OFFICE OF THE YUKON CHILD & YOUTH ADVOCATE
2070 – 2nd Ave. Whitehorse, Yukon Y1A 1B1
Ph: 867-456-5575 www.ycao.ca

April 29, 2026

Kate White, Chair
Standing Committee on Public Accounts
36th Yukon Legislative Assembly
Box 2703
Whitehorse, YT
Y1A 2C6

Re: 2026 Report of the Auditor General of Canada to the Yukon Legislative Assembly – Child and Family Services in the Yukon

Thank you for your letter dated April 2, 2026, requesting comments from the Yukon Child and Youth Advocate Office regarding the recommendations of the Office of the Auditor General of Canada and the response from Yukon government's department of Health and Social Services.

Additionally, I accept your offer to be in attendance in person at the meeting of the Standing Committee on Public Accounts on May 25, 2026, at 1:00 pm.

Through our individual and systemic advocacy, we have a unique understanding of child and youth service systems, including the scope of services provided by designated services, such as Family and Children's Services. We look forward to ongoing conversations that support the transformation of systems. We have summarized our perspective in themes similar to the report and are recommending the following response by Health and Social Services.

Summary of recommendations:

- Address Staffing Instability and Its Impact on Children
- Strengthen Workforce Retention Analysis and Feedback Mechanisms
- Audit of Screened-Out Cases
- Review of Legislative and Policy Definitions
- Incorporate Proactive Oversight Mechanisms
- Strengthen Information Sharing With YCAO, and Provide Access to YCAO to Children Connected to Family and Children's Services
- Mandatory Notification to YCAO of Critical Incidents and Death
- Establish a Child Death Review Process
- Strengthen Incident Review and Learning Processes
- Enhance Post-Care Supports
- Strengthen Child and Youth Participation and Representation
- Expand Supports for Caregivers and Strengthen Prevention

We appreciate your consideration of these recommendations and welcome the opportunity to discuss them further. Strengthening services for children and their families is an investment in our community's future, and we are committed to working towards meaningful, lasting improvements for the young people we serve.

Respectfully,

Annette King
Child and Youth Advocate

Encl. YCAO Report to the Standing Committee on Public Accounts Committee

cc. Logan Ockenden, Clerk of the Committee
Matt King, Deputy Minister of Health and Social Services

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Report to the Standing Committee on Public Accounts

This report provides the Yukon Child and Youth Advocate's comments on the March 2026 Report of the Auditor General on Family and Children's Services in Yukon, and the Government of Yukon's response.

Yukon Child and Youth Advocate Office
April 2026

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Land Acknowledgement

The Yukon Child & Youth Advocate Office (YCAO) respectfully acknowledges that we work and live on the traditional territories of the 14 Yukon First Nations. Colonial government policies have caused long-lasting impacts to Indigenous children and youth, and we commit ourselves to working alongside Yukon First Nations by integrating traditional knowledge and culture for the safety and wellbeing of children throughout the territory.

About YCAO

The YCAO is an independent office of the Yukon Legislative Assembly mandated by the *Child and Youth Advocate Act (2009)* to represent the rights, views, and preferences of children and youth who are eligible for, or currently receiving, government services and programs. The YCAO provides services to young people: under 18 years of age under the *Youth Criminal Justice Act*; under 19 years of age under the *Child and Family Services Act;* under 21 years of age under the *Education Act*; and between the ages of 19 and 26 that are eligible or receiving services under section 17 and 18 of the *Child and Family Services Act*. YCAO is a part of the Canadian Council of Child and Youth Advocates (CCCYA) and operates from a children's rights framework as informed by the United Nations Convention on the Rights of the Child (UNCRC) – Appendix B.

Introduction

The Office of the Auditor General of Canada (OAG) released its audit report regarding Family and Children's Services (FCS) in March 2026, concluding that *"Yukon Health and Social Services did not provide timely, effective, and inclusive services to protect the safety and well-being of at-risk children and young adults."* The Standing Committee on Public Accounts has requested that the YCAO provide perspective on these findings and to the response from Health and Social Services (HSS) included in the audit report.

The OAG audit covered the period November 30, 2022, to March 31, 2025. The audit examined the FCS branch of HSS to assess whether it:

- Met its responsibilities under the *Child and Family Services Act* to protect and support at-risk children (under 19), young adults (19–26), and families;
- collaborated with Indigenous partners to deliver culturally appropriate services to Indigenous children, youth, and families; and
- effectively managed human and financial resources, including staff training, reporting requirements, and information systems/data needs.

The audit examined:

- 48 child protection files (covering 134 reports of suspected harm);
- 39 children-in-care files;
- 32 foster home files;

- 38 extended family home files; and
- 31 young adult (post-care) files.

It also examined the training records for 37 group home staff and 26 social workers on required health/safety and Indigenous awareness training, and a complete review of all 14 critical incidents and 37 serious incidents reported during the audit period, assessing compliance with incident management policies.

What makes the OAG's findings particularly alarming is that they are based on a limited scope, examining only children already in care and investigations that FCS intake had screened in. YCAO is well aware that the full picture of unmet needs is significantly broader.

Children have an inherent right to meaningful participation in matters that affect them. Children have a right to be protected from abuse, to be raised by their parents if it is safe to do so, and to maintain connections to their family and culture if they cannot live with their parents. Children who live in out-of-home care have a right to have their living arrangements reviewed periodically to ensure their physical, mental, emotional, and spiritual wellbeing is supported. Children's best interests, including their views and cultural rights, must be considered in all decisions made about them (UNCRC Articles 3, 6, 9, 12, 18, 19, 20, 24, 25, 30, 31, 33, 34, 39). These rights are also articulated in s. 88 of the *Child and Family Services Act*.

As an independent oversight body representing the rights and views of children and youth, the Advocate welcomes this opportunity to share our perspective. We do so with a clear purpose: to support enhancement of service delivery for the Yukon's most vulnerable young people.

These findings are not new

The OAG's conclusions echo concerns the Advocate has raised through both individual and systemic advocacy over many years. The following YCAO reports, provided to HSS, outline similar gaps in service delivery:

- *Child Rights Impact Assessment on Bill No. 11, Act to Amend the Child and Family Services Act (2022)*
- *Systemic Issue Report on Extended Family Care (2020)*
- *Systemic Issue Report on Permanency Planning (2020)*
- *Systemic Issue Report on Prevention (2020)*
- *Systemic Issue Report on Youth Homelessness (2020)*
- *Empty Spaces Caring Connections – The Experiences of Child and Youth in Yukon Group Care (2019)*
- *Systemic Issue Report on Ageing Out of Care (2019)*

The issues identified by the OAG align with what we continue to hear directly from children, youth, and families navigating the FCS system. The persistence of these concerns, despite repeated recommendations, is deeply troubling.

The stories not told

The experiences of children in care are often invisible to the public. These are sensitive, confidential matters, and young people involved with FCS, many of whom are quite young, rarely have opportunities to share their perspectives publicly. In our annual reports, we identify themes emerging from individual advocacy, but the children themselves remain largely voiceless in public discourse.

A path forward

The Advocate has met with FCS managers, directors, the Assistant Deputy Minister, Deputy Minister, and Minister to share these concerns directly. We approach this work hoping to strengthen our relationship with the department, beginning with senior leadership. Our approach is not intended to be adversarial. We maintain constructive working relationships with other Yukon government (YG) departments, and we seek the same collaborative foundation with FCS.

We aim to find common ground and a shared commitment to the well-being of children. The children served by FCS are among the most vulnerable in the territory. Since the OAG's audit's review period, we have become aware of critical injuries and death among children in care. The consequences of inaction are not theoretical; they are immediate and profound, with long-term implications for community safety, health outcomes, and the life trajectories of young Yukoners.

Any action plan put forward by YG must incorporate the experiences of children and youth themselves, and YCAO is prepared to support that work, and to provide opportunities to amplify the voices that too often go unheard. We were aware the OAG was undertaking this review, and we were anxiously awaiting it as we knew it would inform our assessment of FCS's progress toward recommendations we have made in YCAO's systemic reports.

This audit represents a rare moment of public accountability for this department. It offers a window into the reality facing children and youth who are too often disempowered and unheard. The OAG's findings underscore why independent oversight matters, and why the experiences of young people must remain central to any conversation about reform.

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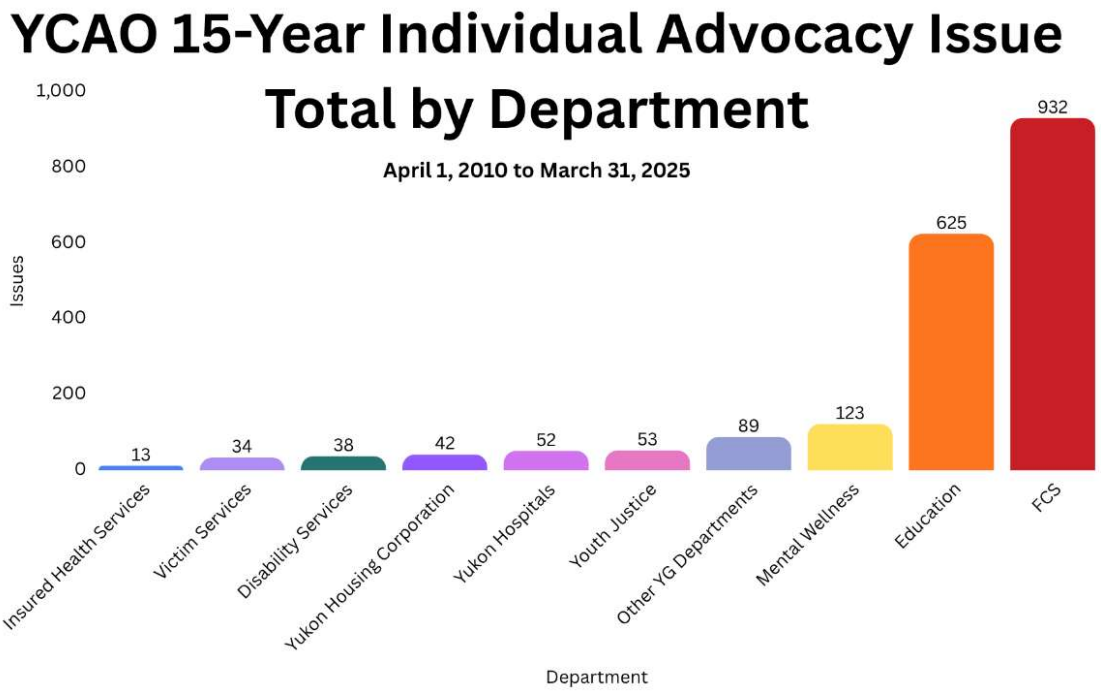
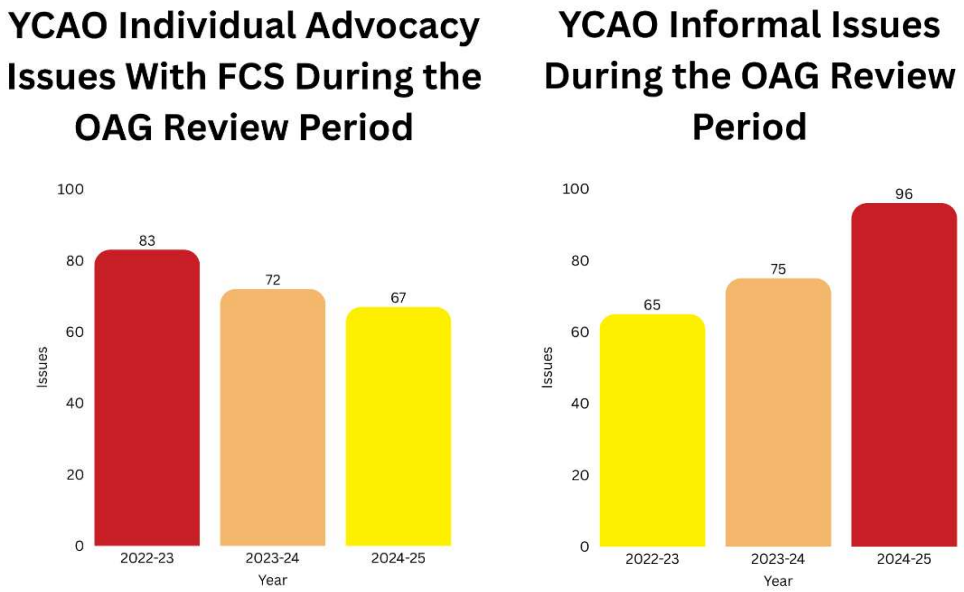
YCAO Summary of Data



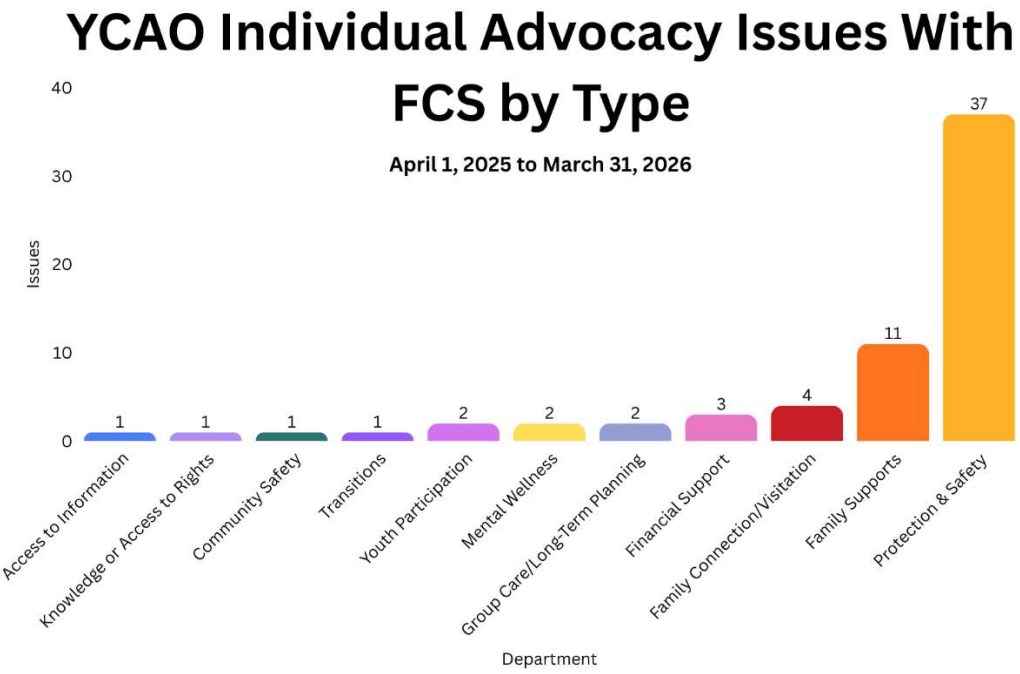
Of the 1850 individual advocacy issues referred to YCAO between April 1, 2010 and March 31, 2025, 932 have been with FCS.



While there appears to be a modest reduction in the number of individual advocacy cases involving FCS since the OAG announced its review, this does not necessarily reflect a corresponding decrease in the number of children and youth requiring advocacy in relation to FCS. Rather, it reflects a shift in FCS intake practices: following the 2022 amendments to the *Child and Family Services Act* and related funding changes, FCS has more frequently screened out cases on the basis that their mandate has since narrowed. Many of these referrals involve individuals who clearly required FCS support but were screened out by FCS for reasons detailed later in the section *Service Gaps Outside the Report's Scope.*

The concurrent increase in YCAO's informal advocacy cases over the same time frame reflects YCAO's understanding of FCS's narrow mandate. For example, we receive numerous referrals from parents concerned about their children being exposed to high conflict parenting following separation but there is not currently a designated YG department that intervenes in this matter. Instead, families are told to protect their children by taking the matters to court. YCAO does not have authority to represent children and youth in court and must advocate without interfering or impeding in a court process.

When issues are referred to YCAO but do not fit within our mandate, we provide informal advocacy by making referrals to the appropriate services or informing relevant YG departments of the issue. This communication is usually done at a higher level between the Advocate or Deputy Advocate and the relevant YG Managers, Directors, Assistant Deputy Ministers or equivalent. In these cases, YCAO cannot direct YG to act, but we can make sure that there is attention brought to the issue(s) and that the information and concerns are shared with the appropriate people.



Preliminary YCAO data for 2025-26 shows there were 65 new individual advocacy cases involving FCS opened between April 1, 2025 and March 31, 2026, which is immediately following the OAG audit review period. When these new individual advocacy files involving FCS are categorized by issue, the predominant issue arising is regarding protection and safety.

HSS and FCS have stated that there have been many improvements in service delivery since the OAG review period ended. However, YCAO data and experience does not support an appreciable change in the outcomes for children. Alarmingly, among the YCAO cases post-OAG review, there has been a death of a child in care. Further, even on cases screened in, YCAO has found that FCS often moves too quickly to close files without adequately addressing protection concerns.

Staffing Pressures and Impacts on Service Delivery

The OAG's report identified persistent staffing challenges within FCS, including difficulties with recruitment, retention, and maintaining sufficient qualified personnel to meet service demands.

YCAO acknowledges that FCS has faced sustained workforce pressures over several years. Through engagement with FCS managers, as well as senior leadership at the Director and Assistant Deputy Minister levels, it is clear that staffing shortages are both longstanding and widely recognized within the system. However, the impacts of these shortages on children and youth are significant and concerning. In practice, we have observed:

- Children not knowing who their assigned social worker is.
- Extreme turnover in staff, where children have had multiple social workers in short time periods.
- Gaps in case management and continuity of care.
- Limited oversight in active files, increasing the risk that emerging concerns are not identified or addressed in a timely manner.

These challenges directly affect the consistency, quality, and reliability of services provided to vulnerable children and families.

YCAO Recommendations

Address Staffing Instability and Its Impact on Children

Children need to know who the people are taking care of them. Staffing challenges were identified by the OAG as a key factor affecting service delivery. Consistently, high turnover and workforce instability disrupt relationships and undermine consistent care.

We recommend that FCS:

- Implement immediate retention strategies to stabilize the workforce, including workload management and support for frontline staff;
- prioritize continuity of relationships with significant staff for children and youth to minimize disruption caused by frequent staff changes;

- ensure all staff meet mandatory training requirements, using existing systems rather than delaying improvements pending new platforms (e.g., YGLearn can be linked to the HRMS system to track training completion); and
- as part of accountability measures, tack and report publicly on staffing levels, turnover rates, and training completion.

Children and youth are directly impacted by instability in staffing, particularly when they are required to repeatedly build trust with new workers. This is exceptionally challenging for children and youth who have experienced harm and have had to adjust to living with numerous caregivers in out-of-home placements.

Strengthen Workforce Retention Analysis and Feedback Mechanisms

To better understand and address the root causes of staffing instability, we recommend that FCS:

- Conduct a comprehensive review of existing exit interview data to identify systemic issues contributing to staff turnover;
- establish mechanisms to gather feedback from former social workers who may not have participated in formal exit processes, including those who have left the jurisdiction or profession;
- take action toward recruitment of First Nations employees; and
- use this information to inform targeted retention strategies, workplace improvements, and workforce planning.

Failure to Protect Children and to Support Wellbeing – Screening Child Abuse Referrals and Assessing Risk

The OAG found significant deficiencies in how FCS screens reports of suspected harm, assesses risk, and responds to children in need of protection.

Key findings include:

- Delayed response times, with over one-third of reports of suspected harm not assessed within the required 24-hour period;
- incomplete interventions, where required steps to ensure child safety were not consistently carried out; and
- failures to meet basic investigation standards, including requirements that all household members be interviewed and that children be seen in person to verify their safety.

These gaps are critical, as failure to complete these steps may result in children remaining in unsafe environments without adequate assessment or protection.

Within the OAG sample:

- 55 reports were screened out;
- 33 were directed to an alternative response; and,
- 46 were screened in for investigation.

While the OAG findings raise serious concerns within the investigation process, our data and advocacy experience indicate broader systemic issues affecting children's safety, particularly in areas that were not fully within the audit scope.

Since amendments to the *Child and Family Services Act* and FCS policies in 2022, FCS has narrowed its operational focus primarily to investigations that meet a high threshold for screening in, and services for children already in out-of-home care. This shift has resulted in a significant reduction in prevention, early intervention, and family support services provided by FCS. As a result, YCAO has observed:

- Increased concerns regarding children's wellbeing in situations that do not meet the current threshold for investigation;
- a growing number of cases where families are screened out without meaningful follow-up or facilitated connection to supports; and
- limited participation by FCS in collaborative, culturally safe, wraparound approaches to care.

The audit did not examine s. 10 of the *Child and Family Services Act* and the role of the Family Resource Unit, which historically contributed to prevention and early intervention. YCAO hears from FCS that funding for prevention services has moved to First Nation governments and organizations but the absence of these functions in FCS practice represents a critical gap in the continuum of care provided by FCS.

Screened-In Cases: Ongoing Concerns

Even where cases are screened in by FCS, YCAO has identified ongoing concerns through follow-up advocacy, including inconsistent investigations, limited or delayed contact with children, gaps in alternative measures, risk assessment and safety planning. These findings align with those of the OAG and reinforce concerns about whether children's safety is being adequately verified.

Screened-Out Cases: Emerging Risks

Concerns are particularly acute in screened-out cases. YCAO has received numerous referrals involving children whose situations raise clear wellbeing and safety concerns but do not meet FCS's current threshold for intervention. In these cases, there is often no formal assessment of risk, families may receive little to no support, and responsibility is effectively shifted to other systems, such as the Department of Education, First Nation governments, or community organizations. However, referrals are not typically facilitated by FCS. Youth are often left on their own to navigate supports.

This approach increases the likelihood that risk will escalate over time, potentially resulting in more serious harm before intervention occurs.

Service Gaps Outside the Report's Scope

While the OAG's report identifies key systemic issues, our advocacy work indicates significant gaps in areas currently considered by FCS to be out of scope for their intervention. We are increasingly supporting children and families who are unable to access services despite clear indicators of risk.

These include cases where:

- Abuse is alleged by a non-parent, such as another child, educator, or step-parent, and is not investigated by FCS.
- Chronic absenteeism and mental health challenges in children or a parent are present, but referrals are screened out despite clear underlying risk factors.
- Youth homelessness occurs, including situations where youth refuse to return home, yet no direct engagement, family mediation or housing supports are offered.
- High-conflict parenting following separation can involve risk, such as coercive control or exposure to unsafe caregivers, but they are not investigated when one parent is deemed "protective". Families are then redirected to the courts to amend parenting orders, rather than supporting the child's right to safe access to both parents.
- Children with disabilities are no longer eligible for FCS supports following the repeal of s. 13 services in the *Child and Family Services Act*.

Families are frequently turned away with explanations such as:

- *FCS is not a mental health facility or program.*
- *FCS does not provide prevention services.*
- *FCS no longer has the funding for prevention.*
- *FCS does not have a role in telling parents to send their child to school – absenteeism is not a protection concern.*
- *Prevention services are voluntary.*
- *FCS does not provide supports to youth refusing to go home due to safety concerns unless there is evidence of harm and the parents agree to FCS supporting the youth.*
- *Services for children with disabilities have been repealed.*
- *Custody disputes should be resolved through the courts.*
- *When there is one protective parent, FCS does not have a role.*
- *FCS does not investigate child abuse when the alleged perpetrator is not a parent.*

Many of these concerns are included in the systemic review YCAO is currently compiling on the impacts on children in high conflict family separation matters.

These service gaps raise important concerns regarding the current interpretation and application of key concepts such as "parent" and "protective parent." In practice, these definitions limit intervention in situations where children are exposed to harm outside of a primary caregiver relationship or across multiple caregiving environments.

In response to these gaps, other service providers, including education and community-based programs, are increasingly attempting to fill the void. However, siloed service delivery continues to create barriers to coordinated care. The education system, in particular, has recently absorbed a disproportionate share of unmet needs, creating a whole new division called Student Wellbeing and Inclusion, an expansion of the existing Student Support Services.

We have observed over the last few years that FCS has, in some cases, declined participation in interagency responses, including school-based wellness supports and multidisciplinary risk assessment processes (e.g., complex case committees and violence threat risk assessments). This lack of engagement undermines collective efforts to manage risk and provide comprehensive support to families.

As a result, YCAO's advocacy services are experiencing a significant increase in demand across all areas falling outside the narrow interpretation of the FCS mandate. We are currently advocating for an increasing number of non-Indigenous children and youth being denied intervention by FCS. This, combined with the extraordinarily high number of Indigenous children placed in out-of-home care by FCS leads to additional questions about the families who are screened out of receiving FCS services and programs.

Families who are already struggling have the added burden of navigating services. Some families can access alternate services if they belong to a larger First Nation with family support and prevention resources or they are eligible to access Family Preservation programming at the Council of Yukon First Nations, or wrap around supports at the First Nation Education Directorate. However, YCAO also hears directly from First Nation service providers who are struggling to get intervention from FCS for the families they work closely with.

YCAO Recommendations

Audit of Screened-Out Cases

Conduct a comprehensive review of all cases screened out by FCS to assess:

- Whether screening decisions appropriately accounted for potential risk in children's living environments.
- Whether the views and experiences of children and youth were considered in the decision not to intervene.
- Whether referrals to alternative services were meaningfully facilitated.
- Whether risk escalated following initial screening, including repeat reports.
- Whether families who are screened out for intervention have access to First Nations services.

Review of Legislative and Policy Definitions

Re-examine the definitions of "parent" and "protective parent" to ensure they reflect the full scope of children's lived realities and do not inadvertently exclude situations of harm.

Checking in on Children in Care

Regular, meaningful contact with children in care and effective case planning are foundational to ensuring their safety and wellbeing. The OAG found significant gaps in these core responsibilities within FCS.

Under policy, a Plan of Care must be completed within 30 days of a child entering care and reviewed at least annually to assess progress and adjust supports. The audit found that these requirements were not

consistently met, limiting FCS' ability to monitor children's wellbeing, track outcomes, and ensure appropriate services are in place.

The OAG also identified concerns with regular contact between social workers and children in care, including instances where required visits were not completed. Without consistent, direct engagement, there is an increased risk that changes in a child's circumstances, including safety concerns, may go unnoticed.

The OAG found that over a third of children living in group care were under six years of age, often in an attempt to keep siblings placed together. The OAG found that FCS has improved collaborations with Indigenous governing bodies but that cultural plans were not developed for most children living in out-of- home placements. The OAG reaffirmed that children should be placed with extended family members or within their community where possible, consistent with policy and best practices. However, the OAG audit identified significant weaknesses in how these placements are assessed and monitored.

In particular:

- Screening requirements for caregivers were not consistently completed, including key safety checks;
- annual reviews of community caregivers and extended family placements were not reliably conducted; and
- there were gaps in verifying whether all required documentation and approvals were in place to support safe placements.

While it is essential and encouraging that children are maintaining belonging and connection by being placed with siblings and extended family members, these findings raise serious concerns about whether all children in out-of-home care are living in environments that have been properly assessed, are receiving adequate support, and are subject to ongoing oversight.

The audit also pointed to deficiencies in ensuring that all relevant information about caregivers is appropriately considered and documented. This underscores the need for robust, consistent screening and monitoring practices, particularly in extended family care arrangements, where oversight requirements must be equivalent to other placement types.

Concerns related to caregiver screening, support, and oversight have also been raised in previous Yukon reviews, including those examining the quality and safety of out-of-home care, further highlighting that these are long-standing and unresolved issues.

Supports for Children in Care

Children and youth living in out-of-home placements are entitled to consistent oversight, planning, and supports as set out under s. 88 of the *Child and Family Services Act*, as well as Article 25 of the UNCRC. These include regular visits, comprehensive case and cultural plans, and effective long-term planning.

However, the ability of FCS to consistently meet these obligations is significantly affected by ongoing staffing pressures. Gaps in service delivery, such as missed visits, incomplete case plans and cultural

plans, and limited long-term planning, raise concerns about whether children in care are receiving the level of oversight and support to which they are entitled.

The OAG previously identified deficiencies in case management and record keeping in its 2014 audit. While a new case management system was developed, FCS has not fully implemented it. As a result, persistent challenges remain in tracking, monitoring, and ensuring accountability for the care of children and youth. Children cannot wait for administrative systems to be resolved before receiving consistent and appropriate care.

YCAO works to ensure that representation and oversight is in place for children and youth; however, our current model is primarily reactive. Advocacy services are typically provided only when a referral is made, most often by concerned adults or sometimes by a direct request from a youth. There remains a widespread misconception that YCAO is automatically connected to all children in the care of the Director.

At present:

- YCAO does not receive automatic notification when a child in care is injured, dies, or is involved in a critical incident – even when YCAO is actively advocating for the child or youth.
- Yukon does not have a formal child death review mandate, unlike other Canadian jurisdictions.
- There is no systematic mechanism to ensure that all children in care are aware of, or connected to, advocacy supports.

To address this gap, YCAO has undertaken public education efforts to increase awareness among children, youth, and caregivers. However, without formalized referral pathways, many children remain without the option to engage YCAO services.

Effective advocacy depends on timely and accurate access to information. Over the years, YCAO has made many attempts to find a process for information sharing that mitigates FCS's perceived adversarial interpretation of the advocacy role. The current process, identified by FCS, relies heavily on summaries provided by an FCS policy liaison to YCAO, rather than providing YCAO with direct access to case files through the FCS system, or consistent communication with frontline staff, managers, or the Director of FCS. This creates challenges in verifying information and limits YCAO's ability to review FCS decisions. YCAO has experienced delays or reluctance in sharing information, inconsistent support from FCS when requesting to attend case planning meetings to support or represent a child or youth, and inconsistent cooperation from FCS in providing formal records. In some Canadian jurisdictions, the Advocate has direct access to case management systems.

The lack of transparency is concerning, particularly given that YCAO must rely on FCS as the primary source of information while also serving an independent oversight function.

YCAO Recommendations

Incorporate Proactive Oversight Mechanisms

Implement automated alerts when key standards are not met, such as missed visits, incomplete or overdue care plans, or a lack of case activity over a defined period.

Strengthen Information Sharing With YCAO, and Provide Access to YCAO to Children Connected to Family and Children's Services

Ensure FCS staff are aware of responsibilities for sharing information and records with YCAO for the purposes of advocacy and continue to work with YCAO staff to support advocacy for children and youth through effectively and timely communication and sharing of information.

Mandatory Notification and Referral

Establish mandatory referral requirements to YCAO for all critical incidents involving children in care, including serious injury and death.

Establish a Child Death Review Process

Support implementation of YCAO's proposed child death review model. Until legislative amendments occur, this can be accomplished through a Ministerial referral of child deaths to YCAO under s. 15 of the *Child and Youth Advocate Act*. Further, the *Coroners Regulation*, O.I.C. 2021/114, s. 4 may be amended to ensure the Advocate is immediately notified of the death of a child, in addition to the Chief Coroner.

Responding to Incidents Involving Children in Care

The OAG identified significant gaps in how FCS responds to critical and serious incidents involving children in care, particularly with respect to communication, accountability, and follow-up.

While the audit found that FCS generally responded to the immediate health and safety needs of children in the incidents reviewed, critical deficiencies were identified in how these incidents were managed afterward. In particular:

- Family members were not informed in 33% of critical and serious incidents, despite policy requirements.
- Indigenous partners were not notified in 23% of cases where notification was required.
- In more than half of the incidents reviewed, there was no evidence that families were informed at all.
- There was no consistent evidence that incidents were reviewed in accordance with policy to identify lessons learned and prevent recurrence.

These failures undermine transparency, erode trust, and limit the ability of a child's support network to respond appropriately and support the child's wellbeing.

Despite the seriousness of these incidents, there is currently no formal mechanism to ensure independent oversight. YCAO is not automatically notified when a child living in out-of-home care is seriously injured, a critical incident occurs, or if a child dies. FCS has indicated that they would require direction if they were to formalize such automatic notification to YCAO.

The absence of a structured notification and review process is a significant gap. Unlike other jurisdictions, the Yukon does not have a mandated child death review model. This limits opportunities for accountability, systemic learning, and prevention of future harm.

S. 17 and 18 of the *Child and Family Services Act* contemplate supports for youth transitioning out of care. However, in practice, positive outcomes for youth are often linked not to formal systems, but to informal and community-based supports, including former caregivers, First Nation governments and community support. This raises concerns about the consistency and reliability of post-care planning and services provided through FCS. It is promising that the 2022 amendments to the *Child and Family Services Act* increased eligibility for supports to age 26 but more needs to be done to ensure family and cultural connections and the development of skills for independence.

YCAO Recommendations

Mandatory Notification to YCAO of Critical Incidents and Death

As noted in the previous section.

Strengthen Incident Review and Learning Processes

Ensure all critical and serious incidents are reviewed in accordance with policy, with documented findings and clear actions to prevent recurrence.

Enhance Post-Care Supports

Strengthen implementation of s. 18 of the *Child and Family Services Act* to ensure all youth leaving care have access to consistent, reliable, and culturally appropriate supports.

YG's Response to the OAG Report

HSS has formally agreed with the findings of the OAG and has committed to a multi-year plan focused on improving compliance, training, policy, and system oversight. While this acknowledgement is important, the proposed response raises significant concerns regarding timeliness, scope, and reliance on internal processes, particularly given the severity and immediacy of the risks identified in the audit.

Extended timelines given the context of immediate risk

One of YCAO's central concerns with YG's response to the OAG recommendations is the extended implementation timeline. Key elements of the Department's response, which include full policy updates, training improvements, and case management system alignment, are not scheduled for completion until late 2027, with some compliance review cycles extending to 2029.

This approach is not commensurate with the urgency of the findings. The OAG identified failures in core protection functions, including delayed responses to reports of harm, incomplete investigations, and gaps in oversight of children in care. These findings represent immediate safety concerns.

Children cannot wait multiple years for systemic improvements while known deficiencies in service delivery persist. The absence of clear interim safeguards or accelerated actions to address high-risk areas raises concern that children may continue to be exposed to preventable harm during the implementation period.

Incremental approach to known and long-standing issues

Several commitments such as improving screening practices, ensuring contact with children, and completing Plans of Care and Cultural Plans, reflect core legislative and policy requirements that should already be consistently met. Similarly, issues related to staffing shortages and workforce instability, incomplete caregiver screening and annual reviews, and inconsistent compliance with group home standards, have been identified repeatedly over multiple years, including in prior audits. YG's response does not clearly demonstrate how this cycle of identifying and re-identifying the same issues will be broken.

Gaps in immediate accountability for children in care

HSS has committed to improvements in group home standards, cultural planning, and caregiver screening. While these are important, the timelines again extend into 2026-27, and in some cases rely on future budget and planning processes. There are also noticeable absences including immediate mechanisms to ensure that all children currently in living in out-of-home placements are safe and receiving required oversight. There is an absence of clear processes to ensure timely notification and response to critical incidents, and any concrete actions to address existing non-compliance in real time, rather than through future reviews.

Cultural planning and engagement with First Nations

HSS's efforts to engage Yukon First Nations and Indigenous governing bodies, and to complete cultural plans for children in care, are positive steps. However, progress is partial, with processes established for some, but not all, partners. There is also limited detail on how these plans will be implemented, monitored, or resourced.

Given the ongoing over-representation of Indigenous children in care, and the importance of cultural continuity to child wellbeing, delays in this area are significant and in opposition to the preamble and guiding principles in the amended *Child and Family Services Act*.

Additional YCAO Recommendations

Strengthen Child and Youth Participation and Representation

Children and youth must be meaningfully included in decisions that affect their lives. Current practice does not consistently reflect this principle, and there are ongoing concerns regarding the recognition of

youth voice and the role of independent advocacy. Please see Appendix A for a small sample of views of young people.

We recommend that FCS:

- Establish mandatory processes to ensure children and youth are heard or represented in all key decisions, including care planning, placement changes, and case reviews.
- Ensure all staff are trained on child rights and participation, the role of independent advocacy and are aware of relevant systemic reports completed by YCAO.
- Ensure all FCS staff have orientation and awareness of the *Child and Family Services Act* and associated policies.
- Provide children and youth with accessible information about their rights and available advocacy supports.
- Formalize consistent processes for independent advocacy representatives to participate in meetings or convey youth perspectives.

Expand Supports for Caregivers and Strengthen Prevention

Community caregivers (formerly referred to as foster families), extended family placements, and group home staff, require consistent, proactive support to provide safe and stable care environments. The current system places responsibility on caregivers without sufficient guidance, training, and wraparound services. YCAO frequently hears frustration from caregivers about their needs for support, information, and timely decisions. They share that they are not valued as part of the care team, their concerns and perspectives are unheard and are often interpreted as unwelcome. Consequently, we are aware of caregivers who have chosen to not continue in the role due to these frustrations.

We recommend that FCS:

- Reinvest in collaborative prevention and early intervention supports for families and caregivers.
- Strengthen collaboration with First Nations and community partners to support culturally appropriate caregiving environments.
- Provide ongoing training, respite, and mental health supports for caregivers.
- Ensure equitable standards of support and oversight across all placement types, including extended family care.
- Address issues as they arise.

Appendix A


"I don't think anyone will even call me on my birthday."
"NO [I DON'T SEE MY SOCIAL WORKER OFTEN]. I DON'T REMEMBER THE LAST TIME I SAW HER."
"THERE ARE HARDCORE ADDICTS IN THE HOUSE AND I'M WORRIED ABOUT MY SOBRIETY. IT'S VERY TRIGGERING."
YOUTH Voice
"When I get out of here I am going to go to the shelter. But I don't know what I'll do between 8 and 4. That's a lot of time to fill when I'm not allowed to be there."
"I DON'T WANT TO BE SEPARATED FROM HER [MOM]. I DON'T THINK SHE'LL BE OKAY WITHOUT ME."
"I don't want to go with that family. I only want to see them sometimes."
"I'm not safe there."
"I get why other kids have to go to camp, because their parents are at work. But they [group home workers] are already at work, so why do I have to go?"
"HIGHER UPS AT FCS MUST THINK I'M OK AND NOT TO WORRY ABOUT ME. I'VE STOPPED CALLING AND ASKING BECAUSE NOTHING IS BEING DONE."

OFFICE OF THE YUKON CHILD & YOUTH ADVOCATE
2070 – 2nd Ave. Whitehorse, Yukon Y1A 1B1
Ph: 867-456-5575 www.ycao.ca

Appendix B