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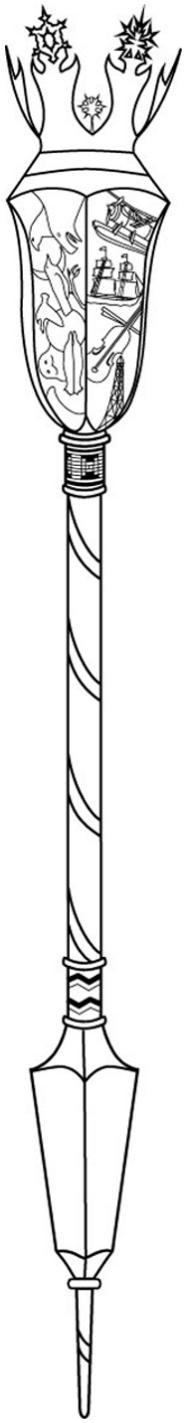

18th Legislative Assembly of the Northwest Territories

Standing Committee on Government Operations

Report on the Review of the 2018 Report of the Auditor General of Canada on Northwest Territories Child and Family Services

Chair: Mr. Kieron Testart

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February 26, 2019

SPEAKER OF THE LEGISLATIVE ASSEMBLY

Mr. Speaker:

Your Standing Committee on Government Operations is pleased to provide its *Report on the Review of the 2018 Report of the Auditor General of Canada to the Northwest Territories Legislative Assembly (Child and Family Services)* and commends it to the House.

Kieron Testart
Chair
Standing Committee on Government Operations

STANDING COMMITTEE ON GOVERNMENT OPERATIONS

REPORT ON THE REVIEW OF THE 2018 REPORT OF THE AUDITOR GENERAL OF CANADA TO THE NORTHWEST TERRITORIES LEGISLATIVE ASSEMBLY (CHILD AND FAMILY SERVICES)

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STANDING COMMITTEE ON GOVERNMENT OPERATIONS

REPORT ON THE REVIEW OF THE 2018 REPORT OF THE AUDITOR GENERAL OF CANADA TO THE NORTHWEST TERRITORIES LEGISLATIVE ASSEMBLY (CHILD AND FAMILY SERVICES)

ACKNOWLEDGEMENTS

Before we begin, we would like to recognize the contribution of the Auditor General of Canada, Mr. Michael Ferguson, to the completion of this report. Mr. Ferguson, who passed away on February 2, 2019, was a dedicated public servant who will be greatly missed. We offer our condolences to his family, friends, and colleagues.

INTRODUCTION

On October 23, 2018, the Speaker of the Legislative Assembly of the Northwest Territories tabled the 2018 *Report of the Auditor General of Canada to the Northwest Territories Legislative Assembly – Child and Family Services.* The Standing Committee on Government Operations ("the Committee") then convened a public hearing with staff from the Office of the Auditor General (OAG) and with representatives of the Northwest Territories Department of Health and Social Services ("the department") on December 12, 2018.

Like many Northwest Territories residents, Members know and care for those whose lives have been intimately affected by the child and family services (CFS) system. Some have been affected themselves. The CFS system shapes the lives of all children and families involved it. In doing so, it shapes our territory's future. The importance of this work cannot be overstated.

To address the issues identified by the OAG, the Department of Health and Social Services has committed to achieving major, much-needed change within the next two years. This work is both urgent and challenging, and the stakes are high: two years is not a long time — unless you are a child in care that is not working.

ROLES OF THE AUDITOR GENERAL OF CANADA AND THE STANDING COMMITTEE ON GOVERNMENT OPERATIONS

The Auditor General of Canada is an Officer of Parliament, with additional auditing responsibility for the territorial governments, including the Government of the Northwest Territories (GNWT). When delivering financial or performance audits of the GNWT, the

Auditor General reports directly to the Legislative Assembly as one of its statutory officers.

The Committee, which has oversight responsibility for each of the Assembly's statutory officers, then reviews that report and makes recommendations to the GNWT. This work is part of the Committee's core mandate.

CHILD AND FAMILY SERVICES IN THE NORTHWEST TERRITORIES

Under the umbrella of the Department of Health and Social Services, the Director of Child and Family Services (assigned by statutory appointment), and the health and social services authorities, including the Northwest Territories and Hay River authorities (NTHSSA and HRSSA) and the Tłı̨chǫ Community Services Agency (TCSA), work together to deliver services as set out in the *Child and Family Services Act* and the *Child and Family Services Standards and Procedures Manual*. Through CFS, the GNWT must fulfill a parent's duties and responsibilities for each child in care, in addition to providing various other services to children and their families.

As OAG staff told the Committee, "the department [has] a fundamental responsibility for children in care; the department has to figure out how to make that work."

WHAT DID THE OAG LOOK AT?

The OAG's report is the latest contribution to a large body of work on CFS, including past OAG audits, standing committee reports, third-party analyses, and internal government documents, such as action plans and annual reports. Much of this prior work is described in detail in Committee Report 16-17(5), issued by our predecessor committee on May 29, 2014. Interested readers may find all committee reports online at the Legislative Assembly's website or through the Legislative Library.

For its 2018 report, the OAG audited the department's and authorities' performance against current laws, policies, and procedures, focusing on whether the department and authorities "met key responsibilities for the protection and well-being of children, youth, and their families, [including] whether [they] had implemented selected recommendations from [the] 2014 audit." Auditors examined 37 child files and 37 foster care files in the Yellowknife, Beaufort Delta, and Tłı̨chǫ regions, which together serve as home to 67 per cent of children in care in the Northwest Territories, and extended their file review of guardianship agreements and out-of-territory placements across all authorities. The audit also included engagement with child protection workers (CPWs) in all regions.

Overall, the findings are troubling: service delivery continues to be plagued by "serious deficiencies" and rather than see improvement, many services have worsened since 2014.

WHAT DID WE LOOK AT?

This report is about the OAG's 2018 audit of child and family services. It does not provide a comprehensive review of the CFS system, nor does it examine the *Child and Family Services Act* or internal CFS policies.

As the standing committee with the responsibility to oversee statutory officers, this Committee is concerned with the official findings of the OAG regarding performance and compliance. Our objective is to make recommendations to the GNWT that will result in improved services to children and families and also, as elected officials responsible for the approval of the GNWT's annual budget, to ensure optimal allocation of public resources. Our colleagues on the Standing Committee on Social Development continue to monitor the ongoing delivery of CFS.

It is also important to note that the Committee is concerned with overarching management and the direction of departmental business at the senior level, not with the day-to-day performance of front-line and other staff.

The department is developing a quality improvement plan for CFS. This plan should incorporate the recommendations made in this report.

Recommendation 1

The Standing Committee on Government Operations recommends that the Department of Health and Social Services incorporate into its quality improvement plan for child and family services the recommendations made in this report.

GENERAL CONSIDERATIONS

Accepting the findings of the Auditor General

The department has previously questioned the OAG's findings regarding CFS. For example, the 2015-16 annual report of the CFS director,[1] states,

[1] Tabled Document 205-18(2), p.6.

> "Finally, there is a major limitation in both the Auditor General's findings and the current department audit findings, one that calls into question any conclusions drawn from the findings. Neither the Auditor General nor the Director of Child and Family Services were able to distinguish between "work not done" and "work not recorded" using the current methodology."

Similarly, during the public hearing, although departmental staff stated that they respect the OAG's findings, they also spoke of "debate over methodology" and their preference for internal audit results over the OAG's findings.

The Committee requested the OAG's perspective on these matters. We determined that the OAG's findings are fully vetted with each audited department. OAG staff said, "We go through a very active process to vet with departments, and give them every opportunity to provide any evidence. We vetted all of our findings, and the department and authorities signed off [on all of them]." The OAG dedicated a combined 7,000 hours to their audit.

The Committee urges all audited departments to refrain from questioning the OAG's findings once these are accepted.

Timely Receipt of Materials

In 2016 and 2017, the Committee recommended that any GNWT department being audited provide the Committee with its action or implementation plan no later than three business days before the public hearing.[2] A process convention is presently in development to clarify procedures for the distribution of such documents.

Recommendation 2

The Standing Committee on Government Operations recommends that any government department, board, or agency being audited produce a draft action or implementation plan in response to the audit, provide the Committee with a copy of that plan consistent with the appropriate process conventions, and present the plan at the Committee's public hearing.

[2] See Committee Report 9-18(2) and Committee Report 6-18(3), p.10 and p. 10.

Quality Assurance

Some performance parameters for CFS are immediately clear because they are set out in the *Child and Family Services Act*. Regarding these, the Committee concurs with the OAG that 100 per cent compliance is the department's legal obligation and that anything less is insufficient.

After the OAG's 2014 report, our predecessor committee recommended that the department and authorities conduct annual compliance audits, and that these audits, along with any subsequent action plans, be shared with the Standing Committee on Social Programs (now called the Standing Committee on Social Development) and tabled in the Legislative Assembly.[3] At that time, the GNWT agreed to these recommendations[4] and cited *Building Stronger Families: An Action Plan to Transform Child and Family Services*, which included commitments to a common audit tool and reporting template.[5]

Since that time, however, the internal auditing process has been hindered by several issues. The department has dedicated significant resources to attempting to replicate the OAG's process in in its own internal quality assurance work.[6] These attempts have left the department with unusable data, a "broken" audit tool, and inconsistency in reporting across regions.[7]

Considering this, the Committee is reminded of advice from the OAG's staff: "if you're going to do the quality assurance work, you have to make sure you have the resources." This will be discussed further under the heading "Assessment of required financial and human resources."

The Committee also wishes to raise two additional points.

First, it is important to understand that the department's internal audit process and the work of the OAG are entirely distinct. These differences mean that findings cannot be compared in an "apples-to-apples" way.

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[3] See Recommendations 11, 12, and 13 in Committee Report 6-17(5), *Report on the Review of the 2014 Report of the Auditor General of Canada on Northwest Territories Child and Family Services*, pp.11-12.

[4] See Tabled Document 119-17(5), *Government of the Northwest Territories Response to Committee Report 6-17(5) – Report on the Review of the 2014 Report of the Auditor General of Canada on Northwest Territories Child and Family Services*, pp.5-6.

[5] See Tabled Document 120-17(5), pp.12-13.

[6] See Tabled Document 205-18(2), *Annual Report of the Director of Child and Family Services 2015-2016*, p.6.

[7] See "NWT Child and Family Services audits are unusable, after computer system crashes," as reported by CBC North on January 20, 2017.

The OAG's performance audit covered the period between April 1, 2014 and September 12, 2018. The department's most recent internal audit covered only the period between April 1, 2016 and March 31, 2017.

- The OAG examined 37 child files and 37 foster care files, and engaged with CFS staff in all regions. The department examined "a sample of 711 child protection and prevention events,"[8] including all foster care files within the audit period, and offered an online anonymous survey to staff employed in the authorities.

Second, since becoming aware of the OAG's findings, the department appears to have initiated comprehensive system-wide quality assurance, but failed to address immediate service gaps identified by the OAG. For example, at the public hearing, three months after the OAG's audit was concluded, departmental staff were unable to identify whether unscreened guardians and foster homes had since been screened, and referred instead to plans for system-wide quality assurance.

Departmental staff framed this as a "dilemma," or a choice between "perfect" performance and a "quality improvement approach." But the OAG's report has shown that the department's present "quality improvement approach" resulted in worsened services over time. "Perfection" may be difficult to achieve, but regardless, 100 per cent compliance is required by law. The Committee echoes its predecessors and urges the department to "begin immediately and in earnest to correct deficiencies in child and family services,"[9] even while it continues to develop its medium- and long-term plans.

Recommendation 3

The Standing Committee on Government Operations recommends that the Department of Health and Social Services act immediately to ensure that all gaps in screenings and reviews identified by the Office of the Auditor General, including screening for guardianship agreements and foster homes, are addressed, and that it advise the Committee when this is completed.

[8] See Tabled Document 243-18(3), p.39.

[9] See Committee Report 6-17(5), p.9.

Recommendation 4

The Standing Committee on Government Operations recommends that the Department of Health and Social services appear before the appropriate standing committee twice yearly to report on its compliance with the *Child and Family Services Act* and its progress on its quality improvement plan.

Performance Evaluation Through Measurable Outcomes

However, compliance alone does not ensure that children and families are adequately supported, nor do individual measures, lacking context, provide a complete portrait of performance.

For example, the department has identified increasing rates of children receiving services in the home and increasing rates of voluntary services agreements (VSAs) as demonstrating improved services.[10] Yet the OAG found that monitoring of children at risk under parental care at home had worsened since 2014, and that VSAs require no interaction with child protection workers (CPWs) and may be ended by the parent at any time. To quote directly from the OAG's report:

> "In most cases, we found that [plan-of-care] agreements were not monitored as required, and that the monitoring that did take place focused mostly on parents instead of on the children these plans were intended to protect. For example, we found that in most cases, HSSAs had some contact with parents but did not interview children as often as the plans required to make sure they were safe and to assess their health and well-being. We found that this occurred even in some high-risk cases.
>
> We also found that [authorities] allowed some children to remain under a plan-of-care agreement even when it was clear the conditions were not being met, and sometimes extended these same agreements. Further, in a few cases we examined, authorities allowed a parent to terminate the plan-of-care agreement early without being assured that the child was no longer at risk. These findings are significant because these agreements are often an alternative to removing a child from the home, and the termination of the agreement by the parents may not be in the best interests of a child."

[10] Minister's Statement 99-18(3)

Simply put, more children may have been assigned to receive services at home, but the services received, if any, were subpar and staff often failed to follow up.

To deliver effective services, the department must assess performance over time through both compliance rates and contextualized, client-centred performance measures. These should include desirable long-term outcomes intended to assess whether children engaged with the CFS system are flourishing over time. These might include social inclusion (e.g., extracurricular activities or the desire and ability to set and pursue educational or career goals) and other health indicators (e.g., educational performance or mental health), as well as quality assurance practices focused on assessing children's satisfaction as "clients" of the system.

The department has accepted the OAG's recommendation that it "identify specific indicators to measure whether the system is achieving the desired results and is better supporting children." This work will be a critical component of the department's work over the next two years.

Recommendation 5

The Standing Committee on Government Operations recommends that the Department of Health and Social Services publicly identify performance indicators, including client-centered outcomes, that it will use to assess improvements in child and family services over time;

And that reporting on these measures be incorporated into the department's annual business plan and the annual report of the director of child and family services.

Cultural Safety

It is well known that Indigenous children and families are over-represented within CFS. Further, while the number of non-Indigenous children in care has declined over the past ten years, the proportion of Indigenous children has remained roughly the same: approximately 95 per cent. The Committee is also aware that many residents have observed or experienced parallels between involvement with CFS and the residential school system, particularly the very real fear of having one's children removed from their home and community by government officials.

During the public hearing, when Members questioned the department about engagement with Indigenous communities, staff advised that they had been "focused

internally" and that they "haven't done [that] fulsome kind of outreach," but were "confident… that grassroots staff were working with communities." The department must show leadership and ensure that senior staff connects with front-line staff, and that

both regularly engage with Indigenous and community governments. Notably, this was also recommended by our predecessor committee.

If the department wishes to make meaningful, permanent change in CFS, Indigenous people must be engaged as part of the solution. The department and authorities must maintain children's access to their culture and traditions, and ensure staff is regularly engaged in community immersion and cultural safety training.

Recommendation 6

The Standing Committee on Government Operations recommends that the Department of Health and Social Services incorporate into its quality improvement plan on child and family services a commitment to strengthen working relationships with Indigenous and community governments;

And that the department regularly report on its progress as set out in Recommendation 5.

Community Engagement

The department must also regularly collaborate with other community partners, including the Foster Family Coalition of the Northwest Territories and the extended families of children in care. Foster parents are eager and willing partners, waiting to be engaged, and families of children in care want to know that they are being heard and that the children they love are being given the opportunity to thrive. As our predecessor committee noted, improvements are still needed in supports for kinship care – that is, children being cared for by grandparents and other relatives in lieu of being cared for by their parents.

When the OAG examined supports for foster parents, it found that one audited authority offered "specialized training to some foster parents," while the other two offered "very little or no such training." The Committee would like to see these supports distributed equitably across the entire territory and designed to recognize foster parents' prior experience, abilities, and unique needs (for example, particularly in kinship care) and to

help foster parents navigate the CFS system and the challenges it poses to those involved.

Recommendation 7

The Standing Committee on Government Operations recommends that the Department of Health and Social Services incorporate into its quality improvement plan on child and family services a commitment to strengthen working relationships with community stakeholders in child and family services, including the Foster Family Coalition of the Northwest Territories and the extended families of children in care;

And that the department regularly report on its progress as set out in Recommendation 5.

Recommendation 8

The Standing Committee on Government Operations recommends that the Department of Health and Social Services develop and implement training for foster parents.

Recommendation 9

The Standing Committee on Government Operations recommends that the Department of Health and Social Services establish an information-sharing agreement with the Foster Family Coalition of the Northwest Territories to ensure that all foster parents may be connected with that organization's resources.

Engagement with Front-line Staff

The OAG's engagement with CPWs also showed that front-line staff continue to face significant pressures, particularly in their workloads, which in turn negatively impacts children in care, whether through high staff turnover, duties "falling through the cracks," or in administrative burdens demanding CPWs' limited time. The Committee heard of

one employee assigned to complete, by themselves, quality assurance reviews of roughly 3,000 child protection decisions. This is not sustainable.

The department has used various methods to reach out to staff, including teleconferences, meetings, and surveys. Over the next two years and into the future, all staff must have the opportunity to provide free and honest feedback, whether positive or negative. An open, ongoing process with guaranteed anonymity is one way to achieve this.

Recommendation 10

The Standing Committee on Government Operations recommends that the Department of Health and Social Services develop and implement mechanisms to enable staff to provide free and honest feedback anonymously.

SPECIFIC OBSERVATIONS

Services for Children in Parental Care

Structured Decision Making®

Structured Decision Making® (SDM) is a proprietary tool intended to aid CPWs in making decisions about child safety and to ensure consistency in decision-making. It is relatively new to the Northwest Territories. Although it is in use, it is not yet fully implemented.

The OAG found that in about eight of every ten case reviews, CPWs did not use the SDM tool to assess longer-term risk for children in parental care, even though this was mandatory and risk assessment was an outstanding performance issue. The OAG also found insufficient staff training and significant lag in internal quality assurance. As discussed earlier, in one case a single employee was tasked with reviewing 3,000 decisions in addition to their regular job duties.

Further, a review commissioned by the department and undertaken by the National Council on Crime and Delinquency Children’s Research Center, who created SDM, found a 50 per cent error rate. This means that the tool's creators, experts in their field, disagreed with one in every two decisions made by a territorial CPW on a child's safety using SDM. This is not an acceptable standard of reliability.

Plan-of-Care Agreements

Plan-of-care agreements (POCAs) are used where CPWs have established that a child is in an unsafe situation, but may remain in parental care under conditions tailored to address that situation. POCAs set out these conditions and "the support needed to help parents meet [them]."

As discussed, the OAG found that compliance rates for the management and monitoring of POCAs had declined since 2014. Children rarely received the services due to them, and some POCAs were continued even where parents failed to meet conditions. In some instances, CPWs "allowed a parent to terminate the [POCA] early without being assured that the child was no longer at risk."

The Committee is concerned that whether intentionally or not, as our predecessor committee warned, reductions in the number of child apprehensions may have been "achieved by cutting back on child protection services."[11] The Committee supports the general objective of limiting the number of apprehensions, but this cannot be achieved at the expense of children's right to a safe living environment or the department's compliance with its legal responsibilities.

Services for Children in Temporary and Permanent Care

Transferring Guardianship of Children in the Care of the Director

The OAG found that in 22 cases CPWs, without the knowledge of senior staff in the authorities or the department, "worked with [children's] biological parents to transfer guardianship… to a family member or other person, who then were given full parental rights and responsibility." Significantly, when a guardianship agreement is completed, CFS cedes its right to act on behalf of (or for) the child in question.

At the time of the OAG's review, there was no related legislation or formal policies, standards, rules, or advice to guide CPWs in the matter of guardianship. Further, in the 22 cases reviewed by the OAG, only eight guardians had been screened and one of the unscreened guardians later assaulted the child in their care. During the public hearing, the department also advised that half of these agreements have since broken down, meaning that CFS failed to achieve permanency for those children. Staff were also unable to identify how many of these guardians had been screened or otherwise followed up with *since the audit was concluded*.

[11] Committee Report 6-17(5), *Report on the Review of the 2014 Report of the Auditor General of Canada on Northwest Territories Child and Family Services*, p.7

Responding to these findings, the department stated that staff had "acted with good intentions." Similarly, during the public hearing, staff emphasized to Members that the agreements had been reviewed by legal counsel. Such responses appear to focus on legal liability rather than practical responsibility. That front-line staff considered such use of guardianship agreements to be part of their regular suite of tools, with senior staff unaware, suggests a considerable breakdown in communications.

Foster Care

Screening and Annual Reviews of Foster Homes

During the public hearing, the Committee also considered authorities' failure to properly screen and review foster homes. Since 2014, "serious deficiencies in the screening and ongoing monitoring of foster homes [have] persisted": two-thirds of reviewed foster care files revealed that the home had not received an initial screening, including criminal-record and reference checks, and that most files contained only incomplete annual reviews, largely because children were not interviewed.

Again, departmental staff were unable to identify how many of these foster homes had been appropriately screened and/or reviewed *since the audit was concluded*.

Persistent Deficiencies in Foster Care Monitoring and Support

The department must act to address severe gaps in permanency planning for children in care. Quoting from the OAG's report:

> "In particular, HSSAs did not maintain the required regular contact with many of the children they had removed from homes and placed in foster care or other out-of-home placements. As a result, they had no way of knowing whether these children were receiving the care they needed. They also did not develop permanency plans for most of these children. In some cases, this contributed to children moving between foster care homes multiple times. Such frequent moves make it difficult to provide children with stability and support."

An "Early Warning System" for Children in Care

During the public hearing, the department told the Committee that its new information system, MATRIX NT (which is new and was not part of the OAG's audit), would enable staff to quickly and effectively "track children who make multiple [moves], which will trigger a quality review."

This type of "early warning" mechanism for children in care is necessary not only to track the movement of children in care, but system-wide. The department must be able to identify common "pinch points" in the CFS system, then intervene before children themselves are harmed. The Committee hopes that new tools, including MATRIX NT and SDM, will prove useful. We also counsel the department to provide regular adequate training, including refresher training, to staff and to ensure that "boots on the ground" action accompanies all "tabletop" data analysis.

The System for Delivering Child and Family Services

Assessment of Required Financial and Human Resources

The OAG "found that the department had still not determined the financial and human resources required to delivery child and family services, [and] had only started to assess what was needed toward the end of [the] audit period." The OAG also found that authorities' CFS funding was "based on historical amounts dating back to 1998" and that the daily rate paid to foster parents has only recently been increased for the first time in 10 years. The OAG also noted that outside Yellowknife, authorities still did not employ family preservation workers.

None of these issues are new. The recommendation that the department do this work has been made and reiterated for the past 18 years. That it remains unaddressed has significant continuing implications: without a clear understanding of what is needed, the department cannot assess the value or impact of staff vacancies, make appropriate budget proposals, identify the positions and skillsets needed, or implement initiatives to resolve longstanding issues. Such a needs assessment would also need to account for the unique challenges presently facing the system (for example, the demographics of system users, or the OAG's finding that 80 per cent of children's files identified alcohol or drug misuse as a factor, while 50 per cent identified domestic violence, which itself is more likely to negatively affect women. Appropriately resourcing the department's ambitious two-year quality improvement plan will be key to its success.

At the public hearing, departmental staff told the Committee that an assessment of resource need would be presented as part of the 2019-20 budget. This assessment has yet to be considered and assessed. However, the Committee is troubled that it appears that increases to CFS will be partially funded through reductions to other health and social services functions, including a reduction to homecare. Without a detailed resource needs assessment, money alone will not solve the problems facing CFS, and certainly not money reallocated from other departmental priority areas.

Recommendation 11

The Standing Committee on Government Operations recommends that the Department of Health and Social Services incorporate into its quality improvement plan for child and family services a clear commitment to complete the assessment of financial and human resources required to deliver child and family services, as recommended by the Auditor General of Canada,;

That this assessment incorporate gender-based analysis (e.g., via the Gender-based Analysis Plus tool);

That the department share with the Committee its project plan for this work, developing subsequent timelines in discussion with the Committee;

And that the quality improvement plan for child and family services be revised and re-released to reflect this assessment upon its completion.

Caseload Management

Nearly two decades ago, the Child Welfare League of Canada (CWLC) recommended that the department develop caseload standards for CPWs. Following the OAG's 2014 report, the department commissioned the CWLC to complete a workload management study, wherein the CWLC repeated its recommendation. Our predecessor committee made a similar recommendation in 2014.[12]

Despite this, the OAG found that the department had still not completed this work.

Recommendation 12

The Standing Committee on Government Operations recommends that the Department of Health and Social Services develop and implement caseload standards for child protection workers by June 30, 2019.

[12] Recommendation 24 in Committee Report 6-17(5)

The Role of an Advocate for Children and Youth

Our territory is one of just two jurisdictions in Canada without a child and youth advocate – that is, an independent officer of the legislature dedicated specifically to the rights, interests, and voices of children and youth, particularly those who are especially vulnerable, such as children in care. The Committee observes that a similar role may be performed by the future ombud.

RECOMMENDATIONS

The Committee's recommendations have been listed above. We also note that we have considered the recommendations of our predecessor committee. Although some progress has been made (for example, in the areas of extended services for youth aged 19-24), many of that committee's 30 recommendations remain incompletely addressed. Looking to the future, we hope for change.

In keeping with regular practice, the Committee recommends that the GNWT formally respond to this report.

Recommendation 13

The Standing Committee on Government Operations recommends that the Government of the Northwest Territories provide a comprehensive response to this report within 120 days.

CONCLUSION

This concludes the Committee's *Report on the Review of the 2018 Report of the Auditor General of Canada to the Northwest Territories Legislative Assembly (Child and Family Services)*.

All committee reports are available online at the Legislative Assembly website: www.assembly.gov.nt.ca.