expressed concern about Brandon not getting enough to eat and missing the hot lunch program, but Frank refused to set another meeting – and hung up on them.

189 The worker and principal decided to walk the short distance from the school to the family's home to offer assistance. When they arrived, the television was on so loud, they could hear it from the elevator. They had to bang on the door to get a response.

190 Both were extremely concerned by the state of the home when they finally gained entry. The worker described the scene to us in detail:

> So, we walked in and the place was in complete disarray… it was garbage everywhere, more so than when I had been there the time before. Soiled pull-ups throughout the floor. Feces on the floor. There was a litter box in the kitchen for the cats and clearly this litter box had not been changed in some time. … There was again that strange odour and I could see Brandon lying on the futon, which is in the main living area … curled up … facing the wall. And he looked quite grey to me. … I was quite alarmed at what I saw. … In the moment, I was overwhelmed.

191 The principal told us Brandon was "white as a ghost… and catatonic." When she tried to talk to Brandon, he didn't respond. His hair was greasy.

He smelled of body odour and the sheets where he was lying were completely soiled.

192 Frank claimed that Brandon was fine and his behaviour was not unusual. He called Cindy, who arrived minutes later. Cindy said Brandon had been fine the night before and had eaten, although he had complained about pain in his side.

193 Emergency services were called, and two paramedics and two police officers arrived. At one point, when the paramedics were going to test Brandon's blood sugar, he began yelling and swearing, and turned the television volume higher. An officer asked Frank and Cindy to intervene, but they did nothing. The paramedics eventually unplugged the television and managed to complete their assessment.

194 The two officers described the scene in detail to our investigators, noting the overwhelming smell of cigarette smoke and cat feces, Brandon's stained futon and bedding, the dirty walls and floors, and the soiled diapers strewn about. One noted the presence of cockroaches, alive and dead – "as if someone would step on them and not clean it up." The other said the home's filthy state was disturbing: "I go to a lot of homes that aren't exactly clean and I have never seen [a] standard of living this horrible for a child."

195 The officers told us that the paramedics suggested taking Brandon to the hospital, but Cindy said he had been there the previous week and there was nothing wrong with him. Frank consented to the hospital trip, but upon hearing this, Brandon picked up a baseball and threw it at those in the room. This in turn led to Cindy yelling and swearing at Brandon, resulting in Brandon crawling in panic between some boxes and the futon, screaming and throwing whatever he could reach.

196 The CAS worker told us: "And this is all occurring while the police officers were all there and the paramedics…. So I thought to myself, you know, what is life like when nobody is here?"

197 One of the officers told us that given his visual impairment, Frank didn't seem to understand what was happening. Cindy made herself a sandwich and commented on the fact that there was food in the house and Brandon was not starving. It took the efforts of both paramedics and the police officers to subdue Brandon and strap him onto a stretcher. According to the CAS worker and the principal, Frank went to the bathroom and returned smelling of cannabis before getting into the ambulance with Brandon.

Apprehension about apprehension

198 The CAS worker discussed the situation with the supervisor on duty at the CAS. She reported that the family was not providing a safe environment for Brandon, and requested permission to apprehend him, as she felt that Brandon was at immediate risk. The supervisor told her the CAS would not apprehend Brandon, as they were working with the family, there was a supervision order, and they had no reason to believe the family was not looking out for Brandon's best interests..

199 When they heard the CAS would not apprehend Brandon, one of the police officers asked their supervisor to meet them at the hospital. As one told us: "There was no way we were leaving him in that home. Period."

200 Before arriving at the hospital, the worker called the supervisor again to update her and repeat her concern about not apprehending Brandon.

At the hospital

201 Brandon's mood changed once he was at the hospital. He was talkative and smiling. He was very hungry and ate a significant amount. At one point, Cindy called 911, claiming that she was a caregiver and didn't want the doctors examining her child.

202 The police supervisor spoke to the officers and the CAS worker at the hospital, and told the worker that police would apprehend Brandon. He told our investigators that this decision was based on the state of the apartment and Brandon's condition. He relayed this information to the CAS supervisor on duty, and was told the CAS was not apprehending Brandon because the family was working with them to address the concerns and there was a supervision order in place.

203 When our investigators interviewed the CAS supervisor, she told us she did not want to make a decision on apprehending Brandon until he had been examined at the hospital. There is no contemporaneous case note confirming this rationale for not approving Brandon's apprehension. Neither the CAS worker nor police recalled the supervisor conveying this information.

204 The supervisor also told us that the police officers might have been understandably shocked because they were seeing the home for the first

time, “but I was coming from a point of view where …we’d had ongoing involvement with this family.” She explained that she didn’t want to be in a position where the CAS prematurely apprehended Brandon, only for the court to return him days later. She noted that the family had been in court just five days before, where the judge had presumably been updated on the family’s situation and could have easily ordered Brandon into care, if warranted.

Reaction to the apprehension

205 The CAS worker told us that when Frank was told that the police were apprehending Brandon – and that the CAS would work with him to clean up his home – Cindy became extremely agitated. She said Cindy had already been “completely deregulated… yelling and screaming,” and this news led to her punching herself and threatening suicide. Security guards were called to monitor her.

206 The attending physician informed the worker that Brandon was malnourished and almost anemic, with a low red blood cell count and low hemoglobin. He was 15 pounds underweight for his age and height, and had an enlarged kidney. An appointment was booked for the pediatric clinic the next day.

207 Brandon became hysterical when he learned he was not returning home. The police officers recalled that he told them his mother had said bad things happen to boys in foster homes. They carried Brandon out of the hospital to the worker’s car and strapped him in a car seat, and one officer sat with him in the back seat while they travelled to the foster home. Brandon was placed with a couple who had experience caring for children with trauma and developmental delays.

The aftermath

208 The day after the apprehension, the CAS worker met with Brandon at a hospital pediatric clinic, along with Frank, Cindy and the foster parents. She noted that he was clean, full of energy, vibrant and happy. He was engaging with his foster parents, smiling and interacting well with Cindy and Frank. However, Cindy and Frank were angry with the worker, and Frank yelled at a medical student who inquired about Brandon’s medical history.

209 The attending physician at the clinic reported that Brandon's bowels were severely backed up, causing pain and loss of appetite. A urine sample, obtained by Brandon's foster father, revealed that he was also suffering from a kidney infection. The same day, Brandon's pediatrician also told the worker that she had been worried about Brandon's health and safety for a long time. She said Brandon had kidney scarring from withholding urine and bowel movements, which might lead to dialysis and could be life threatening. She said she had told Cindy and Frank this several times. She thanked the worker for essentially saving Brandon's life.

210 On October 24, Frank and Cindy went to Brandon's school. The principal told us that Frank smelled of alcohol and appeared dishevelled, and tried to "intimidate" her by threatening legal action. She called the CAS to report this and was told by a CAS supervisor that they planned to recommend that Brandon be returned to Frank's care in a few days. The principal told the supervisor she would send her concerns in writing. She told our investigators that she feared Brandon would die if he were returned to the family home. She said she did not want him to be "taken in a body bag the next time that this happens."

211 On October 25, the principal provided further information to the CAS, writing, in part:

> I wish to express my extreme concerns for the safety of Brandon if he is put back into the care of … his great-uncle. I have been observing Brandon at my school over the last six weeks and have had grave concerns about his gaunt state, constant hunger, lethargy during the school day, lack of cleanliness and hygiene and his frequent absences from school. I have expressed these concerns to his worker on a multitude of occasions….

212 The CAS supervisor responded by phone and told the principal the CAS would likely recommend that Brandon not be returned to Frank after all. The CAS filed for a court order to have Brandon placed in its temporary care and custody, referencing the events of the past two months.

213 The police officers who had been present when Brandon was apprehended made a point of attending court for the CAS's motion on October 26, but were not allowed into the closed proceeding.

214 The court placed Brandon in the temporary care and custody of the CAS, and adjourned the matter to November 20. The judge observed that this would give Frank time to clean his apartment, while Brandon remained with the foster family.

215 The CAS assigned a new family service worker to the family, and the previous worker continued to act as a children's services worker on Brandon's behalf. Over the next few weeks, the CAS was still working towards reuniting the family, however, an assessment prepared by the children's services worker in mid-November rated the risk of this as "very high."

216 On December 21, Brandon was assessed by a psychiatrist, who found him to be severely traumatized. He recommended that Cindy and Frank not attend appointments with Brandon. Both Cindy and Frank maintained that Brandon's health was fine before he came into CAS care, and that the situation had been orchestrated to remove Brandon from them. They continued to have weekly access visits with Brandon.

217 Our investigators first met with Brandon's foster parents in April 2019. They told us that during the first six months in their care, Brandon's hygiene had improved and he had undergone re-toileting training. His appetite was good and he had gained weight. They had attended to his dental and medical needs, including multiple visits to address kidney, bladder and constipation issues, and surgery to provide relief from the painful urination that had plagued Brandon for years, related to urine retention. They were also working with the CAS to arrange mental health counselling and an occupational therapist for Brandon. Brandon was regularly attending school, and his skills and marks had progressed. His foster mother told us he had transformed "from a kid who didn't want to live, to a kid who loves to live."

218 On November 18, 2020, the court ordered that Brandon be placed in extended CAS care, where he has remained. His mother and great-uncle continue to have access rights.

Failing to meet the Child Protection Standards

219 Brandon's story might have been very different if police had not apprehended him for his protection on October 22, 2018. His physical pain and trauma might also have been relieved much sooner if the CAS had intervened more swiftly to address his situation. Brandon was not the victim of deliberate abuse, and the records reflect that he had a close relationship with his mother and great-uncle. However, Cindy was not a suitable caregiver, and as time passed, Frank's capacity to care for Brandon became severely compromised. Cindy and Frank clearly demonstrated that they were unable to follow through on the

recommendations related to Brandon's medical and educational needs. Despite all this, the CAS labeled the family as co-operative and permitted Brandon to live in chronically neglectful conditions.

220 The Ontario Child Protection Standards were established to guide children's aid societies and help promote consistently high quality service delivery and ensure that the focus of care is on the best interests of the child. Unfortunately, in Brandon's case the CAS repeatedly failed to fulfill key requirements established by these standards.

Timely investigations and safety assessments

221 The regulations under the *Child, Youth and Family Services Act, 2017* provide that children's aid societies must ensure that when investigations are undertaken, certain investigative steps are completed in accordance with the Ontario Child Protection Standards.[16] For instance, safety assessments must be conducted at the time of the first meeting with a child and this must occur within the response time. The Ontario Child Protection Standards recognize that timely commencement and completion of child protection investigations and safety assessments is critically important. In accordance with Standard 3, safety assessments must be completed within seven days, when there is no immediate threat identified.[17] According to Standard 5, investigations should conclude within 45 days – or 60 days in certain circumstances, but only with supervisor approval.[18] The CAS's own policy at the time required that investigations be completed within 30 days. In Brandon's case, the CAS fell below these standards on several occasions.

222 On December 31, 2015, police first reported to the CAS that they were concerned about the cleanliness of the home and that it was not suitable for a child. This triggered an investigation. The CAS set a response time of seven days and assigned an investigator five days later. However, the CAS worker's first attempt to reach Frank was an unanswered call on January 6, 2016. The next day, the worker learned that Frank had suffered a heart attack. It was unclear where Brandon was staying, and the worker did not reach Cindy when she made an unannounced visit to her home on January 8. Even though the worker had no idea of Brandon's whereabouts, there was no attempt to meet with him at school. The first

[16] O Reg 206/00, s 3; O Reg 156/18, s 31.
[17] Ontario Child Protection Standards, *supra* note 2 at 48.
[18] *Ibid* at 63.

contact with the family didn't happen until Frank called the worker on January 11, and the first home visit was January 14. This was two weeks after the CAS had received the police referral.

223 The worker also did not conduct a safety assessment until January 14, over a week beyond the prescribed standard. She told our investigators that she was aware of the expectation that efforts be made to see the family within seven days.

224 When the CAS received the first of several reports from school officials about Brandon's hygiene, behaviours, and attendance on June 2, 2016, it was once again slow to act. The file wasn't assigned to a worker for investigation until June 14, 12 days beyond the seven-day response time required by Standard 1. The worker didn't attempt to contact Brandon until two weeks later, June 23. After several failed attempts to reach him at school, her first actual meeting with Brandon was on August 16 – 75 days after the CAS received the initial call about his welfare.

225 Although a supervisor noted in a contact log that the safety assessment and start of the investigation were not in compliance with the standard, a departure from the standard was not actually requested until August 12, more than two months after the CAS received the referral. The investigation itself was not closed until September 20, 2016 – 110 days after it was opened, and well beyond the limit set by Standard 5 and the CAS's own policy. There was no formal approval for this departure from the standard or any documented explanation for this delay.

226 On October 7, 2016, the CAS received a new referral from Brandon's school. It assigned the file on October 14 to the same worker who had conducted the previous investigation. The worker only attempted to complete a safety assessment on October 31 – 24 days after the CAS received the referral, and well beyond the time frame established by Standard 3. The worker told our investigators that she understood the meeting with Brandon and his family should have occurred within seven days, but could not explain the delay. It was not until March 6, 2017, that the CAS determined that the allegation was verified. By that point, the investigation had continued for 150 days – more than double the length provided for in Standard 5, and well beyond any time allowed for a departure from the standard.

227 A sense of complacency rather than urgency appears to underscore these three investigations – from the initial delay in assigning the cases for investigation, to delays in meeting with Brandon and his family, to delays in completing the investigations. The lack of timely response does not

necessarily reflect lack of awareness of the requirements of the standards and the CAS's own policy. The workers who conducted the investigations told us they knew they should make efforts to meet with a child and family within the seven-day response period. However, there was no overriding drive to meet that expectation. The critically important step of promptly seeing a child and assessing their safety took a back seat to matters of expediency. To avoid similar delays in the future, the CAS should direct staff to ensure that safety assessments and investigations are commenced and completed in accordance with the regulatory requirements, the Ontario Child Protection Standards, and its own policy.

Recommendation 1
The Children's Aid Society of Toronto should direct staff to comply with regulatory requirements, Standards 1, 3 and 5 of the Ontario Child Protection Standards, and its own policy regarding timely commencement and completion of investigations and safety assessments.

Investigating new referrals

228 Standard 7 provides that when a children's aid society receives a new referral unrelated to an incident or condition for which a family is already receiving service, Standard 1 applies. In such circumstances, Standard 1 requires a separate assessment and determination of the appropriate disposition of the referral. If it relates to a known incident or condition, there is no new investigation, but the worker should discuss it with the family at the next possible opportunity.

229 The Children's Aid Society of Toronto received several referrals about Brandon that it did not consider new or warranting additional assessment under Standard 1. Its response to a series of referrals received in 2017 appears to have fallen below the level of service contemplated by the standards.

230 On April 26, 2017, while the CAS was investigating the issue referred by Brandon's school regarding his hygiene and attendance, it received another referral from the vice-principal regarding Brandon's mental health and an incident of suicidal ideation. There is no record of any follow-up with the family or attempt to interview Brandon after this incident.

231 A month later, Brandon's pediatrician told a CAS worker that there was evidence that Brandon had kidney damage and was in urgent need of

mental health support as well as another placement option. She also said Frank had been slurring his words. It does not appear that there was any substantive follow-up on these allegations.

232 The CAS received yet another referral on November 15, 2017, from an anonymous caller who reported concerns about Frank's alcohol use, the state of Brandon's home, and his mother's conduct towards him. The worker and her supervisor determined that these concerns were similar to those the CAS was already aware of, and therefore did not require investigation. The supervisor told us that in the wake of this call, he had assigned a worker to visit the family's home while the regular worker was on vacation. However, there is no record of this visit, or any discussion of the situation with Frank until November 29, 2017, some two weeks after the anonymous report.

233 All three of these referrals appear to have raised new concerns about Brandon's mental health and about Frank's ability to care for him. The vice-principal's referral should have prompted consideration of another child protection investigation. The pediatrician's concerns that Frank might be impaired were not addressed. Finally, the CAS should have acted in a timely manner to address the serious allegations in the anonymous call.

234 In keeping with Standard 7, CAS staff should carefully consider referrals received during ongoing case management and ensure that they are acted upon promptly, including through consideration of a separate investigation, if warranted.

Recommendation 2
The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards regarding assessment of referrals received during ongoing case management.

Conducting interviews in private

235 According to Standard 2 and the accompanying practice notes, interviews during investigations should be conducted individually with family members, including affected children. This makes sense for several reasons. It allows witnesses the opportunity to speak frankly and mitigates the risk that the presence of others will influence their evidence. It also limits their ability to tailor their evidence and assists workers in assessing witnesses' credibility.

236 In the CAS's investigations about Brandon's welfare, workers routinely interviewed the family as a group rather than individually, and made little effort to interview Brandon outside of the home. On January 14, 2016, the worker met with Cindy, Frank and Brandon to investigate the police referral regarding the situation at Cindy's apartment and the state of Frank's home. During the investigation of the June 2, 2016 school complaint relating to Brandon's hygiene, behaviour and attendance, the first time that the worker saw Brandon was August 16, 2016, two months after the investigation began. She discussed the situation with Cindy, Frank and Brandon together, later noting that Brandon refused to make eye contact or answer any questions.

237 The CAS's failure to follow Standard 2 and its practice of interviewing family members collectively during several investigations may well have compromised the reliability of the information it gathered. It should remind staff of the importance of conducting private interviews. It should also ensure that staff explore alternatives to doing interviews in the home, particularly with children, when it would allow for greater privacy and openness.

Recommendation 3
The Children's Aid Society of Toronto should direct staff to comply with Standard 2 of the Ontario Child Protection Standards regarding interviewing family members in private.

Recommendation 4
The Children's Aid Society of Toronto should direct staff to consider interviewing family members, particularly children, in settings outside the home if it would allow for privacy and encourage more open communication.

Focus on the child: Katelynn's Principle

238 Katelynn Sampson, 7, died tragically in 2008 at the hands of her guardians. The inquest into her death revealed that she had never been interviewed privately while child protection services were provided or during family court proceedings. The inquest jury's first recommendation became known as "Katelynn's Principle." It states that children must be at the centre when they are receiving services through the child welfare, justice, and education systems. The *Child, Youth and Family Services Act, 2017* and the Ontario Child Protection Standards reflect this principle. Standard 7 requires that children receiving ongoing service are to be

interviewed privately every 30 days. In Brandon's case, workers habitually failed to meet with him in private, and supervisors routinely approved departures from the standard, with the usual reason being that Brandon refused to speak to a worker.

239 The worker assigned to the October 2016 investigation met with Brandon at school on October 31, but he was not responsive to her attempts to engage him. She did not attempt to meet again with him privately for the more than six months that she remained assigned to the case. After the file was transferred to ongoing services in May 2017, the new worker completed six home visits, but never met with Brandon privately. There is no documentation confirming whether these failures to meet the standard were approved by a supervisor, or what reasons were given.

240 On January 5, 2018, a worker requested a departure from the requirement for a private interview with Brandon, but it is unclear if this was approved or not. The worker did not meet with Brandon during home visits in April, June and July, and no one met with him or the family between July 18 and October 2018.

241 In our interviews with the CAS workers, they emphasized that Brandon refused to speak with them. The supervisor we interviewed confirmed that he regularly approved departures from the standard on this basis. He told us he didn't recall whether he discussed alternative strategies with workers to get around this issue, but he observed, in hindsight:

> We know how important the children's voice is. It's Katelynn's Principle. And despite Brandon refusing to meet with [a worker] and [her] having a lot of experience with kids, that would be the moment to pause. It's hard to know exactly how Brandon's voice was heard in this case.

242 Brandon was not an infant or non-verbal. His pediatrician commented that he was more talkative when she met with him alone and he had forged relationships with several school officials. The CAS should have at least attempted different strategies to encourage Brandon to meet privately with workers, including in alternative settings. There was little genuine effort demonstrated to develop trust and connect with Brandon on an individual basis, which severely limited the CAS's insight into his circumstances. It relied heavily on comments from his mother and great-uncle about his conduct, preferences and feelings.

243 Frank and Cindy were strong influences in Brandon's life. It is reasonable to presume that their presence would affect how Brandon perceived and

interacted with CAS workers. Frank and Cindy often expressed anger and frustration about the CAS's involvement, and it is understandable that Brandon may have been apprehensive about speaking with workers in their presence.

244 One of the workers told us that in the year she dealt with the family, she never had a conversation with Brandon, not even a sentence. She always saw him in the company of his caregivers and never attempted to meet with him at school or try other approaches. She said Brandon was scared of her and suggested that Frank and Cindy had told him the CAS was there to take him away. Ultimately, on December 21, 2018, a psychiatrist found that Brandon was severely traumatized and recommended his mother and great-uncle not attend sessions with him.

245 The standard requiring private interviews with children was established for a sound reason – to ensure that children's voices are heard. Brandon was resistant to speaking with CAS workers, and the failure to interview him in private took place over several years, over the course of several investigations and the involvement of successive workers and supervisors. Rather than routinely granting departures from the standard, the CAS should have made efforts to develop and apply alternative strategies to establish a rapport with Brandon and encourage him to speak freely. It should direct staff to comply with the standard, and ensure that they are adequately trained in methods and strategies for overcoming children's resistance to meeting privately. Finally, it should inform the courts overseeing child protection proceedings in cases where private visits have not taken place and a child's voice has not been heard.

Recommendation 5
The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards, requiring workers to meet with children in private and promote adoption of strategies and alternative approaches to encourage children to communicate with workers in private.

Recommendation 6
The Children's Aid Society of Toronto should train staff in methods and strategies for interviewing children that encourage co-operation and reduce resistance.

Recommendation 7
The Children's Aid Society of Toronto should direct staff to plan and strategize for situations when a child is reluctant to participate in an

interview during an investigation, and document in detail their attempts to meet privately with children and the strategies employed.

Recommendation 8
The Children's Aid Society of Toronto should ensure that, during ongoing child protection proceedings, the courts are informed if private visits with a child have not taken place and the reasons for this omission.

Service plans

246 When a CAS concludes an investigation, finds a child in need of protection, and opens a case for ongoing services, the worker must develop a service plan within 30 days. Standard 7 requires that a service plan include specific activities, objectives and timeframes, and it must be reviewed and evaluated every six months.

247 Brandon's case was transferred to ongoing service in March 2017, but a service plan was not prepared within the 30-day standard.

248 The CAS finally created an initial service plan on May 5, 2017, a day before the court issued a temporary supervision order. The service plan on file largely reflects the terms of that order. It contained timelines for goal achievement and identified family members affected, but did not state who was responsible for meeting the goals. The worker revised the service plan three months later to add goals for Brandon, but there was no reference to how they would be measured or achieved. The worker told us she never discussed service plans with the family. Instead, she would informally speak to them about what was expected of them.

249 The first six-month review took place almost a month late, on December 4, 2017. It noted "fair" and "good" progress in achieving service goals – although this appears inconsistent with other comments in the same report. For instance, the worker noted that there was progress with Brandon's hygiene, but the section regarding academic success stated he was still experiencing challenges with personal cleanliness.

250 The worker did not complete the next six-month review, due on June 5, 2018. The worker told our investigators she was aware of the requirement, but overlooked it. She noted that her supervisor never asked that she complete a plan and she never requested a departure from the standard. The next six-month review did not occur until November – by which time Brandon was in foster care.

251 It is apparent that the family made little headway in meeting Brandon's needs between December 2015 and October 2018. One worker, reflecting on more than a year of observing Brandon's psychological issues, told us: "He made very little progress. And if there was any progress, it was very, very slow and I think, I think, I knew it didn't benefit Brandon at all." She recalled that "there were peaks and valleys" in the cleanliness of the home, and a lack of follow-through on Brandon's medical needs. She admitted that, in retrospect: "It seems we failed the family…"

252 The worker's supervisor also acknowledged to us that he had no knowledge of any conversation between the worker and the school about Brandon's progress, and that there was nothing in the file suggesting that the family was meeting Brandon's medical needs.

253 Had the CAS ensured that there were timely service plans with concrete goals, activities, and timelines, it might have assisted workers in effectively monitoring the family's progress and identified gaps in their ability to meet Brandon's needs. The CAS should direct staff with respect to the Standard 7's requirements for service plans. As an added precaution and as a best practice, the CAS should specifically ensure that its supervisors review service plans to verify that they are complete and consistent with the relevant requirements established by Standard 7.

Recommendation 9
The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards regarding the timing, completion, review and revision of service plans, as well as requirements for including specific goals, objectives and activities, references to those responsible and timeframes for completion.

Recommendation 10
The Children's Aid Society of Toronto should specifically direct supervisors to review service plans to ensure that they are complete and consistent with the requirements of Standard 7.

Regular visits

254 Standard 7 requires that a children's aid society worker visit families who are receiving ongoing services once every 30 days. When a case is transferred to a new worker, Standard 6 requires a "transfer visit" in which

both the existing and new worker meet with the family. In Brandon's case, the CAS failed to regularly meet the standards for visits.

255 When CAS transferred the family to ongoing service in March 2017, there should have been a home visit. At that point, no one from the CAS had seen Brandon since October 2016. In May of 2017, there should have been a formal transfer visit, as required by Standard 6. Instead, the two workers met on May 18 with various community health and school officials in the absence of the family, and the new worker did not schedule a home visit within 30 days of the previous visit. Her first home visit took place on June 1, but Brandon was not present and she did not actually observe him until June 15.

256 The September 2017 visit was delayed more than two weeks due to the worker's absence, leaving Brandon unobserved for 48 days. A supervisor approved a departure from the standard based on the worker's unavailability, rather than Brandon's best interests. The November 2017 visit was also late by three days.

257 The home visit that should have taken place on December 28, 2017, was delayed until January 5, 2018. No departure was documented for this delay.

258 During her February 1, 2018 meeting with the family, the worker scheduled a visit for March 7, 2018, which fell outside of the 30-day timeframe. She emailed her manager that she would be on vacation February 19-28.

259 After a home visit on April 5, 2018, the worker scheduled the next visit for May 17, outside of the 30-day timeframe, noting she would be on holiday. That visit was then cancelled because of a personal issue and rescheduled for May 31 – meaning the CAS did not observe and meet with any family member for 56 days.

260 The CAS completely neglected home visits between July 18 and October 4, 2018. One was cancelled because Brandon had a medical appointment, and then the worker was on sick leave. The absence of any visibility into what was happening to Brandon for such a long period was inexcusable and clearly contrary to his best interests.

261 When asked by our investigators about a delay of more than 30 days in visiting Brandon, one worker commented:

> "[S]tandards are standards that are great, but family are people, right?... You never want to be authoritarian… to a family and you try to be co-operative and supportive with the family… unless there was like an immediate concern…"

262 Such a lax attitude towards the family visit standards is disturbing. As Brandon's case reflects, children's situations can change significantly between visits. The CAS should direct staff on the importance of maintaining contact with families to ensure that there is consistent visibility into the evolving circumstances of children in care.

Recommendation 11
The Children's Aid Society of Toronto should direct staff to comply with Standards 6 and 7 of the Ontario Child Protection Standards in conducting timely monthly and transfer visits with families.

Departures from standards

263 The Ontario Child Protection Standards account for the unique circumstances of individual cases by allowing for departures from the standards in appropriate situations. It is a responsibility of supervisors to ensure "that any departures from the standards are linked to increased safety for the child and/or to better meeting the unique needs of the child and family."[19] Supervisors must also ensure that documentation in child protection cases is timely, thorough and accurate.[20]

264 In Brandon's case, the CAS failed to meet the standards in many instances. Sometimes there was no formal approval of a departure from the standards; at other times, a supervisor approved departures late or without clear justification or consideration of Brandon's best interests.

265 In one particularly egregious instance, on August 12, 2016, a supervisor approved a delay in completing a safety assessment, when the investigation had already been pending for 59 days. In another, the investigation following the October 7, 2016 referral from Brandon's school took 150 days, but no formal departure approval was recorded. There were also no departure approvals for the lack of a service plan in March 2017, or the failure to conduct a transfer visit in May 2017.

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[19] Ontario Child Protection Standards, *supra* note 2 at 16.
[20] *Ibid* at 118.

266 There were a substantial number of departure requests and approvals in connection with monthly visits and private interviews with Brandon. However, on September 14, 2017, a departure was granted days after the visit should have taken place, and the reason was that the worker was on jury duty. This was not a child-centered basis for forgoing the visit, and there was no indication why another worker was not sent instead.

267 The CAS frequently used Brandon's reluctance to speak with workers to justify departures from the standard requiring that he be interviewed in private. Sometimes these departures were not formally requested or approved, and sometimes they were approved retroactively. The reasons for the approvals were typically not child-centered, but reflected a standard practice based on convenience.

268 Departures from the standards relating to visits increased substantially in the months leading up to Brandon's apprehension. On January 5, 2018, a week after a home visit and private interview with Brandon should have taken place, a worker marked in the CAS's records that a departure from the private interview standard had been approved. However, there is no record of a supervisor approving either the private interview departure or the delayed visit.

269 On February 2, 2018, a worker again recorded an approved departure from the standard requiring a monthly visit and private interview, noting that the visit would fall on a holiday – but there is no record of a supervisor's approval. On March 8, 2018, a supervisor did approve a departure, but days after a private interview should have taken place. On April 27, 2018, a departure was granted from the monthly visit because the worker was on vacation. There is no indication that the supervisor considered Brandon's best interests in approving this departure, and no explanation why a replacement worker was not sent. On June 1, 2018, another was approved on the grounds that Brandon would not respond to the worker, but it was almost two weeks after a private interview should have taken place.

270 On July 17, 2018, a similar departure was approved. On August 13, 2018, departures were granted to allow the worker to conduct a monthly home visit and private interview with Brandon a few days late. The visit was later rescheduled and then cancelled, and another departure approved on August 27.

271 On October 1, 2018, a departure from the monthly visit and private interview standard were approved, as the worker had been on sick leave

since August. The supervisor recorded that he did not feel it made sense to send another worker in her place. This departure was retroactively dated September 4. On October 15, 2018, another departure was approved several days after an interview should have taken place. By this point, there had been no home visits for three months. It is unclear how this extensive delay in visiting the family and observing Brandon could be considered as in his best interests.

272 Although some flexibility is required in applying the Ontario Child Protection Standards, the circumstances under which departures are requested and authorized should be scrutinized carefully. All requests for and approvals of departures should be timely. Approval of departures should not become a pro forma procedural step, and the documented reasons for them should be comprehensive and clearly reflect the best interests of the child. Finally, all requests for, approvals of and reasons for departures should be properly and promptly recorded in the CAS's records, along with plans for meeting the standard at a later date, and the safety factors in place to mitigate any relevant risks of harm to the child.

Recommendation 12
The Children's Aid Society of Toronto should direct staff to:

- **Make timely requests for and grant timely approvals of departures from standards prior to the time the standard must be met, rather than retroactively;**
- **Justify all departures based on the best interests of the child, in accordance with the Ontario Child Protection Standards; and**
- **Prepare proper and timely documentation of departure requests and approvals, including fulsome and clear reasons justifying departures based on the best interests of the child, plans for meeting the standard at a later date, and identification of the safety factors in place to mitigate any relevant risks of harm to the child when departing from the standard.**

273 In Brandon's case, departures were routinely requested and granted for significant child protection standards. They had reached the point where the important protections offered by the standards were rendered virtually meaningless. It is incumbent on the CAS to put additional safeguards in place to prevent this from recurring in future.

Recommendation 13
The Children's Aid Society of Toronto should implement a policy requiring supervisors to consult with and obtain approval from a director before a second consecutive departure is granted from the requirements to interview a child during an investigation, conduct a monthly family visit, or meet with a child in private.

Supervision sessions

274 Standard 7 requires that supervisors and workers review ongoing child protection cases in a "supervision session" at a minimum of once every six weeks. A review of the documentation relating to Brandon's case indicates that this schedule was often missed by a wide margin. In fact, between August 2017 and October 2018, there were five instances where supervisory sessions were held at least two weeks late, and twice when they were more than nine weeks late.

275 More consistent and regular supervisory reviews could have been valuable in Brandon's case. Regular communication and discussion of his situation might have encouraged clearer understanding and direction in dealing with the family's inability to meet Brandon's needs and developing strategies to address his reluctance to meet privately with workers.

276 The CAS should reinforce with supervisors the need to hold supervision sessions at least every six weeks and require written justification for any departure from this standard.

Recommendation 14
The Children's Aid Society for Toronto should remind supervisors of the importance of complying with Standard 7 of the Ontario Child Protection Standards regarding the timing of supervision sessions.

Recommendation 15
The Children's Aid Society of Toronto should require supervisors to keep case notes of supervision sessions, including detailed justifications for any delayed sessions.

The decision not to apprehend

277 When the question of apprehending Brandon for his protection was raised on October 22, the CAS placed significant emphasis on the existing supervision order. As one supervisor told us, this essentially meant the court was already holding the CAS and Frank accountable for Brandon's safety.

278 The reality is that those in direct contact with a family are likely in the best position to assess whether a situation has deteriorated in the wake of a court proceeding. Prior to the assignment of a new worker on October 1, 2018, there had been a significant period when the CAS had no sight lines into the family's functioning. The new worker expressed substantial discomfort about Brandon's situation, and on October 18, the court recognized that there was increasing cause for concern. The worker was just beginning to explore all of the circumstances when the events of October 22 unfolded.

279 This was a family crisis that had been building over the course of months – if not years. After Brandon's grandmother died, there were concerns that he was grappling with his grief, and Frank's caregiving responsibilities increased significantly. Frank demonstrated a chronic inability to cope with Brandon's physical and mental health issues and school attendance. Frank was also clearly overwhelmed by the task of keeping the apartment clean, given his own health issues and successive bedbug infestations.

280 When they went to see Brandon in his home on October 22, the CAS worker, the school principal and police officers felt strongly that he was at immediate risk and needed protection. It is concerning, given the family's long history with the CAS, that more credence was not given to those who had witnessed Brandon's physical state, behaviour and living conditions that day.

281 The suggestion that the family's co-operation with the CAS was also a factor in the decision not to apprehend is also worrisome. Its own records reflect that this co-operation was often grudging at best. The application for supervision expressly noted that Frank had not been willing to engage voluntarily with the CAS to address the identified child protection

concerns. Frank also frequently questioned the need for CAS involvement. In any event, co-operation is not particularly meaningful if a child's mental, physical and educational needs are repeatedly unmet.

282 Given that Brandon has remained in care since October 22, 2018, it is clear that apprehension was the prudent course of action, and warranted by the circumstances. Every situation must be considered on its own unique facts, and the CAS is entitled to require workers to consult with supervisors about such a significant step. However, the justification for a decision about whether to apprehend a child for their safety should always be centered on the best interests of the child at that point in time. Eyewitness accounts should be weighted appropriately when arriving at this determination.

283 The CAS should use Brandon's case as an example for supervisors, to encourage them to carefully consider the opinions of workers and other professionals in the field when assessing immediate risks of harm and a child's best interests.

Recommendation 16
The Children's Aid Society of Toronto should use Brandon's story as a training tool for supervisory staff, to reinforce the need to keep the best interests of the child central to its service provision, as well as the importance of carefully weighing the direct observations of CAS workers and other professionals in the field when assessing whether a child is at immediate risk of harm.

Best interests of the child versus "trying their best"

284 CAS staff, some school officials and others tended to describe Frank and Cindy's efforts to provide for Brandon's needs with phrases like "they were trying their best" and "they were doing everything they could." Although the family may have been genuinely trying, they were struggling and chronically failing to sustain the clean and safe environment, structured routine, medical care and psychological supports that Brandon desperately required.

285 Frank is legally blind, at one point suffered a heart attack, and had a history of alcohol abuse – a fact that at least one worker appears to have overlooked when carrying out an assessment. He became solely responsible for Brandon's care in September 2016. Several officials involved with Brandon commented on Frank's affection for him and his

efforts to meet Brandon's needs. But Frank's ability to keep to a routine and to maintain a clean and safe home environment was inconsistent. He was also prone to missing appointments and failing to follow through on medical recommendations.

286 In March 2016, approximately a month after the CAS closed an investigation into Brandon's care, a pediatric nurse reported that Brandon had missed an appointment. She also noted that Frank had not followed up on the pediatrician's recommendation that Brandon go to the emergency psychiatric unit, or CAMH's recommendations for counselling. This report could have triggered an investigation, based on caregiver response to a child's mental, emotional and developmental condition. Instead, the CAS worker was satisfied with Frank's explanation that Brandon was finished with CAMH and well connected at school. The allegation appeared to be minimized by the CAS on the basis that the family were "trying their best."

287 Despite evidence that Frank repeatedly missed appointments, failed to follow through on medical recommendations and was unable to ensure Brandon's regular attendance at school, notes in the CAS's files suggest that he was meeting the conditions of the supervision order.

288 Brandon had been removed from Cindy's care as an infant, and the court had reaffirmed that she did not have the cognitive capacity to parent Brandon on her own. Despite this, she remained integrally connected to his life. After Brandon's grandmother died, he lived full-time with Frank, but Cindy lived close by. She was present for most CAS visits and regularly went to medical and school appointments with him. Both Brandon's pediatrician and school officials raised concerns about the relationship between Brandon and his mother and their interaction.

289 A CAS supervisor acknowledged to our investigators that he was under the misapprehension that Cindy was not that involved in Brandon's life. However, the worker who was assigned to the family at the time Brandon was apprehended told us she was quite concerned about the fact that Cindy was clearly co-parenting Brandon.

290 The standard in child protection is not "trying their best," but the best interests of the child. This distinction appears to have been lost at times in Brandon's case. Based on our interviews with CAS staff, it seems there was a conscious effort to ensure that the CAS did not display cultural, neurotypical or socioeconomic bias when evaluating the family's efforts to care for Brandon. While that is generally a positive perspective to adopt, if the best a family can do – with supports – does not lead to a safe

environment, then it is simply not good enough and a more intensive response may be warranted.

291 A series of workers and supervisors dealt with Brandon's case. The sequence of gaps and failures that occurred – many of which appear inexplicable – should not be viewed as a singular or "one-off" situation. The CAS should use Brandon's story as a learning exercise for its staff, and a reminder that their work must be centred on the best interests of the child.

Recommendation 17
The Children's Aid Society of Toronto should use Brandon's story as a training tool for staff to reinforce the need to keep the best interests of the child central to its service provision.

Opinion

292 Children are our most precious resource and protecting their welfare is a vital public service. The province has established regulatory requirements and standards to guide children's aid societies in carrying out their important functions. Unfortunately, in Brandon's case, the Children's Aid Society of Toronto frequently failed to observe the Ontario Child Protection Standards without reasonable justification and without proper consideration of Brandon's best interests. The regulatory requirements were also disregarded at times, particularly around the timing of safety assessments.

293 The CAS's services and its response to concerns about Brandon's welfare were marred by a series of delayed investigations, safety assessments, visits, supervision sessions, and service plans. Numerous standards were ignored, including the requirement to conduct private interviews during investigations and create meaningful service plans. CAS staff also over-relied on the use of departures from the standards. The reasons given for these departures typically reflected personal convenience, rather than Brandon's best interests. Perhaps the CAS's most significant failure was the virtual absence of private interviews with Brandon, which left his voice unheard and unheeded.

294 The CAS's response to the child protection concerns raised in Brandon's case were often untimely and inadequate. Rather than proper diligence, its actions were characterized by delays and deficiencies. The intervention in

October 2018 might well have averted a more tragic scenario – and it was the result of a decision by the Toronto Police Service, not the CAS.

295 Accordingly, it is my opinion that the Children's Aid Society of Toronto's conduct in serving Brandon and his family was contrary to law, unreasonable, and wrong under s. 21(1)(a), (b) and (d) of the *Ombudsman Act.*

296 I have set out recommendations to improve the CAS's compliance with regulatory requirements and the Ontario Child Protection Standards, and to enhance its child protection services. I will monitor the CAS's response to ensure it takes action to address the issues documented in this report.

Recommendation 18
The Children's Aid Society of Toronto should report back to my Office in six months' time on its progress in implementing my recommendations, and at six-month intervals thereafter until such time as I am satisfied that adequate steps have been taken to address them.

Recommendations

Recommendation 1
The Children's Aid Society of Toronto should direct staff to comply with regulatory requirements, Standards 1, 3 and 5 of the Ontario Child Protection Standards, and its own policy regarding timely commencement and completion of investigations and safety assessments.

Recommendation 2
The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards regarding assessment of referrals received during ongoing case management.

Recommendation 3
The Children's Aid Society of Toronto should direct staff to comply with Standard 2 of the Ontario Child Protection Standards regarding interviewing family members in private.

Recommendation 4
The Children's Aid Society of Toronto should direct staff to consider interviewing family members, particularly children, in settings outside the

home if it would allow for privacy and encourage more open communication.

Recommendation 5
The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards, requiring workers to meet with children in private and promote adoption of strategies and alternative approaches to encourage children to communicate with workers in private.

Recommendation 6
The Children's Aid Society of Toronto should train staff in methods and strategies for interviewing children that encourage co-operation and reduce resistance.

Recommendation 7
The Children's Aid Society of Toronto should direct staff to plan and strategize for situations when a child is reluctant to participate in an interview during an investigation, and document in detail their attempts to meet privately with children and the strategies employed.

Recommendation 8
The Children's Aid Society of Toronto should ensure that, during ongoing child protection proceedings, the courts are informed if private visits with a child have not taken place and the reasons for this omission.

Recommendation 9
The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards regarding the timing, completion, review and revision of service plans, as well as requirements for including specific goals, objectives and activities, references to those responsible and timeframes for completion.

Recommendation 10
The Children's Aid Society of Toronto should specifically direct supervisors to review service plans to ensure that they are complete and consistent with the requirements of Standard 7.

Recommendation 11
The Children's Aid Society of Toronto should direct staff to comply with Standards 6 and 7 of the Ontario Child Protection Standards in conducting timely monthly and transfer visits with families.

Recommendation 12
The Children's Aid Society of Toronto should direct staff to:

- **Make timely requests for and grant timely approvals of departures from standards prior to the time the standard must be met, rather than retroactively;**
- **Justify all departures based on the best interests of the child, in accordance with the Ontario Child Protection Standards; and**
- **Prepare proper and timely documentation of departure requests and approvals, including fulsome and clear reasons justifying departures based on the best interests of the child, plans for meeting the standard at a later date, and identification of the safety factors in place to mitigate any relevant risks of harm to the child when departing from the standard.**

Recommendation 13
The Children's Aid Society of Toronto should implement a policy requiring supervisors to consult with and obtain approval from a director before a second consecutive departure is granted from the requirements to interview a child during an investigation, conduct a monthly family visit, or meet with a child in private.

Recommendation 14
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Recommendation 15
The Children's Aid Society of Toronto should require supervisors to keep case notes of supervision sessions, including detailed justifications for any delayed sessions.

Recommendation 16
The Children's Aid Society of Toronto should use Brandon's story as a training tool for supervisory staff, to reinforce the need to keep the best interests of the child central to its service provision, as well as the importance of carefully weighing the direct observations of CAS workers and other professionals in the field when assessing whether a child is at immediate risk of harm.

Recommendation 17
The Children's Aid Society of Toronto should use Brandon's story as a training tool for staff to reinforce the need to keep the best interests of the child central to its service provision.

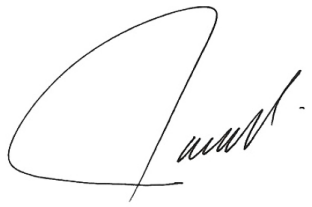
Recommendation 18
The Children's Aid Society of Toronto should report back to my Office in six months' time on its progress in implementing my recommendations, and at six-month intervals thereafter until such time as I am satisfied that adequate steps have been taken to address them.

Response

297 The Children's Aid Society of Toronto was given an opportunity to review and respond to my preliminary findings, opinion, and recommendations. All comments received were taken into consideration in the preparation of my final report.

298 The CAS has accepted all of my recommendations, and I commend its exemplary response, both in form and substance. It provided a chart detailing the steps it plans to take to address each of my 18 recommendations, which is appended to this report.

299 I am encouraged by the CAS's plans to implement my recommendations, and will be reviewing its progress in doing so.



Paul Dubé
Ombudsman

Appendix

Children's Aid Society of Toronto Response

CHILDREN'S AID SOCIETY OF TORONTO

Response to Recommendations Arising from Brandon's Story

Recommendations	Work that has been completed	Actions/next steps planned
1. The Children's Aid Society of Toronto should direct staff to comply with regulatory requirements, Standards 1, 3 and 5 of the Ontario Child Protection Standards, and its own policy regarding timely commencement and completion of investigations and safety assessments.	The Toronto Society launched a Quality Improvement Plan (QIP) dashboard in May 2021 to track compliance across several key indicators in real time and maintain historical compliance reports to be used for accountability tracking and performance management purposes. This dashboard is accessible to workers, supervisors, and directors/executive team. It is an expectation that staff and supervisors view the dashboard on a regular/ongoing basis and that directors maintain oversight for their respective departments. Directors follow up with supervisors on a case-by-case basis when areas of non-compliance are noted. Prior to the launch of the dashboard (between March 2019-May 2021), supervisors were provided with quarterly compliance reports to assist them in tracking their staff's compliance across key indicators/Standards. Compliance across standards/QIP indicators has been set as a performance expectation for all protection workers and supervisors and is included in their performance appraisals. The Executive Team reports quarterly to the Toronto Society's Board of Directors on QIP outcomes. QIP performance is reviewed regularly at the Quality and Outcomes Sub Committee of the Board.	The Toronto Society launched an online policy platform (Navex) in 2021. All policies that contain information pertaining to Standards 1, 3 and 5 will be reviewed to ensure they are current in the online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have been reviewed. The plan will be to send one Standard per month, beginning in January 2023. In addition to reviewing Standards/policies online, it will be an expectation that supervisors review Standards at team meetings, (one per month, beginning in January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors. To ensure that staff and supervisors understand the Standards, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Sessions for new supervisors (supervisors promoted January 2020 or later). The role of the

	In addition to the dashboard, Directors receive quarterly compliance reports for their respective departments and follow-up with supervisors regarding any areas of concern. New supervisor orientation sessions have been developed and launched in June 2022. The Intake/Investigation module cover Standard #5 in detail. In January 2017, the Ontario Association of Children's Aid Societies (OACAS) launched the Child Welfare Pathways to Authorization Series. In the Child Welfare Pathways to Authorization Field Guide, it states "For staff re-entering the field after some absence: Any absence from the field of greater than 5 years will require Refresher courses. A Prior Learning Assessment will be used to determine areas where the staff member may be exempt from Refresher training (this includes existing staff who are exempt in 2017)." The Toronto Society adheres to this directive, and also expects supervisors to assess the worker's ability to perform their job as it relates to their role, offering additional training, if necessary. The Toronto Society has also implemented a practice whereby any child protection worker who is away from service for more than two years will complete the Society's Clinical Framework and Equity training upon their return to practice.	supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired. The Toronto Society will continue to pull compliance statistics on a quarterly basis to demonstrate progress and outcomes. Reports are provided to Directors for follow-up with supervisors. The Ombudsman report will be discussed at an upcoming Service Directors meeting (fall 2022) so that Directors are aware that a case review was conducted and know the key findings/recommendations. A review of current historical compliance data will be conducted to assess progress over time.
2. The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards regarding assessment of referrals	The Toronto Society adheres to the OACAS's regulation whereby staff who are entering/returning to protection roles after a period of absence (5 years or longer) are required	The Toronto Society launched an online policy platform (Navex) in 2021. All policies that contain information pertaining to Standard 7 will be reviewed to ensure they are current in the

received during ongoing case management.	to complete new worker authorization or refresher training so that they are well-equipped to manage protection cases and their knowledge of Standards is current. The Toronto Society adheres to this directive, and also expects supervisors to assess the worker's ability to perform their job as it relates to their role, offering additional training, if necessary. In situations where a referral received during ongoing service results in a new investigation, service teams utilize the tools referenced below to assist in the management and tracking of compliance with investigation Standards. The Toronto Society launched a Quality Improvement Plan (QIP) dashboard in May 2021 to track compliance across several key indicators in real time and maintain historical compliance reports to be used for accountability tracking and performance management purposes. This dashboard is accessible to workers, supervisors, and directors/executive team. It is an expectation that staff and supervisors view the dashboard on a regular/ongoing basis and that directors maintain oversight for their respective departments. Directors follow up with supervisors on a case-by-case basis when areas of non-compliance are noted. Prior to the launch of the dashboard (between March 2019-May 2021), supervisors were provided with quarterly compliance reports to assist them in tracking their staff's compliance across key indicators/Standards.	online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have reviewed. The plan will be to send one Standard per month, beginning in January 2023. In addition to reviewing Standards/policies online, it will be an expectation that supervisors review Standards at team meetings, (one per month, beginning in January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors. To ensure that staff and supervisors understand the Standard, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The role of the supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired. The Toronto Society will continue to pull compliance statistics on a quarterly basis to

	Compliance across standards/QIP indicators has been set as a performance expectation for all protection workers and supervisors and is included in their performance appraisals. The Executive Team reports quarterly to the Toronto Society's Board of Directors on QIP outcomes. QIP performance is reviewed regularly at the Quality and Outcomes Sub Committee of the Board. In addition to the dashboard, Directors receive quarterly compliance reports for their respective departments and follow-up with supervisors regarding any areas of concern.	demonstrate progress and outcomes. Reports are provided to Directors for follow-up with supervisors.
3. The Children's Aid Society of Toronto should direct staff to comply with Standard 2 of the Ontario Child Protection Standards regarding interviewing family members in private.	New supervisor orientation sessions have been developed and were launched in June 2022. The Intake/Investigation module covers Standard #2 in detail. The Toronto Society adheres to the OACAS's regulation whereby staff who are entering/returning to protection roles after a period of absence (5 years or longer) are required to complete new worker authorization or refresher training so that they are well-equipped to manage protection cases and their knowledge of Standards is current. The Toronto Society adheres to this directive, and also expects supervisors to assess the worker's ability to perform their job as it relates to their role, offering additional training, if necessary.	The Toronto Society launched an online policy platform (Navex) in 2021. All policies containing information pertaining to Standard 2 will be reviewed to ensure they are current in the online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have reviewed. The plan will be to send one Standard per month, beginning in January 2023. In addition to reviewing Standards/policies online, it will be an expectation that supervisors review Standards at team meetings, (one per month, beginning in January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors.

		To ensure that staff and supervisors understand the Standard, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The role of the supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired. During investigations, workers will include strategies/considerations for how they plan to engage the child(ren) using a trauma-informed lens in their investigation plan contact log. At ongoing services, considerations will be documented in a supervision contact log. This practice will be discussed with teams in conjunction with their review of the investigation Standards.
4. The Children's Aid Society of Toronto should direct staff to consider interviewing family members, particularly children, in settings outside the home if it would allow for privacy and encourage more open communication.	Child-Centered Practice training is being developed/launched. This training will be mandatory for all service staff and supervisors and will focus on centering the child's voice and Katelynn's Principle.	Consideration of interviewing family members, particularly children, in settings outside of the home will be discussed as part of the six-week case review (for ongoing cases) and during supervisor consultations (for investigation cases). Considerations discussed and rationale for decisions will be documented in a supervision contact log. This practice will be discussed with teams in

		conjunction with their review of investigation and ongoing service Standards. The case worker and supervisor will make appropriate decisions to ensure adequate privacy for children/youth during the interview process. This should be done in consideration of the age of the children, nature of the allegations, and availability of private space to conduct the interview. In situations where the service team believes it would be beneficial to interview a child in an out of home setting, but barriers exist (for example, parental consent), the team will consider utilizing anti-Black Racism or Indigenous consultations, case conferencing, and Signs of Safety mappings to develop strategies to reduce these barriers. Consideration of these strategies will be clearly documented in contact logs in the ongoing or investigation case. The Toronto Society launched an online policy platform (Navex) in 2021. Policies pertaining to the expectation that all family members are interviewed, and all children interviewed/seen during ongoing service, will be reviewed to ensure they are current in the online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have reviewed. The plan will be to send one Standard per month, beginning in January 2023.

		In addition to reviewing Standards/policies online, it will be an expectation that supervisors review Standards at team meetings, (one per month, beginning in January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors. To ensure that staff and supervisors understand the Standard, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The role of the supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired.
5. The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards, requiring workers to meet with children in private and promote adoption of strategies and alternative approaches to encourage children to communicate with workers in private.	Child-Centered Practice training is being developed/launched. This training will be mandatory for all service staff and supervisors and will focus on centering the child's voice and Katelynn's Principle.	The Toronto Society launched an online policy platform (Navex) in 2021. All policies that contain information pertaining to Standard 7 will be reviewed to ensure they are current in the online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have reviewed. Plan will be to send

		one Standard per month, beginning in January 2023. In addition to reviewing Standards/policies online, it will be an expectation that supervisors review policies at team meetings, (one per month beginning in January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors. To ensure that staff and supervisors understand the Standard, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The role of the supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired. Consultation with the Information Management team will take place (September-December 2022) to develop a strategy for accessing data re: private interviews with children/youth during investigation and ongoing services as an added level of transparency and accountability measure.

6. The Children's Aid Society of Toronto should train staff in methods and strategies for interviewing children that encourage co-operation and reduce resistance.	Child-Centered Practice training is being developed/launched. This training will be mandatory for all service staff and supervisors and will focus on centering the child's voice and Katelynn's Principle. New protection workers and workers returning to/entering protection roles after a period of absence (5 or more years) are required to attend Child Welfare Worker Authorization or refresher training. Strategies for interviewing children is covered in this training.	During investigations, workers will include strategies/considerations for how they plan to engage the child(ren), using a trauma-informed lens, in their investigation plan contact log. At ongoing services, considerations will be documented in a supervision contact log. This practice will be discussed with teams in conjunction with their review of the investigation Standards. Where barriers exist, workers shall seek guidance/consultation from a supervisor or others (e.g. ABR or Indigenous Practice Lead) with the goal of developing strategies to engage the child/youth, and document these strategies in a contact log. Consultations should not be used to seek reinforcement for the rationale to not interview children and departures from interviews with children/youth should only be used in exceptional circumstances, grounded in clear clinical rationale.
7. The Children's Aid Society of Toronto should direct staff to plan and strategize for situations when a child is reluctant to participate in an interview during an investigation, and document in detail their attempts to meet privately with children and the strategies employed.	Child-Centered Practice training is being developed/launched. This training will be mandatory for all service staff and supervisors and will focus on centering the child's voice and Katelynn's Principle. The Toronto Society launched trauma-informed practice training in September 2021. This training is mandatory for all service staff and supervisors. Training includes the following learning objectives: 1. Explain and identify types of trauma 2. Create linkage to Signs of Safety in Trauma Informed Practice and engage clients with holistic conversations	During investigations, workers will include strategies/considerations for how they plan to engage the child(ren), using a trauma-informed lens, in their investigation plan contact log. At ongoing services, considerations will be documented in a supervision contact log. This practice will be discussed with teams in conjunction with their review of the investigation Standards. Contact logs will clearly identify attempts to meet with children privately, strategies that were employed, and future strategies that will be explored if private interviews are unsuccessful.

	3. Demonstrate knowledge and skills in serving clients who have experienced trauma using a Trauma Informed Practice approach 4. Develop competencies in cultural safety and cultural humility As of August 22, 2022, 69% of service staff and 68% of service supervisors have completed the training.	Where barriers exist, workers shall seek guidance/consultation from a supervisor or others (e.g. Anti-Black Racism lead or Indigenous Practice Lead) with the goal of developing strategies to engage the child/youth using a trauma-informed lens and document these strategies in a contact log.
8. The Children's Aid Society of Toronto should ensure that, during ongoing child protection proceedings, the courts are informed if private visits with a child have not taken place and the reasons for this omission.	The Toronto Society established a Legal/Services Committee in 2020 that looks at issues that involve the intersection of legal and clinical service. One of the items the group is examining is the use of early and ongoing case consultations between service staff and legal to identify areas of worry and develop strategies to address in a proactive way.	Case-by-case consultations will need to take place between workers and supervisors to determine at what point an absence of private visits or other Standards that are not being met poses a worry that would prompt the service team to raise this with their lawyer. A plan will be developed to inform service staff of the expectation that they inform legal counsel if private visits have not taken place on a case that is before the court, and/or if other Standards have not been met that impact child safety, and the reasons for this. The Toronto Society legal team will discuss this item at an upcoming all-counsel meeting (September-October 2022) to come up with a plan for how they will convey this information to the court.
9. The Children's Aid Society of Toronto should direct staff to comply with Standard 7 of the Ontario Child Protection Standards regarding the timing, completion, review and revision of service plans, as well as requirements for including specific goals, objectives and activities, references to those responsible and timeframes for completion.	The Toronto Society launched a Director-led "cohort review analysis" process in July 2022. This process involves directors doing a deep dive into cases to review a specific aspect of service. Compliance/timely completion of service plans is incorporated as an objective in service staff and supervisor performance appraisals. Supervisors and/or Directors will follow-up with a	A clinical learning session will be developed and presented to service staff and supervisors that focuses on the development of service plans. This expectation falls on both the worker who is developing the plan in collaboration with the family and the supervisor who is approving it. The learning session will focus on creating objectives/activities using Specific, Measurable,

	performance management plan as needed.	Achievable, Relevant and Time-Bound (SMART) principles, centering the voice of the child and the family's identity, updating activities as they are completed in accordance with the family's progress and adding to the plan as new areas of need emerge (to occur at a minimum, when the Service Plan is due or at the point of a new investigation/verification of new concerns). Methods for engaging the family in the planning process and providing them with details of the plan will also be discussed to promote greater transparency and accountability. Target date for the learning session is Spring 2023. There is still work to be done in the timely completion of service plans as per Standard 7. This will be monitored using the QIP dashboard and will be included in quarterly reporting for director oversight and follow-up. Consideration will be given to adding this item to the Director cohort review analysis in 2023. A review of current historical compliance data will be conducted to assess progress over time.
10. The Children's Aid Society of Toronto should specifically direct supervisors to review service plans to ensure that they are complete and consistent with the requirements of Standard 7.	The Toronto Society launched a Director-led "cohort review analysis" process in July 2022. This process involves directors doing a deep dive into cases to review a specific aspect of service. Compliance/timely completion of service plans is incorporated as an objective in service staff and supervisor performance appraisals. Supervisors and/or Directors will follow-up with a performance management plan as needed.	A clinical learning session will be developed and presented to service staff and supervisors that focuses on the development of service plans. This expectation falls on both the worker who is developing the plan in collaboration with the family and the supervisor who is approving it. The learning session will focus on creating objectives/activities using Specific, Measurable, Achievable, Relevant and Time-Bound (SMART) principles, centering the voice of the child

		and the family's identity, updating activities as they are completed in accordance with the family's progress and adding to the plan as new areas of need emerge (to occur at a minimum, when the Service Plan is due or at the point of a new investigation/verification of new concerns). Methods for engaging the family in the planning process and providing them with details of the plan will also be discussed to promote greater transparency and accountability. Target date for the learning session is Spring 2023. There is still work to be done in the timely completion of service plans as per Standard 7. This will be monitored using the QIP dashboard and will be included in quarterly reporting for director oversight and follow-up. Consideration will be given to adding this item to the Director cohort review analysis in 2023. A review of current historical compliance data will be conducted to assess progress over time.
11. The Children's Aid Society of Toronto should direct staff to comply with Standards 6 and 7 of the Ontario Child Protection Standards in conducting timely monthly and transfer visits with families.	There is currently a Director group that is working on developing practice guidelines for transfer visits. Timeline for this work to be complete is December 2022. The Toronto Society launched a Quality Improvement Plan (QIP) dashboard in May 2021 to track compliance across several key indicators, (including monthly visits), in real time and maintain historical compliance reports to be used for accountability tracking and performance management purposes. This dashboard is accessible to workers, supervisors, and directors/executive team. It is	The Toronto Society launched an online policy platform (Navex) in 2021. All policies that contain information pertaining to Standards 6 & 7 will be reviewed to ensure they are current in the online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have reviewed. Plan will be to send one Standard per month, beginning in January 2023.

	an expectation that staff and supervisors view the dashboard on a regular/ongoing basis and that directors maintain oversight for their respective departments. Directors follow up with supervisors on a case-by-case basis when areas of non-compliance are noted. Prior to the launch of the dashboard (between March 2019-May 2021), supervisors were provided with quarterly compliance reports to assist them in tracking their staff's compliance across key indicators/Standards. Compliance across standards/QIP indicators has been set as a performance expectation for all protection workers and supervisors and is included in their performance appraisals. The Executive Team reports quarterly to the Toronto Society's Board of Directors on QIP outcomes. QIP performance is reviewed regularly at the Quality and Outcomes Sub Committee of the Board. In addition to the dashboard, Directors receive quarterly compliance reports for their respective departments and follow-up with supervisors regarding any areas of concern.	In addition to reviewing Standards/policies online, it will be an expectation that supervisors review policies at team meetings (one per month, beginning January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors. To ensure that staff and supervisors understand the Standard, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The role of the supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired. The Toronto Society will continue to pull compliance statistics on a quarterly basis to demonstrate progress and outcomes. Reports are provided to Directors for follow-up with supervisors. Consultation with the Information Management team will take place (September-December 2022) to determine what enhancements can be made to the dashboard and/or what reports can be accessed

		to track compliance re: timely completion of transfer visits. A review of current historical compliance data will be conducted to assess progress over time.
12. The Children's Aid Society of Toronto should direct staff to: • **Make timely requests for and grant timely approvals of departures from standards prior to the time the standard must be met, rather than retroactively;** • **Justify all departures based on the best interests of the child, in accordance with the Ontario Child Protection Standards; and** • **Prepare proper and timely documentation of departure requests and approvals, including fulsome and clear reasons justifying departures based on the best interests of the child, plans for meeting the standard at a later date, and identification of the safety factors in place to mitigate any relevant risks of harm to the child when departing from the standard.**		The Standard for Approved Departures will be reviewed with service supervisors during a management meeting to take place in the fall of 2022. Consultation with the Information Management team will take place (September-December 2022) to determine what enhancements can be made to the dashboard and/or what reports can be accessed to better track departures and incorporate these statistics into quarterly reporting. A clinical learning session will be developed for service staff and supervisors to review the Standard pertaining to Approved Departures. The session will cover timing of departures, what constitutes a clinical departure, and what needs to be covered in an Approved Departure contact log (clinical reason based on best interests of the child, plan to meet the Standard at a later date, identification of safety factors in place to mitigate any risk or harm to the child). Target date for this session is Spring 2023.
13. The Children's Aid Society of Toronto should implement a policy requiring supervisors to consult with and obtain approval from a director before a second consecutive departure is granted from the requirements to interview a child during an investigation, conduct a monthly family		Consultation with the Information Management team will take place (September-December 2022) to determine what enhancements can be made to the QIP dashboard to more accurately track departures, including the frequency and types.

visit, or meet with a child in private.		Consultation with the Information Management team will take place (September-December 2022) to determine what systems can be developed to identify: children who have not been seen for more than 30 days, in-home monthly visits that have not occurred for more than 30 days, and children who were not interviewed privately during an investigation for reporting and follow-up by Directors. Consultation with Service Directors will be sought to discuss what role they can play to increase oversight and accountability with their supervisors in their approval of Departures.
14. The Children's Aid Society for Toronto should remind supervisors of the importance of complying with Standard 7 of the Ontario Child Protection Standards regarding the timing of supervision sessions.	The Toronto Society launched a Quality Improvement Plan (QIP) dashboard in May 2021 to track compliance across several key indicators, (including six-week supervision reviews), in real time and maintain historical compliance reports to be used for accountability tracking and performance management purposes. This dashboard is accessible to workers, supervisors, and directors/executive team. It is an expectation that staff and supervisors view the dashboard on a regular/ongoing basis and that directors maintain oversight for their respective departments. Directors follow up with supervisors on a case-by-case basis when areas of non-compliance are noted. Prior to the launch of the dashboard (between March 2019-May 2021), supervisors were provided with quarterly compliance reports to assist them in tracking their staff's compliance across key indicators/Standards.	The Toronto Society launched an online policy platform (Navex) in 2021. All policies that contain information pertaining to the timing of Supervision requirements will be reviewed to ensure they are current in the online system (begin September 2022). A plan and timeline will be developed to send the Standards/policies to staff/supervisors with an expectation that they review and confirm that they have reviewed. Plan will be to send one Standard per month, beginning in January 2023. In addition to reviewing Standards/policies online, it will be an expectation that supervisors review policies at team meetings, (one per month, beginning in January 2023), as demonstrated through the item being on their team meeting agenda and reflected in minutes which are posted and accessible to branch directors.

	Compliance across standards/QIP indicators has been set as a performance expectation for all protection workers and supervisors and is included in their performance appraisals. The Executive Team reports quarterly to the Toronto Society's Board of Directors on QIP outcomes. QIP performance is reviewed regularly at the Quality and Outcomes Sub Committee of the Board.	To ensure that staff and supervisors understand the Standard, the associated practice notes, and what is expected of them, subject matter experts will be engaged to develop questions and discussion prompts to be used at team meetings in conjunction with the review of the Standard. The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The role of the supervisor in overseeing/managing compliance with Standards will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired. The Toronto Society will continue to pull compliance statistics on a quarterly basis to demonstrate progress and outcomes. Reports are provided to Directors for follow-up with supervisors. A review of current historical compliance data will be conducted to assess progress over time.
15. The Children's Aid Society of Toronto should require supervisors to keep case notes of supervision sessions, including detailed justifications for any delayed sessions.	Supervisory contact logs are recorded in CPIN and are tracked on the QIP dashboard to monitor compliance regarding the 6-week supervision review requirement. Compliance outcomes for 6-week supervisor case reviews are included in quarterly reports that are sent to Directors for their oversight and follow-up. While the rationale for not meeting the 6- week supervision requirement is not	Staff, supervisors and directors will continue to review the QIP dashboard regarding the 6-week supervision requirement to ensure that reviews are occurring as per Standard. Director oversight and follow-up will occur when the supervision Standard is not being met. Performance management processes will be put into place in situations where the Standard is not being met.

	documented as part of the client record; these conversations take place between supervisors and directors when compliance is an issue. This Standard is integrated into staff and supervisor performance appraisals.	The Toronto Society is launching Peer Learning Groups for new supervisors (supervisors promoted January 2020 or later). The importance of the 6- week supervisor case review and other critical decision points will be integrated into the content that is discussed during these groups. Peer learning sessions will be launched in October 2022 and run once monthly for a period of nine months then repeat as new supervisors are hired.
16. The Children's Aid Society of Toronto should use Brandon's story as a training tool for supervisory staff, to reinforce the need to keep the best interests of the child central to its service provision, as well as the importance of carefully weighing the direct observations of CAS workers and other professionals in the field when assessing whether a child is at immediate risk of harm.	Child-Centered Practice training is being developed/launched. This training will be mandatory for all service staff and supervisors and will focus on centering the child's voice and Katelynn's Principle.	Information from this case will be used as a training tool in a variety of spaces, including existing and new training and service staff and supervisor meetings. All service staff meetings are being launched in September 2022 and will be held on a quarterly basis. Service supervisor meetings are held twice per month. Examples from this case will be integrated into the upcoming clinical learning session that will be focused on approved departures (target date December 2022). The Ombudsman report will be discussed at an upcoming Service Directors meeting so that Directors are aware that a case review was conducted and know the key findings/recommendations.
17. The Children's Aid Society of Toronto should use Brandon's story as a training tool for staff to reinforce the need to keep the best interests of the child central to its service provision.	Child-Centered Practice training is being developed/launched. This training will be mandatory for all service staff and supervisors and will focus on centering the child's voice and Katelynn's Principle.	Information from this case will be used as a training tool in a variety of spaces, including existing and new training and service staff and supervisor meetings. All service staff meetings are being launched in September 2022 and will be held on a quarterly basis. Service supervisor meetings are held twice per month.

		Examples from this case will be integrated into the upcoming clinical learning session that will be focused on approved departures (target date December 2022). The Ombudsman report will be discussed at an upcoming Service Directors meeting so that Directors are aware that a case review was conducted and know the key findings/recommendations.
18. The Children's Aid Society of Toronto should report back to my Office in six months' time on its progress in implementing my recommendations, and at six-month intervals thereafter until such time as I am satisfied that adequate steps have been taken to address them.		A tracking form will be developed to track progress/outcomes for the 17 stated recommendations. Target date for the first report back to the Ombudsman office is February 28, 2023.