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Missing in Inaction: Misty's Story

Investigation into the adequacy of measures undertaken by Johnson Children's Services Inc., Anishinaabe Abinoojii Family Services, and a Southwestern Ontario children's aid society to ensure the safety of "Misty"

OMBUDSMAN REPORT

Paul Dubé, Ombudsman of Ontario

April 2023

Missing in Inaction: Misty's Story

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The Ontario Ombudsman's work takes place on traditional Indigenous territories across the province we now call Ontario, and we are thankful to be able to work and live on this land. We would like to acknowledge that Toronto, where the Office of the Ontario Ombudsman is located, is the traditional territory of many nations, including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee, and the Wendat peoples, and is now home to many First Nations, Inuit and Métis peoples.

We believe it is important to offer a land acknowledgement as a way to recognize, respect and honour this territory, the treaties, the original occupants, their ancestors, and the historic connection they still have with this territory.

As part of our commitment to reconciliation, we are providing educational opportunities to help our staff learn more about our shared history and the harms that have been inflicted on Indigenous peoples. We are working to establish mutually respectful relationships with Indigenous people across the province and will continue to incorporate recommendations from the Truth and Reconciliation Commission into our work. We are grateful for the opportunity to work across Turtle Island.

Ce rapport est aussi disponible en français.

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Table of Contents

Executive Summary

1 By the time 13-year-old "Misty"[1] arrived in a Southwestern Ontario city in early summer 2020, she had already lived an unsettled life, full of trauma, loss, and numerous interactions with the child welfare system. Misty, who is Indigenous, is a particularly vulnerable child. She lives with Fetal Alcohol Spectrum Disorder and Attention Deficit Hyperactivity Disorder, has been the suspected victim of sexual assault and human trafficking, and has a history of using powerful street drugs.

2 The children's aid society in Misty's home community in Northern Ontario, Anishinaabe Abinoojii Family Services,[2] had been unable to find resources closer to her home that could meet her complex needs. It sought care for her in Southern Ontario as a last resort. Arrangements with other foster care providers had already collapsed before it entered an agreement with a foster care agency, Johnson Children's Services Inc.

3 Misty spent some 25 days at her first placement in Southwestern Ontario. From the outset, she did not settle well into the foster home. She went missing the first day, and again on two occasions shortly thereafter. When Misty was found after her third disappearance, she was bloody, bruised, covered with tiny bugs, and disheveled. She was taken to hospital for treatment for assault. Less than a week later, Misty went missing again for two days. The following week, disturbed by another resident in the home, Misty began threatening others and damaging property. Police were called, and the next day she was transferred to another home run by the same foster care agency.

4 Misty's time at the second home was short-lived. She and another resident at the home went missing a few days later, when a worker left them alone at a park. The other girl returned the next day, but there was no sign of Misty for two days, when she briefly returned in an intoxicated state and covered in vomit. She took off again that day while out for a drive with a worker, and was not seen again for more than two weeks. She then returned to a previous foster home, explaining that she had overdosed, been revived twice with naloxone, and then used more drugs. She was treated in hospital, and released the next day into the care of a staff member from Anishinaabe Abinoojii Family Services, who drove her back up north.

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[1] The names of the child and their family members have been anonymized in this report for reasons of confidentiality. In addition, certain dates, place names, agencies, and identifying details have been generalized or omitted to protect the privacy of Misty.
[2] Misty's interaction with Anishinaabe Abinoojii Family Services was primarily through a specific agency that serves her First Nation and provides certain services on behalf of Anishinaabe Abinoojii Family Services under agreement.

5 Over the course of the 47 days Misty spent in the care of Johnson Children's Services in Southwestern Ontario, she went missing seven times, including one period of 19 days. There is evidence that during these absences, she was physically and sexually assaulted, suffered injuries requiring medical treatment, used methamphetamines, fentanyl, cannabis, cocaine and Xanax – and overdosed.

6 My Office was alerted to concerns about the adequacy of the care that Johnson Children's Services provided to Misty while she was in Southwestern Ontario. Although a community agency had direct responsibility for her day-to-day care, Anishinaabe Abinoojii Family Services had responsibility for Misty's placement with them. In addition, a Southwestern Ontario children's aid society was responsible for providing services to Misty while she was located within its catchment area.[3] After a preliminary review, I launched an investigation on my own initiative into the adequacy of the measures each agency undertook to ensure Misty's safety while she resided in Southwestern Ontario.

7 The National Inquiry into Missing and Murdered Indigenous Women and Girls has specifically highlighted the obligation of the child welfare system to protect Indigenous children from exploitation and the risk of being recruited into the sex industry.[4] My investigation revealed that various components of the system failed Misty during her stay in Southwestern Ontario, leaving her at significant risk of human trafficking and other harm.

8 Johnson Children's Services was primarily responsible for ensuring Misty's safety in its foster homes. My investigation found that this agency was particularly remiss in fulfilling its duty. Although Misty was uniquely vulnerable to sexual abuse, overdose, and human trafficking when she went missing from the agency's care, its staff appeared oblivious to this reality. They overlooked the requirements of the agency's own protocols relating to missing children, repeatedly assured police there were no particular concerns regarding her safety, and, in one instance, delayed notifying police for more than four hours after Misty disappeared. This attitude and inaction affected the urgency of the police response. (Fortunately, others did not share the agency's perspective. A police officer in the North who was familiar with Misty proactively notified his

[3] To protect Misty's confidentiality and comply with the *Ombudsman Act,* I have chosen to anonymize the name of the community agency that served Misty and that of the children's aid society that oversaw her placement in Southwestern Ontario. Section 7.3(4) of the *Ombudsman Act* provides that I shall not disclose in any report the name of or any identifying information about a child to whom an investigation may relate.

[4] Call for Justice 12.14: *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, vol. 1b (Ottawa, 2019) at 196 [MMIWG National Inquiry 1b], online: <https://www.mmiwg-ffada.ca/final-report>.

Southwestern Ontario counterparts about Misty's risk factors, and during her extended absence, Anishinaabe Abinoojii Family Services and her home community took the exceptional step of organizing a search party to comb the streets for her.)

9 My investigation also determined that Johnson Children's Services failed to deliver the 1-to-1 supervised care (meaning one worker assigned only to her) that Misty required – and that it was paid to provide. This lapse likely contributed to the many instances in which she ran from its homes. We discovered the agency has a patchy history of compliance with child protection requirements, which it continued to demonstrate in this case. Johnson Children's Services failed to comply with a condition placed on its licence relating to reporting to the Ministry of Children, Community and Social Services about its staffing. It also failed to report two incidents of serious bodily harm to my Office, as required by regulation.[5] In addition, it contravened the Ministry's requirements for reporting serious occurrences, failing to file reports in at least three instances, and neglecting to include important details when it did submit reports. Finally, it often failed to communicate effectively with Anishinaabe Abinoojii Family Services and other organizations involved in Misty's care, and demonstrated significant gaps in its documentation, record-keeping, and training practices.

10 Given the many serious issues my investigation identified with Johnson Children's Services Inc., I found its conduct to be unreasonable and wrong under s. 21(1)(b) and (d) of the *Ombudsman Act.*

11 Anishinaabe Abinoojii Family Services shares some responsibility for the poor service Misty received while in Southwestern Ontario. It did not notify the local children's aid society that Misty was in its catchment area and failed to enter a courtesy supervision agreement with it. In fact, that children's aid society didn't even know about Misty's presence until it was contacted by police after one of her disappearances. Anishinaabe Abinoojii Family Services also failed to provide timely and relevant information to the Southwestern Ontario children's aid society about Misty's circumstances and care needs.

12 Although Anishinaabe Abinoojii Family Services was clearly concerned about Misty, particularly when she went missing for an extended period, it did not consider using a child welfare warrant, a powerful tool to assist police in finding missing children. It also failed to scrutinize the conditions placed on Johnson Children's Services Inc.'s licence, and monitor the quality of care it provided. Anishinaabe Abinoojii Family Services also neglected to file a serious bodily harm report with my Office, as required by regulation.

[5] O Reg. 80/19, s 1.

13 In addition, there were many gaps apparent in Anishinaabe Abinoojii Family Services' internal communications, supervision, and documentation relating to Misty's care, as well as in its training. Its records were also incomplete and not in compliance with the Ontario Child Protection Standards. Given the gaps in its monitoring, documenting, and reporting on the services that Misty received from Johnson Children's Services, it is my opinion that Anishinaabe Abinoojii Family Services' conduct was wrong under s. 21(1)(d) of the *Ombudsman Act.*

14 The Southwestern Ontario children's aid society did provide services to Misty, despite the absence of a formal agreement with Anishinaabe Abinoojii Family Services. My investigation revealed that, unlike the other two agencies whose conduct we reviewed, the Southwestern Ontario children's aid society had many exemplary practices. However, it is my opinion that its practices related to child welfare warrants, which led it to overlook the possibility of issuing one in Misty's case, as well as its failure to file a serious bodily harm report with my Office, were wrong under s. 21(1)(d) of the *Ombudsman Act.*

15 In this report, I have made 58 recommendations aimed at improving the services provided to children in care. I have addressed 31 recommendations to Johnson Children's Services Inc., 23 to Anishinaabe Abinoojii Family Services, and four to the Southwestern Ontario children's aid society. These organizations have accepted all of my recommendations, and my Office will monitor their efforts to implement them and address the concerns identified in this report.

16 Misty ultimately survived her time on the streets of the Southwestern Ontario city where she went missing, and today remains in the care of Anishinaabe Abinoojii Family Services. However, she could have easily become another missing or murdered Indigenous girl. It was up to the child welfare authorities responsible for her care to protect her against this risk. Unfortunately, many acting within the system let Misty down. It is a sad reality that there are no specialized culturally appropriate resources in Northern Ontario available to treat children like Misty. It is particularly pressing that agencies in Southern Ontario such as Johnson Children's Services Inc. educate themselves and their staff on the learnings from the Truth and Reconciliation Commission and the National Inquiry into Missing and Murdered Indigenous Women and Girls. They should also consider the risk factors unique to Indigenous children in their decision-making around their care.

Investigative Process

17 My investigation was prompted by a complaint from a community agency serving a specific First Nations community in Northwestern Ontario. That agency expressed concern about the quality of care that 13-year-old Misty – who has developmental and mental health disabilities and a history of serious drug use,

and was at risk of sex trafficking – received while living in foster homes in Southwestern Ontario run by Johnson Children's Services Inc. Specifically, the complaint raised issues about the circumstances that led to Misty repeatedly going missing and the adequacy of the response during her absences.

18 In November 2021, after my Office conducted a preliminary review of the situation, I notified all three organizations responsible for Misty's care of my intent to investigate, on my own initiative, the adequacy of measures undertaken to ensure her safety.

19 My investigation focused on a six-week period in the summer of 2020, from the day Misty arrived in Southwestern Ontario to the day she returned to the care of her home community's children's aid society, Anishinaabe Abinoojii Family Services.

20 This investigation is not the first in which the conduct of Johnson Children's Services Inc. has come under the scrutiny of an Officer of the Legislature. In March 2019, the former Provincial Advocate for Children and Youth issued a report that found the agency's staff in foster treatment homes in Thunder Bay were poorly trained and ill equipped to meet the complex needs of children under their care. In May 2017, the Ministry of Children, Community and Social Services ordered the agency's homes in the North closed.

21 As a result of the *Restoring Trust, Transparency and Accountability Act, 2018* (Bill 57), the Office of the Provincial Advocate for Children and Youth was eliminated and its investigative responsibilities transferred to the Ontario Ombudsman, effective May 1, 2019. Although my investigation did not address the same issue raised in the Advocate's report, it is concerning that this is the second time an oversight body has identified serious concerns with this particular children's services provider.

22 My Office's investigation was conducted by staff from our dedicated Children and Youth Unit, who have specialized experience and expertise in child welfare issues, and by members of our Legal Services team. It was also assisted by members of the Indigenous Circle team within our Office, which is led by Indigenous staff and has the capacity to incorporate Indigenous practices such as smudging, talking circles, and Elder participation into our work.

23 The investigative team conducted 41 interviews with staff and former staff from the child welfare organizations involved in Misty's care, as well as others who had information relevant to the issues under investigation. They included young people who lived with Misty at foster homes, the local police who assisted in searching for her, members of the search party that looked for her, an Ontario Provincial Police officer from Northwestern Ontario, and other organizations that

provided services to Misty. Our staff spoke with Misty on several occasions to obtain her perspective on the issues under investigation. Misty's well-being remained central to our investigation, and our staff remain in contact with her.

24 Given the limitations presented by the COVID-19 pandemic, all interviews were conducted by video teleconference or telephone rather than in person. Investigators requested and reviewed extensive documentation from the organizations that provided service to Misty, as well as others who were involved in searching for her. This included hundreds of documents relating to Misty, as well as relevant policies, internal communications and other documents.

25 The organizations co-operated fully with this investigation.

Confidentiality and Terminology

26 Section 7.3(4) of the *Ombudsman Act* requires that my Office protect the name and identifying information of children who may be featured in my reports. Given the specific circumstances of this case, my Office has anonymized or omitted certain information including names, geographic areas, identifying details, and the name of the children's aid society in Southwestern Ontario that provided services to Misty during the period considered in this investigation.

27 Throughout this report, the three organizations involved in Misty's care are referred to as follows:

- **Anishinaabe Abinoojii Family Services:** The children's aid society operating in Misty's home community, also referred to by the acronym **"AAFS"**
- **Johnson Children's Services Inc.:** The foster care agency responsible for Misty's care while she was in Southwestern Ontario, also referred to as **"Johnson Children's Services,"** or abbreviated to **"Johnson"**
- **The Southwestern Ontario children's aid society:** The children's aid society (CAS) whose catchment area includes the city where Misty was placed and went missing, also referred to as **"the Southwestern CAS"** or **"the local CAS"**.

Child Welfare in Ontario

28 The *Child, Youth and Family Services Act, 2017* (the *CYFSA*)[6] governs the provision of child welfare services in Ontario. It sets out who is allowed to provide these services, how they must operate, and what the rights of children and youth receiving services under the Act are. In many cases, individuals and organizations must be licensed or designated by the Ministry of Children, Community and Social Services to provide services.[7]

29 The Ministry of Children, Community and Social Services oversees all of Ontario's children's aid societies and licensed residential service providers. This function includes issuing licences to foster care providers and conducting licensing inspections to ensure compliance with the terms and conditions of the licence, statutory requirements found in the *CYFSA* and any regulations, and all policies, procedures and directives issued by the Ministry. Children's aid societies are also held accountable to the legislative, regulatory and policy requirements through their contracts with the Ministry and reporting requirements.

Children's aid societies

30 There are 50 children's aid societies, including 13 Indigenous child and family well-being societies, designated and funded by the Ministry. Each is authorized to operate within a specific territorial jurisdiction and may be approved by the Ministry to provide a variety of services related to children, such as:

- Investigating allegations or evidence that children may be in need of protection;
- Protecting children where necessary;
- Providing guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children;
- Providing care or supervision for children; and
- Placing children for adoption.[8]

[6] *Child, Youth and Family Services Act*, 2017, SO 2017, c 14, Sched. 1 [*CYFSA*].
[7] *Ibid*, s 244.
[8] *Ibid*, s 35(1).

31 All Ministry-designated children's aid societies are subject to the *CYFSA* as well as its accompanying regulations. Among other things, the Act obligates children's aid societies to follow Ministry-prescribed standards of service, procedures, and practices.[9]

Indigenous child and family services

32 Some of the designated children's aid societies in Ontario have a specific mandate to provide services to identified First Nations, Inuit, and Métis communities. This is consistent with one of the guiding principles of the *CYFSA*, which is that Indigenous peoples are entitled to provide their own child and family services and that "all services to First Nations, Inuit and Métis children and young persons and their families should be provided in a manner that recognizes their cultures, heritages, traditions, connection to their communities, and the concept of the extended family."[10]

33 Under section 70 of the *CYFSA*, if an organization is authorized by a band or First Nations, Inuit or Métis community to operate as a "child welfare authority," the Minister may, at the community's request, designate the organization as a children's aid society. In this report, the term "Indigenous child and family well-being society" is used to refer to children's aid societies designated under this section of the Act.

34 In Misty's case, Anishinaabe Abinoojii Family Services (AAFS) is the Indigenous child and family well-being society authorized to provide services to a number of First Nations communities over a large geographic area, including her specific First Nations community. AAFS has a three-party contract between itself, the specific First Nations band, and a community agency that works with that Band. This allows the First Nation greater control over how child welfare services are provided to their community, and under this agreement the community agency is responsible for providing day-to-day protection, prevention and caregiver services (e.g. foster care) on behalf of AAFS.

35 The community agency is not designated by the Ministry as a children's aid society, but a service agreement outlines the specific obligations of the agency and AAFS. Ultimately, AAFS is responsible to the Ministry for the provision of child welfare services within its jurisdiction. This report refers to all services provided on behalf of Anishinaabe Abinoojii Family Services as having been provided by that society, and all recommendations related to these services are directed to AAFS.

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[9] *CYFSA, supra* note 6, s 35(2).
[10] *Ibid*, s 1(2)(6).

Residential service providers

36 Children's aid societies sometimes enter into contracts or "agreements for service" with external organizations that specialize in providing residential care to children.

37 A foster care agency, or anyone seeking to provide foster care to three or more children, is required to obtain a licence to provide residential care.[11] As described in the *Foster Care Licensing Manual,* the licensing process is intended to be "a systematic means of assessing whether or not a basic level of care and safety is being provided to children and youth by a foster care licensee".[12]

38 Licensed service providers are required to comply with legislation, regulations, and policy requirements.[13] Licensees are also required to meet "standard" terms and conditions added to all Ministry licenses, and any "specific" terms and conditions that have been added to their licence to address compliance issues. *Ontario's Quality Standards Framework* and the *Foster Care Licensing Manual* confirms that the government maintains overall responsibility for licensing, enforcement and compliance with the rules.[14] When a children's aid society places a child with a foster care agency that is a licensed residential service provider, the foster care agency must provide a copy of its licence to the placing children's aid society before the child can be placed in a home.[15]

39 Typically, the placing children's aid society and the foster care agency enter into a written "agreement for service" that outlines the obligations of both parties. Service agreements may be supplemented by "special rate agreements," which are used to facilitate additional staff supports for children and youth. Close supervision of a child through 1-to-1 staffing is one type of additional support that can be covered in these types of agreements. There was a common understanding among the children's aid and foster care workers we interviewed in this investigation that the role of a 1-to-1 worker is to be with the child or young person at all times, and to follow them wherever they go. The agreement for service and special rate agreement, if there is one, form the basis for the financial and reporting relationship between the two organizations.

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[11] *CYFSA, supra* note 6, s 244(2).
[12] Ontario, Ministry of Children and Youth Services, *Foster Care Licensing Manual* (2012) at 8 [*Foster Care Licensing Manual*]; and Ontario, Ministry of Children, Community and Social Services, *Ontario's Quality Standards Framework* (2022) at 20.
[13] *Foster Care Licensing Manual, supra* note 12 at 9. [*Ontario's Quality Standards Framework*].
[14] *Ibid* at 8.
[15] *CYFSA*, *supra* note 6, s 249(1).

40 In Misty's case, Anishinaabe Abinoojii Family Services sought residential care for her with an external organization – Johnson Children's Services – because her northern home community did not have the resources to meet her needs. Johnson operates many foster care homes throughout Southern Ontario. They are typically owned or leased by the agency, with foster parents living on site to provide care with the assistance of paid staff.

41 As a residential service provider, Johnson Children's Services is required to hold a licence from the Ministry, and must provide a copy of this licence to a placing agency before a child is placed in a home.[16]

Johnson's licensing history

42 Johnson Children's Services Inc. had a checkered history of non-compliance with Ministry requirements. For instance, when the Ministry conducted a standard audit of the agency's operations around the time of its licence renewal in March 2016, it identified 21 "observed non-compliances." These included problems with:

- Documentation and processes related to the handling of high-risk situations and the administration of psychotropic medications;
- Staff review of policies related to the safe administration, storage, and disposal of medication;
- Staff knowledge of the serious occurrence reporting processes;
- Staff knowledge of "duty to report" requirements; and
- Staff unfamiliarity with "high-risk situations" involving psychotropic medications.

43 As a result, in May 2016 the Ministry attached additional terms and conditions to Johnson's licence, requiring that "corrective action be taken to support children's health, safety and well-being and to address outstanding issues related to staff training." The additional terms and conditions included:

- Conducting and logging a monthly trend analysis of serious occurrences to be submitted to the Ministry;
- Ensuring all staff and parents working with high-risk youth are provided with training on the individual needs of the youth;
- Ensuring all staff and foster parents are aware of their respective roles and responsibilities in relation to youth in their care;

[16] *CYFSA, supra* note 6, s 249(1).

- Ensuring all staff are aware of their roles with respect to youth who have a 1-to-1 staff, and clearly recording this information on a daily log available to placing agencies and the Ministry as requested; and
- Ensuring that individualized safety protocols are established for all youth in care.

44 Two months later, in July 2016, in response to concerns reported by the former Provincial Advocate for Children and Youth, the Ministry conducted unannounced visits to Johnson's homes in Thunder Bay. The Ministry identified several areas of non-compliance, including:

- Training related to serious occurrences and the duty to report;
- Hiring related to reference checks and criminal record checks; and
- Documentation in youth files (lack of individualized safety plans).

45 On August 16, 2016, the Ministry provided written notification to Johnson Children's Services Inc. that its licence had been further amended to include additional terms and conditions, including requirements that:

- Individualized safety plans for each youth in care be submitted to the Ministry every quarter, which were to include a procedure "that ensures the health, safety and welfare of the child/youth by outlining the needs of the child/youth, behaviours the child/youth displays, triggers, what works with the youth, and how to handle these situations as they arise";
- The Ministry be provided with a checklist to demonstrate that a vulnerable sector screening police check, reference checks and orientation/training were received/completed for staff and foster parents; and
- The Ministry be provided with a schedule showing, among other things: the hours a foster parent is in the home, the hours staff are working in the home, when a foster parent is on relief and being covered by staff, and when a staff person is working 1-to-1 with a child or youth and being paid by the placing agency.

46 On March 17, 2017, the Ministry issued a six-month provisional licence to Johnson Children's Services, with one added term and condition requiring that it provide its current licence to all placing agencies that had a child placed in a specific foster home and submit written confirmation of having done so.

47 After receiving six complaints about Johnson and a death of one of its residents in Thunder Bay, the Ministry conducted further unannounced visits at the agency's Thunder Bay residences. Shortly after, the Ministry amended Johnson's licence, requiring that its three homes in Thunder Bay be closed immediately, and prohibiting it from operating any new foster homes or accepting new children for placement in its existing foster homes. The Ministry's findings included concerns that one foster parent's training consisted only of online training and reviewing the agency's binders and that she did not understand the purpose of 1-to-1 care.

48 At the time of my investigation, Johnson Children's Services held a "regular" licence that included standard terms and conditions, as well as additional conditions imposed by the Ministry. In response to previously identified concerns, the Ministry had imposed enhanced conditions in order for the agency to maintain its licence. These conditions included a requirement that the agency submit a copy of monthly staff schedules to the Ministry that included the names of staff who spent time in every foster home, their role, the amount of time the staff person spent in the home, and the services the person provided to the foster child. Johnson was also required to establish an individualized safety plan for all children, and for those with a history of going missing, the plans needed to specifically address strategies to prevent this behaviour, including how the foster parent and support staff are to respond if the child leaves. Lastly, the licence conditions required that Johnson ensure there is a means to communicate regularly and routinely with foster parents who work with the agency.

Courtesy supervision by children's aid societies

49 When a child is placed in a residential setting a significant distance away from their home community, it is common for the children's aid society placing the child to enter into a "courtesy supervision agreement" with the children's aid society in the geographic area of the foster home. A typical agreement includes practical arrangements, relevant information about the child, reporting requirements between societies, and recommendations about the frequency of contact with the child. This helps ensure that the child is able to meet with a children's aid society worker on a regular basis, and gives the placing society a practical way to monitor the child's well-being. These agreements are typically made further to a provincial "Interagency Protocol" that outlines relevant processes when different children's aid societies are involved with the same family or child.

50 When Misty was placed with Johnson Children's Services away from her home community, the Southwestern Ontario children's aid society assigned a worker to provide courtesy supervision once they became aware of her placement. This meant that Misty had a worker at Anishinaabe Abinoojii Family Services, and eventually also had a worker at the Southwestern CAS.

Relevant law and policy

Child, Youth and Family Services Act, 2017 and related regulations

51 The *CYFSA* and its regulations, Ministry guidelines, and the standard license conditions for all foster care agencies set out various powers and duties for children's aid societies and residential licensees when a child goes missing. Residential licensees must file a report with the Ministry (known as a "serious occurrence report") when a child or young person has been missing from a residence without permission for 24 hours – or earlier than 24 hours if the residential licensee considers the child's absence to be "a serious matter."[17] The licensee is also required to notify the placing children's aid society and the police.

52 Children's aid societies and residential licensees are also required by regulation to inform my Office, in writing and without unreasonable delay, if either learns of the death of or serious bodily harm to a child who sought or received services in the last 12 months (this is known as a "Death and Serious Bodily Harm report").[18] In addition, they must also inform the child about my Office's services and provide our contact information.[19]

53 Children's aid societies have broad powers when a child goes missing. To help protect missing children, children's aid societies are empowered to obtain warrants to apprehend children who have left without consent and bring them to a place of safety.[20]

[17] Refer to O Reg. 156/18, s 84(2) and standard condition 6 included on all foster care agency licences. The Ministry's Serious Occurrence Report Guidelines also create reporting obligations: See Ministry of Children, Community and Social Services, Serious Occurrence Reporting Guidelines, (2019) at 5-6 [Serious Occurrence Reporting Guidelines].
[18] O Reg. 80/19, s 1(1).
[19] *Ibid*, s 1(4).
[20] *CYFSA*, *supra* note 6, s 83.

Ontario Child Protection Standards

54 The Ontario Child Protection Standards are established by the Ministry and set out the framework and level of service the Ministry expects from children's aid societies.[21] 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 (for example, if the child and family are unavailable for interviews), as long as a supervisor reviews and approves them.[22]

55 The standard most relevant to this investigation relates to note-taking. This standard applies to all phases of child protection service delivery. It requires staff to create contemporaneous case notes that document the date, time, method of contact, and the names of individuals involved in or related to the discussion, as well as significant dates, decisions and observations related to the contact.[23] The standards indicate that timely case notes help ensure their accuracy, and that delay can impact the child welfare professional's independent recollection of significant events.

Serious Occurrence Reporting Guidelines

56 In some cases, children's aid societies and residential licensees are required to provide a report to the Ministry when a serious event occurs with respect to a child who has interacted with the child welfare system.[24] The Ministry*'s* Serious Occurrence Reporting Guidelines set out the specific requirements surrounding this reporting and apply to, among others, licensed foster care agencies and other residential service providers.[25]

57 The Serious Occurrence Reporting Guidelines establish two levels of "serious occurrence": Level 1 and Level 2.[26] Level 1 occurrences are to be reported within one hour of an organization becoming aware. Level 2 occurrences are to be reported as soon as possible, but no later than 24 hours after the incident comes to the service provider's attention. Service providers are required to provide

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[21] Ministry of Children and Youth Services, Ontario Child Protection Standards, (2016) at 4 [Child Protection Standards].
[22] Child Protection Standards, *supra* note 21 at 16.
[23] *Ibid* at 16-17.
[24] Refer to O Reg. 156/18, s 84 and standard condition 6 included on all foster care agency licenses. The Ministry's Serious Occurrence Report Guidelines also create reporting obligations: Serious Occurrence Reporting Guidelines, *supra* note 17.
[25] Serious Occurrence Reporting Guidelines, *supra* note 17 at 5-6.
[26] *Ibid* at 10.

updates to the Ministry at least every seven business days (or as directed by the Ministry) and must continue to provide updates until the Ministry advises that no further update is required.[27]

58 For missing children, the reporting guidelines recommend a designation of "Level 1" in situations where the absence "poses a serious concern about the individual's safety," and "Level 2" designation in other circumstances. In Level 1 situations, the Ministry must be notified within one hour; in Level 2 cases, within 24 hours.[28]

59 A Serious Occurrence report about a missing child must include:

- Description of whether the child poses a serious risk to themselves or others;
- Actions taken to locate the child;
- How the child became absent (one example given is involvement in human trafficking);
- Whether the child has a prior history of going missing;
- The child's state of mind;
- Where staff were at the time the child went missing; and
- An indication of when the child returned.[29]

60 The reporting guidelines state that, in most circumstances, residential service providers have the lead responsibility for Serious Occurrence reporting when children go missing from their foster homes.[30]

Ministry-authored manuals

61 The Ministry has also published two manuals that serve as reference guides for organizations and individuals providing services to children in care.

62 The *Children in Care Manual* was developed by the Ministry in 1985 and integrates the relevant policy, guidelines and legislation at the time (the *Child and Family Services Act*), into one document. Despite being published almost 40 years ago, it continues to serve as a resource by providing best practices and outlining the roles and responsibilities of placing societies and residential

[27] *Ibid* at 15.
[28] Serious Occurrence Reporting Guidelines, *supra* note 17 at 30-1.
[29] *Ibid* at 33.
[30] *Ibid* at 11-2.

service providers.[31] For example, the Manual notes that the operator of a residence is required to ensure that case records are maintained, that appropriate policies and procedures are established, and that staff are trained accordingly.[32]

63 A similar guide published by the Ministry in 2012, the *Foster Care Licensing Manual*, focuses on the licensing requirements set out in relevant legislation and regulations at that time. It also establishes the "minimum level of care that must be provided by a foster care licensee"[33] and confirms that a licensee is required to comply with child welfare legislation, associated regulations, and Ministry policies and procedures.[34] In July 2020, the Ministry released new guidance, referred to as *Ontario's Quality Standards Framework*, which addresses similar policy requirements for home care licensees.[35] This framework is in the process of being implemented by regulation, and did not create any requirements for residential licensees at the time Misty went missing.

Johnson Children's Services policies

64 Johnson Children's Services Inc. also had its own internal policies and procedures to govern its operations. Three areas of the agency's *Policies and Procedures Manual* were significant to the issues in our investigation: The "Log Book," "Serious Occurrence," and "Missing from Care Protocol" sections.

65 Johnson's policies and procedures require each foster parent to maintain a "log book" for each child in their care. The log book is supposed to document, among other things, unusual events, happenings, or behaviours and incidents affecting the health, safety and well-being of the child.[36] The policy notes that the purpose of the log book is to support "continuity of care" and that any information that would be helpful to future caregivers should be included in the notes.

66 The policy manual specifically acknowledges and operationalizes the Ministry's own Serious Occurrence Reporting Guidelines. It lists specific details to be included in a Serious Occurrence report, including the "Current Condition (Health and Safety) of Involved Persons." As well, it sets out the roles and responsibilities of agency staff in these reports.

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[31] Ministry of Community and Social Services, *Children in Care Policies,* (1985) at CH-0101-01 [*Children in Care Policies*].
[32] *Ibid* at CH-0305-03.
[33] *Foster Care Licensing Manual*, *supra* note 12 at 11.
[34] *Ibid* at 9.
[35] *Ontario's Quality Standards Framework, supra* note 12.
[36] Johnson Children's Services, Policies and Procedures at 158 [Johnson Policies and Procedures].

67 Johnson's "Missing from Care Protocol and Procedures" comprehensively sets out how to respond when a child goes missing. It establishes the roles and responsibilities of different individuals, including the service provider itself, foster parents, and others. It also discusses how the risk to the child will be assessed when determining a response and what the response will be, based on that assessment. It provides details about how information will be shared among different parties, and sets out strategies to help prevent a child from going missing again.

Anishinaabe Abinoojii Family Services policies

68 Anishinaabe Abinoojii Family Services also had policies and procedures setting out how it provides service to the children in its care. Of relevance to this investigation are procedures for the placement of children out of the community, and the society's obligations when a child goes missing.

69 When placing children out of the community, the policy stipulates that a child is to be placed in a home that is appropriate to meet the child's needs. Placement decisions must comply with outlined priorities. For example, the first priority is to place a child with extended family in the child's home community when possible. Extended family in another community are then considered, followed by non-Indigenous families in the home community. Only as a last resort is a child to be placed with an external organization that provides foster or group care, as occurred with Misty.

70 If a child goes missing, the policy states that every attempt must be made to find them and return them to a safe place as soon as possible. It emphasizes that the child's safety and protection are of paramount concern, and notes that co-ordinated efforts to locate them should be made by the child's worker, alternative caregivers or other placement resources. This may include contacting friends and others who might know of the child's whereabouts, and going to the places the child frequents. The policy specifically provides that a missing person report should be filed with the police.

Policies of the Southwestern CAS

71 The Southwestern Ontario children's aid society similarly has its own policies and procedures. Most relevant to this investigation are those related to missing children and youth. These policies require the care provider to notify the CAS upon becoming aware of a missing child, and instruct the worker who receives this notification to consult with their supervisor immediately.

72 The policies note that the local police service has two levels of response for missing persons: Level 1 (identifiable risk) and Level 2 (no identifiable risk), and that risk factors are determined by a questionnaire. Answering "yes" to any of the questions results in a Level 1 classification, for example: Is the person under the age of 16 years and involved in prostitution or the use of cocaine, heroin or crystal methamphetamine or like drug?

73 In most circumstances, the policies direct the child's CAS worker to contact key people with whom the missing child might be in contact to help determine their location.

74 The policies also identify the potential option of obtaining a "warrant of apprehension" under section 83 of the *CYFSA* in situations where the local children's aid society worker expects there might be difficulties in returning the child to care. These warrants empower police to enter premises where the child might be staying without having to obtain other types of warrants. The policies also say police have the authority to apprehend a child under 16 without a warrant if they believe them to be in need of protection, and that police generally consider a missing child under 16 to be at substantial risk of harm.

Known Tragedy: Missing and Murdered Indigenous Women and Girls in Ontario

75 Misty's experience must also be considered within the larger social context of the vulnerability of young Indigenous girls who go missing. Although many reports and studies have considered the violence and oppression faced by Indigenous people,[37] the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls,[38] released in 2019, provides a comprehensive summary of the circumstances facing Indigenous girls like Misty.

76 As the report documents, the history of colonization has altered the relationships of First Nations, Inuit, and Métis Peoples to their culture and identity, through targeted policies designed to sever their cultural and kin connections. Residential schools, the Sixties Scoop, and government and other assimilatory policies were the starting points for further forms of violence that Indigenous women and girls

[37] For example, see: *Honouring the Truth, Reconciling for the Future Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (Ottawa: 2015), online: <https://nctr.ca/records/reports/#trc-reports>; Canada, Report of the Royal Commission on Aboriginal Peoples (Ottawa, 1996), online: <https://www.bac-lac.gc.ca/eng/discover/aboriginal-heritage/royal-commission-aboriginal-peoples/Pages/final-report.aspx>.
[38] *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, vol. 1a (Ottawa, 2019) [MMWIG National Inquiry 1a], online: <https://www.mmiwg-ffada.ca/final-report>; MMWIG National Inquiry 1b, *supra* note 4.

experience today. The report points out that child welfare systems in particular have created conditions that maintained violence in families, in communities, and within Indigenous groups in Canada.[39]

77 The report also finds a direct link between current child welfare systems and the disappearances and murders of Indigenous women and girls, and many of its recommendations relate to improving child welfare outcomes for Indigenous children and their families. It concludes that the child welfare system fails to meet the needs of Indigenous children and youth and to protect them from abuse and exploitation. This has assisted human traffickers in targeting Indigenous children and youth in care for sexual exploitation.[40] The report calls upon all child welfare agencies to establish more rigorous requirements for safety, harm prevention and needs-based services within foster and group homes to prevent the recruitment of Indigenous children in care into the sex industry.[41]

78 While an exact figure is not available, several studies have estimated that the majority of individuals trafficked for sex in Canada are Indigenous.[42] Researchers have pointed to root causes that often put Indigenous girls at risk of sexual exploitation, including poverty and homelessness, substance use, mental health concerns, and a history of abuse.[43] Researchers have also identified that the movement of Indigenous youth from tightly connected reserves to big cities can add to a feeling of isolation, yet another risk factor identified in victims of sex trafficking. One study also noted that girls are commonly first trafficked at around age 13 or 14.[44]

Misty's story: Chronology

79 In order to better understand the impact of the events and conduct of various child care organizations involved in Misty's care, it is important to review her personal history and experiences before she arrived in Southwestern Ontario in

[39] MMWIG National Inquiry 1a, *supra* note 38 at 339.
[40] *Ibid* at 355.
[41] Call for Justice 12.14, MMWIG National Inquiry 1b, *supra* note 4 at 196.
[42] See: Canada, Department of Justice, *Victims of Trafficking in Persons: Perspectives from the Canadian Community Sector* by Jacqueline Oxman-Martinez, Marie Lacroix and Jill Hanley, (Ottawa: Department of Justice, Research and Statistics Division, August 2005) at 10.
[43] See: Anupriya Sethi, "Domestic Sex Trafficking of Aboriginal Girls in Canada: Issues and Implications," (2007) 3:3 First Peoples Child and Family Rev 57 at 61-3; Anette Sikka, *Trafficking of Aboriginal Women and Girls in Canada*, (Ottawa: Institute on Governance, Aboriginal Policy Research Series, May 2009).
[44] Canadian Women's Foundation, *An Assessment of Sex Trafficking in Canada* by Nicole A. Barrett (May 2013) at 13, online: <https://www.canadiancentretoendhumantrafficking.ca/wp-content/uploads/2016/10/Assessment-of-Sex-Trafficking-in-Canada.pdf>.

the summer of 2020. At age 13, Misty had already lived a life full of challenges, trauma, and loss.

Pre-2020

Early years in Northern Ontario

80 Misty's involvement with child protective services began in 2006, when she was a newborn. She first formally came into the care of Anishinaabe Abinoojii Family Services on October 10, 2007. Over the years, AAFS was periodically engaged with Misty as a result of protection concerns including parental alcohol and drug use, lack of supervision, neglect, and domestic violence. When she was not with her mother or other relatives, Misty lived in a series of foster homes.

81 Misty has been diagnosed with Attention Deficit Hyperactivity Disorder and Fetal Alcohol Spectrum Disorder, which have led to serious behavioural challenges. Many who know her have said she struggles to control her impulses and can be easily led or influenced.

82 Misty's most recent contact with the child protection system began in 2019, after she moved to a larger town in Northwestern Ontario to attend school. When she first arrived there, Misty stayed with her mother. During this period, Misty also spent considerable time living on the streets, and the local Ontario Provincial Police received 22 calls about her safety. We were told Misty was regularly using hard drugs such as methamphetamines. Local police and AAFS workers also strongly suspected that she was the victim of sexual assault and sex trafficking involving much older men. One 40-year-old man had been charged with sexual assault.

83 AAFS entered into a customary care agreement[45] relating to Misty's care on June 14, 2019. The next day, Misty's father died unexpectedly. His sudden and tragic death intensified Misty's mental health challenges. She remained in the customary care placement until November 12, 2019, when AAFS placed her in one of the foster homes it operated locally.

84 In January 2020, Misty's mental health declined to the point where she was hospitalized for a week. Anishinaabe Abinoojii Family Services recognized its own resources were inadequate to meet her complex needs and engaged in considerable efforts to find an appropriate placement close to her home. Several witnesses interviewed during our investigation stressed that there are limited placement options available in Northern Ontario for children like Misty. Staff at

[45] The concept of "customary care" is defined as "the care and supervision of a First Nations, Inuk or Métis child by a person who is not the child's parent, according to the custom of the child's band or First Nations, Inuit or Métis community,": *CYFSA, supra* note 6, s.2(1).

AAFS told us there was nowhere she could live safely in her community or the surrounding area. Each placement they tried broke down due to Misty's drug seeking, threatening and violent behaviours. After exhausting all available resources in the North, they began to consider options in Southern Ontario as a last resort.

Initial placements in Southern Ontario

85 Staff at AAFS told us they thought "treatment foster homes" in Southern Ontario would offer Misty the resources and access to medical professionals she desperately required. The reality is that the term "treatment foster homes" is of little significance.[46] There are no standards covering the use of this term, and foster care providers have considerable scope when it comes to describing their services.

86 Misty's AAFS worker had limited experience with placing children in Southern Ontario. Several staff from AAFS told us how difficult it was to find a foster placement that would accept Misty and meet her significant needs. Most of the homes they contacted indicated that they would not be an appropriate fit after they reviewed Misty's circumstances.

87 Eventually, they found a home for her in Southwestern Ontario. This first placement began on February 6, 2020, but broke down almost immediately. The documentation suggests that Misty was frustrated to be placed with a non-Indigenous foster parent in a community with very few Indigenous people. Her behaviours escalated, and while awaiting a placement change, she and another child went missing. Her behaviour resulted in police involvement, and she was admitted to hospital on February 14 for the night. She was placed in another foster home in the area on February 15, then discharged on February 18 to the care of her AAFS worker, who had flown down to assist.

88 Misty and the AAFS worker stayed in a hotel for several days, while the worker once again embarked on the challenging task of trying to find a placement willing and able to meet Misty's needs. On February 21, she was successful and Misty began a new placement in a foster home, this time in Southeastern Ontario.

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[46] In his March 2019 report regarding Johnson Children's Services Inc., the Provincial Advocate for Children and Youth made several recommendations addressed to the Ministry to provide greater definition and monitoring of "treatment foster homes," including that the Ministry should establish clear and objective criteria that must be met before a residential service provider is permitted to market itself to placing agencies as providing "treatment" to children and youth in a residential setting. See: Ontario Child Advocate, *Investigation Report: Johnson Children's Services Inc., (Thunder Bay) Office*, (March 2019) at 62, online: <https://ocaarchives.files.wordpress.com/2019/05/jcsinvestigationreporten.pdf>.

89 On February 25, Anishinaabe Abinoojii Family Services received a call from police indicating that Misty would be charged with mischief for damaging the home and assaulting foster home staff. She was arrested March 4 and held by police. An officer noted in a report on the incident that the foster home was incapable of meeting Misty's needs. She remained in police custody for more than a week. On March 11, she was released to the care of her AAFS worker, as the foster home could not take her back.

Initial placement with Johnson Children's Services

90 Misty's worker again searched for a new appropriate placement, and continued to be told by many homes that they could not meet her needs. A senior official at Anishinaabe Abinoojii Family Services described the situation in stark terms:

> Desperation sets in. You know you don't have the resources [for Misty] back here. If we bring her back here, she is going to be trafficked, she possibly goes back to that full lifestyle of meth and will be dead. That's what's in your head when you're desperately looking for [a placement] for her.

91 Johnson Children's Services agreed to accept Misty into a foster home in a different area of Southwestern Ontario, and she went to live there on March 11. AAFS and the agency entered into agreements setting out terms relating to Misty's care and providing for her to receive 1-to-1 staffing.

92 Our Office reviewed the admission package that was submitted to Johnson regarding Misty's placement. It contained detailed information about Misty's needs and the struggles she had faced at previous foster placements. It specifically referenced her drug and alcohol use, her relevant medical diagnoses, and the concern that she was at risk for human trafficking.

93 Although Johnson was willing to accept Misty, there was some reason for concern. A senior executive at AAFS told us that staff at a children's aid society in Southern Ontario advised against placing any children in homes run by Johnson. However, AAFS considered itself out of other options by that point.

94 Misty adapted to the new foster home better than the previous ones, and notes we reviewed from that time suggest that she got along with the foster mother and the other youth in the home. We understand Misty received 1-to-1 staffing at this home, with staff supervising her at all times. She also regularly attended counselling and was adjusting well.

95 Then, in the spring of 2020, Misty was notified of another tragic loss. Her teenaged brother was killed in a car accident. After she returned from his funeral

in Northwestern Ontario, Misty began to engage in increasingly risky behaviour, including using drugs and running away. She refused grief counselling and even with the help of 1-to-1 staff, the foster mother did not feel capable of meeting her needs and asked that Misty be moved. Johnson Children's Services transferred Misty on an emergency basis over a weekend in early summer 2020 to one of its homes in Southwestern Ontario.

Period under investigation – summer 2020

First placement in a new city in Southwestern Ontario

96 Misty did not settle well into the new foster home in a different area of Southwestern Ontario. As Johnson Children's Services had not notified Anishinaabe Abinoojii Family Services of the move in advance, her AAFS worker was not present to help Misty adjust to her new surroundings. Her foster mother at the placement recalled that the Johnson worker who escorted Misty to the new city walked into the home, threw Misty's bags down, said that was all she needed, and left.

97 The foster mother told us she was not informed of Misty's recent challenges in advance. However, the safety plan that was developed for Misty by Johnson highlighted many of her risk factors and troubling behaviours. The plan identified strategies such as keeping Misty occupied, and contacting the police immediately if she went missing. It also said Misty was supposed to be supervised at all times. The Johnson resource worker, whose role included recruiting and training foster parents, ensuring compliance with applicable rules and acting as a liaison for foster parents, told us this plan was reviewed by the foster mother and every staff person who worked in the house. However, there was no documentation confirming when this occurred. Individual staff members we interviewed told us they were also largely unfamiliar with the safety plan for Misty and the strategies it identified.

98 Misty ran away the same day she arrived at the new home. She returned the next day. She ran away again several days later and threw rocks at staff who attempted to follow her. She returned later that night and was cautioned by police.

99 Misty went missing for a third time less than a week later. When the Johnson resource worker found her the next afternoon on a roadway near the home, Misty said she had been assaulted. The foster mother described Misty at the time as filthy, bloody, bruised, with her hair in disarray, blood running down her legs, and little bugs crawling over her. She was wearing someone else's clothes, including combat boots that were taped to her feet. Emergency medical services and

police were called and Misty was taken to hospital. She tested positive for cannabis and amphetamines.

100 The local children's aid society was not aware of Misty's presence in Southwestern Ontario until she was taken to hospital. Around that time, police informed this CAS that Misty had been reported missing several times since arriving in the region less than two weeks earlier. The Southwestern CAS assigned a worker from its Indigenous Unit to Misty's case almost immediately.

101 The Southwestern CAS worker met with Misty shortly thereafter. The worker's notes indicate that Misty was very quiet and seemed to be experiencing "massive cultural shock." That same day, a police officer from Northwestern Ontario sent an email to police in her new location. He was familiar with Misty and wanted to alert the service's human trafficking unit to her unique vulnerabilities. This officer felt that Misty was at risk of death by overdose as well as human trafficking – there was evidence that she had been the victim of sexual assaults, and one sexual assault charge was pending. He was concerned that Misty could easily become another missing or murdered Indigenous girl.

102 Two days after meeting with the Southwestern CAS worker, Misty went missing again, this time for two days. Police returned her to the foster home.

103 For the first two weeks of her placement, Misty was the only child in the home. There were few rules and she was allowed to set her own schedule, which typically involved staying up very late and sleeping through most of the day. We were told that various staff members were present in the home on a rotating basis, but there were periods of time with no adult supervision. While this would be disturbing in any event, it was even more troubling because the Johnson Children's Services policy manual indicated that its programs had a high adult-to-child ratio and provided highly structured and supervised home environments.

104 About two weeks after Misty was placed in the home, a second girl came to stay there, followed a bit later by a third. Misty did not get along with one of these girls, and there was frequent peer conflict.

105 On one occasion, Misty became extremely agitated with one of the girls in the home, and began to throw mugs and other objects at the foster mother and other residents. She called the police on herself and then left. She returned a short time later and threw bricks and other objects at the house, breaking windows. Next, she damaged the windshield and windows of the foster mother's car, and slashed the interior.

106 When police arrived, they charged Misty with mischief and uttering threats. She remained in police custody for one night while the Southwestern CAS attempted to contact her Anishinaabe Abinoojii Family Services worker to get directions on where Misty should be placed once she was released. The foster home was unwilling to take her back, and her bail conditions also prevented her from returning there.

107 The situation was challenging for Misty. She told several people that she was close to the foster mother at the home and liked living with her. She didn't want to go to another placement.

108 Johnson ultimately agreed to accept Misty into another foster home in the same area. She was released from police custody to this new home and her Southwestern CAS worker and the Johnson resource worker helped her move into the new home.

Second placement in the Southwestern Ontario city

109 Misty spent very little time at her second placement in the Southwestern Ontario city. Shortly after her move, she returned to her previous placement, then walked away after refusing to be brought back to her new foster home, saying that she was looking for someone to party and do drugs with. She was reported missing to police, and returned later that night.

110 The next day, Misty ran away again. This happened when a staff member took Misty and "Ella," another youth at the home, to a park. Despite the fact that Misty was to receive 1-to-1 supervision, the staff member allowed the two girls to go off on their own and they disappeared from the park at approximately 6:30 p.m. We were told the staff member looked for the girls and then returned to the foster home. The worker contacted the foster parent and the Johnson resource worker to tell them what had happened.

111 The resource worker eventually called police at 10:37 p.m., more than four hours after the girls had gone missing. This resource worker also informed the Southwestern CAS and the Ministry that the girls were missing, and the AAFS worker was notified the next business day.

112 Misty remained missing for most of the next 19 days.

On the run

113 In the early hours after Misty went missing, the police officers assigned to her case interviewed the Johnson resource worker, the staff member who was at the park, and the foster mother from her latest placement. The officers noted that the resource worker said Misty had previously gone to a "drug house," but she wasn't aware of the address. According to the officers' notes and report:

> [The resource worker] had no specific safety concerns for the two [girls] as both of the [girls] have gone missing from the group home before…. Worker wished to report [the girls] missing as per their group home policy… she did mention that [Misty] used drugs.

114 The worker who was with the girls when they ran off provided a similar statement, indicating that she was not worried and did not have safety concerns for Misty.

115 Based on a conversation with the foster parent from the latest placement, the police determined that Misty had not returned by her curfew, which was a breach of her bail conditions. A warrant of arrest was issued based on this breach, which would allow the police to take Misty into custody if they found her.

116 In addition to notifying police that Misty was missing, Johnson Children's Services also notified the Southwestern CAS. Emails we reviewed indicate that Misty's AAFS worker was notified the next business day, which is consistent with the Ministry's and Johnson's policies. There were numerous emails and phone calls between staff at all three agencies in the days immediately after Misty went missing.

117 However, due to confusion and poor communication within Anishinaabe Abinoojii Family Services, many staff there were not aware that Misty was missing. Staff we interviewed consistently told our investigators they were not notified that Misty was missing until many days later. One senior official said AAFS first learned that Misty had disappeared over a week later, when a family member posted on Facebook that they hadn't been in contact with her and thought she might be missing. Our investigation was unable to determine the source of this confusion at AAFS, given the communication it received from Johnson Children's Services regarding Misty's absence.

Searching for Misty

118 Based on the information provided by Johnson staff, the police applied their assessment methodology and rated the missing persons report for Misty and Ella as non-urgent. When we asked about this assessment, one police officer told us "the staff members … didn't emphasize real risk to the children's safety." Another said he was given the impression that "these two young [girls] are chronically missing... but there is nothing to raise the alarm that they were in imminent danger." He emphasized that, based on what he was told, there were no specific risk factors that stood out to him that would have changed the police response.

119 Over the next day and a half, the police Missing Persons Co-ordinator struggled to connect to the Johnson resource worker, sending numerous texts and leaving several voicemails. Three days after Misty went missing, the resource worker told police that Ella, the youth who had left with Misty, had returned and was willing to speak with police in person. The police notes also indicate that the resource worker told them Ella had suggested Misty was likely in a "trap house," (a place where illegal drugs are sold), possibly doing drugs and having sex with adult men.

120 Before the police acted on this information, however, Misty returned to her previous foster home. Although she was not allowed to be there because of her bail conditions, she told our investigators that she didn't know where her new foster home was or how to get there, as she wasn't familiar with the area she was living in. Staff at the home said Misty arrived intoxicated, hungry, and covered in vomit. They escorted her back to her new placement, as she was not allowed to be in contact with the former foster mother or another youth at that home. Police issued another warrant for Misty's arrest, based on her breach of bail conditions.

121 Misty's return was brief. After she took a shower and changed clothes, she asked a staff person to take her for a drive. The worker agreed, but said she would not take Misty downtown. Misty accepted, but while in the car, she became upset when the worker again refused to take her downtown. The worker told us that while the car was going 60 kilometres per hour, Misty took off her seatbelt, opened the door, and looked like she was about to jump out. The worker slowed down to prevent Misty from jumping out of the moving car, but once the car stopped, Misty got out and started walking away. The worker said she immediately called police and the resource worker, but was unable to follow Misty because she was in traffic and could not quickly turn the car around.

122 The police attempted to find Misty at a specific address, based on information from the resource worker and Misty's former foster mother. They conducted surveillance of the house, and made repeated visits, gaining entry at least once,

but the residents either denied knowing anything about Misty or her whereabouts.

123 Around 10 days after Misty went missing, the police officer from Northwestern Ontario who had previously spoken to police in Southwestern Ontario about Misty reached out to them again. The officer told our investigators he was contacted by Anishinaabe Abinoojii Family Services, which wanted to ensure everything possible was done to look for Misty, and that police in Southwestern Ontario had information about her risk factors. He explained that in his experience as an officer, knowing Misty's risk factors would change how he approached the case. The local officers we spoke with agreed, noting that the information provided by this officer was alarming and increased the urgency of their search.

124 The next day, the police in Southwestern Ontario issued a media release to assist in locating Misty. They also contacted social media outlets to determine whether she was accessing her accounts and from what location. That same day, the resource worker spoke with police again, highlighting Misty's drug use and her belief that Misty was involved in human trafficking. A day later, the foster mother discussed the situation with police, but given her limited contact with Misty, she had no further information to provide.

125 After multiple attempts to meet with Ella, the officers were able to interview her the following day. Ella told them she saw Misty use methamphetamines, fentanyl, cannabis, cocaine, and Xanax, and that Misty was being used by others to sell drugs. Ella also reported that she herself had been sexually assaulted and that Misty had engaged in sexual intercourse with an adult male at the same address that the police had visited and were monitoring. In these circumstances, Misty was below the age of consent under the *Criminal Code* ***and*** this situation would have been a serious crime. Ella told the officers she was worried about Misty, but didn't know where she was.

126 The day after speaking with Ella, the police searched Misty's room, but found only a few phone numbers that did not advance their investigation, including one for a staff member at our Office who had spoken with her regularly. They also found several pipes used to smoke crystal meth and empty baggies.

127 The police continued to conduct surveillance on the address provided by the resource worker, but did not find any evidence of Misty's presence. They also continued their search, attempting to locate potential addresses and identify persons of interests, following up on tips generated by the media release, and contacting social media outlets for information.

Failure to communicate

128 As the search stretched on, the Anishinaabe Abinoojii Family Services worker struggled to connect with the Johnson resource worker to obtain updates. She received no response to her emails, calls or texts, and could no longer leave a voicemail message because the resource worker's voice mailbox was full. She also tried to contact Johnson's Executive Director, but received no response.

129 Anishinaabe Abinoojii Family Services was unaware that the resource worker had stopped responding to communications because she had gone on leave from her position shortly after her last contact with the police. Johnson's Executive Director told our investigators that the workers would know who to call at the office if they could not reach the resource worker. He also said he had told the police, AAFS and the Southwestern CAS about the staffing change. We found no evidence to support this claim. The record-keeping by police and the CAS was exemplary, and it is unlikely that both would have failed to record this information. Without the resource worker, AAFS tried desperately to obtain updates about the search for Misty. It also took some time for the worker at the Southwestern CAS to learn that the resource worker was no longer available.

130 When the Johnson Children's Services Executive Director did eventually reach out to AAFS, more than two weeks after Misty went missing, it was to discuss officially discharging Misty from Johnson's care. AAFS declined this request, as its staff wanted to ensure Misty had an address in the area to return to – they were worried police might stop looking for her if she didn't have one. One told us it felt as though Johnson Children's Services wanted "to wash their hands" of Misty.

Northern search party

131 Fourteen days after Misty had left her latest foster home, a search party representing her northern community arrived in Southwestern Ontario. The group included a retired police officer from her home community with experience in looking for youth, and a Child Advocate from Misty's community. Two other searchers joined the team: A crisis worker from Southwestern CAS with expertise in working with missing youth, and a retired police officer who had previously worked with members of the search party.

132 The decision to send a search party was a serious response to an alarming situation. A senior AAFS official told us they were extremely concerned about Misty's vulnerability, her desire to be loved, and her risk factors for trafficking:

> [W]e lost her in [Southwestern Ontario] and we [didn't] want to lose her across Canada…the danger of death was primary for her…that she would be a missing and murdered Indigenous woman…that she would be another statistic lost and we would just hear about it in the news.

133 The search party worked closely with the local police. They relied on group chats and in-person briefings to ensure relevant information was shared between their members and police. They followed up on reported sightings of Misty and monitored locations known to be used by traffickers and drug dealers. We were told that this "lit a fire on the street," which increased Misty's profile and led to more tips and sightings being reported.

134 The police officers told us civilian search parties of this type are very rare. One experienced officer said "this was the first time I had ever seen an organization send their own group, from their own community, hours and hours away, to assist in trying to locate an individual." He noted this "spoke volumes to their concern and care." Staff from the Southwestern CAS also said of the search party: "The work they did was exceptional… these folks need to be commended."

Misty returns

135 Despite the extensive search, Misty was not found. She eventually chose to return to her first foster home in the Southwestern Ontario city, 19 days after initially going missing. The police were called, and Misty told them she had recently overdosed on fentanyl, had been revived twice with naloxone (a medication used to reverse the effects of opioids), and had taken more drugs after overdosing. Based on this information, the police immediately took her to hospital for assessment. A staff member from the Southwestern CAS who accompanied her told us "she looked like she was 11, skinny, dirty, messy hair, [and] not lucid in her thinking." He added that while Misty had a "tough exterior" she was "just a little girl under all that."

136 Once she had been medically cleared, Misty was released from hospital into the care of the Anishinaabe Abinoojii Family Services staff member who was part of the search team. We were told Misty was happy to see people from her community. The search team determined it was in her best interest to drive home with her, rather than fly. During the lengthy drive, Misty was largely quiet.

137 Misty's return to her northern community was not the end of her journey. At the time this report was written, she remained in the care of AAFS. Although Misty initially experienced some improvement after participating in a particular specialized treatment program in Southern Ontario, she continues to face many significant challenges, according to our most recent contacts with her caregivers.

138 Misty survived her time on the streets in Southwestern Ontario against the odds, but she did not escape unscathed. We will likely never know the full extent of what Misty experienced during the periods she went missing. But we do know that she returned visibly injured and in need of medical treatment at one point, and clearly unwell on another occasion. She admitted to having overdosed on powerful drugs, and a former housemate reported that she and Misty had been sexually assaulted while they were missing together.

Near Miss: Failure to Consider Risk Factors

139 My investigation has revealed numerous failures and missteps on the part of the organizations responsible for Misty's welfare. However, before addressing the many instances when the requirements of standards, policies, and agreements were disregarded, I would first like to discuss an issue that I consider particularly disturbing, given the findings of the National Inquiry into Missing and Murdered Indigenous Women and Girls.

140 Misty was a 13-year-old Indigenous girl, far away from her northern home, cut off from her family and cultural identity, living with mental health and developmental challenges, having a history of drug use, and suspected of being the victim of sexual abuse and trafficking. The academic literature is clear that Misty's particular circumstances placed her at exceptional risk for human trafficking. A Northwestern Ontario police officer familiar with her circumstances was justifiably concerned about Misty's potential to join the ranks of missing and murdered Indigenous women and girls, and took action to notify his counterparts in Southern Ontario. Anishinaabe Abinoojii Family Services similarly recognized the danger, and members of Misty's community mobilized in a remarkable effort to search for her before it was too late.

141 However, Johnson Children's Services Inc., which was responsible for Misty's care in the summer of 2020, failed to demonstrate an awareness of how uniquely vulnerable she was to drug overdose, sexual abuse, and sex trafficking. On at least one occasion, its staff delayed contacting the police by several hours – and when they did report Misty missing, they minimized the situation. They labeled her as a chronic runaway and told police that there were no safety concerns. It wasn't until much later that Misty's risk of harm became clearer and a press release was issued.

142 It is a sad and longstanding reality that Northern Ontario lacks sufficient resources to offer the treatment and care required to address the complex challenges faced by Indigenous children like Misty. Although this chronic problem is not within the scope of my current investigation, it is the underlying reason that

Misty ended up in Southwestern Ontario in the first place. Misty was not the first – nor is she likely to be the last – young Indigenous girl transplanted to Southern Ontario by child protection authorities because they have run out of options closer to home.

143 I note that on April 27, 2022, the Minister of Children, Community and Social Services issued a policy directive under the *CYFSA* that will come into effect on July 1, 2023, which includes a requirement that foster parents undergo interactive training on First Nations, Inuit and/or Métis cultural competency.

144 Before Johnson Children's Services accepts another Indigenous child into its care, it should ensure that all of its foster parents, along with its staff, receive robust training in the spirit of the Calls to Action of the Truth and Reconciliation Commission relating to child welfare, as well as specific learning about the findings and recommendations of the National Inquiry into Missing and Murdered Indigenous Women and Girls.[47] It should also ensure that information about the history and culture of Indigenous peoples in Canada, including the impact of colonialism, residential schools, the Sixties Scoop and other issues that have contributed to placing Indigenous children at particular risk for sex trafficking and other harms are factored into its decision-making about Indigenous children placed in their care.

Recommendation 1
Johnson Children's Services Inc. should ensure that all of its foster parents and staff receive Indigenous cultural safety training.

Recommendation 2
Johnson Children's Services Inc. should ensure that it considers risk factors unique to Indigenous children in its decision-making about their care.

Lapses in Care

145 Misty's disappearance could have ended more tragically, and it is vital that the organizations tasked with her care learn from what she experienced. Children must be able to expect that they will be kept safe by the adults and institutions meant to protect them. Unfortunately, in Misty's case the organizations entrusted with her care repeatedly failed to meet the requirements established by law, the

[47] The Ministry of Children, Community and Social Services advised our Office that as of November 18, 2022, Johnson's licensing conditions no longer allow it to accept new children into its residences.

Ontario Child Protection Standards, Ministry manuals, inter-agency agreements, and the organizations' own policies.

Failure to comply with the service agreement

146 On March 11, 2020, Anishinaabe Abinoojii Family Services and Johnson Children's Services entered into a service agreement setting out the key terms of the care that Misty would receive. During the time that Misty was in Johnson's care, it repeatedly failed to abide by the agreement.

147 According to the agreement, Johnson was required to consult with AAFS seven days in advance and obtain approval before moving Misty to a different foster home. Johnson neglected to do so when it moved Misty on an emergency basis to a different area of Southwestern Ontario. During our investigation, Johnson Children's Services acknowledged that permission was required to change Misty's residence. However, it was unable to produce any documentation confirming that it sought or received prior approval. The AAFS worker's case notes indicate that she eventually received a call informing her of the move after the fact. She also told us that Johnson never advised her of any incident that would warrant an emergency move. AAFS was caught off guard by the sudden move and was unable to assist with Misty's transition to the new placement.

148 Under the agreement, Johnson also committed to reporting all Serious Occurrences to the Ministry as required, and to also forward these reports and related incident reports to AAFS. Although Johnson submitted several Serious Occurrence reports to the Ministry when Misty went missing, it did not provide them to AAFS. The Southwestern Ontario children's aid society had to formally request this documentation from Johnson after receiving a request for the records from AAFS.

149 In future, Johnson Children's Services Inc. should ensure that it complies with the terms of the service agreements it enters into. It should provide notice and seek prior approval from placing societies before moving children in its care. As well, it should provide the societies with copies of any Serious Occurrence reports relating to children they have placed in its care.

Recommendation 3
Johnson Children's Services Inc. should ensure that it complies with the terms of service agreements it enters into with societies that have placed children in its care.

Recommendation 4
Johnson Children's Services Inc. should provide notice and obtain approval from societies before moving children they have placed in its care.

Recommendation 5
Johnson Children's Services Inc. should provide copies of all Serious Occurrence reports to societies relating to children they have placed in its care.

Failure to deliver 1-to-1 care

150 Johnson Children's Services also failed to deliver the level of service for Misty that it had committed to provide, despite receiving payment for it. A separate document, called a special rate agreement, set out additional services that would be provided to Misty and the fees for those services. We reviewed this document. It covered a three-month period that ended before the period under investigation and specified that Misty would receive 1-to-1 support for 12 hours a day at a cost of $30 per hour. It was signed by Johnson, but **not signed** by AAFS or anyone else on its behalf.

151 The special rate agreement noted that Misty would need 1-to-1 support to ensure the placement did not break down and "to ensure [Misty's] safety in the home and in the community." The "rationale" section also stated that Misty required adult supervision to complete tasks such as brushing her teeth, taking a shower and cleaning her room, that she should not be left alone with other youth, and that she required constant supervision. It notes that Misty could become agitated when overwhelmed and behave aggressively and impulsively. The agreement set specific goals to be achieved in order to terminate the 1-to-1 staffing. These included Misty engaging in positive relationships with her peers, learning to self-regulate and manage outbursts, and increasing daily living skills.

152 The special rate agreement indicated that it would not be in effect if Misty was "out of the program." It specifically noted that being absent without permission would meet that criteria.

153 Everyone who we spoke with about Misty's needs agreed that she required constant supervision to remain safe, and Anishinaabe Abinoojii Family Services incurred great financial expense to provide her with this care. We were also told that Misty had had this type of support and supervision in a previous Johnson placement in Southwestern Ontario, and that it had worked relatively well. However, there was immense confusion among those we interviewed about exactly how much 1-to-1 support Misty was supposed to receive, what that support was supposed to entail, and how much support she actually received.

154 The foster mother and workers at the first foster home in the Southwestern Ontario city all told us there was no 1-to-1 worker arranged for Misty. Her safety plan also contained no reference to 1-to-1 staffing. Others who were present in the home could not identify who provided 1-to-1 support for Misty, and we were not provided with a staff schedule or other documentation of it. There was also no special rate agreement covering most of the period while Misty was at this placement.

155 Instead, the time sheets we reviewed indicated that staff provided relief care for the foster mother, for example, by supervising the home and all the girls there while the foster mother worked or required respite. The time sheets did not refer to 1-to-1 coverage for Misty.

156 The foster mother told us the resource worker for the home and other staff would often supervise the house, since the foster mother had a full-time job outside the home. This was an unusual arrangement, as resource workers are not typically responsible for direct child care.

157 Despite all evidence to the contrary, the resource worker for the home repeatedly told us that 1-to-1 staffing for Misty had been arranged, and the special rate agreement between Johnson and AAFS indicated that she should receive 12 hours of support per day. There was no further evidence supporting the resource worker's position that Misty received 1-to-1 support at this placement.

158 In any event, the resource worker at Misty's first Johnson home in the Southwestern Ontario city contacted the Southwestern CAS worker to request 24/7 1-to-1 support for her, in place of the 12 hours per day that she should have already been receiving. In response to this request, the CAS worker contacted the AAFS worker, who responded that there was already a special rate agreement that provided for 24/7 support. The AAFS worker suggested that the Southwestern CAS worker have the resource worker check with Johnson's head office for further details. It is unclear what further steps, if any, were taken after this conversation.

159 The information we obtained about the services provided to Misty during her next brief placement suggested she did not receive 1-to-1 support on a 24-hour basis. We were told that a staff member occasionally came to take Misty out from this home. However, we found no evidence confirming that Misty was provided with the 1-to-1 care that AAFS paid for her to receive.

160 No one was able to provide our Office with documentation regarding the change from 12-hour to 24-hour 1-to-1 support. We were unable to determine when this change occurred, who agreed to it, or whether it was documented in any fashion.

However, Johnson billed for round-the-clock care and AAFS covered the cost for the entire two-month period Misty was in Southwestern Ontario. The combined total amounted to $43,920 for 61 days – including the days Misty was missing. This was despite the fact that eyewitnesses confirmed that Misty did not receive 1-to-1 support, and the only existing agreement specifically indicated that the rate would not apply if Misty was missing from the foster home.

161 When we spoke to Anishinaabe Abinoojii Family Services about how this type of 1-to-1 support is typically arranged for a child, we were told that requests are made by the organization seeking the additional support, and they must be considered and approved by a specific committee at AAFS. The committee approved a three-month special rate agreement in March 2020 for 12-hours of 1-to-1 support. We were told such agreements are usually approved for 30 days, that it would be extraordinary to approve 24/7 support, and that once additional support is approved, the responsibility for ensuring that the support is actually provided to the child falls to the supervisor of that child's worker. However, there is no evidence that a special rate agreement providing for 24/7 support for Misty was ever formally approved by AAFS or that one was ever prepared and signed.

162 Despite our extensive interviews, we were unable to identify the staff who actually provided 1-to-1 care for Misty, and Johnson did not have time sheets or schedules documenting the staff coverage. This is especially troubling, as Johnson is required to report this information to the Ministry as a condition of its licence – and it has been identified as an area of concern with Johnson's services for more than six years. We found no evidence that AAFS took steps to ensure that Misty received 1-to-1 support, and it did not even tell the Southwestern CAS of this arrangement until almost a month after her first placement in the area.

163 When we asked how AAFS would know whether or not Misty received 1-to-1 supervision, a manager bluntly responded, "I don't know how to answer that one." We found no evidence that it tracks and reconciles services received prior to paying invoices from a service provider like Johnson. We were told that AAFS' finance department should have been able to review the 1-to-1 special rate agreement prior to paying the invoice, but that could not have occurred in this case since there was no agreement in place.

164 For Misty, 1-to-1 support was intended to assist her with activities of daily living and help mitigate the risk that she would go missing. We were repeatedly told by the Johnson resource worker and AAFS staff that the expectation was that 1-to-1 staff would have "eyes on" her at all times, and in a position to immediately follow Misty and return her to the foster home if she attempted to leave. While it is impossible to know precisely what difference provision of 1-to-1 staffing would have made, the fact is that the prolonged period during which Misty went missing

began when she was given “privacy” by a staff person who had accompanied Misty and another girl to a public park.

Johnson Children’s Services

165 The failure by Johnson Children’s Services to provide meaningful supervision and 1-to-1 support for Misty is one of the biggest concerns uncovered in this investigation. It should ensure that it consistently provides supervision and 1-to-1 support in accordance with a child’s safety plan and the special care rate agreements that it enters into with children’s aid societies.

166 Consistent with its licensing requirements, Johnson Children’s Services Inc. should keep records of specific information about the staff who provide these services, in order to allow the Ministry and the placing society to audit the services provided to each child. When a staff person is fulfilling the role of 1-to-1 support, they should not be responsible for supervising any other children or performing other tasks in the foster home. Johnson should ensure that any 1-to-1 support arrangements and any changes or extensions to an existing special rate agreement are documented in a formal signed agreement. Finally, it should reimburse Anishinaabe Abinoojii Family Services for the monies it received for the 1-to-1 services it did not provide during the period that Misty was in Southwestern Ontario, including while she was missing.

Recommendation 6
Johnson Children’s Services Inc. should ensure that it consistently provides supervision and 1-to-1 supervision in accordance with its policies, a child’s safety plan, and the special rate agreements that it enters into with children’s aid societies.

Recommendation 7
Johnson Children’s Services Inc. should keep records of specific information about the staff who provide 1-to-1 supervision services, in order to allow the Ministry of Children, Community and Social Services and the placing society to audit the services provided to each child.

Recommendation 8
Johnson Children’s Services Inc. should ensure that when a staff person is fulfilling the role of 1-to-1 support, they are not responsible for supervising any other children or performing other tasks in the foster home.

Recommendation 9
Johnson Children's Services Inc. should ensure that any special rate arrangements and changes or extensions to an existing special rate agreement are documented in a formal signed agreement.

Recommendation 10
Johnson Children's Services Inc. should repay Anishinaabe Abinoojii Family Services the amount that it billed for 1-to-1 services that were not provided during the period that Misty was in Southwestern Ontario.

Anishinaabe Abinoojii Family Services

167 Anishinaabe Abinoojii Family Services also failed to adequately supervise Johnson's provision of Misty's 1-to-1 support, or to notify the Southwestern CAS so that it could do so. In failing to realize or take action on the fact that Misty was not receiving the services that she was supposed to, her society missed an opportunity to intervene before she went missing.

168 AAFS should ensure that staff carefully monitor the services provided under special rate agreements, including 1-to-1 services. Staff should be trained to request specific documentation, such as staff schedules or weekly progress updates, to help monitor the provision of these services. It should ensure that staff share relevant information about the services that children are entitled to receive, including 1-to-1 support, with any children's aid society that is providing courtesy supervision. All special rate arrangements and any changes or extensions should be set out in a formal signed agreement, and considered and approved by the appropriate committee, and documented in the child's file.

Recommendation 11
Anishinaabe Abinoojii Family Services should ensure that staff carefully monitor the services provided under special rate agreements.

Recommendation 12
Anishinaabe Abinoojii Family Services should ensure that staff are trained to request specific documentation, such as staff schedules or weekly progress updates, to help monitor the provision of services, including 1-to-1 services.

Recommendation 13
Anishinaabe Abinoojii Family Services should ensure that staff share relevant information about the services that children are entitled to receive, including 1-to-1 support, with any children's aid society that is providing courtesy supervision.

Recommendation 14
Anishinaabe Abinoojii Family Services should ensure that all special rate arrangements and changes or extensions to an existing special rate agreement are set out in formal signed agreements and considered and approved by the appropriate committee, and that this is documented in the child's file.

Inadequate supervision and safety plan

169 In addition to the lack of 1-to-1 supervision, there were several serious and unexplained deficiencies in the supervision that Johnson Children's Services provided to Misty in Southwestern Ontario. Various individuals told us about instances where Misty and other children in her first foster home were left entirely without adult supervision, even though Misty's safety plan indicated that she should be supervised at all times. Johnson had no documentation confirming that staff had actually reviewed Misty's safety plan, and the foster parents and staff we interviewed did not appear to be conversant with its terms.

170 The foster mother at the home described a particularly disturbing incident when Misty and several youth living in the home were left unattended. She said she was off that evening and left the children in the care of the resource worker. However, the resource worker also left the home, and while she was away, one of the children experienced a serious medical emergency. Another child contacted the foster mother, who rushed to the home and found paramedics already there, but no other staff were supervising the children. When we asked the resource worker about this incident, she denied having left the children unattended, although paramedics and another independent witness who had accompanied the foster mother to the home corroborated the foster mother's account. We were also told of similar incidents – documented by third-party witnesses, including police – when children were left alone in the home.

171 We even heard concerns about the supervision provided when additional staff support was in the home to assist the foster mother manage all children placed there. One worker occasionally brought her three children, all under the age of five, to work when she didn't have child care. The foster mother raised concerns to the resource worker about this practice, but was told that it wasn't a concern and that there is no policy to prevent staff from bringing their children to work. When asked about this situation, Johnson's Executive Director told us he was aware of it, but noted only that the girls living in the house were not to be transported along with the worker's own children.

172 Johnson Children's Services promotes itself as providing a highly structured environment with a high staff-to-child ratio. This is not borne out by the facts in Misty's case. The failure to provide adequate supervision at all times, particularly in the case of a child with known risk factors and complex needs such as Misty, is inexcusable. Johnson should take immediate steps to prevent the care it provides from falling below an acceptable standard in future.

173 In addition, although Johnson did create a safety plan for Misty as required by its licence conditions, the strategies that it outlined to keep her safe – including the requirement that she never be left unsupervised – were not implemented. In future, it should ensure that staff not only review and understand children's safety plans, but that this is clearly documented in its records and the strategies carried out by staff. It should also ensure that staff implement these plans.

Recommendation 15
Johnson Children's Services Inc. should ensure that adequate supervision is provided to children within its care at all times.

Recommendation 16
Johnson Children's Services Inc. should direct staff that they are not to bring children to work with them.

Recommendation 17
Johnson Children's Services Inc. should ensure that all foster parents and staff review and implement the safety plans relating to children in their care, and that this is documented in the agency's records.

No courtesy supervision agreement

174 When a child is placed in a residential setting beyond the geographic boundaries of a children's aid society, it is common for the placing society to enter into a "courtesy supervision agreement" with the local children's aid society. These agreements typically address practical arrangements that help ensure that the child is able to meet in-person with a CAS worker who can monitor their well-being. Agreements are supposed to be completed prior to the placement of a child, or in the case of an emergency, within 72 hours of the placement. However, no courtesy supervision agreement was ever entered into when Misty was moved to the new city in Southwestern Ontario.

175 Anishinaabe Abinoojii Family Services' documentation indicates that Misty's worker left a voicemail message at the general number for the Southwestern Ontario CAS five days after Misty moved into the new area, but no response was received. When asked about the delay in contacting the CAS, the AAFS worker

told us she wasn't initially told of Misty's move. Once she learned of it, she didn't realize that the new foster home came within the boundary of a different children's aid society. From her perspective in Northwestern Ontario, the placements were not that far apart. The worker also said she wasn't familiar with the process for finalizing supervision agreements and thought it was her supervisor's responsibility. As for the Southwestern CAS failing to respond to voicemail, we were told it does not have a general voice mailbox, and staff couldn't identify where the AAFS might have left such a message.

176 The Southwestern CAS only learned about Misty's arrival in its catchment area when the police called about her being reported missing three times. After learning of Misty's placement in a Johnson foster home, an intake worker at the CAS reached out to the AAFS to discuss Misty's circumstances, and to arrange a courtesy supervision agreement.

177 We were told the Southwestern CAS viewed Misty's case as urgent and high priority, given the information it had obtained from police as well as the Child Protection Information Network (CPIN), a provincewide system used by many designated children's aid societies in Ontario. Another children's aid society that had been involved in one of Misty's previous placements had noted in CPIN that she was at high risk due to possible human trafficking and drug use.

178 The Southwestern CAS intake worker spoke with Misty's AAFS worker, requested further information about Misty and her history, and AAFS to make a formal request for a courtesy supervision agreement. Southwestern CAS protocols state that interagency supervision agreements can only be entered into once it has specific information about the child and the services they require. This helps ensure that both parties clearly understand their roles and responsibilities.

179 The AAFS worker agreed to provide the necessary documentation and formalize the agreement. Our investigation found no evidence that this ever occurred or that a courtesy supervision agreement was finalized. Still, it is clear that the Southwestern CAS did provide services to Misty. A worker from its Indigenous team was assigned to review Misty's circumstances and arrange a visit with her. We were told that the visit was considered urgent due to Misty's risk factors and because it had already been more than seven days since she was placed in the new foster home. Ontario Regulation 156/18 and the *Children in Care Manual* require that children receive a visit from their worker within seven days of placement.[48]

[48] O Reg. 156/18, s 51(1); *Children in Care Policies, supra* note 31 at CH-0302-03.

180 The Southwestern CAS did provide courtesy supervision on an informal basis. However, because there was no agreement, there was no mutual understanding of the specific services that would be provided to Misty and what information would be reported to Anishinaabe Abinoojii Family Services. In addition, the CAS initially had limited information about Misty's personal circumstances because her AAFS worker had not forwarded additional relevant material, and the information from CPIN only addressed her relatively short placement before arriving in the CAS's catchment area. It did not provide a full picture of Misty's complex needs.

181 Courtesy supervision and the agreements that govern it are more than formalities. They are a vital mechanism for ensuring that children are receiving appropriate services while living far from their homes. In Misty's case, the lack of a formal agreement and communication meant that the Southwestern CAS was not initially aware that Misty was living in the area, or that she should be receiving extensive 1-to-1 supervision. These omissions may have impacted the ability of the CAS to ensure that she was receiving appropriate services.

182 To prevent similar gaps in future, Anishinaabe Abinoojii Family Services should ensure that it enters into courtesy supervision agreements that set out the expectations and responsibilities for each children's aid society. In addition, it should develop its own policy to guide staff when entering into these agreements and provide training to staff on the policy. The policy should establish clear roles and responsibilities for frontline and management staff, and ensure that appropriate information is shared when negotiating courtesy supervision agreements. At a minimum, AAFS staff should ensure that the other children's aid society has complete information about the child, the services they should be receiving, and any other relevant information. If a placement change occurs for a child, AAFS staff should verify whether the new placement comes within the geographic boundary of the same children's aid society, and enter into a new courtesy supervision agreement if necessary.

Recommendation 18
Anishinaabe Abinoojii Family Services should ensure that when placing children outside of its geographic area, it enters into courtesy supervision agreements with local children's aid societies, which set out the expectations and responsibilities for both parties.

Recommendation 19
Anishinaabe Abinoojii Family Services should develop its own policy to guide staff when entering into courtesy supervision agreements, which should include:

- **A description of the roles and responsibilities of front-line and management staff, and**
- **Reference to the necessity of sharing appropriate information with the local children's aid society when negotiating these agreements, including all relevant information about the child and the services they should be receiving.**

Recommendation 20
Anishinaabe Abinoojii Family Services should ensure that its staff are trained on the policy concerning courtesy supervision agreements addressed in recommendation 19.

Recommendation 21
Anishinaabe Abinoojii Family Services should ensure that whenever a child involved with a local children's aid society under a courtesy supervision agreement is moved, it confirms which children's aid society operates in the area of the new placement, and enters into a new courtesy supervision agreement, as appropriate.

Inadequate response to Misty's absence

183 Another significant concern arising from this investigation was the response of Johnson Children's Services and its staff when Misty went missing. Johnson has relatively robust protocols and procedures setting out the steps that should be taken if a child goes missing from its care. However, our investigation found that its staff did not follow these when determining how to respond to Misty's absence.

184 Johnson's Missing from Care Protocol and Procedures differentiate between children and youth who are absent in three different circumstances:

- A child can be **absent without permission** if, for instance, they break curfew or otherwise leave the home without the permission of the foster parent.
- A child is **missing** if they do not return after being absent without permission, or if they are absent without permission in combination with a list of factors suggesting greater risk (e.g., the child is under 12; has a recent and repeated history of drug abuse; or is suspected of associating with individuals who pose an immediate safety threat, such as a pimp).
- The third category of absence addresses **abducted children and youth.**

185 Step two of the protocol requires a determination as to how much risk the child faces. There are three categories:

- **Low:** No identified risk;
- **Medium**: The risk posed is likely to place the child in danger, or the child is a threat to themselves or others;
- **High:** The risk posed is immediate and there are substantial grounds for believing the child may be the victim of a serious crime or is in danger due to their vulnerability.

186 The protocol indicates that Johnson Children's Services is to immediately notify the placing children's aid society when a child is missing, regardless of which of the three categories of absences applies. It provides that Johnson will collaborate with the CAS to share information about the youth, determine what steps will be taken to locate them, and decide who is responsible for each step. In situations where the child is considered "missing" or "abducted," the protocol states that Johnson will have ongoing communication with the placing CAS.

187 Our investigation found no evidence that Johnson assessed which level of risk Misty faced and adapted its response based on that assessment. We also found little evidence that either AAFS or the Southwestern CAS were consulted about what steps should be taken when searching for Misty.

188 Furthermore, our investigation found that the steps that Johnson did take in response to Misty's absence were inadequate. In one instance, staff did not notify police for more than four hours. They also failed to provide police with information that reflected the seriousness of Misty's absence and the risks that she faced, even though her safety plan identified any absence as high risk. Instead, police documentation specifically indicates that they were repeatedly told Misty's absence did not pose a safety concern.

189 The best protocols and procedures are of no assistance when staff do not follow them. Johnson Children's Services Inc. should ensure that staff receive training on the Missing from Care Protocol and Procedures so that they are prepared to apply them if a child goes missing. It should also ensure that staff provide accurate, complete, and timely information to police regarding children in its care who go missing.

Recommendation 22
Johnson Children's Services Inc. should ensure that staff receive training on the Missing from Care Protocol and Procedures so that they are prepared to apply them if a child goes missing.

Recommendation 23
Johnson Children's Services Inc. should ensure that its staff provide accurate, complete, and timely information to police regarding children who go missing while in the agency's care.

Child welfare warrant

190 During the 19 days that Misty was missing, neither the Southwestern Ontario children's aid society nor Anishinaabe Abinoojii Family Services chose to obtain a warrant of apprehension, also known as a child welfare warrant. Under section 83 of the *Child, Youth and Family Services Act, 2017,* children's aid societies are empowered to obtain warrants to apprehend children who have left without consent and bring them to a place of safety.[49] This warrant is exceptional, as it does not need to specify the premises where the child is located,[50] and gives the police officer or child welfare worker legal authorization to bring a child against their will to a place of safety, even if they are not at immediate risk.[51]

191 A child protection warrant can be an extremely useful instrument when searching for missing children, as it empowers the police and child welfare staff to enter premises where the child might be staying and compel them to leave. Other police warrants and provisions under the *CYFSA* are more limited. For instance, warrants for arrest, including the ones that were issued in Misty's case after she breached her bail conditions, only allow the police to enter a dwelling-house if it is specifically indicated in the signed warrant.[52] Children in care can only be taken to a place of safety without a warrant when they are younger than 16, have left without consent, and there would be substantial risk to their health or safety during the time necessary to obtain a warrant.[53]

192 When we asked a Southwestern CAS supervisor why they did not obtain a child welfare warrant, we were told they didn't feel it was useful or necessary, as Misty already had several other arrest warrants for breaching her bail conditions. However, these warrants do not grant the police the same powers to enter any private premises to search for a missing child. They simply entitle the police to arrest a person if they are found in the community or in a specific home authorized by the warrant. The Southwestern CAS's policies specifically speak to the option of obtaining a child welfare warrant where there might be difficulties in returning the child to care – although they note that local police usually do not require this warrant when the child is missing and under 16. We found no

[49] *CYFSA*, *supra* note 6, s 83(1).
[50] *Ibid*, s 83(3).
[51] *Ibid*, s 83(1) and (4).
[52] *Criminal Code*, RSC 1985, c C-46, Form 7.
[53] *CYFSA*, *supra* note 6, s. 83(4).

evidence that the CAS spoke with the police about whether this type of warrant would assist in the search efforts for Misty. We also found no evidence that staff at AAFS were familiar with child welfare warrants or consulted about the possibility of obtaining one.

193 Although it is impossible to know how the search might have progressed if either society had sought a child welfare warrant, it would have given the police an additional powerful tool in their search for Misty. During the search, police officers went to some places they believed Misty frequented, and either no one answered or the occupants denied knowing Misty and would not let them in. With a child welfare warrant, the police could have entered the premises. In addition, Misty was known to be at risk for human trafficking across Canada; a child welfare warrant would have alerted police departments from other jurisdictions that she was missing and supposed to be in care.

194 Anishinaabe Abinoojii Family Services and the Southwestern Ontario children's aid society should ensure that their staff receive training on what a child welfare warrant is, the powers it confers, and the application process. Each agency should also establish guidelines setting out the circumstances in which staff should seek this type of warrant.

Recommendation 24
Anishinaabe Abinoojii Family Services should ensure that its staff receive training on what a child welfare warrant is, the powers it confers, and the application process.

Recommendation 25
Anishinaabe Abinoojii Family Services should establish guidelines setting out the circumstances in which staff should seek a child welfare warrant.

Recommendation 26
The Southwestern Ontario children's aid society should ensure that its staff receive training on what a child welfare warrant is, the powers it confers, and the application process.

Recommendation 27
The Southwestern Ontario children's aid society should establish guidelines setting out the circumstances in which staff should seek a child welfare warrant.

Licensing conditions ignored

195 Johnson Children's Services is required to hold a licence from the Ministry. It is also required by law to provide a copy of this licence to the placing agency before a child is placed in a home, which it did in this case.[54]

196 Johnson had a history of non-compliance, and the Ministry had imposed enhanced conditions on the licence it held at the time, including a requirement to submit staff schedules to the Ministry. However, our investigation found it failed to comply with this condition while Misty was placed in its homes. This made it more difficult for my Office to determine the level of supervision in the home and whether Misty received the 1-to-1 support that Anishinaabe Abinoojii Family Services had paid for.

197 This was not Johnson's first contravention of its licence conditions. In fact, the Ministry had established a standing bi-weekly meeting to build better communication with it and overcome issues with the "accuracy, timeliness and forthcomingness" of its communication. However, these meetings were paused during periods of the COVID-19 pandemic, including during Misty's placement.

198 The conditions that applied to Johnson's licence are not routine. They should have served as incentive for it to improve its practices, but it did not do so. In fact, in November 2022, the Ministry added further conditions to Johnson's licence, and as of the writing of this report, Johnson is not allowed to accept new children into any of its parent-model foster homes or open new parent-model foster homes, among other conditions. Johnson Children's Services Inc. should carefully review all conditions placed on its licence and take steps to ensure that it fully complies with them. It should also establish a broader improvement plan that, once fully implemented, would remedy the concerns that led the Ministry to implement the licence conditions, with the long-term goal of having the conditions removed.

Recommendation 28
Johnson Children's Services Inc. should carefully review the conditions that have been placed on its licence and comply with them.

Recommendation 29
Johnson Children's Services Inc. should establish a comprehensive improvement plan that, once fully implemented, would remedy the concerns that led the Ministry of Children, Community and Social Services

[54] *CYFSA*, *supra* note 6, s 249(1). Licences and conditions applying to residential service providers are now also posted on the Ministry's website.

to implement the licence conditions, with the long-term goal of having the conditions removed from its licence.

199 The number and nature of the conditions on Johnson's licence should have been a warning to Anishinaabe Abinoojii Family Services, which had earlier learned that another children's aid society was unwilling to place its own children with it. Children's aid societies should be able to rely on the Ministry's licensing process to vet potential foster home agencies. But our investigation found no evidence that AAFS reviewed or considered Johnson's licensing conditions prior to placing Misty in its care. Although there were few options for a placement for Misty, knowing about the conditions on Johnson's licence may have alerted AAFS to matters that required closer monitoring.

Recommendation 30
Anishinaabe Abinoojii Family Services should review a residential licensee's licence and any licensing conditions before placing a child in its care.

Recommendation 31
Anishinaabe Abinoojii Family Services should consider any licensing conditions applying to residential service providers when monitoring the care that a child receives from the provider.

Ineffective communication

200 Johnson's communication with others regarding Misty's care was often quite poor. It failed to notify AAFS and obtain approval before Misty was moved to Southwestern Ontario. AAFS also struggled to maintain contact with Johnson during the search for Misty. The Johnson resource worker who was supposed to be the main contact for AAFS did not answer the phone or return voicemails or texts, and eventually her voicemail filled up and it was impossible to leave messages. The police and Southwestern CAS also had trouble reaching her.

201 Some of the communication problems can be explained by the fact that the resource worker went on leave while Misty was still missing. Given the gravity of Misty's absence, Johnson's failure to notify other organizations that there was a new primary contact was a major misstep.

202 Johnson Children's Services Inc. should ensure that it maintains effective communication with other organizations involved in the care of children in its homes. If an agency staff person is no longer the appropriate contact, it should proactively inform the other organizations who can be reached instead.

Recommendation 32
Johnson Children's Services Inc. should ensure that it maintains effective communication with other organizations involved in a child's care. If a staff person is no longer the appropriate contact, Johnson Children's Services Inc. should proactively inform the other organizations who can be reached instead.

Poor Serious Occurrence reporting

203 Serious Occurrence reports are one of many mechanisms intended to help ensure the safety of children in care, and to afford the Ministry a means of overseeing the appropriateness and quality of service delivery by licensees. There is a specific process for managing incidents as they occur, documenting the incident and any response, and monitoring in order to prevent or mitigate similar incidents in future.

204 All staff at Johnson Children's Services, Anishinaabe Abinoojii Family Services and the Southwestern CAS must follow the Ministry's Serious Occurrence Reporting Guidelines. These guidelines establish two levels of "serious occurrences," with Level 1 requiring a report within an hour, and Level 2 requiring a report as soon as possible, but no later than 24 hours. Further updates must be provided to the Ministry until the Ministry indicates this is not necessary. Johnson has further policies operationalizing these requirements.

205 The Ministry had previously identified concerns with Johnson's compliance with these requirements. Our investigation uncovered many instances in which Johnson failed to meet its Serious Occurrence reporting obligations. For instance, we learned of several incidents related to Misty that, based on witness recollection and other documentation, appear to meet the criteria for filing a Serious Occurrence report. In one example, we were told that Misty was found to have hoarded medication in her bedroom. In another, we learned that Misty and other young people were alone in the home when a child suffered a serious medical incident that required emergency medical treatment. In a third, we were told that police found pipes for smoking crystal meth and empty baggies when they searched Misty's room. However, there was no evidence that Johnson filed a report in any of these three cases.

206 Johnson's Executive Director told us he was not aware of the details of these incidents, but agreed that they would meet the criteria for filing a report with the Ministry. Without these reports, Johnson had no documentation related to these serious incidents other than witness recollection, and the Ministry, the Southwestern CAS and AAFS were left in the dark. Even more disturbingly, Johnson lost an opportunity to proactively consider how similar occurrences could be prevented or mitigated.

Recommendation 33
Johnson Children's Services Inc. should ensure that all serious occurrences are reported in accordance with the Ministry's Serious Occurrence Reporting Guidelines and its own policies and procedures.

207 Even when Johnson did file Serious Occurrence reports related to Misty's care, they were not always timely and often lacked the level of detail required by the Ministry's guidelines. When children go missing, residential service providers have lead responsibility for filing these reports with the Ministry. The reporting guidelines recommend a designation of "Level 1" (notification to the Ministry within 1 hour) in situations where the absence "poses a serious concern about the individual's safety."[55] The guidelines set out very specific information that must be included in Serious Occurrence reports about a missing child, to assist the Ministry and others who see the report in assessing the risk that the child may face.[56]

208 For each Serious Occurrence report that Johnson submitted when Misty was missing, it specifically indicated that her absence did not pose a serious concern for her immediate safety. It also treated the reports as Level 2, as opposed to the more serious Level 1. It is impossible to justify this determination, given Johnson's knowledge of Misty's risk factors – which are documented in her safety plan and include a history of human trafficking – and the fact that the safety plan identifies all absences as high risk.

209 Other important information was left out of the reports that were filed. For instance, Misty returned briefly during the period she was missing and was described by multiple witnesses as intoxicated, hungry, and covered in vomit. When she went missing again a few hours later, this information was not included in the Serious Occurrence report update and did not change the agency's risk level assessment from Level 2 to Level 1. More generally, the reports failed to provide the mandatory information enumerated in the Ministry's

[55] Serious Occurrence Reporting Guidelines, *supra* note 17 at 30-31.
[56] *Ibid* at 33.

guidelines for reports regarding missing children, including details about actions taken to locate Misty, her history of going missing, and her state of mind when she left. These omissions may well have contributed to staff and others minimizing their understanding of the risks Misty faced while missing.

210 Serious Occurrence reports are only effective and meaningful if they reflect all relevant information related to an occurrence and capture the true level of risk that a child may face in a particular circumstance. Johnson Children's Services Inc. should ensure that its staff receive comprehensive training on the Ministry's Serious Occurrence Reporting Guidelines. It should also ensure that Serious Occurrence reports provide all relevant information about an incident, including any specific information identified as mandatory in the Ministry's guidelines. In addition, it should ensure that it accurately assesses and reports the risk posed by each occurrence, consistent with the Ministry's guidelines.

Recommendation 34
Johnson Children's Services Inc. should train its staff on the Ministry's Serious Occurrence Reporting Guidelines.

Recommendation 35
Johnson Children's Services Inc. should ensure that its Serious Occurrence reports provide all relevant information about an incident, including any specific information identified as mandatory in the Ministry's Serious Occurrence Reporting Guidelines.

Recommendation 36
Johnson Children's Services Inc. should ensure that it accurately assesses and reports the risk posed by each occurrence, consistent with the Ministry's Serious Occurrence Reporting Guidelines.

No Death and Serious Bodily Harm reports

211 In addition to the Ministry's Serious Occurrence reporting process, the law requires that all licensees – including Johnson Children's Services – report to my Office without unreasonable delay if they learn of the death of or serious bodily harm to a child who has received service within 12 months.[57] Although not defined by regulation, serious bodily harm is interpreted to include any injury that requires medical treatment beyond basic first aid.

[57] O Reg. 80/19, s 1(1).

212 When Misty returned to her foster home after being missing for 19 days, she told the police that she had recently overdosed and been revived by two doses of naloxone. She also told them she used drugs again after receiving the naloxone, which can pose a substantial risk. Based on this information, she was immediately taken to hospital to be medically assessed. Although Misty avoided more serious consequences, a significant overdose of this nature is considered serious bodily harm that should have been reported to my Office under Ontario Regulation 80/19. However, no such report was ever filed by Johnson, the Southwestern CAS or AAFS, all of which were aware of these circumstances. Nor did my Office receive a report from Johnson on a previous occasion when Misty had to be taken to hospital for treatment for assault after she returned to the foster home with bruises, blood running down her legs and her hair in disarray. Johnson was aware of this incident and should have reported it; it is unclear whether it ever notified the Southwestern CAS or AAFS of the situation.

213 The Death and Serious Bodily Harm reporting requirements are an important oversight mechanism. Each organization should review these requirements, as set out in O. Reg. 80/19, and ensure that staff are trained to report all incidents that result in the death or serious bodily harm of a child in accordance with the requirements. My Office provides free virtual training about these reporting requirements. Southwestern CAS staff have already attended this training, and I encourage the other organizations to have relevant staff participate as well.

Recommendation 37
Johnson Children's Services Inc. should review and train its staff on the Death and Serious Bodily Harm reporting requirements in Ontario Regulation 80/19 and report all incidents that result in the death or serious bodily harm of a child in accordance with the requirements.

Recommendation 38
Anishinaabe Abinoojii Family Services should review and train its staff on the Death and Serious Bodily Harm reporting requirements in Ontario Regulation 80/19 and report all incidents that result in the death or serious bodily harm of a child in accordance with the requirements.

Recommendation 39
The Southwestern Ontario children's aid society should review and continue to train its staff on the Death and Serious Bodily Harm reporting requirements in Ontario Regulation 80/19 and ensure that staff report all incidents that result in the death or serious bodily harm of a child in accordance with the requirements.

Documentation gaps

214 Our investigation found that staff at the Southwestern CAS kept exemplary notes of the information they received about Misty and the steps they took in providing her care and searching for her. The CAS is to be commended for this practice, which greatly assisted my Office in piecing together the circumstances of Misty's time in its catchment area. In contrast, we identified serious issues with the record-keeping and note-taking by staff at Anishinaabe Abinoojii Family Services and Johnson Children's Services.

215 AAFS has adopted an electronic information system to maintain its records. Ministry guidelines and AAFS's polices require that staff document matters related to the children in their care. This creates a historical record, continuity across different caregivers, and helps ensure that children receive the best possible support and care. It allows others, including supervisors, to understand what steps have been taken with respect to a child in care, and permits oversight bodies like the Ministry or my Office to review the appropriateness of an organization's actions. Without clear and comprehensive written records, it can be very difficult to reconstruct what occurred, especially if there is conflicting witness testimony.

216 Our investigation found substantial gaps in the documentation kept by AAFS. Many conversations between Misty's worker and others involved in her care were not documented at all, or were documented substantially after they occurred (more than six months later). Some messages, including text messages exchanged between the AAFS worker and the Johnson resource worker, were never entered into the system and were eventually lost from both of their phones.

217 According to the Ontario Child Protection Standards, all case notes are to be contemporaneous and entered "in a timely manner (e.g., within 24 hours)". These case notes must document the date, time, method of contact, and the names of individuals involved in or related to discussions, as well as significant dates, decisions and observations related to contacts.[58] The standards indicate that timely case notes help ensure their accuracy, and that delay can impact the child welfare professional's independent recollection of significant events. Misty's worker at AAFS told us she was familiar with this standard, but said she had never received any training on writing case notes or contact logs. As a result of this missing documentation, it was difficult to confirm what AAFS had been told about Misty's movement between foster homes, the instances in which she went missing, changes to her 1-to-1 support, and other important matters.

[58] Child Protection Standards, *supra* note 21 at 16-17.

218 We also identified significant concerns with the adequacy of Johnson's documentation. Its policies and procedures require each foster parent to maintain a "log book" for each child in their care. The log book is supposed to document, among other things, unusual events, happenings or behaviours and incidents affecting the health, safety and well-being of the child.[59] The policy notes that the purpose of the log book is to support "continuity of care" and that any information that would be helpful to future caregivers should be included in the notes.

219 Johnson's Executive Director told us that by 2020, staff and foster parents were expected to log information about children in their care using specific software, which it had recently adopted. We reviewed the records from this software system, and there was very little that related to Misty's day-to-day experience with the agency. Some staff we spoke with said they were not familiar with the software and did not have any way to access it.

220 We were told that some frontline staff at the first foster home where Misty stayed in the Southwestern Ontario city documented information in a physical "communication book" kept in the home. The Executive Director initially denied that this book existed, but we were later told that it went missing without explanation – at an unknown time, in an unknown way – before our Office was able to obtain a copy for this investigation. We were only able to obtain a copy of a "communication book" that largely covered the period **after** Misty went missing.

221 Even where documentation did exist about Misty, it often lacked key details. For instance, the foster mother at Misty's second foster home in the Southwestern Ontario city entered notes into Johnson's system. Her notes from the day when Misty returned briefly after running away do not include pertinent details about Misty's well-being. There were no notes written at all once she went missing again. This means there was no documentation of the police contacting the foster home, of the resource worker meeting with police, of Misty's room being searched by police, or even of Misty being found and then discharged from the home. It is unclear why these events weren't documented. However, we were told that Johnson staff and foster parents do not receive any training on writing case notes, contact logs, or other types of documentation.

222 We discovered many other examples where important documentation at Johnson Children's Services was missing or incomplete. There was scant written documentation about the steps that staff took to look for Misty, or details of their interactions with the police. While numerous staff told us that they helped look for Misty, we were not provided with any notes reflecting what they did or any information they may have uncovered to assist in the search. In particular, the resource worker said she reported to police that she saw Misty enter a specific

[59] Johnson Children's Services Policies and Procedures, *supra* note 36 at 158.

address and the police eventually responded to investigate. While the police documented this event in detail, there is no mention of it in any Johnson records.

223 Both Anishinaabe Abinoojii Family Services and Johnson Children's Services should make a concerted effort to improve their documentation practices. They should ensure that all staff who provide services to children are trained to document all relevant information about them, and to enter it into their respective information systems. All forms of communication, including telephone calls, in-person meetings, emails, and text messages should be documented. When an incident occurs with a child in care, each staff person involved should document the circumstances in the incident report and, if necessary, a Serious Occurrence report. If a supervisor reviews a matter and provides feedback to a worker, they should each specifically document this review in the child's record. They should also implement a file review system to audit staff's adherence to these documentation requirements.

224 Johnson should also ensure that all staff who provide care to a child have access to the software used to document information about the child and the care provided.

Recommendation 40
Anishinaabe Abinoojii Family Services should ensure that all staff who provide services to youth are trained to document and record all relevant information related to a child in its information system in a timely manner.

Recommendation 41
Anishinaabe Abinoojii Family Services should ensure that it documents information in accordance with the Ontario Child Protection Standards, which require contemporaneous case notes that document the date, time, method of contact, and the names of individuals involved in or related to the discussion, as well as significant dates, decisions, and observations related to the contact.

Recommendation 42
Anishinaabe Abinoojii Family Services should ensure that any supervisor feedback or direction is specifically documented in a child's record by the worker and the supervisor.

Recommendation 43
Johnson Children's Services Inc. should ensure that all staff who provide services to youth are trained to document and enter all relevant information related to them using its software in a timely manner.

Recommendation 44
Johnson Children's Services Inc. should ensure that all forms of communication are documented, including telephone calls, in-person meetings, emails, and text messages.

Recommendation 45
Johnson Children's Services Inc. should ensure that each staff person involved in an incident related to a child in care documents the circumstances, including, if necessary, in a Serious Occurrence report.

Recommendation 46
Johnson Children's Services Inc. should ensure that any supervisor feedback or direction is specifically documented in the child's record by the worker and the supervisor.

Recommendation 47
Johnson Children's Services Inc. should ensure that all staff who may provide care to children – including foster parents, child and youth workers, and others – have access to the software used to document information about children in their care.

Training gaps

225 I have already identified several specific areas of training that Johnson Children's Services and Anishinaabe Abinoojii Family Services should implement. However, my investigation also revealed additional issues with the adequacy of the staff training provided by these organizations.

226 Our investigation found significant gaps in how Johnson trained its staff. They were not familiar with relevant agency policies and procedures, which likely affected their ability to meet Misty's high needs and keep her safe.

227 The staff and foster parents we spoke with indicated that they did not generally receive interactive training from Johnson and instead "signed off" on having read certain policies. For instance, there was no specific training on important administrative aspects of the job, including how to complete case notes and how to fill out Serious Occurrence and incident reports. This is particularly concerning, given that the Ministry had previously identified issues with the adequacy of Johnson's training, particularly for Serious Occurrence reports. One staff person told us the hiring process was very informal compared to other organizations she had worked for. She said she was contacted by the Johnson resource worker based on their connection with a mutual friend, and asked if she wanted to start in the next day or two. She was not asked to undergo any training or provide

references or the results of a vulnerable sector check – although she said she did apply for one and provided a receipt.

228 One foster mother we spoke with said she had no prior experience and did not attend the training programs (known as PRIDE and SAFE[60]) commonly provided to foster parents and required for those who foster directly through children's aid societies. She said that the only training she received from Johnson was about how to complete medication administration reports.

229 Johnson's own policy manual indicates that new staff must complete five shifts of orientation prior to being scheduled to provide residential services to children. It notes that this orientation includes the reading of the policy and procedure manual, training in safety procedures, and training in procedures to be followed during shifts.

230 Foster parents and the staff who assist them have the most important, hands-on role in providing care to children. It is vital that they receive adequate training, including periodic refresher training, to understand how they are expected to perform this role, and the steps they must take in different types of situations. This is especially true since foster parents and staff, by their very nature, are providing services in a private home environment without direct supervision by the agency. A "tick the box" exercise where foster parents and staff indicate that they have read a policy is not a meaningful or effective way to ensure that policies are understood and followed. Training should be robust, with records kept to confirm that each foster parent and staff member has received it.

231 In addition, the requirement to have staff work orientation shifts prior to caring for children is a good procedure, but only if it is implemented in practice. Johnson Children's Services Inc. should ensure that staff comply with this requirement before being placed in a home to care for children.

Recommendation 48
Johnson Children's Services Inc. should provide foster parents and staff with comprehensive, meaningful training and periodic refresher training regarding relevant legislation, Ministry guidelines, and its policy and procedures, and ensure training records are kept for each foster parent and staff member.

[60] These refer to the Structured Analysis Family Evaluation (SAFE) home study tool and the Parent Resources for Information, Development and Education (PRIDE) training tool for foster and adoptive parents.

Recommendation 49
Johnson Children's Services Inc., consistent with the requirement set out in its policy manual, should ensure that staff work five orientation shifts prior to being assigned to provide direct care to children.

232 Our investigation also identified serious gaps in the training for staff at Anishinaabe Abinoojii Family Services. One worker we spoke with said she never received training on writing case notes or contact logs, or the requirement that they be completed in a timely manner. She said she didn't initially receive any training on how to draft plans of care, which are important documents intended to set out how a child's care needs will be met. We also heard that staff were not trained on how or when to enter into courtesy supervision agreements.

233 We were told by AAFS management that staff are supposed to receive orientation and training, including on case notes and plans of care, although it is not clear if that occurred in the case of the workers we spoke with. In any event, staff we interviewed told us they did not feel adequately trained and supported to do their job.

234 For all newly hired staff, Anishinaabe Abinoojii Family Services should ensure that comprehensive training and orientation is provided to assist them in fulfilling their job responsibilities and their obligations to children in their care. It should also ensure that staff are provided with periodic "refresher" training on areas of key responsibility, and that new training is provided when there are meaningful changes to legal and policy requirements. Training records should be kept to confirm that each staff member has been adequately trained.

Recommendation 50
Anishinaabe Abinoojii Family Services should ensure that newly hired employees receive comprehensive training and orientation necessary to fulfill their job responsibilities and their obligations to children in their care.

Recommendation 51
Anishinaabe Abinoojii Family Services should ensure that staff are provided with periodic "refresher" training on areas of key responsibility, and that new training is provided when there are meaningful changes to legal and policy requirements.

Recommendation 52
Anishinaabe Abinoojii Family Services should ensure that it keeps a record of training that each staff member receives.

AAFS staff supervision

235 Our investigation also revealed that staff at Anishinaabe Abinoojii Family Services did not have frequent interaction with supervisors regarding the care provided to individual children. This meant that staff did not always receive the direction or support they needed, and that supervisors missed opportunities to catch staff errors and provide guidance and training. For instance, a supervisory review might have identified that the courtesy supervision agreement was not finalized, that the special rate agreement for 1-to-1 support was out of date, and that the agreement was not approved by the appropriate committee in accordance with AAFS policy. Even more importantly, a supervisor's second look and greater experience may have caught that the AAFS worker had been notified that Misty was missing, and prompted management to address the situation sooner.

236 These concerns could be addressed by establishing regular meetings between supervisors and staff to discuss and review updates regarding the children assigned to each worker. The outcomes of such discussions, along with important details, could then be documented in the child's file for future reference. This practice would create a culture that values quality service and accountability, and give supervisors the opportunity to share their knowledge and experience with their staff. It would also help ensure that no children fall through the cracks. If the practice had existed during the period covered by this investigation, it might have identified and remedied specific errors in how Misty's case was handled.

237 Regular supervisory consultations are also helpful to identify situations of non-compliance with the society's policies or the Ontario Child Protection Standards, and, in appropriate circumstances, to discuss approval of departures from those policies or standards.

238 Anishinaabe Abinoojii Family Services should ensure there are regular meetings between supervisors and frontline workers to review and provide direction on children's cases. These discussions should be specifically documented in a child's file, along with any approvals of departures from policies or provincial standards that would otherwise apply.

Recommendation 53
Anishinaabe Abinoojii Family Services should ensure that supervisors meet with frontline staff on a regular basis to review and provide direction on worker's cases.

Recommendation 54
Anishinaabe Abinoojii Family Services should ensure that discussions between supervisors and staff are specifically documented in the child's file.

Recommendation 55
Anishinaabe Abinoojii Family Services should ensure that any instance when a supervisor has approved a departure from its policies or the Ontario Child Protection Standards is documented in the child's file.

Opinion

239 At the time Misty was moved by Johnson Children's Services to a new Southwestern Ontario city in the summer of 2020, she was an extremely vulnerable 13-year-old Indigenous girl. Misty was living with significant developmental and mental health challenges, had a well-documented history of substance use, and was already suspected to be the victim of human trafficking. Far from home, among strangers, and in unfamiliar surroundings, the risks Misty faced were acute and should have been clear to those responsible for her care. The National Inquiry into Missing and Murdered Indigenous Women and Girls has specifically highlighted the obligation of the child welfare system to protect Indigenous children from exploitation and the risk of being recruited into the sex industry. Unfortunately, the child welfare system failed Misty during her stay in Southwestern Ontario. Over the course of 47 days, Misty went missing seven times, including for a period of some 19 days. While missing, Misty was reportedly physically and sexually assaulted, suffered injuries requiring medical treatment, and overdosed on powerful street drugs.

240 **Johnson Children's Services Inc.**, which was responsible for Misty's day-to-day care while she was in Southwestern Ontario, was particularly remiss in carrying out its role. Misty's story might well have had a more tragic conclusion. As some observed, there was a strong possibility that Misty could have shared the terrible fate of other missing and murdered Indigenous women and girls documented by the National Inquiry. It is extremely disturbing that Johnson's staff were not alert to this reality. When Misty went missing, they downplayed the urgency – in one instance delaying notifying police for hours. Staff also repeatedly failed to communicate the serious safety risk Misty faced each time she went missing, and failed to comply with the Johnson's own protocol regarding missing children.

241 Johnson Children's Services committed to provide a level of service that it did not deliver. It breached its service agreement with Anishinaabe Abinoojii Family Services by failing to obtain approval before suddenly moving Misty and neglecting to provide copies of Serious Occurrence reports regarding her care. More significantly, it did not ensure that Misty received the 1-to-1 supervised care that she required, and that AAFS paid it to provide. In fact, my investigation found that at times Misty and other children were left unsupervised. Had Johnson complied with its obligations, it may well have assisted in mitigating the risk of Misty coming to serious harm.

242 Johnson Children's Services does not appear to have learned from its history of non-compliance with child welfare requirements. While caring for Misty, it contravened one of the conditions the Ministry had placed on its licence, by failing to submit staffing records. This requirement was designed to protect children within its care by ensuring adequate staffing. As Misty's case demonstrates, there were several times when her foster home was not properly staffed. Johnson also didn't comply with Serious Occurrence reporting requirements, failing to file reports and to record important details. In addition, it neglected to provide my Office with Death and Serious Bodily Harm reports as required by regulation.

243 Finally, Johnson frequently failed to communicate effectively with AAFS and others, and demonstrated serious gaps in its documentation, record-keeping, and training practices.

244 Section 21 of the *Ombudsman Act* lists several adjectives that I may use in forming an opinion regarding the problematic conduct that my investigations uncover, and I am required to describe maladministration using the wording of the Act.[61] Given the many serious issues my investigation identified with the conduct of Johnson Children's Services Inc. during the summer of 2020, it is my opinion that its actions, omissions, and decisions relating to Misty were unreasonable and wrong under sections 21(b) and (d) of the *Ombudsman Act.*

245 **Anishinaabe Abinoojii Family Services**, which was the most familiar with Misty's personal history, also shares some responsibility for the poor level of service she received while in Southwestern Ontario. It failed to notify the Southwestern Ontario children's aid society that Misty required courtesy supervision, never formalized the arrangement, and didn't provide timely and relevant information about her circumstances and care needs.

[61] RRO 1990, Reg. 865, s 6.

246 While Misty was missing, AAFS failed to consider using a child welfare warrant, a powerful tool to assist police in finding missing children. It also did not scrutinize the conditions placed on Johnson's licence, and did not ensure, given the concerns reflected in those conditions, that it closely monitored the quality of care provided by Johnson. AAFS also neglected to file a Death and Serious Bodily Harm report with my Office as required by regulation.

247 There were many gaps apparent in Anishinaabe Abinoojii Family Services' internal communications, supervision, and documentation relating to Misty's care. Its records were incomplete and not in compliance with the Ontario Child Protection Standards. It was evident during the course of our investigation that it lacked adequate policies and training around such matters as special rate agreements, courtesy supervision, child welfare warrants, and record-keeping.

248 Although limited by geography and resources, Anishinaabe Abinoojii Family Services should have been carefully monitoring, documenting, and reporting on the services that Misty received from Johnson Children's Services. If it had done so, it might have helped safeguard her from that agency's inadequate practices. In my opinion, its failure to do so was wrong under section 21(d) of the *Ombudsman Act.*

249 My investigation revealed that many of the practices of the **Southwestern Ontario children's aid society** were exemplary. However, it is my opinion that its practices related to child welfare warrants, which led it to overlook the possibility of issuing one in Misty's case, as well as its failure to file a Death and Serious Bodily Harm report with my Office, were wrong under section 21(d) of the *Ombudsman Act.*

250 I have set out recommendations aimed at improving the services provided by these three organizations and am committed to monitoring their efforts to address the lapses revealed in this report.

Recommendation 56
Johnson Children's Services Inc. should report back to my Office in six month's 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.

Recommendation 57
Anishinaabe Abinoojii Family Services should report back to my Office in six month's 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.

Recommendation 58
The Southwestern Ontario children's aid society 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

251 I make these recommendations with the aim of improving the safety of children in care in Ontario:

1. Johnson Children's Services Inc. should ensure that all of its foster parents and staff receive Indigenous cultural safety training.

2. Johnson Children's Services Inc. should ensure that it considers risk factors unique to Indigenous children in its decision-making about their care.

3. Johnson Children's Services Inc. should ensure that it complies with the terms of service agreements it enters into with societies that have placed children in its care.

4. Johnson Children's Services Inc. should provide notice and obtain approval from societies before moving children they have placed in its care.

5. Johnson Children's Services Inc. should provide copies of all Serious Occurrence reports to societies relating to children they have placed in its care.

6. Johnson Children's Services Inc. should ensure that it consistently provides supervision and 1-to-1 supervision in accordance with its policies, a child's safety plan, and the special rate agreements that it enters into with children's aid societies.

7. Johnson Children's Services Inc. should keep records of specific information about the staff who provide 1-to-1 supervision services, in order to allow the Ministry of Children, Community and Social Services and the placing society to audit the services provided to each child.

8. Johnson Children's Services Inc. should ensure that when a staff person is fulfilling the role of 1-to-1 support, they are not responsible for supervising any other children or performing other tasks in the foster home.

9. Johnson Children's Services Inc. should ensure that any special rate arrangements and changes or extensions to an existing special rate agreement are documented in a formal signed agreement.

10. Johnson Children's Services Inc. should repay Anishinaabe Abinoojii Family Services the amount that it billed for 1-to-1 services that were not provided during the period that Misty was in Southwestern Ontario.

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12. Anishinaabe Abinoojii Family Services should ensure that staff are trained to request specific documentation, such as staff schedules or weekly progress updates, to help monitor the provision of services, including 1-to-1 services.

13. Anishinaabe Abinoojii Family Services should ensure that staff share relevant information about the services that children are entitled to receive, including 1-to-1 support, with any children's aid society that is providing courtesy supervision.

14. Anishinaabe Abinoojii Family Services should ensure that all special rate arrangements and changes or extensions to an existing special rate agreement are set out in formal signed agreements and considered and approved by the appropriate committee, and that this is documented in the child's file.

15. Johnson Children's Services Inc. should ensure that adequate supervision is provided to children within its care at all times.

16. Johnson Children's Services Inc. should direct staff that they are not to bring children to work with them.

17. Johnson Children's Services Inc. should ensure that all foster parents and staff review and implement the safety plans relating to children in their care, and that this is documented in the agency's records.

18. Anishinaabe Abinoojii Family Services should ensure that when placing children outside of its geographic area, it enters into courtesy supervision agreements with local children's aid societies, which set out the expectations and responsibilities for both parties.

19. Anishinaabe Abinoojii Family Services should develop its own policy to guide staff when entering into courtesy supervision agreements, which should include:

- **A description of the roles and responsibilities of front-line and management staff, and**
- **Reference to the necessity of sharing appropriate information with the local children's aid society when negotiating these agreements, including all relevant information about the child and the services they should be receiving.**

20. Anishinaabe Abinoojii Family Services should ensure that its staff are trained on the policy concerning courtesy supervision agreements addressed in Recommendation 19.

21. Anishinaabe Abinoojii Family Services should ensure that whenever a child involved with a local children's aid society under a courtesy supervision agreement is moved, it confirms which children's aid society operates in the area of the new placement, and enters into a new courtesy supervision agreement, as appropriate.

22. Johnson Children's Services Inc. should ensure that staff receive training on the Missing from Care Protocol and Procedures so that they are prepared to apply them if a child goes missing.

23. Johnson Children's Services Inc. should ensure that its staff provide accurate, complete, and timely information to police regarding children who go missing while in the agency's care.

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29. Johnson Children's Services Inc. should establish a comprehensive improvement plan that, once fully implemented, would remedy the concerns that led the Ministry of Children, Community and Social Services to implement the licence conditions, with the long-term goal of having the conditions removed from its licence.

30. Anishinaabe Abinoojii Family Services should review a residential licensee's licence and any licensing conditions before placing a child in its care.

31. Anishinaabe Abinoojii Family Services should consider any licensing conditions applying to residential service providers when monitoring the care that a child receives from the provider.

32. Johnson Children's Services Inc. should ensure that it maintains effective communication with other organizations involved in a child's care. If a staff person is no longer the appropriate contact, Johnson Children's Services Inc. should proactively inform the other organizations who can be reached instead.

33. Johnson Children's Services Inc. should ensure that all serious occurrences are reported in accordance with the Ministry's Serious Occurrence Reporting Guidelines and its own policies and procedures.

34. Johnson Children's Services Inc. should train its staff on the Ministry's Serious Occurrence Reporting Guidelines.

35. Johnson Children's Services Inc. should ensure that its Serious Occurrence reports provide all relevant information about an incident, including any specific information identified as mandatory in the Ministry's Serious Occurrence Reporting Guidelines.

36. Johnson Children's Services Inc. should ensure that it accurately assesses and reports the risk posed by each occurrence, consistent with the Ministry's Serious Occurrence Reporting Guidelines.

37. Johnson Children's Services Inc. should review and train its staff on the Death and Serious Bodily Harm reporting requirements in Ontario Regulation 80/19 and report all incidents that result in the death or serious bodily harm of a child in accordance with the requirements.

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39. The Southwestern Ontario children's aid society should review and continue to train its staff on the Death and Serious Bodily Harm reporting requirements in Ontario Regulation 80/19 and ensure that staff report all incidents that result in the death or serious bodily harm of a child in accordance with the requirements.

40. Anishinaabe Abinoojii Family Services should ensure that all staff who provide services to youth are trained to document and record all relevant information related to a child in its information system in a timely manner.

41. Anishinaabe Abinoojii Family Services should ensure that it documents information in accordance with the Ontario Child Protection Standards, which require contemporaneous case notes that document the date, time, method of contact, and the names of individuals involved in or related to the discussion, as well as significant dates, decisions, and observations related to the contact.

42. Anishinaabe Abinoojii Family Services should ensure that any supervisor feedback or direction is specifically documented in a child's record by the worker and the supervisor.

43. Johnson Children's Services Inc. should ensure that all staff who provide services to youth are trained to document and enter all relevant information related to them using its software in a timely manner.

44. Johnson Children's Services Inc. should ensure that all forms of communication are documented, including telephone calls, in-person meetings, emails, and text messages.

45. Johnson Children's Services Inc. should ensure that each staff person involved in an incident related to a child in care documents the circumstances, including, if necessary, in a Serious Occurrence report.

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47. Johnson Children's Services Inc. should ensure that all staff who may provide care to children – including foster parents, child and youth workers, and others – have access to the software used to document information about children in their care.

48. Johnson Children's Services Inc. should provide foster parents and staff with comprehensive, meaningful training and periodic refresher training regarding relevant legislation, Ministry guidelines, and its policy and procedures, and ensure training records are kept for each foster parent and staff member.

49. Johnson Children's Services Inc., consistent with the requirement set out in its policy manual, should ensure that staff work five orientation shifts prior to being assigned to provide direct care to children.

50. Anishinaabe Abinoojii Family Services should ensure that newly hired employees receive comprehensive training and orientation necessary to fulfill their job responsibilities and their obligations to children in their care.

51. Anishinaabe Abinoojii Family Services should ensure that staff are provided with periodic "refresher" training on areas of key responsibility, and that new training is provided when there are meaningful changes to legal and policy requirements.

52. Anishinaabe Abinoojii Family Services should ensure that it keeps a record of training that each staff member receives.

53. Anishinaabe Abinoojii Family Services should ensure that supervisors meet with frontline staff on a regular basis to review and provide direction on worker's cases.

54. Anishinaabe Abinoojii Family Services should ensure that discussions between supervisors and staff are specifically documented in the child's file.

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56. Johnson Children's Services Inc. should report back to my Office in six month's 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.

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Response

252 Johnson Children's Services Inc., Anishinaabe Abinoojii Family Services, and the Southwestern Ontario children's aid society were given an opportunity to review and respond to my preliminary findings, opinion, and recommendations. We also shared a copy of the preliminary report with the Ministry of Children, Community and Social Services. All comments received were taken into consideration in the preparation of this final report.

253 All three organizations accepted all of the recommendations I directed to them. I am hopeful that these recommendations, once implemented, will help ensure that other children will not end up in the same circumstances as Misty, who found herself far from home, shuffled from placement to placement with little appreciation for her unique vulnerabilities, and without the supervision, supports, and cultural connection that she desperately required.

254 In its response accepting my recommendations, the Southwestern Ontario children's aid society indicated that it had recently provided supervisory staff with in-person training on the use of child welfare warrants in certain high-risk situations. It also explained that it plans to roll out this training to all frontline child protection staff in the near future. The response further indicated that the CAS has updated its Missing Children and Youth Policy to include guidelines for

seeking child welfare warrants, and that staff will receive additional training on the Death and Serious Bodily Harm reporting requirements.

255 In a lengthy response, Johnson Children's Services Inc. set out the steps it intends to take to respond to each of my recommendations and highlighted what it has done so far. Among other initiatives, it pointed to a new training requirement for all foster parents and direct staff serving Indigenous children. Within the next year, these individuals will receive training from the San'yas Indigenous Cultural Safety Training Program, and going forward, Indigenous children will only be placed in homes where foster parents and staff have received this training.

256 Anishinaabe Abinoojii Family Services' response noted the systemic issues that contribute to the challenges it faces when providing services. It also indicated that it shared my preliminary report with the community agency that was responsible for providing services on its behalf to Misty.

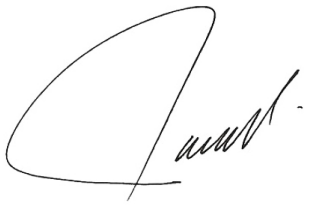
257 The community agency responded separately to my preliminary findings and also highlighted key systemic issues, including a lack of mental health and substance abuse treatment resources for youth in the region, that require children to be placed in Southern Ontario away from their home communities. The agency's Executive Director wrote that they have long advocated to resolve this issue:

> The local agencies […] have collectively raised this issue with the Ministry in the past but to no avail. At one point, we were spending 12 million [dollars] a year collectively, sending our children away. We put forward a proposal for a treatment centre that would pay for itself in a year. All we needed was capital dollars and developmental dollars. We were politely listened to and the needs were acknowledged, but the proposal went nowhere even though the issue was raised up to the Deputy Minister's level…
>
> [The community agency serving Misty] and other northern agencies have in the past asked other agencies for assistance only to turn away due to lack of cultural and contextual understanding and system overload. So, we stopped seeking such assistance and made the decision to attempt to serve our children wherever they may be to the best of our ability. There was an initiative by the Ontario [Association of] Children's Aid Societies to gather information on outside paid institutions and rate them on the quality of their service provision. This information was to be made available and provide support to agencies, especially in the North. I am not sure what happened to this initiative. Partnerships between agencies in the North and South and East would enhance these efforts, and mutual cross cultural and contextual training would be useful.

258 Her letter also noted the struggles that the organization and other community agencies face in hiring and retaining skilled, trained and culturally competent workers given limited resources for salaries and benefits. She stated that along with others, the community agency is in "constant crisis" due to understaffing, although it is always trying to build additional capacity through on-the-job training, mentoring and supervision.

259 The letter concluded by inviting me and my staff to review this report with the community agency in order to move forward together "in a good way." My Office is committed to working towards meaningful and lasting reconciliation, and I am honoured to accept this offer and to work together on our shared goal of supporting Indigenous children in Northern Ontario.

260 I will closely monitor how my recommendations are implemented by Johnson Children's Services Inc., Anishinaabe Abinoojii Family Services, and the Southwestern Ontario children's aid society, and will report on their progress in my subsequent annual reports.



Paul Dubé
Ombudsman of Ontario

Appendix – List of Recommendations by Agency

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Our Values:
Fair treatment
Accountable administration
Independence, impartiality
Results: Achieving real change

Our Mission:
We strive to be an agent of positive change by promoting fairness, accountability and transparency in the public sector and promoting respect for French language service rights as well as the rights of children and youth.

Our Vision:
A public sector that serves citizens in a way that is fair, accountable, transparent and respectful of their rights.

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