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The content of this audit report and the materials related to it may negatively impact readers.

2026 REPORT OF THE AUDITOR GENERAL OF CANADA TO THE YUKON LEGISLATIVE ASSEMBLY

Child and Family Services in Yukon

Office of the Auditor General of Canada
Bureau du vérificateur général du Canada

INDEPENDENT AUDITOR'S REPORT

This publication is available on our website at www.oag-bvg.gc.ca.

Cette publication est également offerte en français.

Cat. No. FA3-200/2026E-PDF

ISBN 978-0-660-79514-0

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At a Glance

Overall message

Overall, we concluded that Yukon's Department of 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 audit found serious gaps across a range of child protection services, from responding to reports of suspected harm, to completing investigations and following up with children in care and young adults receiving support services.

The department failed to assess the need for protective intervention within the mandated 24-hour window in 37% of child harm allegations. Moreover, in cases where assessments identified the need for further investigation, the department did not complete these investigations within the required 30 days in 41% of the cases examined.

We found that there were gaps in screening homes before the department placed children with extended family members or in foster homes. For example, criminal record checks were not completed for all adults in the extended family homes in 22% of the cases examined. We also found that the department did not meet the requirement to have face-to-face contact at least once a month with children in care in 74% of the cases examined, and it did not meet that requirement in any of the cases of young adults receiving support services.

We found that group homes were operating at capacity, and many of the children were living with a disability. In addition, while group homes are meant for children aged 12 and older, we found that about a third of children were under 6 years of age. These factors impacted the ability of staff to provide supervision tailored to the needs of the children and increased safety risks for all children.

We found a number of issues contributed to the gaps in timely assessments, interventions, and monitoring. These included poor management of staffing, insufficient tracking of mandatory safety and cultural training, a lack of reporting on compliance with child welfare standards, and the department's failure to use functions of its case management system; for example, actioning automated reminders and reporting on outcomes for children and families.

Considered together, these findings reveal a child and family services system that is not effectively protecting the young people who depend on it most. Yukon's Department of Health and Social Services must act urgently to strengthen its child protection services to support the well-being of children and their families.

Key facts and findings

- When there were concerns about a child's safety in their home setting, the department did not maintain the required monthly face-to-face contact with the child and their family in 55% of the cases in our sample.
- Annual reviews of foster homes were not completed by the department to verify that the homes remained safe for children in 58% of cases in our sample.
- The department did minimal tracking of the human and financial resources required to deliver child protection services, resulting in poor governance oversight, and a lack of informed decision-making capacity.
- Only 62% of social worker and supervisor positions were staffed as of March 2025.
- Despite the staffing shortages, payroll costs increased, with overtime and casual staff spending rising by more than 75% from April 2022 through March 2025.
- Many group home staff did not have complete or up-to-date training in Indigenous awareness, or in health and safety topics such as non-violent crisis intervention.

See **Recommendations and Responses** at the end of this report.

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Introduction

Background

Child and family services in Yukon

1. Children have a right to be protected from physical and emotional harm and to have their needs met for shelter, food, and education. Some Yukoners face challenges, including intergenerational trauma of residential schools, compounded by social and economic challenges such as housing affordability, homelessness, poverty, food insecurity, substance abuse, and family violence. These challenges create a complex range of issues that put some children and families at risk, necessitating child protection and family support services.

2. The estimated population of Yukon as of March 2025 was about 47,000 of which about 21% identified as Indigenous. The Family and Children's Services Annual Report 2023 to 2024 indicated that 93% of children (under 19 years of age) in out-of-home care receiving supports from the Department of Health and Social Services and 84% of young adults (aged 19 to 26) who were previously in out-of-home care and were receiving supports from the department to prepare for independent living, identified as Indigenous.

Roles and responsibilities

3. **Department of Health and Social Services.** The department is responsible for the management and administration of the Child and Family Services Act and protecting children from abuse and harm. These responsibilities include promoting the safety and well-being of children who require protective intervention by offering services designed to maintain, support, and preserve families to:

- alleviate the need to separate children from their families
- reunify children in out-of-home care with their families

Focus of the audit

4. This audit focused on whether the Department of Health and Social Services provided timely, effective, and inclusive services to protect the safety and well-being of vulnerable children and families.

5. More details about the audit objective, scope, approach, and criteria are in **About the Audit** at the end of this report.

Findings and Recommendations

The Department of Health and Social Services did not provide timely and effective protection and support to children, young adults, and their families

Why this finding matters

6. The Department of Health and Social Services is responsible for protecting the safety and well-being of children when their parents or guardians are unable to do so. The department is also responsible for supporting and monitoring children, young adults, and their families who are receiving services. When protective services fall short, vulnerable children can remain in harmful environments or may not get the support they need to thrive physically, emotionally, and mentally.

Over a third of reports of suspected harm were not assessed within 24 hours, and interventions were often incomplete

Context

7. When the Department of Health and Social Services receives a report of suspected physical, sexual, or emotional harm to a child, it must act quickly to determine whether that child needs protective intervention. Under the Child and Family Services Act, reports of suspected harm must be assessed within 24 hours. The assessment process determines whether the report of suspected harm to a child is screened in for intervention or screened out based on various factors including the child's level of risk for harm.

8. If the report is screened in as requiring intervention, the Child and Family Services Policy Manual requires the department to complete the intervention within 30 days. Child protection interventions can take 1 of 2 forms:

- an investigation—a fact-finding process for child protection reports that allege serious harm to the child, to be completed within 30 days
- an alternative response—a collaborative information-gathering process for child protection reports that allege less serious harm to the child

There were no timelines established for the completion of alternative responses prior to July 2024. Since July 2024, all interventions are required to be completed within 30 days. Timely and thorough assessments and interventions are critical so that any child in immediate or imminent risk can be protected as quickly as possible.

Findings

9. We found that between November 2022 and March 2025, the department received about 2,100 reports of suspected harm to children—about 2 per day. These reports came from law enforcement, educational services, and other sources. We used representative sampling to examine 48 randomly selected child protection files of families with reported concerns of harm to children to determine whether the department responded within required timelines. Within our sample, there were 134 reports of suspected harm to a child, indicating that some families had multiple reports.

10. We found that the department used a structured, risk-based approach to assess and rate concerns raised in each report of suspected harm as **lower**,[1] **moderate**,[2] or **higher risk**.[3] Regardless of the risk level, the assessment informs screening decisions and is used to determine what actions the department will take.

1 **Lower risk**—The child could experience some form of harm remaining in the home, but the risk can be addressed with minimal departmental involvement.

2 **Moderate risk**—The child is likely to suffer some degree of harm remaining in the home.

3 **Higher risk**—A child is likely to be seriously harmed, injured, suffer permanent disability, or die if left in present circumstances without protective intervention.

Source: Based on the Child and Family Services Policy Manual

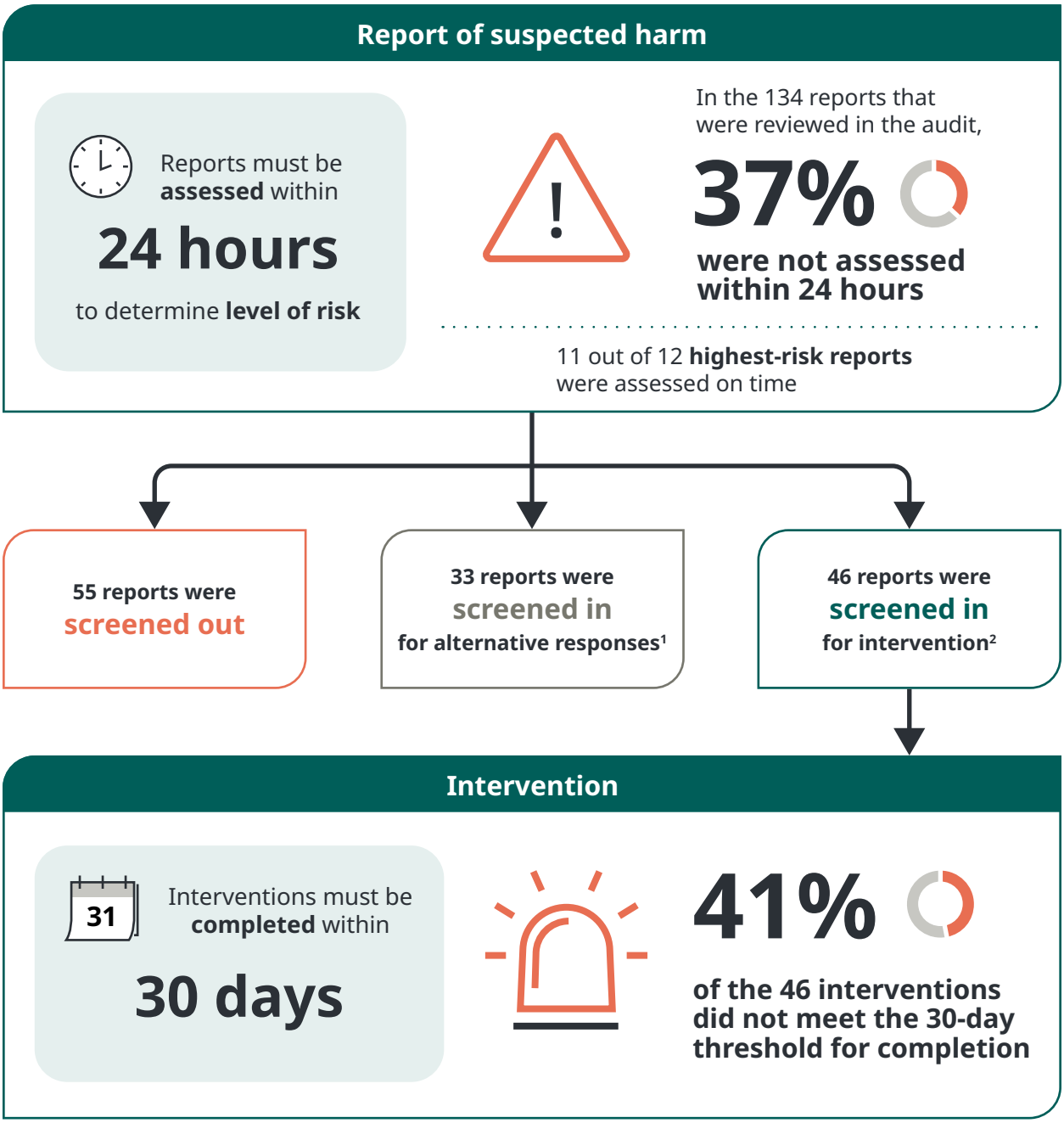
11. We found that 37% of reports of suspected harm in our sample were not assessed and screened within 24 hours of receiving the report (Exhibit 1). Twelve reports of suspected harm in our sample were rated as higher risk. We found the department responded within 24 hours to 11 of these 12 reports. For the twelfth higher risk report, the department responded within 36 hours. For reports where the assessment and screening decision took longer than 24 hours, the median decision time was 4 days, and 1 took as long as 245 days.

12. When a report of suspected harm is screened in, intervention protocol requires that all members of the household are interviewed. Departmental officials are also required to have face-to-face contact with children to verify their well-being. We found that officials did not make this contact with children in 36% of the interventions in our sample. In 1 intervention, we found that the department did not make face-to-face contact with 2 older children where suspected harm was reported, and the department closed the family's case after interviewing only the alleged adult perpetrator of harm, potentially leaving the children at risk.

13. We also found that 41% of interventions in our sample were not completed within 30 days as required. These interventions can be investigations or alternative responses and involve gathering additional information about the report of harm from a variety of sources and assessing the best approach to reduce the risk of harm to the child. We found that the time to complete these interventions ranged from 32 to 695 days, with a median of 142 days.

14. There were also some cases where the department was required to maintain monthly face-to-face contact to monitor the children's safety within their living environment because the department had ongoing concerns with a family's situation. This included cases where alternative responses were provided. We found that in 55% of cases where this was required, monthly monitoring was not completed and, on average, contact was about once every 2 months. For example, in 1 case where safety measures were put in place to allow a child to remain in their family home, the department did not maintain monthly contact to confirm the child's ongoing safety and well-being, despite receiving 10 additional reports of suspected harm over a 2-year period.

Exhibit 1—Required actions were not timely after a report of suspected harm was received by the Department of Health and Social Services



[1] Alternative responses did not have a timeline for completion before July 2024. After that date, alternative responses had to be completed within 30 days.

[2] Interventions include all investigations and any alternative responses after July 2024.

Source: Based on the Child and Family Services Policy Manual and case file data from the Department of Health and Social Services

Read the Exhibit 1 text description

15. Departmental staff must also complete family assessments for all screened-in reports of suspected harm to evaluate the safety, well-being, and needs of the child in their family home and environment and outline support services that could help address family challenges. We found that these family assessments were not completed for 37% of the 79 screened-in reports of suspected harm in our sample. In the case of 1 family, where a youth was facing charges for a sexual offence involving a child, the department only intervened 3 weeks after the reported incident involving the youth to protect another child in the home. While records showed that the other child in the home was not harmed, the delay in completing the family assessment and putting safety measures in place meant that the department did not know whether the other child in the home was at risk during this 3-week period.

Plans of care were not completed and monthly contact was not maintained for most children in care

Context

16. Children can come into the Department of Health and Social Services' care for various reasons, such as risk of harm or the unexpected loss of guardians. The department has many of the rights and responsibilities of a parent or guardian for the children in its temporary or permanent care. This responsibility is important because the department is ultimately accountable for the children's safety and well-being.

17. Upon a child's entry into care, the department must, as mandated by the Child and Family Services Act and policy, assess their safety, stability, and well-being needs. A plan of care to address these needs must be developed within 30 days and reviewed at least annually to track progress. Regular contact between the child and social worker is also vital. This contact helps ensure the child's well-being, fosters a relationship, monitors progress, evaluates their placement, and supports their cultural identity.

Findings

18. We found that the department failed to meet its obligations for creating and reviewing plans of care for children. We used representative sampling to review 39 randomly selected files of children in the care of the department to assess whether plans of care were in place and whether the department provided key supports and services to these children. We found that 34 of these 39 children in care required a plan of care. As of March 31, 2025, of these 34 children in the department's care, 47% (16 children)

either did not have a plan or had one that was out of date. We also found that 74% of the plans of care that were over 1 year old were not reviewed annually.

19. We also found that the department did not maintain critical monthly face-to-face contact with children. This requirement was not met for 74% of children, with gaps in contact extending up to 14 months. This lack of regular interaction makes it difficult to build trust and quickly identify when children need help. For example, for 1 child in the care of the department, we found that the failure to meet minimum monthly contact requirements contributed to delays by the department in identifying a caregiver who was struggling to meet the needs of the child. Though delayed, the department provided the caregiver with additional supports so that the child could remain in their care.

There were gaps in administering supports and maintaining contact with young adults preparing for independent living

Context

20. The department provides support services to assist young adults who were previously in its care, or previously in the care of extended family through an agreement or a court order, to begin to live independently. The department is responsible for helping young adults plan for their needs and goals by completing post-care agreements, which can include financial assistance and supports for housing and education as well as other goods and services. Ongoing contact between the department and the young adult is important to verify that they are receiving the support they need and adhering to the agreement. The Child and Family Services Policy Manual requires that the young adults and their agreements are monitored with face-to-face monthly contact and renewed on an annual basis until an adult turns 26 to adjust supports as needed.

Findings

21. We found that the department did not ensure that agreements were in place for some young adults receiving support services. We used representative sampling to examine 31 randomly selected files of young adults receiving support services. We found that 8 young adults received support payments from the department without a completed post-care agreement. These payments to individual young adults ranged from a total of approximately $3,200 to $40,000. The total amount of payments made without an agreement in place was about $125,000. The period during which these 8 young adults lacked agreements varied from 2 to 18 months. Although the Child and Family Services Act permits support payments without an agreement, departmental policy requires their completion.

22. We also found that 29 of the 31 young adults in our sample were expected to participate in recognized development work, education, employment, or formal training during the period under agreement and this participation was to be monitored by the department. We found that for 27 out of the 29 (93%) young adults receiving supports, the department did not regularly monitor whether the young adults were participating in these activities. Gaps in monitoring ranged from about 6 months to almost 2.5 years. Monitoring and confirming participation are important so the department can adjust supports when required.

23. During our audit period, when support services were provided to young adults for a period greater than 1 month, the department was required to maintain monthly face-to-face contact with the young adults. We found that the department failed to do so for all young adults in our sample, and on average, contact occurred only once every 8.5 months, with some having no contact from the department for over 2 years. This infrequent engagement meant the department could not assess whether supports were effective or whether young adults were progressing toward independent living. For example, 1 young adult, contacted by the department only 3 times in 18 months, was reported missing out-of-territory, and even after their safe return, contact by the department remained minimal.

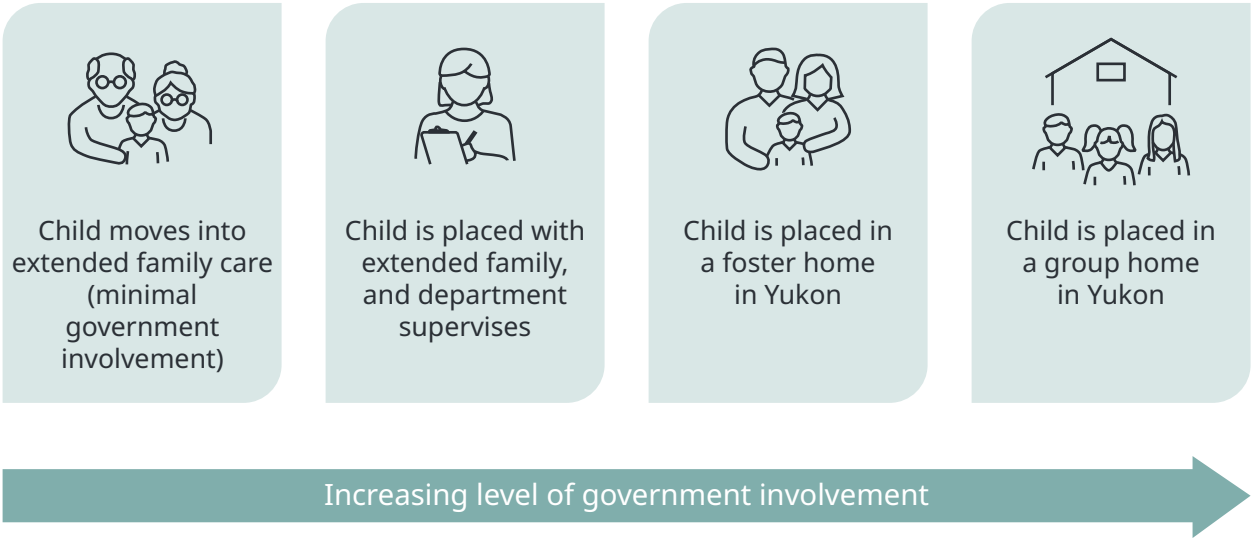
24. In October 2025, about 6 months after the end of our audit period, the department removed the requirement for young adults to participate in recognized development work, education, employment, or formal training and updated its policy for minimum contact with young adults receiving support services to be based on each young adult's specific circumstances.

There was a lack of oversight and screening for out-of-home care

Context

25. To support a child's needs for stability and their emotional and social development, the department created a range of options for out-of-home care. When a child needs to be separated from their immediate family, the first priority is to place children with members of their extended family to help address the need for family, cultural, and other community connections. The second option is foster care, which is explored if family placement is not possible. If neither is possible, the department will consider a placement in Yukon government group homes (Exhibit 2).

Exhibit 2—Options available with increasing levels of government involvement when a child needs to be placed in out-of-home care



Source: Adapted from the Child and Family Services Policy Manual

Read the Exhibit 2 text description

There were gaps in the screening and monitoring of extended family care and foster homes

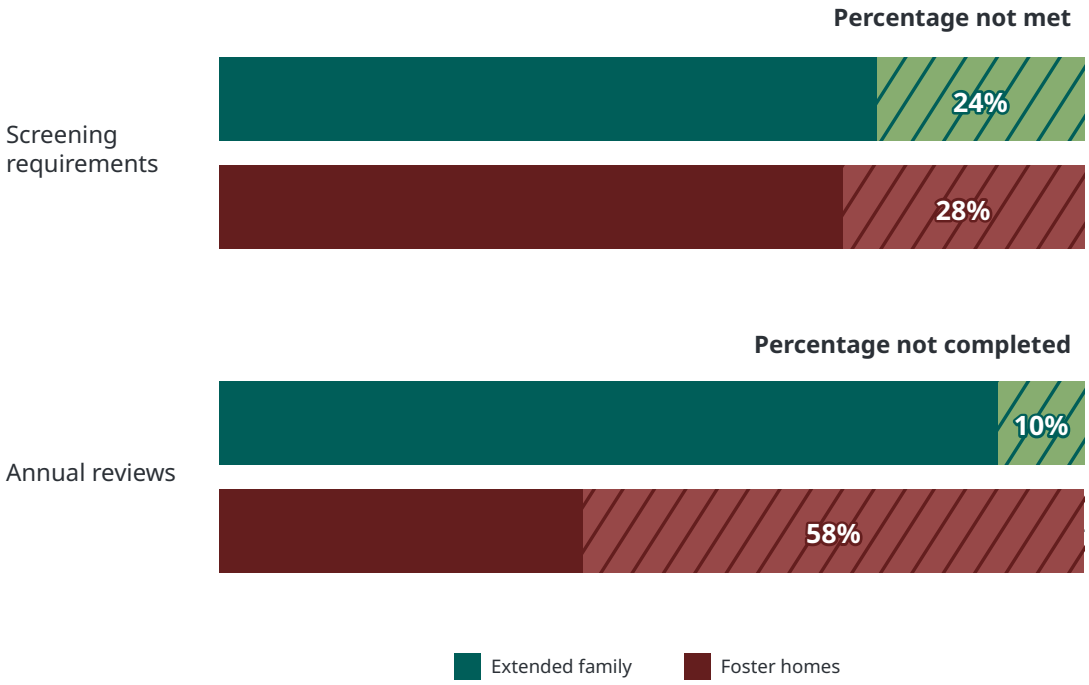
Context

26. To approve extended family care and foster homes, the department conducts several screenings and reviews. For example, it must conduct criminal record checks and child welfare system background checks of all adults residing in the home as required by the Child and Family Services Policy Manual. Once a child is placed in an approved home, annual reviews should be done to determine that the home continues to meet requirements for the child's health, safety, and well-being.

Findings

27. We used representative sampling to examine 38 randomly selected extended family care home files and 32 randomly selected foster home case files to determine whether the department was meeting key screening and monitoring requirements. We found that the department failed to complete key screening requirements in 24% of the extended family care homes and 28% of the foster homes in our samples (Exhibit 3). For example, we found that criminal record checks were not completed for all adults in 22% of the extended family homes.

Exhibit 3—There were gaps in the oversight and screening of extended family and foster homes



Source: Based on data from the Department of Health and Social Services' extended family care and foster home case files

Read the Exhibit 3 text description

28. The department is required to document cases when it decides that children can be placed or remain in a home where an adult has a criminal record. We found that in 1 extended family home in our sample, while a criminal record check was completed for a caregiver who had a criminal record, the department official's rationale to proceed with this caregiver was not documented in the family's file as required by the department's policies. The children were subsequently removed from the extended family home care following new criminal charges against the caregiver.

29. We also found that in 10% of the extended family homes and 58% of the foster homes in our samples, the department did not complete the required annual reviews to verify that the homes remained safe for children (Exhibit 3). While the department had a Family Case Management system that generated reminders for staff to complete important tasks in advance of required timelines, such as annual reviews, staff did not complete them. These annual reviews can help identify significant incidents and other risks or changes in the home so that they can be addressed to maintain the safety and well-being of children placed there. For example, in 1 foster home, we found that annual reviews and visits from the social worker resulted in an investigation by the department

of incidents of a sexual nature that led to the removal of children for their safety and a decision that the caregivers were no longer approved to provide foster care.

The department did not adapt its practices to support the changing safety and care needs of children in group homes

Context

30. The Department of Health and Social Services operates or contracts 8 in-territory 24/7-staffed group homes for children who require out-of-home care and cannot be placed with other caregivers. These children often have complex needs and require close supervision and a high level of care.

Findings

31. We found that the majority of departmental policies that applied to group homes were outdated, having been approved in 2007. These policies had not been reviewed or updated by the department to align with the Child and Family Services Act, which was adopted in 2010, or with the 2022 amendments. For example, an amendment to the act in 2022 required that priority be given to keeping siblings together who require out-of-home care. This priority created challenges as placing large sibling groups together in 1 home can be difficult.

32. The amendments to the act contributed to some group homes caring for children significantly younger than contemplated in approved policies, potentially straining resources and increasing risks. Based on those policies, Yukon group homes are intended for children aged 12 and older. However, departmental approval can allow for the placing of younger children in a group home. We found that as of March 31, 2025, there were 41 children living in group homes of which 61% (25) were under 12 years old and 29% (12) were less than 6 years old. The youngest child was 18 months old and had been placed at a group home with siblings.

33. As of March 31, 2025, we also found that Yukon's 8 child group homes housed 41 children in 40 bedrooms, operating at 103% capacity. Operating at capacity, combined with the presence of many young children and a significant proportion of children in group homes living with disabilities, can compromise staff's ability to provide adequate supervision, thereby placing children at heightened risk of harm. For example, we found that a young child living in a group home was injured in 2 incidents over a 10-day period. The department concluded that the first incident

was due to a lack of direct supervision. The second occurred while only 1 staff member was providing direct supervision to the child and 6 other children.

34. We found that group home policies did not include a specific caregiver-to-child ratio. The department told us that when it developed its group home program, it used a ratio of at least 1 worker for every 4 children during waking hours. We found that the department did not assess whether this ratio was still appropriate even though its group homes were accommodating children much younger than originally intended. These policy gaps and lack of risk assessments meant the department did not know whether its approach to staffing group homes was sufficient to meet the needs of the current population of residents, placing both children and staff at risk.

There were gaps in managing responses to incidents involving children in out-of-home care

Why this finding matters

35. The management of incidents that involve a significant risk of harm or that result in illness or injury directly impacts the safety and well-being of vulnerable children in the Department of Health and Social Services' care. When these incidents are not thoroughly managed, lessons learned are not identified, and preventive measures may not be effectively implemented. The effective management and investigation of incidents provide the department with the opportunity to address risks and prevent future harm, improve its services, and uphold its fundamental duty to ensure the safety of children in its care.

Context

36. The department is responsible for investigating all serious and critical incidents. According to the Child and Family Services Policy Manual, a serious incident requires medical treatment and/or involves a moderate risk of harm but does not result in a child's death or anticipated long-term impairment. Critical incidents result in or may cause a child's death or long-term impairment, require major medical treatments, or involve an allegation of mistreatment or high risk of harm.

37. When the department becomes aware of an incident, it must take immediate steps to verify the safety and well-being of the child and everyone else involved. For critical incidents, the department must also prepare an outcome report based on its investigation

of the critical incident to implement measures to prevent the recurrence of a similar incident or to inform changes to programs and services.

Findings

38. During our audit period, we found that the department identified 37 serious and 14 critical incidents involving children in out-of-home care. We examined all the records of these incidents included in the department's incident management system and found that while the initial safety of the children involved was confirmed by the department, it failed to meet other important incident management requirements. For example, we found that 12 of the 14 critical incidents required outcome reports; however, 10 of the 12 outcome reports, designed in part to identify areas for improvement, were not completed.

39. We also found that the department did not meet its obligation to inform family members and Indigenous partners of critical and serious incidents involving their children as required by the Child and Family Services Policy Manual. We found that family members were not informed in 33% of the critical and serious incidents, and Indigenous partners were not notified in 23% of required cases. This contact is important to maintain transparency, build trust within the child's support network, and provide support for the child's well-being.

40. In our representative sample of 39 children in care case files, we found 6 incidents that were consistent with serious incident criteria but were not recorded in the department's incident management system. This meant that the department underreported the number of serious incidents that occurred during the audit period. While we found that the department acted to address the initial health and safety needs of the children involved in each of the 6 incidents, there was no evidence that the department informed family members about incidents in over half of the cases or that the department managed these incidents in accordance with its policy for serious incidents to identify lessons learned.

Recommendation

41. Many of our findings and resulting recommendations for the Department of Health and Social Services are interrelated.

42. The Department of Health and Social Services should:

- establish a robust mechanism for tracking and analyzing compliance with key requirements of the Child and Family Services Act and its policies and use the information from

the analysis to make improvements, including implementing targeted training for staff to address non-compliance with child welfare standards

- conduct a thorough and immediate analysis of all active foster and extended family care homes. This analysis should verify the completion of all screening requirements and annual reviews. Any identified deficiencies should be promptly addressed to validate the ongoing safety of these environments for children
- review and update all group home policies. This update should ensure full alignment with current legislation while also specifically addressing the diverse care and supervision needs of all residents, with particular attention to younger children and those living with disabilities
- establish a robust and continuous system for monitoring group home accommodations and child-to-staff ratios. The results of this monitoring should be regularly reported to senior management to enable evidence-based adjustments, thereby facilitating the safe and healthy living and care environments needed for children to thrive

The department's response. Agreed.

See **Recommendations and Responses** at the end of this report for detailed responses.

The department collaborated with Indigenous partners to provide inclusive services, but cultural plans were not developed for most Indigenous children in care

Why this finding matters

43. Informing and involving Indigenous partners in decision making as early as possible for Indigenous children and families receiving services from the department respects Indigenous self-determination. This engagement with Indigenous partners also supports culturally sensitive decisions affecting Indigenous children and families to help maintain cultural and community connections and access to culturally inclusive activities. This collaborative approach also helps to strengthen relationships between the Department of Health and Social Services and Indigenous partners.

Context

44. On March 31, 2022, the Yukon government, in collaboration with participating Yukon First Nations and the Council of Yukon First Nations, amended the Child and Family Services Act. The primary goals of these revisions were to enhance outcomes for children and families within the child welfare system and to address the over-representation of Indigenous children in care.

45. A key requirement introduced by these amendments was that when an Indigenous child enters the department's care, a cultural plan must be developed. This plan aims to support the child's connection with their community, identify their specific cultural needs, and ensure access to culturally inclusive activities.

Findings

46. We found that the department provided opportunities to Indigenous partners to be involved to support inclusive service delivery in the majority of case files we examined. For example, it invited Indigenous partners to collaborate in case planning for Indigenous families with identified child protection concerns in all but 11% of reports of harm screened in for intervention in our sample of child protection files. We found that only 10% of Indigenous children in our sample of children in care did not receive support for attending cultural and community activities. However, we also found that 90% of children in care did not have a cultural plan (Exhibit 4).

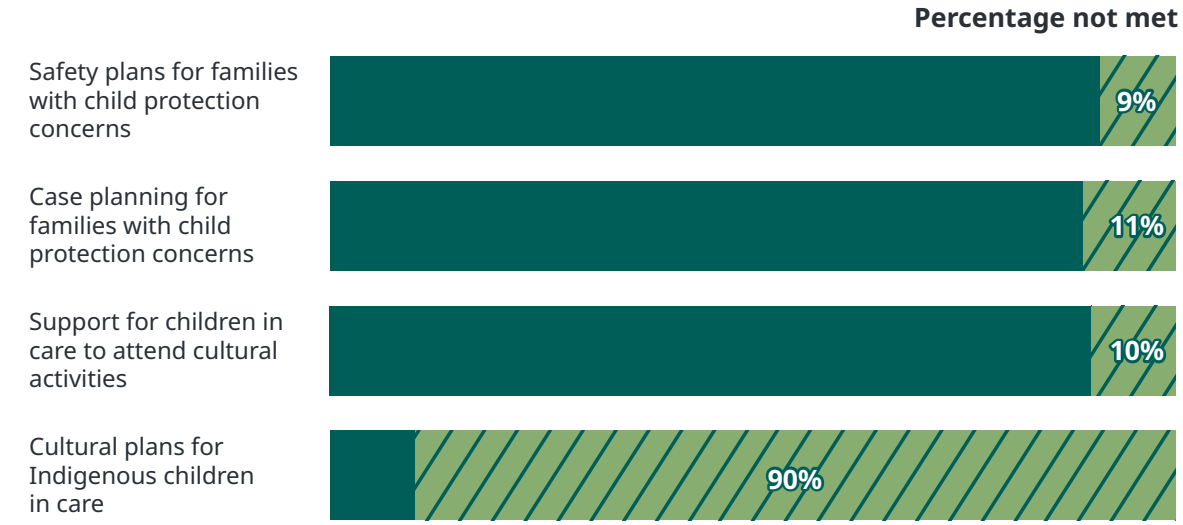
47. We found that after the 2022 amendments to the Child and Family Services Act, the department introduced new practices, and continued to build on existing ones, to support collaboration with Indigenous partners to promote culturally appropriate services. For example, the department:

- participated in 10 meetings with the Trilateral Table on the Wellbeing of Yukon First Nations Children and Families. This table included representatives from the Council of Yukon First Nations and most of Yukon's 14 First Nations
- participated in 2 technical working groups with Indigenous partners to implement and operationalize key amendments to the act

48. We also found that the department worked in collaboration with most Yukon First Nations to deliver culturally relevant programming such as beading and sewing activities, reading programs, and celebrations. From November 2022 to

March 2025, the department collaborated with Yukon First Nations in 8 communities, delivering 106 programs that engaged nearly 1,800 participants.

Exhibit 4—The department worked with Indigenous partners to provide inclusive services, but most cultural plans were not developed



Source: Based on data from the Department of Health and Social Services' case files

Read the Exhibit 4 text description

Recommendation

49. The Department of Health and Social Services should actively collaborate with all Indigenous partners to establish timelines for the completion and ongoing updating of cultural plans for every Indigenous child in its care.

The department's response. Agreed.

See **Recommendations and Responses** at the end of this report for detailed responses.

There were significant gaps in the management of resources and in reporting to the Minister on adherence to child welfare standards

Why this finding matters

50. The Department of Health and Social Services' responsibilities to support at-risk Yukon children, young adults, and families relies on effectively managing financial and human resources and timely staff training.

51. Regular monitoring and consistent reporting to the Minister of Health and Social Services on compliance with key child welfare standards, along with data analysis to measure outcomes for children and families, are important for identifying challenges and areas needing improvement or additional support. Failures in these areas can undermine essential supports, services, and care.

There was a minimal assessment of resource needs

Context

52. Front-line staff within the Department of Health and Social Services are frequently called on to make quick and difficult decisions about a child's best interests, often in stressful or even unsafe situations. Staffing shortages impact the department's ability to administer the Child and Family Services Act and to protect children from abuse and harm. Comprehensive assessments of human and financial resource needs help support good staffing and programming decisions to effectively deliver services to at-risk children.

Findings

53. We found that the department did not complete a comprehensive assessment of the financial and human resources required to deliver services under the Child and Family Services Act. For example, the department did not complete an assessment of staffing, including workload analysis, to develop strategies to manage capacity. This meant that the department was unable to determine the degree to which staffing capacity contributed to deficiencies in case management and monitoring.

54. We found that as of March 31, 2025, the Family and Children's Services branch operated at 81% capacity, with 282 of 348 positions filled. Critically, only 62% (36 of 58) of Whitehorse and regional social worker and supervisor positions were filled, leaving the department significantly understaffed in key front-line roles. This shortage impacts the department's ability to meet child protection requirements and ensure the health and safety of children and families. This is because social workers and supervisors respond to reports of suspected harm to children, maintain minimum contact with children in the care of the department, and carry out screening and reviews of foster and extended family care homes.

55. We also found that the department did not analyze staff vacancy and turnover data, hindering its ability to better target its recruitment and retention efforts. For example, we found that at least 2 smaller communities lacked a permanent social worker for over a year, impairing the department's capacity to respond to urgent matters. We also found that, based on our sample of 39 children in care, children's social workers changed about once every 9 months on average. Continuity in front-line social workers is critical to building and maintaining a trusting and supportive relationship between the child, their family, and the department.

56. We also found that the department did not assess whether its financial resources were sufficient. Our analysis showed payroll costs rose from 60% to 63% of total spending from April 2022 to March 2025, with overtime and casual staff spending increasing over 75% during the audit period. These increases were consistent with staffing vacancies we identified in our analysis. It is noteworthy that the act was amended in 2022 and new requirements for front-line workers were added.

57. Without a comprehensive assessment, the department lacks a complete understanding of its financial and staffing gaps and whether current spending supports its responsibilities under the Child and Family Services Act.

Recommendation

58. The Department of Health and Social Services should rigorously and regularly assess the financial and human resources required to deliver services under the Child and Family Services Act. This assessment should include analyzing the department's data on staffing levels, vacancy rates, turnover, and attrition to inform and tailor its recruitment and retention efforts, in particular for front-line positions needed to deliver services.

The department's response. Agreed.

See **Recommendations and Responses** at the end of this report for detailed responses.

Social workers and group home staff did not consistently complete mandatory training

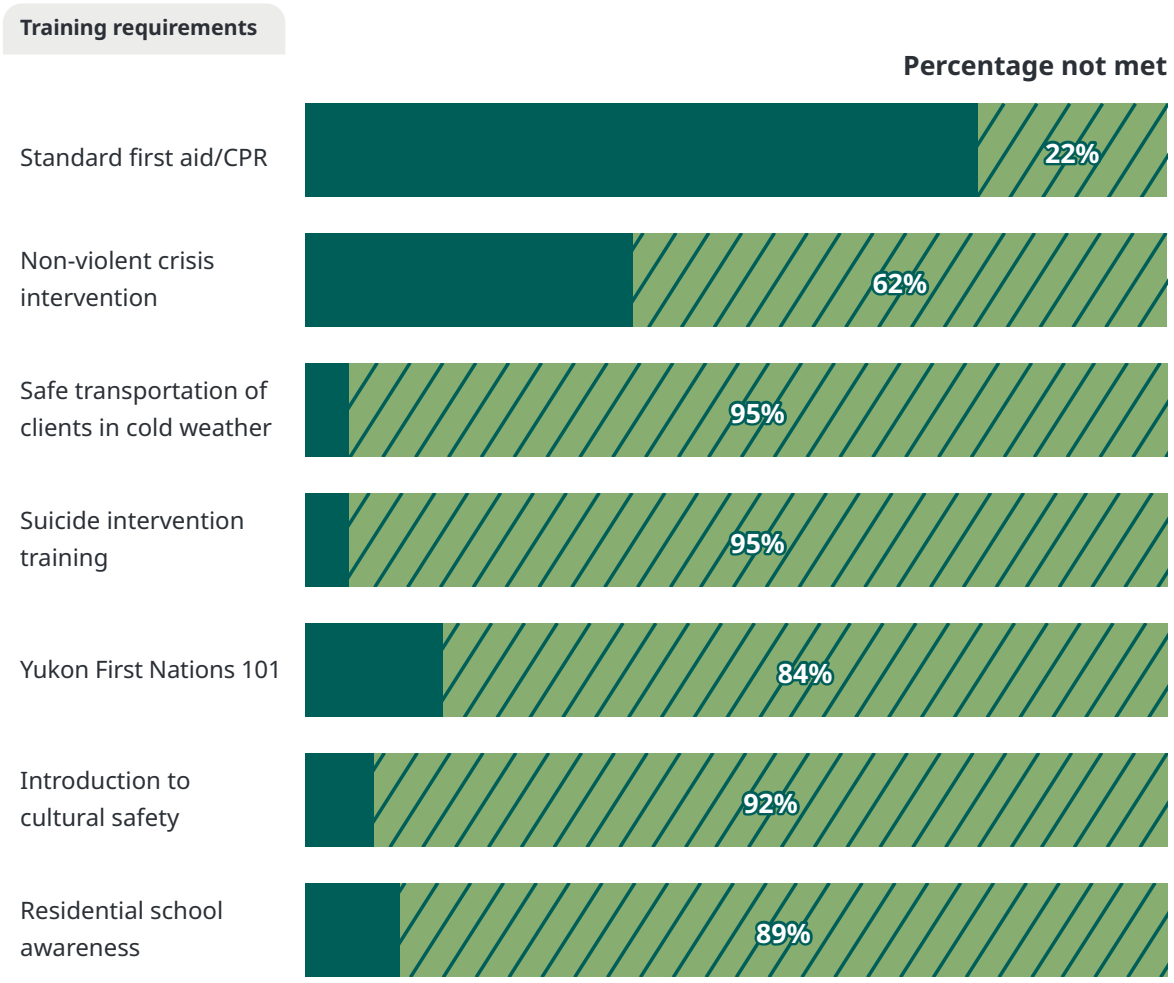
Context

59. Mandatory training for the Family and Children's Services branch covers many areas such as health and safety, including first aid and non-violent crisis intervention, and Indigenous awareness training. Indigenous awareness training is important to support the delivery of culturally appropriate services, especially given the significant number of Indigenous children and families receiving services from the department.

Findings

60. We used representative sampling to examine training files for 26 social workers and 37 group home staff to determine whether they had completed required training to keep staff and children safe and promote a culturally appropriate environment. We found significant gaps in compliance with mandatory training for staff working in group homes as illustrated in Exhibit 5. Furthermore, the department did not have a systemic way of tracking completion of mandatory staff training, relying instead on individual staff members to self-report their compliance.

Exhibit 5—Group home staff had not completed mandatory training

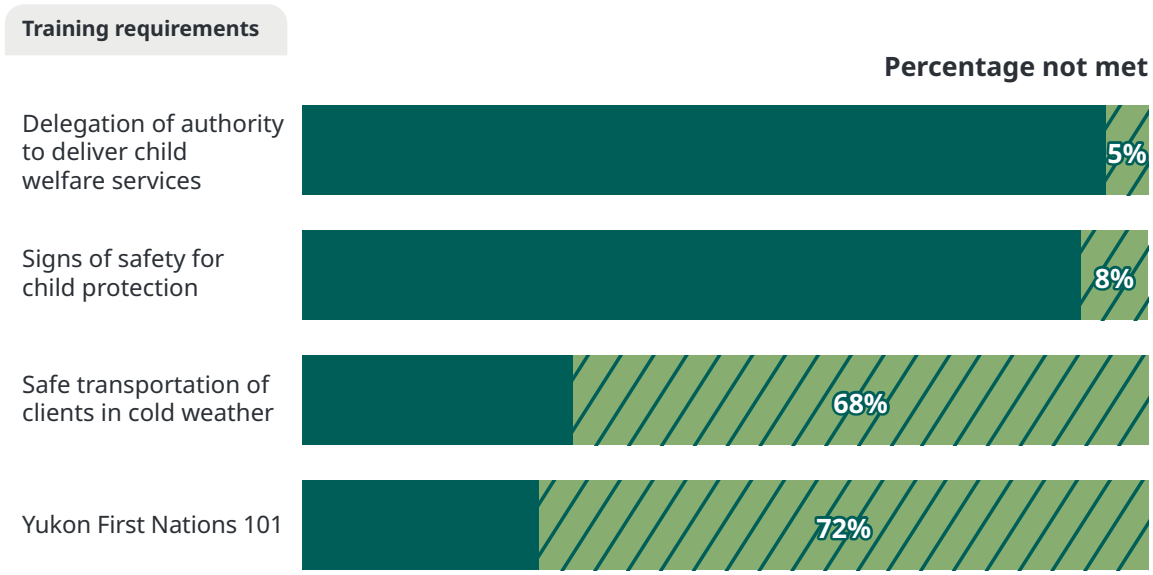


Source: Based on data from the Department of Health and Social Services' staff training completion documentation as of March 31, 2025

Read the Exhibit 5 text description

61. We also found that 95% of social workers received training related to their delegation of authority to deliver child welfare services under the Child and Family Services Act. However, the department could not provide us with evidence that more than half completed other health and safety and Indigenous awareness training (Exhibit 6).

Exhibit 6—Social workers had not completed mandatory training



Source: Based on data from the Department of Health and Social Services' staff training completion documentation as of March 31, 2025

Read the Exhibit 6 text description

Recommendation

62. The Department of Health and Social Services should develop and implement a learning management system to track and report on the completion of all mandatory training activities required for all social workers and group home staff. Using this information, the department should take actions to ensure that all staff complete all mandatory training.

The department's response. Agreed.

See Recommendations and Responses at the end of this report for detailed responses.

Reports of non-compliance with child welfare standards were not provided to the Minister

Context

63. The Child and Family Services Act requires that reports on the Department of Health and Social Services' compliance with the act's standards for child and family services be submitted to the Minister every 3 years. This is intended to result in improved services to vulnerable children and families who are involved with the child welfare system in Yukon by permitting the Minister to identify challenges and areas in need of additional support.

64. In 2021, the department implemented the Family Case Management system to collect child and family services case file information and report on programs and services. The implementation of a case management system was in response to a portion of a recommendation from our 2014 audit report. The new system was intended to increase departmental data capacity, monitor outcomes of children and their families, provide data to Indigenous partners, and improve compliance with child welfare standards and reporting.

Findings

65. We found that a report on the Department of Health and Social Services' compliance with the Child and Family Services Act was last provided to the Minister in 2016, despite a requirement to submit this report every 3 years. We also found that the Family and Children's Services branch conducted some internal checks that identified non-compliance with its service standards from the 2017–18 to 2020–21 fiscal years. However, these reports were provided only to the Director of the Family and Children's Services branch and were not submitted to the Minister.

66. We also found that while the department used data in its case management system for basic service delivery reports, it did not track and analyze compliance with standards to produce reports for senior management, and it conducted minimal analysis of outcomes for children and families receiving services. For example, despite data being available in the system, there was no overall analysis to determine whether the department was achieving its objective for family reunification or for the number of young adults who received support services and achieved independence.

Recommendation

67. The Department of Health and Social Services should:

- complete and submit the required Child and Family Services Act compliance reports to the Minister on a timely basis
- leverage its data capabilities in its case management system for robust monitoring, tracking, and reporting on outcomes for children and families

The department's response. Agreed.

See **Recommendations and Responses** at the end of this report for detailed responses.

Conclusion

68. We concluded that the Department of Health and Social Services did not provide timely, effective, and inclusive services to protect the safety and well-being of vulnerable children, youth, and families.

About the Audit

This independent assurance report was prepared by the Office of the Auditor General of Canada on Yukon child and family services. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the government's management of resources and programs and to conclude on whether the Department of Health and Social Services complied in all significant respects with the applicable criteria.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001—Direct Engagements, set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook—Assurance.

The Office of the Auditor General of Canada applies the Canadian Standard on Quality Management 1—Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we complied with the independence and other ethical requirements of the relevant rules of professional conduct applicable to the practice of public accounting in Canada, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from entity management:

- confirmation of management's responsibility for the subject under audit
- acknowledgement of the suitability of the criteria used in the audit
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided
- confirmation that the audit report is factually accurate

Audit objective

The objective of this audit was to determine whether the Department of Health and Social Services provided timely,* effective,* and inclusive* services to protect the safety and well-being of vulnerable children, youth, and families.

* The expectations for these elements were as follows:

- Timely—services provided in accordance with the timelines outlined in the Child and Family Services Act and policies
- Effective—services provided met the child, youth, and families identified needs and were monitored, reassessed, and adjusted as required
- Inclusive—services engaged and collaborated with Yukon First Nations and/or Indigenous bodies to promote culturally appropriate care for Indigenous children, youth, and families receiving services

Scope and approach

The audit involved an examination of the actions of the Department of Health and Social Services following key areas for child and family services:

- meeting responsibilities for the protection and support of at-risk children, youth, young adults, and families in compliance with the Child and Family Services Act
- collaborating with Indigenous partners to promote culturally appropriate services to Indigenous children, youth, and families involved with the Family and Children's Services branch
- managing human and financial resource capacity, including staff training, meeting reporting requirements, and information system and data needs

We grouped "children" and "youth" under the term "children," representing anyone under the age of 19. "Young adult" was from age 19 to 26.

The audit team examined and analyzed key documents from the department and relevant publicly available information. We had interviews with officials from the department, representatives from Yukon First Nations and Indigenous governing bodies, and representatives from other organizations in Yukon.

This audit examined Yukon's Family and Children's Services, a branch of the Department of Health and Social Services, for its ability to meet key requirements to protect the safety and well-being of vulnerable children, youth and their families and whether they had the information needed to accurately measure and report on services provided to families and children.

Audit work also included a review and analysis of the following types of case files: 1) child protection; 2) children in care; 3) foster homes; 4) extended family homes; and 5) files of young adults receiving support (post-care) services from the department. Representative sampling was used to examine each of these 5 types of case files. We examined 48 child protection files (which included a total of 134 reports of suspected harm to a child), 39 files of children in care, 32 foster care files, 38 extended family home files, and 31 files of young adults. These individual samples of case files were sufficient in size to conclude on their respective populations with a confidence level of no less than 90% and a margin of error (confidence interval) of no greater than +10%.

Audit work also included review and analysis of key required health and safety and Indigenous awareness training for social workers and group home staff. Representative sampling was used to select 37 group home staff and 26 social workers to examine whether key required training was completed. These individual samples of training files were sufficient in size to conclude on their respective populations with a confidence level of no less than 90% and a margin of error (confidence interval) of no greater than +10%.

Audit work also included a review and analysis of all 14 critical incidents and 37 serious incidents identified by the department in its incident management system during the audit period. This review assessed the extent to which the department complied with key requirements of its critical and serious incident policies.

Early in the audit, we identified important areas of concern that, in our view, increased the risk of harm to children and youth. These areas of concern were discussed with the department during meetings in June and July 2025. On October 4, 2025, we formally notified senior management within the Department of Health and Social Services of the need to take immediate action to address those important concerns, including the lack of monitoring of children in care and those receiving child protection services; the increased numbers of younger children and a large portion of children living with disabilities in group homes; and poor compliance with mandatory safety training for front-line staff.

Areas scoped out of the audit included:

- child and family services delivered by Yukon First Nations, Indigenous governing bodies and other partners and interested parties, including those funded by Indigenous Services Canada
- grants and contributions provided by the department to third-party service providers
- adoptions
- Youth Justice programs
- professional practices of social workers

Criteria

We used the following criteria to conclude against our audit objective:

Criteria	Sources
The Department of Health and Social Services assesses, responds, and intervenes in a timely, thorough, and consistent manner in accordance with requirements when it receives a report of children and youth in need of protection.	• Child and Family Services Act • Child and Family Services Act Policy Manual
The Department of Health and Social Services provides required supports and services to children, youth, and their families to address their needs in accordance with the Child and Family Services Act and policy manual requirements to protect the safety, health, and well-being of children, youth, and families.	• Child and Family Services Act • Child and Family Services Act Policy Manual • Residential Youth Treatment Services Policy and Procedures Manual • Report of the Auditor General of Canada to the Yukon Legislative Assembly—2014—Yukon Family and Children's Services—Department of Health and Social Services

Criteria	Sources
The Department of Health and Social Services ensures that children and youth requiring out-of-home care are placed in safe, supportive environments and that the department regularly monitors the well-being of children and youth in out-of-home care to ensure their needs are being met as required.	• Child and Family Services Act • Child and Family Services Act Policy Manual • Residential Youth Treatment Services Policy and Procedure Manual • Report of the Auditor General of Canada to the Yukon Legislative Assembly—2014—Yukon Family and Children's Services—Department of Health and Social Services
The Department of Health and Social Services effectively collaborates and coordinates its activities, programs, and services for Indigenous children, youth, and families with their First Nation and/or Indigenous governing body.	• Child and Family Services Act • Child and Family Services Act Policy Manual • Report of the Auditor General of Canada to the Yukon Legislative Assembly—2014—Yukon Family and Children's Services—Department of Health and Social Services
The Department of Health and Social Services provides services and supports to youth and young adults (aged 19 to 26) as they transition* out of care and monitors results to determine whether services and supports are contributing to improved outcomes. * To avoid confusion, the word "transition" is not used in the report. It is replaced with a few words that describe support to a young adult to move out of care and prepare for independent living.	• Child and Family Services Act • Child and Family Services Act Policy Manual
The Department of Health and Social Services collects, analyzes, and reports performance data to assess its programs and services and to improve its service delivery and outcomes for children, youth, and families.	• Child and Family Services Act • Child and Family Services Act Policy Manual • Financial Administration Manual, Department of Finance, 2024 and 2025 • Report of the Auditor General of Canada to the Yukon Legislative Assembly—2014—Yukon Family and Children's Services—Department of Health and Social Services

Criteria	Sources
The Department of Health and Social Services effectively uses its human and financial resources to fulfill its key responsibilities under the Child and Family Services Act.	• Child and Family Services Act • Child and Family Services Act Policy Manual • Yukon Government Financial Administration Manual • Residential Youth Treatment Services Policy and Procedure Manual • Report of the Auditor General of Canada to the Yukon Legislative Assembly—2014—Yukon Family and Children's Services—Department of Health and Social Services • Health Act, Government of Yukon
The Department of Health and Social Services ensures personnel are adequately trained and supported to uphold the safety and well-being of children, youth, and families receiving welfare services.	• Child and Family Services Act Policy Manual • Residential Youth Treatment Services Policy and Procedure Manual • Report of the Auditor General of Canada to the Yukon Legislative Assembly—2014—Yukon Family and Children's Services—Department of Health and Social Services

Period covered by the audit

The audit covered the period from November 30, 2022, to March 31, 2025. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters that preceded the start date of this period. We also considered as subsequent events 2 sets of changes that were made in October 2025 to the department's policy manual: changes to the requirements for young adults to participate in recognized development work, education, employment, or formal training, and changes to the requirements for minimum contact with young adults receiving support services.

Date of the report

We obtained sufficient and appropriate audit evidence on which to base our conclusion on February 20, 2026, in Ottawa, Ontario, Canada.

Audit team

This audit was completed by a multidisciplinary team from across the Office of the Auditor General of Canada led by Markirit Armutlu, Principal. The principal has overall responsibility for audit quality, including conducting the audit in accordance with professional standards, applicable legal and regulatory requirements, and the office's policies and system of quality management.

Recommendations and Responses

Responses appear as they were received by the Office of the Auditor General of Canada.

In the following table, the paragraph number preceding the recommendation indicates the location of the recommendation in the report.

Recommendation	Response
42. The Department of Health and Social Services should: • establish a robust mechanism for tracking and analyzing compliance with key requirements of the Child and Family Services Act and its policies and use the information from the analysis to make improvements, including implementing targeted training for staff to address non-compliance with child welfare standards • conduct a thorough and immediate analysis of all active foster and extended family care homes. This analysis should verify the completion of all screening requirements and annual reviews. Any identified deficiencies should be promptly addressed to validate the ongoing safety of these environments for children • review and update all group home policies. This update should ensure full alignment with current legislation while also specifically addressing the diverse care and supervision needs of all residents, with particular attention to younger children and those living with disabilities • establish a robust and continuous system for monitoring group home accommodations and child-to-staff ratios. The results of this monitoring should be regularly reported to senior management to enable evidence-based adjustments, thereby facilitating the safe and healthy living and care environments needed for children to thrive	**The department's response.** Agreed. The Department will create and implement a plan by December 2026 that will utilize the case management system, internal audits, supervision with child protection social workers, and other processes to track and monitor compliance with a focus on areas of non-compliance identified by the Office of the Auditor General of Canada. This implementation of this plan will inform a training plan and policy update and review project, both of which are to be completed by November 2027, to ensure that findings translate to policy, process and training improvements. Since October 2025, the Department has updated policies related to screening child protection reports, maintaining contact with children, completing and reviewing Plans of Care, and supporting young adults reach independence. In October 2025, the Department started to review all screening requirements for active foster and extended family caregivers to be completed by March 2026. Work is also underway to complete any gaps in screening requirements by October 2026 to validate that these are safe caregivers and children are in safe environments. The Department will complete the necessary annual reviews for all active foster and extended family caregivers by the end of October 2026. The Department will review and update existing group home policies and begin training group home staff on these updated policies by the end of March 2027. The policy updates will focus on delivering care and supervision to young children, including those living with disabilities.

Recommendation	Response
	The Department will also complete a review and update to the Child and Family Services Act Manual by the end of November 2027. The Department will conduct an analysis of capacity and resource needs of group homes to determine appropriate ratio for supervision (care providers) by children's age group and any disability by the end of June 2026. This will be factored into future budget and program planning processes and is expected to be completed by November 2026. The Department is in the process of reviewing and implementing recommendations from a subject matter expert on childcare facilities who conducted Early Childhood Environmental Rating Scale assessments on all group homes with young children. The Department plans to complete all necessary work by October 2026. The Department will monitor group homes for accommodations and child-to-staff ratios and report to senior management on an annual basis, starting June 2026.
49. The Department of Health and Social Services should actively collaborate with all Indigenous partners to establish timelines for the completion and ongoing updating of cultural plans for every Indigenous child in its care.	**The department's response.** Agreed. In October 2025, the Department began requesting meetings with Yukon First Nations and out-of-territory Indigenous governing bodies with children in care to discuss cultural plans and how the Department can work with them to meet our legislative requirements and establish processes to complete cultural plans. The Department will continue outreach efforts with all 14 Yukon First Nations and Indigenous governing bodies that have children in care. By March 2027, the Department aims to have cultural plans for all children in care. As of February 2026, the Department has agreed upon processes with 8 Yukon First Nations and 4 out-of-territory Indigenous governing bodies to complete cultural plans.

Recommendation	Response
58. The Department of Health and Social Services should rigorously and regularly assess the financial and human resources required to deliver services under the Child and Family Services Act. This assessment should include analyzing the department's data on staffing levels, vacancy rates, turnover, and attrition to inform and tailor its recruitment and retention efforts, in particular for front-line positions needed to deliver services.	**The department's response.** Agreed. The Department of Health and Social Services will assess the current financial and human resources to identify gaps and opportunities to deliver its mandate under the Child and Family Services Act and create a comprehensive plan to address critical social workers vacancies and other gaps limiting service delivery, group home modifications, and child-to-staff ratios required to create safe environments for young children living with disabilities in group homes. The first of these regular assessments will be completed by October 2026. The Department will analyse and report to senior management on current service gaps, vacancy rates, recruitment and retention trends. This information and analysis will be used by the Department to better target its recruitment and retention efforts, as well as make any necessary adjustments to its budget for delivering the child protection services. These efforts will support improved service delivery through increased capacity, recruitment, and retention in the Family and Children's Services branch.
62. The Department of Health and Social Services should develop and implement a learning management system to track and report on the completion of all mandatory training activities required for all social workers and group home staff. Using this information, the department should take actions to ensure that all staff complete all mandatory training.	**The department's response.** Agreed. The Department of Health and Social Services is evaluating options for a Learning Management System to centralize training administration, automate tracking and reporting, and strengthen compliance within Family and Children's Services' mandatory training requirements. The system will be fully implemented by November 2026, with the first comprehensive training completion report issued by February 2027. The Department will conduct a thorough review to confirm that all mandatory training requirements have been met by May 2027. The Department will work with partners to deliver safety training and Indigenous awareness training to social workers and group home staff.

Recommendation	Response
67. The Department of Health and Social Services should: • complete and submit the required Child and Family Services Act compliance reports to the Minister on a timely basis • leverage its data capabilities in its case management system for robust monitoring, tracking, and reporting on outcomes for children and families	**The department's response.** Agreed. By March 31, 2026, the Minister of Health and Social Services will receive a summary report outlining compliance of service standards under the Child and Family Services Act (CFSA) that have been completed to date, which is for 2022-23. The department will then undertake an external full three-year compliance review for the fiscal years 2025-26, 2026-27 and 2027-28. The report will be submitted to the Minister in March 2029. The department will then continue in a 3-year cycle of reviews. The Department of Health and Social Services will develop a plan and begin implementation by March 2027 to fully utilize the necessary features of the case management system to ensure better alignment with the CFSA legislation, policy and practice, and to produce data, monitor and track processes with focus on outcomes for children, youth and families receiving services. This work will include an analysis of data available within the case management system and more efficient ways to have this information accessible for monitoring and reporting purposes by March 2027. This workplan will be tracked alongside CFSA policy and practice updates referenced in these responses to ensure the system can adequately support the work being done.

Appendix—Text Descriptions of Exhibits

Here are the text descriptions of the exhibits.

Exhibit 1—Required actions were not timely after a report of suspected harm was received by the Department of Health and Social Services—Text description

This flow chart shows:

A text box at the top titled “Report of suspected harm.” On the left-hand side, it states that reports must be assessed within 24 hours to determine the level of risk. A clock is beside the words. To the right is a triangle illustration with an exclamation point inside it. To the right of the triangle, it is stated, “In the 134 reports that were reviewed in the audit, 37% were not assessed within 24 hours.” Below that in smaller print, it states that 11 out of 12 highest-risk reports were assessed on time.

Three arrows flow down out of the text box to 3 text boxes that state:

55 reports screened out.

33 reports were screened in for alternative responses. Footnote 1 states that alternative responses did not have a timeline for completion before July 2024. After that date, alternative services had to be completed within 30 days.

46 reports were screened in for intervention. Footnote 2 states that interventions include all investigations and any alternative responses after July 2024.

An arrow points down from the third box to a larger text box with the title “Intervention.” On the left, an illustration of a calendar is accompanied with the statement that interventions must be completed within 30 days. To the right, a statement says 41% of the 46 interventions did not meet the 30-day threshold for completion.

Source: Based on the Child and Family Services Policy Manual and case file data from the Department of Health and Social Services

Back to Exhibit 1

Exhibit 2—Options available with increasing levels of government involvement when a child needs to be placed in out-of-home care—Text description

This flow chart shows:

First box: an illustration of a child and 2 adults who appear to be seniors. Text states child moves into extended family care (minimal government involvement).

Second box: an illustration of an adult with a clipboard. Text states child is placed with extended family, and department supervises.

Third box: an illustration of a child with 2 adults. Text states child is placed in a foster home in Yukon.

Fourth box: An illustration of a building and 3 children. Text states child is placed in a group home in Yukon.

An arrow below the 4 boxes points from the first to the fourth box and says “increasing level of government involvement.”

Source: Adapted from the Child and Family Services Policy Manual

Back to Exhibit 2

Exhibit 3—There were gaps in the oversight and screening of extended family and foster homes—Text description

This horizontal bar chart shows:

Screening requirements for extended family: 24% not met.

Screening requirements for foster homes: 28% not met.

Annual reviews for extended family: 10% not met.

Annual reviews for foster homes: 58% not met.

Source: Based on data from the Department of Health and Social Services' extended family care and foster home case files

Back to Exhibit 3

Exhibit 4—The department worked with Indigenous partners to provide inclusive services, but most cultural plans were not developed—Text description

This horizontal bar chart shows:

Safety plans for families with child protection concerns: 9% were not met.

Case planning for families with child protection concerns: 11% were not met.

Support for children in care to attend cultural activities: 10% were not met.

Cultural plans for Indigenous children in care: 90% were not met.

Source: Based on data from the Department of Health and Social Services' case files

Back to Exhibit 4

Exhibit 5—Group home staff had not completed mandatory training—Text description

This horizontal bar chart shows 7 categories of mandatory training requirements and the percentage of non-compliance:

Standard first aid/CPR: 22% not met.

Non-violent crisis intervention: 62% not met.

Safe transportation of clients in cold weather: 95% not met.

Suicide intervention training: 95% not met.

Yukon First Nations 101: 84% not met.

Introduction to cultural safety: 92% not met.

Residential school awareness: 89% not met.

Source: Based on data from the Department of Health and Social Services' staff training completion documentation as of March 31, 2025

Back to Exhibit 5

Exhibit 6—Social workers had not completed mandatory training—Text description

This horizontal bar chart shows 4 categories of mandatory training requirements for social workers and the percentage of non-compliance:

Delegation of authority to deliver child welfare services: 5% not met.

Signs of safety for child protection: 8% not met.

Safe transportation of clients in cold weather: 68% not met.

Yukon First Nations 101: 72% not met.

Source: Based on data from the Department of Health and Social Services' staff training completion documentation as of March 31, 2025

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