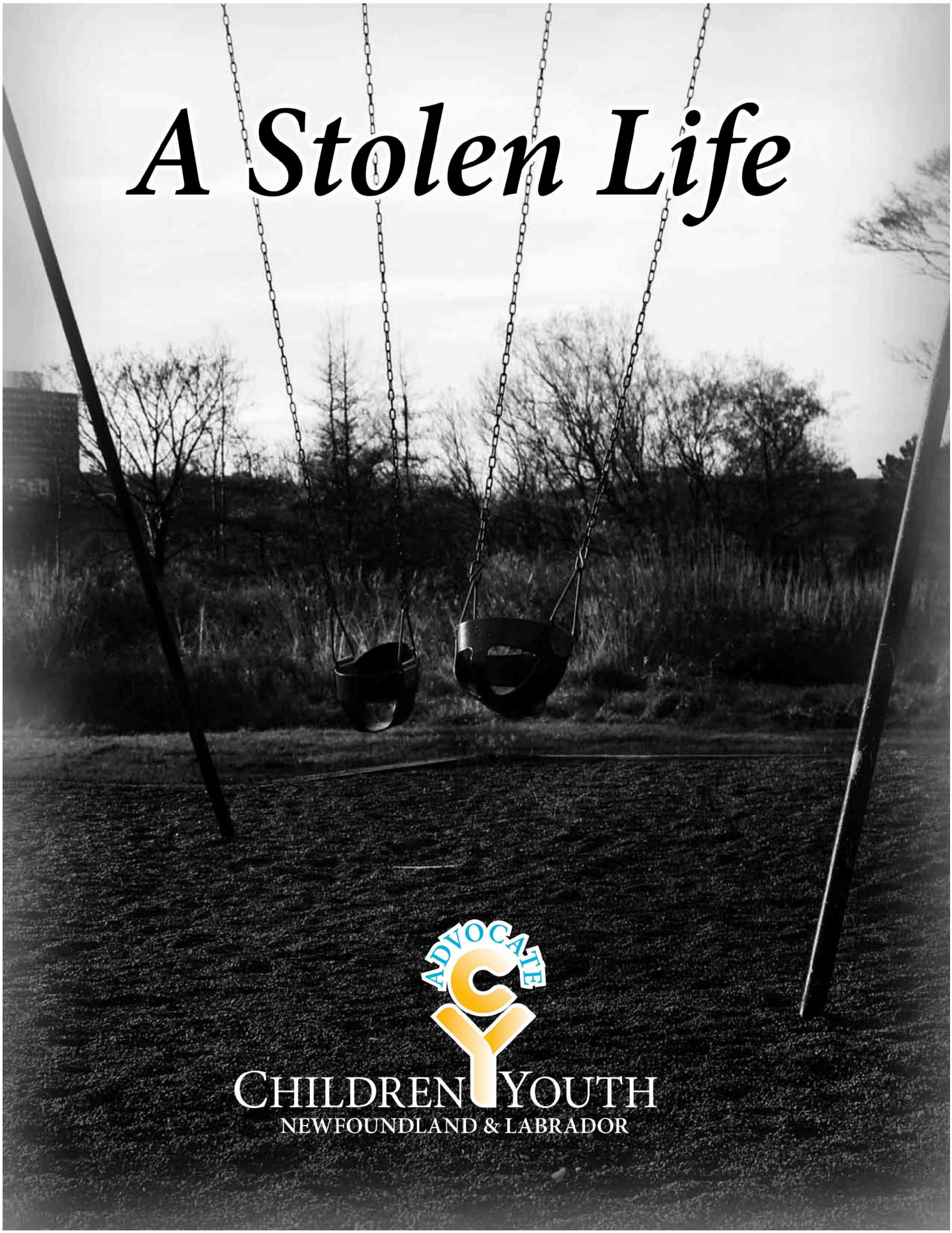
A Stolen Life
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A Stolen Life

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Message from the Advocate

This investigation reveals the story of two vulnerable children and how government services did not meet their needs. For reasons of confidentiality, these children will be known as "Alex" – 4 years old, and "Ben" – 4 months old. Over a period of four (4) years, these children had numerous encounters with many professionals, yet they continued to live in unacceptable and unsafe environments. Unfortunately, the end result was the traumatic death of four (4) month old Ben. Additionally, Ben will never receive the justice of having someone held accountable for his stolen life because government services did not ensure that his right to justice was upheld.

Once again, the same deficiencies are identified in this investigation as those that came before. Once again, it is evident that even though 183 recommendations made by this office since 2006 to government departments and agencies are being addressed, it is not resulting in the necessary changes and standardization of services throughout the Province.

Once again, the Labrador region is highlighted as one with many challenges, and one that requires a more intensive response to address those challenges. We can no longer accept that "change takes time"; action must be taken immediately to make that "change now" so that not one more child or youth suffers because their right to services is not upheld.

Carol A. Chafe
Advocate for Children and Youth

Executive Summary

On May 26, 2014, the Advocate for Children and Youth (ACY) served notice to the Deputy Ministers of the Department of Child, Youth and Family Services (renamed the Department of Children, Seniors and Social Development in August 2016); the Department of Health and Community Services (DHCS); and the Department of Justice (renamed the Department of Justice and Public Safety in October 2014); to the Chief Executive Officer of the Labrador-Grenfell Regional Health Authority (LGRHA); and to the Commanding Officer of the Royal Canadian Mounted Police (RCMP) B Division that she would be *"conducting an investigation into the circumstances surrounding [Alex] and [Ben], children of [Mom]"* who were in receipt of services from these departments and agencies. Ben died suddenly at the age of four (4) months as a result of trauma and his father was charged with second degree murder. The charge was later withdrawn due to lack of evidence.

The purpose of this investigation was to determine whether or not the services provided by the Department of Children, Seniors and Social Development (DCSSD), the DHCS, the Department of Justice and Public Safety (DJPS), the LGRHA, and the RCMP met the needs of Alex and Ben and whether their right to services was upheld. The ACY commenced this investigation on October 6, 2014, and it was completed on June 13, 2016, following a careful examination of the services and interventions provided to this family over a four (4) year period. During this time frame, the family had multiple contacts with service providers from the local community health clinic and hospital, the DCSSD, and the RCMP.

In completing this investigation, the ACY gathered pertinent facts, analyzed the information obtained and recommended changes that are necessary to prevent the reoccurrence of a similar situation. While some of the recommendations are specific to certain departments and agencies, others are relevant to all departments and agencies involved. As with other reports released by the ACY in recent years, the prominent themes throughout this investigation are failure to report child protection concerns; lack of collaboration, communication and information sharing; documentation deficiencies; lack of comprehensive assessment, intervention and followup; and challenges to service provision.

Primary issues identified in the delivery of services provided by the DCSSD to this family include:

- lack of collaboration, communication and information sharing;
- documentation deficiencies;
- lack of comprehensive assessment, intervention and followup; and
- challenges to service provision.

Primary issues identified in the delivery of services provided by the DHCS and the LGRHA to this family include:

- lack of collaboration, communication and information sharing.

Primary issues identified in the delivery of services provided by the DJPS and the RCMP to this family include:

- failure to report child protection concerns; and
- lack of collaboration, communication and information sharing.

Overall, there are six (6) recommendations previously made in investigative reports by the ACY that are applicable to this case. These previous recommendations are highlighted throughout this report and contained in Appendix C. The Advocate has determined that these recommendations are "Implemented" or "Partially Implemented", based on the responses from relevant government departments and agencies. However, despite actions taken by departments and agencies to address the previous recommendations, it is evident in this investigation that they continue to be an issue in practice. Additionally, seven (7) new recommendations have resulted from the completion of this investigation; they are listed in Appendix D. The Advocate will follow up on these recommendations until they are all appropriately addressed by the applicable government department or agency.

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their voices are heard. The ACY also provides information to stakeholders involved about the availability, effectiveness, responsiveness, and relevance of services to children and youth. The goal of this investigative report is to help significantly diminish the likelihood of any similar situation in the future.

Methodology

The Advocate for Children and Youth (ACY) is legislated under Section 13(1) of the *Child and Youth Advocate Act*, Statutes of Newfoundland and Labrador (SNL) 2001, to protect the identity of the parties involved in the investigation. To meet the rigorous requirements of confidentiality under the legislation, this report will identify the parents as Mom, Boyfriend #1, and Boyfriend #2, and the grandparents as Nan, Pop, and Grandma. The children will be known as Alex and Ben.

The investigation was conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act* (SNL 2001). An initial request for documentation was made to each department and agency on July 3, 2014. By August 18, 2014, the ACY had received the requested documentation. Throughout the process of the investigation, additional requests for information were made to the aforementioned departments and agencies. The ACY commenced this investigation on October 6, 2014, and it was completed on June 13, 2016, following a careful examination of the services and interventions provided to this family over a four (4) year period.

Information was obtained from a variety of sources during the investigation in accordance with Section 21(1) of the *Child and Youth Advocate Act* (SNL 2001). Case files and documents were provided by the Department of Child, Youth and Family Services (renamed the Department of Children, Seniors and Social Development in August 2016); the Department of Health and Community Services (DHCS); the Department of Justice (renamed the Department of Justice and Public Safety in October 2014); the Labrador-Grenfell Regional Health Authority (LGRHA); and the Royal Canadian Mounted Police (RCMP). All written correspondence and records were thoroughly reviewed by the ACY. In addition, policies, protocols and legislation that corresponded with the relevant time frames of this investigation were reviewed.

Dr. Desmond Bohn, Professor of Pediatrics and Anesthesia with the University of Toronto, and Member of the Pediatric Review Committee at The Office of the Chief Coroner of Ontario was asked to provide an expert medical opinion on this case. This process involved his review and analysis of Ben's hospital and clinic records that were provided to the ACY by the LGRHA. Dr. Bohn submitted a written report of his conclusions on the case to the Advocate.

In accordance with Section 21(1.2) of the *Child and Youth Advocate Act* (SNL 2001), witnesses were summoned to appear before the Advocate and answer questions under oath in recorded interviews. The ACY interviewed employees of the Department of Children, Seniors and Social Development (DCSSD) and several relatives of Alex and Ben.

This investigative report contains various acronyms in use throughout the system; official agency names and terminology are detailed in Appendix A. Appendix B provides a complete list of investigative documents reviewed and interviews conducted. The reference section of this report contains all literature, websites, policies, standards and legislation reviewed by the ACY for this investigation.

Prior to the completion of the investigative report, to ensure administrative fairness, departments and agencies involved were provided with the opportunity to review and offer feedback on a draft of the factual sections of the report. Departments and agencies included in this process were the DCSSD, the DHCS, the Department of Justice and Public Safety (DJPS), the LGRHA, and the RCMP. Upon completion, a copy of the final report was provided to the aforementioned departments and agencies. In addition, the report was shared with the Newfoundland and Labrador Association of Social Workers.

Case Summary

Mom had her first child, Alex, with Boyfriend #1. Three (3) years later, she had her second child, Ben, with Boyfriend #2. Mom and her two (2) children lived in a small northern community where Alex and Ben were often cared for by extended relatives and friends. Boyfriend #1 and Boyfriend #2 had lengthy criminal histories including convictions of assault. Throughout the time period of this investigation, Alex and Ben were frequently exposed to family violence and substance abuse.

The Labrador-Grenfell Regional Health Authority (LGRHA) was responsible for the delivery of child protection services until March 2012 when this region transitioned to the new Department of Child, Youth and Family Services. The Department of Child, Youth and Family Services was renamed the Department of Children, Seniors and Social Development (DCSSD) in August 2016. The DCSSD is currently responsible for child protection services, and in order to minimize the use of various titles throughout this report, all references to child protection services past and present will be identified as DCSSD. Between 2010 and 2012, the DCSSD generated seven (7) Child Protection Reports (CPRs) on this family. The child protection concerns presented for Alex were that, for the first few years of his life, he witnessed family violence between Mom and Boyfriend #1, and later between Mom and Boyfriend #2. These incidents of violence were often attributed to substance abuse.

Early interventions with this family by the DCSSD involved informal safety planning with Mom, Nan and other relatives. The DCSSD also negotiated their level of involvement with the family. For example, in response to a 2012 CPR, the assigned social worker documented that she explained to the referral source *"that if we became involved the child would come into care"*.

The file documentation indicates that four (4) different social workers responded to CPRs as they were received without any formal assignment or transfer of responsibility to a primary worker. Community Service Workers (CSWs) are members of the community hired by the DCSSD to assist social workers in the daily provision and coordination of activities necessary for effective client service delivery and case management (*Community Service Worker Position Description Form*, 2011). While CSWs lived in the community and often visited this family in person, the family's contact with social workers frequently occurred over the phone.

No formal Safety Plans were documented on this family until 2013, and there was a lack of documentation to indicate if supervisory consultations occurred between social workers and clinical program supervisors. In many cases, documentation was

missing, recorded directly on the CPR instead of on a separate case note, or recorded much later than the events actually occurred. Documentation does not indicate that the DCSSD made contact with this family other than in response to CPRs.

There is no evidence in any of the documentation provided to the Advocate that service providers were aware of Mom's pregnancy prior to Ben's birth. When Ben was two (2) months old, a referral source reported that Alex and Ben were witnessing substance abuse and violence between Mom and Boyfriend #2, and that there had been repeated threats by Mom to *"hurt and abandon"* Ben. Informal safety planning by two (2) social workers, a CSW, and a clinical program supervisor occurred; however, the children remained in the primary care of Mom and Boyfriend #2, with informal support from Grandma, Nan and Pop.

When Ben was three (3) months old, a referral source reported that Alex and Ben had witnessed violence at Grandma's house between Mom, Boyfriend #2, and another relative. Following this violent incident, Nan and Pop removed Alex from the situation as he was mainly living in their home at the time. Ben remained at Grandma's house as he was primarily cared for by Boyfriend #2 and Mom with support from Grandma. A social worker did not follow up with this CPR until one month later.

When the social worker actioned the CPR, one month after it was received, Ben was living with Boyfriend #2 at Grandma's house. The first Safety Plan ever completed on this family was signed by Boyfriend #2, and he was listed as the sole person responsible for Ben's safety. The Safety Plan described Boyfriend #2 as *"very protective of his son"*. Boyfriend #2 told the social worker that Ben was sleeping at the time, and she did not observe him.

Shortly after the Safety Plan was signed, Boyfriend #2 and Mom moved out of Grandma's house and started living on their own with Ben. Alex was primarily living with Nan and Pop and would occasionally stay with Mom and Boyfriend #2. Documentation indicates that the DCSSD were unaware of Ben's living arrangement, and that scheduled or unscheduled home visits did not occur as required with this family after the Safety Plan was signed.

After the Safety Plan with Boyfriend #2 was signed, Ben was brought to the local hospital a total of six (6) times over the course of one month by different relatives. He was diagnosed with baby colic, suck, swallow and breathing issues, and other symptoms of an upper respiratory tract infection, such as a persistent cough and nasal congestion. However, each healthcare professional that observed Ben described him positively in documentation, using terms such as *"appears well," "active," "healthy,"* and *"pleasant"*.

Approximately one month after Boyfriend #2 signed the Safety Plan with the DCSSD, four (4) month old Ben was pronounced dead. When the ambulance arrived on scene, Boyfriend #2 and Mom were present, and Ben was unresponsive in Mom's arms. The hospital staff did not send a CPR to the DCSSD, believing there were *"no other minors within the household"*. The DCSSD zone manager received a call from a social worker that same day informing her of Ben's death. The first time the DCSSD contacted Alex after the death was four (4) days later, in response to a disclosure that Boyfriend #2 had *"kicked [Alex] in the bum"* and *"locked him in a room"* at some point while Mom and Boyfriend #2 were living on their own.

Approximately one month after Ben's death, one of his relatives wrote a letter to the Minister of the DCSSD, expressing disappointment with the Department's handling of this case. The relative remarked that during Ben's short life, several relatives reported to the DCSSD that they were concerned for his safety, and some had offered to take him into their homes. The letter stated that the system dramatically failed Ben, and that his death could have been prevented *"if the CYFS [Child, Youth and Family Services] took action on the first call or report"*.

The Minister of the DCSSD responded to the relative's letter approximately one month later, noting that he could not comment further on the case due to the ongoing court proceedings; however, the letter stated: *"The Department's protocol with respect to addressing all incidents involves a thorough review of the client's file, assessment of risk and discussions with those involved"*. He also noted that he would be visiting the community and would be willing to meet with the relative at that time. Although the Minister did visit the community in early 2014, there is no confirmation that a meeting took place.

Ben's autopsy report indicated that the cause of death was *"blunt force trauma to the head"*. It also indicated that Ben had sustained previous multiple bone fractures which had not caused his death. The fractures were found in his ribs, *"thus giving the impression that these ribs were fractured in the past and had since healed"*, and in his legs; however, it was *"not specifically noted in the findings of the Radiology Report if these [leg] fractures were recent or older/healed"*. Boyfriend #2 was subsequently arrested and charged with the second degree murder of Ben.

Three (3) months after the disclosure that Alex had been abused by Boyfriend #2, the RCMP informed the DCSSD that a joint investigation of the disclosure would not occur. The RCMP documentation states that this was *"based on lack of evidence as there are no witnesses. It was also noted that the age of victim (3) would prove rather difficult to obtain a statement and put through court process"*.

The RCMP received Ben's autopsy results from the Office of the Chief Medical Examiner in February 2014 but did not forward them to the DCSSD until May 2014. On June 1, 2014, the Advocate requested that the DCSSD arrange a thorough medi-

cal examination of Alex, given the autopsy notes from the RCMP which stated: "*... it has not been determined who caused or how [Ben] sustained these previous injuries. Extensive investigation has been conducted into this aspect, however despite efforts by investigators, the cause or manner of these injuries has not been established*". The DCSSD did not comply with the four (4) requests made by the Advocate between June and October of 2014 for a medical examination of Alex. The zone manager at the time responded in an email to her supervisors that:

> *A medical for [Alex] was not warranted at the time of [Ben's] death, as he appeared healthy and active, and there has been no evidence subsequently. As an agency, we have no knowledge or evidence that this child has ever had any treatment or not for any physical injuries. I see no justification to ask the gparents to take [Alex] for a medical.*

Eight (8) months after Ben's death, the DCSSD advised the family that their protective intervention file had been closed as Alex was deemed safe in the care of Nan and Pop, who had "*traditionally adopted*" him. To date, no one has been held accountable for Ben's death.

Findings and Analysis

The purpose of this investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services (renamed the Department of Children, Seniors and Social Development in August 2016), the Department of Health and Community Services (DHCS), the Department of Justice (renamed the Department of Justice and Public Safety in October 2014), the Labrador-Grenfell Regional Health Authority (LGRHA), and the Royal Canadian Mounted Police (RCMP) met the needs of Alex and Ben and whether their right to services was upheld. This section of the report identifies areas for improvement in connection with each relevant department or agency involved, thus informing the recommendations made by the Advocate for Children and Youth (ACY). The areas for improvement will be illustrated through examples that were found throughout the investigative process.

Dr. Desmond Bohn was asked to provide an expert medical opinion on this case. This process involved his review and analysis of Ben's hospital and clinic records that were provided to the ACY by the LGRHA. Dr. Bohn submitted a written report of his conclusions on the case to the Advocate. His confidential written report is referred to in this section as "(Bohn, 2016)".

Many of the areas for improvement and the resulting recommendations identified during this investigation were similar to those identified in other investigations previously completed by the ACY. In March 2016, the ACY released *The Advocate's Report on the Status of Recommendations 2015*, in which the ACY identified the status of 183 previous recommendations after comprehensive followup with the applicable government departments and agencies. Many of these recommendations are relevant to this current investigation and have been reported by the departments and agencies as implemented through education and training of staff as well as policy changes; however, it is evident that corresponding practice has not necessarily changed throughout the Province. It is also evident that the Labrador region continues to be an area with many challenges that government departments and agencies have yet to adequately address. Previous recommendations made in investigative reports by the ACY that are applicable to this case are highlighted throughout this section of the report.

FAILURE TO REPORT CHILD PROTECTION CONCERNS

The primary consideration for any decision made concerning a child under the *Children and Youth Care and Protection (CYCP) Act* (SNL 2010) is the best interest of the child. In keeping with this mandate, Section 11(1) of the Act states: *"Where a person has information that a child is or may be in need of protective intervention, the person shall immediately report the information to a manager, social worker or a peace officer"*. This directive assigns a duty to all citizens, including professionals, to report any instance where a child may be in need of protection. Despite this directive, there were instances during the period of this investigation when issues pertaining to the safety and wellbeing of Alex and Ben were not reported to the appropriate authorities for investigation or action.

Article 3(1) of the *United Nations Convention on the Rights of the Child* (UNCRC, 1989) states that: *"In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interest of the child shall be a primary consideration"*. With the lack of consistent reporting of child protection concerns to the Department of Children, Seniors and Social Development (DCSSD), it is not evident that the best interests of the children were always the primary consideration for the professionals involved with this family.

Department of Justice and Public Safety(formerly the Department of Justice)

Royal Canadian Mounted Police

Prior to 2012, the RCMP's policy for notifying the DCSSD stated that a CPR should be forwarded to the DCSSD within three (3) working days. This policy was changed in 2012 and is now consistent with a recommendation made by the ACY in the investigative report, *"Out of Focus"*, released in 2012. When officers attend a residence where children are present and in a risk situation, information is now relayed immediately to the local DCSSD office. In addition, the policy now directs that upon submission of a CPR to the DCSSD, a telephone call will be made to the local DCSSD office advising of the submitted CPR. The policy goes on to state: *"After normal business hours the on-call Child Protection Worker will be contacted and advised of the report"* (Royal Canadian Mounted Police, 2012).

Although the policy has been updated since 2012, in the investigative report, *"A Tragedy Waiting to Happen"*, released in 2015, the ACY recommended that the draft Memorandum of Understanding (MOU) that guides the sharing of information between the RCMP and the DCSSD also be updated in a timely manner. As per *The Advocate's Report on the Status of Recommendations 2015*, and based on the response from the Department of Justice and Public Safety (DJPS), the Advocate determined in October 2015 that this recommendation was partially implemented, as the MOU between the DCSSD and the RCMP is an intergovernmental agreement that required signed approval. The Advocate received an update from the DCSSD on May 25, 2016 that the *MOU* (Royal Canadian Mounted Police, 2016) between the DCSSD and the RCMP has now been signed and completed. This change will be reflected in *The Advocate's Report on the Status of Recommendations 2016*, to be released in 2017.

Despite the policy that was in place between the RCMP and the DCSSD during the time period of this investigation, there were occasions when the RCMP failed to report child protection concerns. From 2010 to 2013, the RCMP documented their response to several incidents of family violence and substance abuse involving Mom, Boyfriend #1 and Boyfriend #2. Alex was left in the care of relatives previously assessed as a risk to him in earlier CPRs. On one occasion, the RCMP did not send a CPR to the DCSSD until seven (7) days after the incident occurred, contrary to the policy in place at the time. There is also no evidence that the DCSSD received this CPR, meaning there was no followup until the next CPR was received. There were also examples of missing and inaccurate information contained in CPRs sent from the RCMP to the DCSSD.

After Ben's death, the DCSSD received allegations that Boyfriend #2 had assaulted Alex at some point prior to the death, which involved kicking him and locking him in a room as a form of punishment. This information should have been reported immediately to the DCSSD by the RCMP officer who took the statement; instead, it was reported two (2) days later when a different RCMP officer happened to review the recorded statement. RCMP documentation also indicates that allegations were made in recorded statements by two (2) other community members that Mom had been abusive towards Alex and Ben in the past. Although RCMP documentation indicates that a CPR was sent to the DCSSD regarding these allegations against Mom, there is no record that the DCSSD received it.

In 2014, the RCMP contacted the DCSSD with Ben's autopsy results, three (3) months after receiving them from the Office of the Chief Medical Examiner. DCSSD documentation indicates that the RCMP officer in charge of the murder investigation apologized to the DCSSD zone manager for the delay but did not provide a reason why a CPR was not sent immediately upon receipt of the autopsy results. The results indicated that Ben sustained previous injuries that had not caused his death.

The RCMP had a duty to immediately report Ben's autopsy results to the DCSSD as Alex could have also sustained previous injuries. Their delay in sharing this information could have impacted his safety.

Based on the findings of this investigation, a recommendation would typically result that all RCMP and Royal Newfoundland Constabulary (RNC) employees in the Province need to be educated on their legislative duty to report; however, this recommendation was already made by the ACY in the investigative report *"Sixteen"*, released in 2013. As per *The Advocate's Report on the Status of Recommendations 2014*, and based on the response from the DJPS, the Advocate has determined that this recommendation is implemented. However, despite actions taken by the Department to address the previous recommendation, it is evident in this investigation that it continues to be an issue in practice.

It is incumbent upon the Department of Justice and Public Safety to "ensure that all Royal Newfoundland Constabulary and Royal Canadian Mounted Police employees are educated on their [legislative] duty to report" on an ongoing basis.

RECOMMENDATION 1

The Department of Justice and Public Safety (formerly the Department of Justice) ensure that the Royal Canadian Mounted Police and the Royal Newfoundland Constabulary review their current policy and process for completing and delivering Child Protection Reports (CPRs) to the Department of Children, Seniors and Social Development (DCSSD) (formerly the Department of Child, Youth and Family Services) to ensure:

(a) all members understand and comply with their legislative duty to report to the DCSSD any information that a child or youth is or may be in need of protective intervention.
(b) timely delivery of, and confirmation of receipt of CPRs by the DCSSD.

LACK OF COLLABORATION, COMMUNICATION AND INFORMATION SHARING

Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services)

Department of Health and Community Services

Labrador-Grenfell Regional Health Authority

Department of Justice and Public Safety (formerly the Department of Justice)

Royal Canadian Mounted Police

The DCSSD, the LGRHA and the RCMP all had pertinent information about this family, yet these organizations appeared to operate independently of one another. While there were times when discussions would occur between these professionals, reporting was not occurring consistently. Had these organizations been working collaboratively, they would have had a more complete picture of what was going on in the lives of these children.

According to documentation, in Ben's short life of four (4) months, relatives brought him to the local community clinic or hospital a total of twelve (12) times. He was experiencing suck, swallow and breathing issues, and other symptoms of an upper respiratory tract infection, such as a persistent cough and nasal congestion. He was also described as having *"colic"* and *"bronchitis"*. However, each healthcare professional that observed Ben described him positively, using terms such as *"well baby," "normal," "active," "healthy,"* and *"pleasant"*.

Ben's autopsy results indicated that he had sustained multiple bone fractures which had not caused his death. The fractures were found in his ribs, *"thus giving the impression that these ribs were fractured in the past and had since healed"*, and in his legs; however, it was *"not specifically noted in the findings of the Radiology Report if these [leg] fractures were recent or older/healed"*. Of the twelve (12) times that Ben was brought to a healthcare facility by relatives, he was examined by six (6) different doctors and one nurse on nine (9) separate occasions. There is no indication in the healthcare documentation that any of these professionals noticed Ben's injuries or contacted the DCSSD. During an interview with the Advocate, a relative of Ben noted that he *"was always crying… a particular way you handle him when you bathe*

him he'd be screaming, and we told that to the doctor, we don't know why he's crying so much" (Transcript of ACY Interview, 2016, p. 23). Dr. Desmond Bohn reviewed and analyzed a copy of Ben's hospital and clinic records that were provided to the ACY by the LGRHA. In his expert opinion, he stated:

> *After careful review of the multiple encounters that this baby had with medical and nursing professionals I can find no "red flags." This infant was thriving and gaining weight and was frequently described as "healthy and happy." He was fully examined on multiple occasions by different doctors and nurses and the likelihood of anything suggestive of [non-accidental trauma] being missed is remote… I can find nothing that would raise any concern* (Bohn, 2016).

Three doctors worked in consultation with each other on the day of Ben's death. One of them wrote an E.R. Note which was contained in Ben's hospital record. The note indicates that hospital staff contacted the RCMP and the Chief Medical Examiner; however, they did not contact the DCSSD: *"As there are no other minors within the household to our knowledge, the Child & Family Services have not been contacted at this time, though we will leave that to the discretion of the RCMP"*. Another doctor wrote a Record of Care that day, also contained in Ben's hospital record. The Record of Care indicates: *"…the RCMP were contacted and an attempt was made to contact CYFS"*; however, a CPR was not required to be sent from the LGRHA to the DCSSD under the current *CYCP Act* (SNL 2010).

Two (2) days after Ben's death, the DCSSD zone manager wrote in an email to her regional director that a Chief Operating Officer (COO) of the LGRHA did not provide her with a reason why the DCSSD did not receive a CPR from the hospital. The zone manager stated in the same email that the COO told her there would likely be *"learnings for the [hospital] staff coming out of this incident"*. This conversation was not documented by the LGRHA, and upon further followup by the ACY, the COO denied making this statement. The ACY wrote a letter to the LGRHA in April 2015 requesting additional information on any existing policies or procedures concerning the LGRHA's obligation to report a critical incident or death of a child to the DCSSD. In an email to the ACY dated April 20, 2015, a COO of the LGRHA responded:

> *All children in the province are protected by Provincial legislation, and therefore separate memorandums or shared agreements are not required to report critical incidents/deaths involving children. All such incidents are immediately referred to CYFS so they can ensure that all other children within a family environment are safe.*

A clinical nurse manager of the LGRHA also responded to the ACY's request for additional information. She advised via an email dated April 19, 2015 that there is no separate Memorandum of Understanding (MOU) regarding critical incidents or deaths of children between the LGRHA and the DCSSD. LGRHA professionals are expected to follow the *Community Clinic Services Policy and Procedures Manual C-4 Reporting Obligation (Labrador-Grenfell Health, 2008)*, which states: *"If a member of staff reasonably believes a child is being physically harmed by a person, the staff member is obligated to immediately report the matter to a Director, Social Worker or peace officer"* (p.1).

In addition, the LGRHA COO advised the ACY in her email response from April 2015 that she: *"…did a session on 'duty to report' with all our clinical nurses throughout the region on July 3, 2014"*. It was noted in the minutes for this session that *"the earlier a child is on the radar the better. Communicate with other nurses/other communities if you know they were seen there previously"*; and, *"as clinical nurses, you are obligated to make a referral if you feel the child is at risk"*.

There were no "red flags" to alert healthcare professionals of the LGRHA to Ben's previous injuries, and healthcare professionals were not required to directly contact the DCSSD on the day of Ben's death under the current *CYCP Act* (SNL 2010), or under the LGRHA's current policies and procedures. In addition, it was clear from the findings of this investigation that the healthcare professionals of the LGRHA were under the impression that there were no other minors within Ben's household, which also prevented them from directly contacting the DCSSD. The ACY recommends that changes be made to DCSSD legislation, policies and procedures to ensure direct and timely reporting to the DCSSD when a child is or may be in need of protective intervention, including the reporting of any unexplained deaths or critical incidents of children or youth, regardless of whether there are other minors in the household.

RECOMMENDATION 2

The Department of Children, Seniors and Social Development (DCSSD) (formerly the Department of Child, Youth and Family Services):

(a) review and revise legislation, policies and procedures as necessary to ensure direct and timely reporting to the DCSSD when a child is or may be in need of protective intervention, including the reporting of any unexplained deaths or critical incidents of children or youth, regardless of whether there are other minors in the household.

(b) ensure the provision of ongoing education regarding any revisions to their legislation, policies or procedures, both to the general public and to all government departments and agencies.

RCMP documentation indicates that Boyfriend #1 and Boyfriend #2 had accumulated lengthy criminal histories dating back to 2009 that included violent offences. The RCMP had responded to several of the family's complaints since 2010. Some of these complaints involved Alex and Ben witnessing violence between their parents. The documentation does not indicate that the RCMP would regularly share information with the DCSSD regarding this family, other than what was shared via CPR. Increased sharing of information between these government departments and agencies would have established a bigger picture of the family dynamics into which these children were born.

Based on the findings of this investigation, a recommendation would typically result that joint initiatives need to be developed and implemented, such as a multi-disciplinary committee in communities throughout all regions of the Province to ensure collaboration, communication and information sharing among service providers; however, this recommendation was already made by the ACY in the investigative report *"A Tragedy Waiting to Happen"*, released in 2015. As per *The Advocate's Report on the Status of Recommendations 2015*, and based on the responses from the DCSSD, the DHCS, and the DJPS, the Advocate has determined that this recommendation is partially implemented. The Advocate will continue to monitor the status of this recommendation until it is implemented.

> ***It is incumbent upon the Department of Children, Seniors and Social Development, the Department of Health and Community Services, and the Department of Justice and Public Safety to "jointly develop and implement initiatives such as a multi-disciplinary committee in communities throughout all regions of the Province to ensure collaboration, communication and information sharing among service providers".***

When Ben died, the DCSSD did not make contact with Alex until four (4) days later, in response to a CPR from the RCMP. This CPR alleged that Boyfriend #2 had physically assaulted and confined Alex at some point prior to Ben's death. A clinical program supervisor and the zone manager responded immediately to this CPR; they observed Alex, and he was deemed safe in the care of Nan and Pop. An RCMP officer followed up with the clinical program supervisor via telephone three (3) months later regarding the disclosure. The officer directed that a joint investigation of the disclosure would not occur *"based on lack of evidence as there are no wit-*

nesses. It was also noted that the age of victim (3) would prove rather difficult to obtain a statement and put through court process". Moreover, the RCMP told the DCSSD that a *"language barrier"* made interviewing Alex problematic. Since he was in the care of Nan and Pop at this time, and no unsupervised access was occurring with Mom or Boyfriend #2, the matter was dismissed.

In an interview with the ACY, the clinical program supervisor who spoke to the officer regarding this matter stated that this *"should have been a joint decision"* between the DCSSD and the RCMP (Transcript of ACY Interview, 2016, p. 111). The *MOU* (Royal Canadian Mounted Police, 1993) between the DCSSD and the RCMP that was in place during the timeframe of this investigation supported effective and timely investigations of child abuse; however, it did not state that joint investigations between the DCSSD and the RCMP were necessary. Nevertheless, Policy 1.3 of the DCSSD *Protection and In Care Policy and Procedure Manual* (2011), which was in place at the time, states: *"When the information alleges that the child has been physically or sexually abused, a joint decision will be made by CYFS and the police as to the most appropriate means of investigation"*. Furthermore, Policy 1.5 of the same manual states: *"A joint social work/police investigation of alleged physical or sexual abuse shall be conducted whenever possible"*. Despite these existing policies, the clinical program supervisor stated that, in this case, the RCMP made the decision not to interview Alex: *"…the decision was not made by CYFS for [an interview] not to happen. I did not make that decision for that not to happen"* (Transcript of ACY Interview, 2016, pp. 111-112).

The DCSSD and the RCMP should have made a joint decision to conduct a joint investigation into the allegations of physical assault against Boyfriend #2, including the provision of an interpreter in order to interview Alex in his preferred language. The *Risk Management Decision-Making Model Manual* (*RMDM,* 2013) sets out parameters for interviewing and observing children alleged to be in need of protective intervention. It states: *"The social worker should use age appropriate interviewing techniques to gather accurate and pertinent information to minimize trauma to the child"*. Examples of age appropriate interviewing techniques that could have been used with Alex include: building rapport, explaining the rules, and emphasizing the importance of telling the truth (Provincial Advisory Committee on Child Abuse, 2009). Additionally, Section 3.2 of the newly updated *MOU* (Royal Canadian Mounted Police, 2016) that guides the sharing of information between the DCSSD and the RCMP states:

> *The RCMP intends to... Conduct joint investigations with CYFS where it is believed a criminal offence (i.e. physical or sexual abuse) has been committed against a child or youth and the child or youth is or may be in need of protective intervention under the CYCP Act.*

The ACY recommends that the DCSSD and the DJPS ensure compliance with the current MOU's and policies in place regarding joint investigations.

RECOMMENDATION 3

The Department of Children, Seniors and Social Development (DCSSD) (formerly the Department of Child, Youth and Family Services) and the Department of Justice and Public Safety (formerly the Department of Justice) ensure compliance with Policies 1.3 and 1.5 of the *Protection and In Care Policy and Procedure Manual* (2011), and Section 3.2 of both the *Memorandum of Understanding* (Royal Canadian Mounted Police, 2016) and the *Memorandum of Understanding* (Royal Newfoundland Constabulary, 2015), which require that:

(a) a joint decision be made by the DCSSD and the RCMP or the RNC (as applicable) as to the most appropriate means of investigation when a child has been physically or sexually abused.

(b) a joint investigation of alleged physical or sexual abuse of a child be conducted by the DCSSD and the RCMP or the RNC (as applicable).

DOCUMENTATION DEFICIENCIES

Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services)

Deficiencies in documentation were apparent throughout the family's protective intervention file during the time period of this investigation. Deficiencies included lack of documentation and non-adherence to documentation standards and policies. As in previous investigative reports released by the ACY, the most prevalent deficiency identified was timely entry of case notes or Client Referral Management System (CRMS) notes.

DCSSD standards require social workers *"to document all service notes"* in CRMS *(CYFS Best Practice Guidelines for using CRMS,* 2003). The *Child, Youth and Family Services (CYFS) Documentation Guide* (2012) upholds the same standard. CRMS was partially implemented in this community on January 1, 2008; at this time, staff members were only required to enter CPRs and document client-related contacts in

CRMS. CRMS was fully implemented in this community on July 26, 2013. Since that time, staff members have been required to complete all documentation required of the *RMDM* (2013) in CRMS.

There were three risk management manuals in effect during the timeframe of this investigation. According to the DCSSD, the *Risk Management System (RMS*, 2003) was in effect in this community up until May 9, 2010; *RMS* (2010) was in effect from May 10, 2010 to May 31, 2013; and, the *RMDM* (2013) was in effect from June 1, 2013 onwards. The *RMS* (2003 and 2010) states: *"All referrals on new, reopen and active cases shall be recorded on the Child Protection Report form 14-704, and as soon as possible and no later than 24 hours"*. The *RMDM* (2013) upholds the same standard. Furthermore, the *CYFS Best Practice Guidelines for using CRMS* (2003) states: *"ALL referrals, initial and subsequent, received for the Child, Youth and Family Services Program Area must be recorded in CRMS and associated with a program"*.

Regardless of the method of recording, social workers were expected to maintain their own records of contact with clients. The *Standards for Social Work Recording* (Newfoundland and Labrador Association of Social Workers, 2005) outlines the purpose of recording standards:

> *These recording standards acknowledge that social workers have a responsibility for documenting interventions with clients and client systems, and assert that this is an integral part of professional practice. These standards refer to the recording of social work information whether that recording is via electronic or paper means* (p. 2).

Additionally, the *CYFS Best Practice Guidelines for using CRMS* (2003), which was in effect during the time frame of this investigation, outlined the standard for completion time of notes pertaining to the social worker's contact with the family:

> *Client documentation related to Protective Intervention Investigation must be completed within 24 hours of providing a service. All other documentation must be completed within 48 hours of providing a service. This is the standard practice of the organization and promoted as best practice by recognized Child Welfare Organizations.*

On July 1, 2012, the DCSSD updated documentation standards with the creation of the *Child, Youth and Family Services (CYFS) Documentation Guide.* This guide states that *"case notes shall be completed as soon as possible, but in any event, no later than 24 hours after an investigation and no later than 5 calendar days for all other ongoing CYFS involvement"*.

Despite these policy directives, there were many instances where documentation was missing, inaccurate, or unclear. For example, there was a lack of documentation to indicate if supervisory consultations occurred following the receipt of CPRs. Although in some cases a clinical program supervisor would sign and date a CPR, between 2010 and 2013 there were seven (7) instances where it was unclear from the documentation whether a supervisory consultation took place prior to followup with each CPR. In an interview with the ACY, a clinical program supervisor from this time period stated that it would have been an expectation for social workers to document all consultations with their supervisors; however, due to the crisis-driven nature of their work, documentation did not always occur (Transcript of ACY Interview, 2016).

Based on the findings of this investigation, a recommendation would typically result that the DCSSD needs to develop and implement a policy that ensures all managers document all consultations and any decisions made pertaining to a child or youth; however, this recommendation was already made by the ACY in the investigative report *"Sixteen"*, released in 2013. As per *The Advocate's Report on the Status of Recommendations 2015*, and based on the response from the DCSSD, the Advocate has determined that this recommendation is implemented. In May 2015, the DCSSD implemented a revised documentation policy and guide to reflect new documentation standards for consultations with supervisors and zone managers. The new standard now requires front-line social workers and supervisors to document consultations with zone managers and for the consulting zone manager to then review and confirm the activity note reflects the consultation.

RECOMMENDATION 4

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services) ensure compliance with sections 7(a) and 7(b) of the *Child, Youth and Family Services (CYFS) Documentation Guide* (2015) which contains protocol for documenting contact with supervisors and zone managers.

Between 2010 and 2014, CPRs and case notes were frequently recorded late – ranging from one week later to over one year later than when the actual report or service occurred. Case notes were often brief and recorded directly onto CPRs, containing minimal information or context. There were five (5) instances between 2010 and 2012 where handwritten investigative case notes were placed in the file but not added to CRMS. A CPR sent by the RCMP in 2013, and the corresponding case note by the assigned social worker, were added to CRMS two (2) months after the original incident occurred, which was also one day following Ben's death.

The *Child, Youth and Family Services (CYFS) Documentation Guide* (2012) identifies the following examples as information that should not be included in case notes: *"Social worker performance issues; social worker absences from work due to vacation, illness, etc.; social worker reasons for missed visits with clients; social worker's commentary on decisions"*. In 2014, some of the start dates on the first and only Family Centered Action Plan (FCAP) completed on this family were dated as far back as three (3) months before the date of the FCAP. Additionally, the zone manager indicated in an email to the regional director that the assigned social worker did not realize Mom had to sign the FCAP, so completion of this already outstanding document was two (2) weeks delayed until Mom provided her signature. The assigned social worker inappropriately documented that completion of the FCAP was delayed, due in part to her being *"unexpectedly off work"* for personal reasons. Later in 2014, immediately after the zone manager directed the assigned social worker to begin the process of closing the family's protective intervention file, the social worker was out of the office on leave for approximately two (2) months. She documented the personal reasons for her leave at this time, and there is no documentation indicating that anyone from the DCSSD followed up with the family during those two (2) months.

When asked in an interview with the ACY how confident and comfortable she was with the risk management system at the time, including the completion of Safety Plans, Risk Assessments and Family Centered Action Plans, the assigned social worker replied:

> *Not comfortable at all… we receive this short amount of training in St. John's and we come back… we weren't using the risk management documents the way that they're intended to be used because of the office and the caseloads and the consistent level of chaos* (Transcript of ACY Interview, 2016, p. 41).

The social worker commented further on documentation deficiencies at that time:

> *…there was no way, there was no human way, it was impossible to meet the standards… that the province enforces… I had a hundred people on my caseload and this was one case out of one hundred that I was handling at that time* (Transcript of ACY Interview, 2016, p. 23).

She also described her current caseload: *"The last I counted was 34. But then I had a consult with my supervisor and I believe that that's up a little more. Probably might be forty, might be, at the most"* (Transcript of ACY Interview, 2016, p. 14).

Despite the expectation that social workers must complete their own documentation, in an interview with the ACY, a clinical program supervisor from this time period stated that in 2008, an Information Administrator was specifically hired to input CPRs into CRMS because at that point the office was relying on handwritten documentation: *"...there was an improvement at that time… having [the Information Administrator] get this stuff into CRMS… that was a big step forward… she would get [CPRs] and they would be stacked up and she would enter them"* (Transcript of ACY Interview, 2016, p. 127). The clinical program supervisor also noted that while she did not agree with case notes being written directly onto CPRs; unfortunately, this was common practice at the time (Transcript of ACY Interview, 2016). She added: *"…oftentimes referrals and their response priority and all that was entered after the fact"* even if the CPR was addressed in a timely manner (Transcript of ACY Interview, 2016, p. 77).

The clinical program supervisor acknowledged the documentation deficiencies: *"…as I tell social workers now, even if you did intervene and you did do due diligence, if you didn't document it, it is like it didn't happen"* (Transcript of ACY Interview, 2016, p. 63). She noted that while things have improved in the community, they are still struggling with documentation standards. Additionally, the office has consistently encountered issues with recruitment and retention of qualified clerical workers. The clinical program supervisor reported that they currently have *"virtually no clerical support in our office"* (Transcript of ACY Interview, 2016, p. 118). She added:

> *Documentation, there's still a lag in getting CPRs on the computer. There's still a lag in case notes. And then workers leave as happened in this particular file, where workers have become ill or whatever, they can't do the work or, and historically over the years we've had a hundred percent turnover* (Transcript of ACY Interview, 2016, p. 129).

Based on the findings of this investigation, a recommendation would typically result that the DCSSD needs to ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to adhere to documentation standards; however, this recommendation was already made by the ACY in the investigative report *"A Tragedy Waiting to Happen"*, released in 2015. As per *The Advocate's Report on the Status of Recommendations 2015,* and based on the response from the DCSSD, the Advocate has determined that this recommendation is implemented. However, despite actions taken by the Department to address the previous recommendation, it is evident in this investigation that it continues to be an issue in practice.

It is incumbent upon the Department of Children, Seniors and Social Development to "ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to adhere to the documentation standards" on an ongoing basis.

LACK OF COMPREHENSIVE ASSESSMENT, INTERVENTION AND FOLLOWUP

Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services)

A consistent theme noted throughout the DCSSD involvement with this family included a lack of comprehensive assessment, intervention and followup. The DCSSD in this community often failed to provide timely and comprehensive assessment of child protection concerns. Identified issues include delayed responses, lack of observation of the children, and lack of formal Safety Assessments and Safety Plans. There was also inappropriate case management, including lack of planned followup and ongoing monitoring, unprofessional interactions with the family, and lack of formal Risk Assessment Instruments and Family Centered Action Plans. There were a number of DCSSD policies related to assessment, intervention and followup that were in place throughout the time frame of this investigation; unfortunately, many of these policies were contravened by DCSSD professionals.

Risk Decision #2 of the *RMS* (2003 and 2010), which was in effect during the time frame of this investigation, states:

> *The child alleged to have been maltreated shall be seen as soon as possible and no later than 72 hours after the receipt of the report. The social worker shall determine the response priority and document it on the Initial Intake Report form 14-696 as soon as possible and no later than 24 hours.*

Furthermore, Risk Decision #3 of the *RMS* (2003 and 2010) states:

> *The social worker must complete a face to face contact and interview, where developmentally appropriate, with any child defined to be a child in need of protective intervention.*

Between 2010 and 2012, there were seven (7) CPRs received by the DCSSD on this family. Alex was observed once by a clinical program supervisor and three (3) times by Community Service Workers (CSWs) in response to CPRs. For the most part, social workers made telephone contact with the family in response to these CPRs; however, the file documentation does not indicate that Alex was observed by a social worker until 2013. In an interview with the ACY, a clinical program supervisor from this time period indicated: *"Then there was a lot more work being done by CSWs and telephone calls with family… that's not the practice now but it was"* (Transcript of ACY Interview, 2016, p. 81). Despite followup by CSWs, all DCSSD professionals interviewed by the Advocate noted that this particular office consistently encounters issues with recruitment and retention of qualified CSWs. One social worker described the crucial role played by CSWs in this community:

> *…they're an intricate part of the work that we do… and so many times we rely on them and I don't feel that they are given enough. Like they are so critical in delivering service… they have a tremendous amount of power when we're dealing with family that is going through some trauma at that moment… they're able to reduce stress and anxiety to the family… I can't say enough about the importance of community service workers within our office. I believe at the time… there was just the one* (Transcript of ACY Interview, 2016, pp. 10-11).

In addition to a lack of qualified CSWs in this community, there were also inappropriate social work assessments and interactions that took place in response to the first seven (7) CPRs. After a CPR in 2010, the social worker inappropriately stated in her case note: *"[Nan] was informed that CYFS has four children who are currently in the continuous custody of the director and it would be in [Alex's] best interest for her to go immediately and get him from that residence"*. It appears that this confidential information was used as a threat to convince Nan to retrieve Alex. A CPR from 2011 listed the type of allegation as Section 14(c) of the *Child, Youth and Family Services Act* (SNL 1998): *"A child is in need of protective intervention where the child is emotionally harmed by the parent's conduct"*. It was rated *"low risk"*, requiring followup within three (3) days. Given that the referral source indicated there was no one able or willing to care for Alex at this time, the CPR should have

been screened in as *"high risk"*, requiring immediate followup under an additional type of allegation, Section 14(i): *"A child is in need of protective intervention where the child has no living parent or a parent is unavailable to care for the child and has not made adequate provision for the child's care"*.

A final example of inappropriateness was after a 2012 CPR, when the social worker told the referral source that Alex would *"come into care"* if the DCSSD became involved. When asked in an interview with the ACY if this was an appropriate comment to make, the clinical program supervisor from this time period stated: *"…that's not appropriate if that's exactly what was said, no"* (Transcript of ACY Interview, 2016, p. 78). At this time, the DCSSD should have already been actively involved with the family, not negotiating their involvement with a referral source.

Once the response priority for a CPR has been determined, Risk Decision #3 of the *RMS* (2003 and 2010) states:

> *The social worker shall complete the Safety Assessment form 14-628 as soon as possible, and within 24 hours of the child being seen. When the social worker assesses the child's situation as unsafe, a Safety Plan Form #14-855 shall be developed immediately. The social worker shall consult with a supervisor upon completion of the Safety Assessment and the Safety Plan and receive written approval on both.*

The *RMDM* (2013) upholds the same standard. In all of the DCSSD documentation on this family between 2010 and 2014, which includes copies of eleven (11) CPRs, there are no Safety Assessment forms on file. Some of the documented followup to CPRs references the children's safety in an informal manner; however, there is no indication in the documentation that the social workers involved with this family completed formal assessments of the children's safety. In an interview with the ACY, a clinical program supervisor from this time period commented:

> *And that had to do, in my opinion, with the high workload that people had and their unfamiliarity with the system and just feeling that they did not have the time to do that. That it took away from getting out there and seeing people… they weren't done generally* (Transcript of ACY Interview, 2016, p. 39).

In an interview with the ACY, another clinical program supervisor involved with this case commented on current workload and resources in the office. She noted that there are approximately 30 to 40 cases per one social worker and staffing remains an issue:

> *…we've had a huge problem with retaining receptionists and community service workers… CYFS is the only provincial government service in [the community] and it's been a very rocky road… We have relied heavily on CSWs but now when we need them most… it is very difficult to recruit for many reasons… We have ten [social workers], I think… We have chronic, chronic vacancies… Chronic turn over, chronic absenteeism issues because it's a very, very stressful place to work* (Transcript of ACY Interview, 2016, pp. 117-120).

There are only two (2) Safety Plans on file, both from 2013, when the *RMDM* (2013) was in effect in this community. When completing a Safety Plan, a social worker must identify safety threats and protective factors, describe specific actions aimed at reducing safety threats, identify persons responsible, and indicate the expected time frame for completion of each action (*RMDM*, 2013). The first time a formal Safety Plan was completed with this family was in response to a CPR in 2013, which occurred two (2) months before Ben's death. The CPR was documented as requiring a *"same day"* response; however, the DCSSD failed to list Ben as a *"child in need of protective intervention"* on the CPR until one month after the incident occurred. In an interview with the ACY, the clinical program supervisor who provided direction on this CPR explained that the delayed followup was due to the high volume of CPRs received by their office combined with staffing shortages. As a result, the CPR was misplaced: *"I think I found that report and it wasn't entered or actioned properly… I found it and that's why I immediately told [the social worker] to go out"* (Transcript of ACY Interview, 2016, pp. 95-96).

When a social worker and a CSW finally met with Boyfriend #2, he was living with Ben at Grandma's house. Grandma was also present during this home visit, and Ben was not observed by the social worker because Boyfriend #2 said he was sleeping. In an interview with the ACY, the social worker confirmed that Ben should have been observed that day: *"…looking back on it, I absolutely should have insisted… I trust [Grandma] and the care that she… would give any child… so I felt confident leaving that home, that he was safe and that he was asleep"*. The social worker added that this would *"absolutely"* not be the current practice of the DCSSD in this community (Transcript of ACY Interview, 2016, p. 29-30).

Based on the findings of this investigation, a recommendation would typically result that the DCSSD needs to ensure compliance with policy that all children in a family are physically and critically observed during a referral and during every home visit and, where appropriate, interviewed alone if necessary; however, this recommendation was already made by the ACY in the investigative reports *"The Child Upstairs… 'Joey's' Story"*, released in 2011, and *"Turning a Blind Eye"* and *"Out of Focus"*, released in 2012. As per *The Advocate's Report on the Status of Recom-*

mendations 2015, and based on the response from the DCSSD, the Advocate has determined that this recommendation is implemented. However, despite actions taken by the Department to address the previous recommendation, it is evident in this investigation that it continues to be an issue in practice.

> ***It is incumbent upon the Department of Children, Seniors and Social Development to "ensure compliance with policy that all children in a family are physically and critically observed during a referral and during every home visit. Where appropriate, children must be interviewed – alone, if necessary".***

Despite Boyfriend #2's criminal record and the previously documented file concerns, the first formal Safety Plan on this family described Boyfriend #2 as *"very protective of his son"*. Instead of involving Grandma in the Safety Plan, whom the DCSSD believed to be protective of Ben, the social worker listed Boyfriend #2 as the sole person responsible for Ben's safety. When asked in an interview with the ACY why Grandma was not included in the Safety Plan, the social worker confirmed: *"That was an oversight on my part. Yeah, [Grandma] was there and is a wonderful person and the home is lovely… I was thinking about [Boyfriend #2] and [Mom]"* (Transcript of ACY Interview, 2016, p. 28).

The social worker made one attempt to complete a Safety Plan with Mom, as directed by her clinical program supervisor; however, Mom was not at home. The social worker should have made several attempts to contact Mom until the Safety Plan was completed; however, the DCSSD made no further contact with the family until after Ben's death in 2013. In an interview with the ACY, the social worker explained that *"[Boyfriend #2]… was the primary caregiver [of Ben] and that [Mom] was not making good choices at the time"* (Transcript of ACY Interview, 2016, p. 30). The only other Safety Plan on file was signed by Nan and Pop, the zone manager and a clinical program supervisor four (4) days after Ben's death. It stated that Nan and Pop would supervise Alex at all times if he was in the presence of Mom or Boyfriend #2. It was documented that this Safety Plan was supposed to be reviewed and revised two (2) weeks later, but there are no updated Safety Plans on file.

There were a total of nine (9) CPRs on this family prior to Ben's death. Other than the investigative followup that occurred in response to most of these CPRs, there were periods of time from one to fourteen (14) months where there was no documented contact with the family. All four (4) staff members of the DCSSD interviewed by the ACY admitted that their work was crisis-driven (Transcripts of ACY Interviews, 2016). Each CPR involved multiple and concurrent issues, including

addictions, family violence and lack of supervision; however, contact with this family was solely in response to CPRs and they did not receive the comprehensive case management they deserved.

For example, in response to a 2013 CPR, in which it was alleged that Mom had threatened to *"hurt and abandon"* Ben, the assigned social worker addressed the CPR concerns with Mom and family members; however, she did not complete a Safety Assessment to determine if a Safety Plan was needed. The social worker did discuss potential post-partum depression with Mom, which Mom denied. The social worker agreed with Mom's plan to leave her community and attend a treatment program while the children were cared for by a relative in a different province. A comprehensive assessment and intervention should have occurred; however, there was no further DCSSD followup with this family until the next CPR was addressed almost two (2) months later.

In an interview with the RCMP following Ben's death, the same social worker commented that *"while all of [her] involvement with [Mom and Boyfriend #2] has been somewhat intrusive (i.e. crisis driven), it has also been uneventful"*. Informal safety planning occurred; however, Ben remained in the primary care of Mom and Boyfriend #2, with informal support from Grandma. A social worker involved with the family explained in an interview with the ACY that this was due to the confidence the DCSSD had in Grandma, Nan and Pop: *"I never thought… that those children would be in any kind of danger because of the grandparents and the role they played in their lives"* (Transcript of ACY Interview, 2016, p. 21).

With the exception of one CPR, for which there is no corresponding documentation or evidence of followup, the DCSSD only made contact with this family in response to CPRs; ongoing monitoring in between CPRs was non-existent prior to Ben's death. In an interview with the ACY, a clinical program supervisor reflected on past and present working conditions in this community:

> *We didn't have the resources on the ground to deal with the high volume of referrals and crisis… that we were dealing with on a daily basis. We are better in this regard now. We still haven't met the standard but we're striving to meet the standard* (Transcript of ACY Interview, 2016, p. 115).

The risk management process includes two (2) important steps where it has been determined that a child is in need of protective intervention: the completion of both a Risk Assessment Instrument and a Family Centered Action Plan. These steps are in place to ensure that the ongoing monitoring of all families with a protective intervention file is occurring consistently. Risk Decision #6 of the *RMS* (2010) states:

> *The social worker must complete the Risk Assessment Instrument within 60 days of receipt of the Child Protection Report, where it is determined that a child is in need of protective intervention. The Risk Assessment Instrument must be completed at minimum once every six months, for high risk and moderately high risk ratings and at critical points in the case. The Risk Assessment Instrument must be completed at minimum once every nine months, for medium risk and moderately low risk ratings and at critical points in the case…The social worker shall review the Risk Assessment Instrument when a new report is screened in on an active case.*

Furthermore, Risk Decision #7 of the *RMS* (2010) states:

> *The social worker shall complete, with the family, a Family Centered Action Plan (form 14-858). This shall include a face to face interview and contact, where developmentally appropriate with any child defined to be in need of protective intervention and the case remains open. The Family Centered Action Plan (Form 14-858) shall be completed within 60 days of receipt of the Child Protection Report.*

According to the *RMS* (2010), *"Reassessment of risk through completion of the Risk Assessment Instrument will occur during regular case reviews (at least every three months)"*. When a new CPR is received on an open case and an investigation results: *"There is no requirement to complete the entire Risk Assessment Instrument again, instead the review should be documented on the Review of Risk Assessment form"*. The *RMS* (2010) states:

> *The social worker must, at minimum, review/revise the Family Centered Action Plan (Form 14-858) with the family and obtain supervisory approval no longer than 6 months after the initial plan is developed/revised, for high risk and moderately high risk rating and every 6 months thereafter… [and] no longer than 9 months after the initial plan is developed/revised, for medium risk and moderately low risk ratings and every 9 months thereafter.*

In addition, the social worker *"must review/revise the Family Centered Action Plan whenever the Risk Assessment Instrument is completed/reviewed or when other assessments are completed"* (Risk Decision #8, *RMS*, 2010).

This family's protective intervention file was open and active since 2010 with a total of eleven (11) CPRs on file; however, the first Risk Assessment Instrument and Family Centered Action Plan on this family were completed almost four (4) years later in 2013 after Ben's death. By this time, the *RMDM* (2013) had been implemented in the community, meaning that the DCSSD professionals involved with this family disregarded the *RMS* (2003 and 2010) entirely.

Although the *RMS* was developed in 2003 and disseminated to the regions, implementation of the system occurred at a later date in certain communities. The ACY requested additional documentation and information from the DCSSD in April 2015. In their response letter, the DCSSD stated that full implementation of the *RMS* (2003) in this community occurred on April 1, 2005, which included policies regarding the completion of a Risk Assessment Instrument, as outlined previously. Nevertheless, two (2) months after Ben's death in 2013, the zone manager noted in a conference call with the regional director and a program consultant that they had *"not completed [a Risk Assessment Instrument] on any cases in their zone to date"*. In an interview with the ACY, the zone manager confirmed her statement, and added:

> *…in 99 percent of the cases we were probably not completing the risk assessment instrument… Risk assessment, that whole process of moving beyond a safety plan was rarely done... implementing the use of risk assessment would be like changing a tire on a moving bus. Very, very challenging. And did we ever really get that tire changed? No* (Transcript of ACY Interview, 2016, pp. 71-74).

Delayed response times, lack of critical observation of the children, and inappropriate case management continued after Ben's death. In an interview with the ACY, the zone manager confirmed that a social worker contacted her on the day of Ben's death because Nan was asking for additional child care services as there was an emergency with Ben. The zone manager stated:

> *I don't recall asking [the social worker] what's wrong with [Ben]… it did not cross my mind to inquire what was the nature of this infant's medical emergency… And the next thing I heard was the phone call from [the social worker] later that night saying the RCMP has phoned her to say [Ben] had died… on the day [Ben] died, I did not direct anyone to go and see [Alex]… I had no reason to believe that there was any harm to [Alex]* (Transcript of ACY Interview, 2016, pp. 28-33).

The screening and response prioritization guidelines of the *RMDM* (2013) state that the DCSSD: *"…will respond on the same day when there is an unexplained or suspi-*

cious death of a child and there is another child living in the home". The zone manager should have immediately investigated Ben's death further, in order to determine the need for protective intervention of Alex as per Section 12 of the *CYCP Act* (SNL 2010), which directs that:

> *Where a manager or social worker receives information in the form of… other evidence that a child may be in need of protective intervention, the manager or social worker shall investigate whether the child is in need of protective intervention.*

In response to receiving Ben's autopsy results in May 2014, the Advocate made four (4) requests between June and October of 2014 that the DCSSD arrange for a medical examination of Alex, to ensure that he had not experienced previous injuries. The need for a medical examination was disputed by the zone manager in an email to the assistant deputy minister and a regional director of the DCSSD. She stated: *"There would be no reason that I can think of that this child should have a medical at this time"*, as Alex *"appears well and healthy and the gparents have cooperated with us since the time of the baby's death"*. Her case note regarding the autopsy results states that an RCMP officer clarified the cause of Ben's death as *"blunt force trauma to the head"* and:

> *…that they conducted an extensive investigation into the many individuals…who had access to [Ben] prior to his death, including 3 different grandparents, aunts, extended family members and friends and they were not able to determine how or when the baby was previously injured.*

In an interview with the ACY, the zone manager explained that, following the Advocate's request for a medical examination of Alex, she did encourage Nan and Pop to have him examined; however, she did not have the authority to force them:

> *The only information I had about autopsy results came five or six months after [the death]… from the RCMP… taking [Alex] for a medical appointment to see if he had any healed injuries would have involved obviously more than can be done at the local clinic… I could not see any reason to force… the grandparents to take him for a medical. And as the… zone manager, the only way I would have been able to have kind of authority over the child was if the child was in my custody…* (Transcript of ACY Interview, 2016, pp. 98-107).

In an interview with the Advocate, relatives of the children confirmed that they were encouraged by the zone manager to have Alex medically examined; however, they decided against it because they believed he was fine (Transcript of ACY Interview, 2016).

The ACY maintains that the RCMP should have immediately notified the DCSSD of the autopsy results when they first became available. This is addressed in a previous section of this report, entitled "Failure to Report Child Protection Concerns". Additionally, Standard #4 of the *RMDM* (2013) states that when *"making the verification decision and determining the child's need for protective intervention… a social worker may also need to review medical or forensic evidence (e.g., blood work or injuries to a child)"*. Given the cause of Ben's death; the information that Ben had sustained previous injuries that did not cause his death; the allegations that Boyfriend #2 had physically assaulted Alex at some point prior to Ben's death; and, the fact that the RCMP could not determine how or when Ben was previously injured, the DCSSD should have initiated a thorough medical examination of Alex to assess for possible injuries.

RECOMMENDATION 5

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services) review and revise their current policy and procedure pertaining to the verification of child protection concerns and the determination of a child's need for protective intervention, to ensure that:

(a) When a child or youth discloses physical or sexual abuse they receive a thorough medical examination.
(b) Any siblings of a child or youth who died under suspicious circumstances receive a thorough medical examination.

Ongoing monitoring of this family, including scheduled and unscheduled home visits, would have increased the likelihood of the DCSSD becoming aware of Ben's living arrangement, and would have increased the likelihood of a more effective intervention. In interviews with the Advocate, two (2) relatives of Ben agreed that the DCSSD would have been unaware of this living arrangement as the family did not report their concerns for Ben during the month that he lived with Mom and Boyfriend #2. One of the relatives said her lack of reporting was due to the DCSSD response to her previously reported concerns: *"I felt that… they weren't believing me… I was upset after because they didn't do anything… still today I'm still upset"* (Transcript of ACY Interview, 2016, pp. 26-27). During interviews with the Ad-

vocate, three (3) relatives of Ben claimed they had made additional reports during his short life that were not recorded as CPRs by the DCSSD. One of the relatives explained that another relative who was employed by the local DCSSD office:

> *Would come over to the house… when there was incidents [with Mom and Boyfriend #2] and… would tell [the zone manager]. But we never received much help… sometimes [the zone manager] wouldn't… see us if we went to the office, and I was concerned and I told the social worker why is [the zone manager] there if she doesn't want to see clients… if she doesn't want to help us?* (Transcript of ACY Interview, 2016, pp. 8-10).

In an interview with the Advocate, the relative who was employed by the local DCSSD office stated that she reported concerns for Ben to the zone manager on at least three (3) occasions and made one formal report. She noted:

> *…one time… I had to tell [the zone manager] that I have to take a half day off because I wanted to take care of [Ben] because I told [the zone manager] that his parents were fighting when he was in the room* (Transcript of ACY Interview, 2016, p. 9).

The relative claimed that she told the zone manager Mom was holding Ben in one arm while punching Boyfriend #2 with the other arm. She also claimed that the zone manager agreed for her to take the afternoon off to care for Ben that day but did not treat her concerns as a CPR (Transcript of ACY Interview, 2016). The relative made one formal report to a clinical program supervisor on the advice of the zone manager. Following this report, the relative claimed that she:

> *…agreed to take… [Ben] when [the DCSSD] said they were going to remove him from [Mom] and I went on home… I thought they were going to bring [Ben] over… I don't know why they didn't. They didn't listen to me and I don't know why they didn't remove him* (Transcript of ACY Interview, 2016, pp. 15-16).

During the summer of 2013, the DCSSD received two (2) CPRs on this family. Documentation does not indicate that there were any additional reports or requests for assistance. Additionally, DCSSD professionals interviewed by the ACY could not recall these additional reports or requests for assistance, and could not recall any relatives expressing that they were able or willing to take Ben into their care. A clinical program supervisor noted that a removal of Ben was never considered because

the DCSSD did not have "*…any reason to remove him… [or] enough information to remove him*" (Transcript of ACY Interview, 2016, p. 3). The zone manager could not recall any specific requests to meet with this family. She also noted that, while there were occasions when community members would request to speak with her, the accepted protocol would be to direct those individuals to a social worker or clinical program supervisor (Transcript of ACY Interview, 2016).

Article 19(1) of the UNCRC (1989) states:

> *States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.*

Due to the lack of comprehensive assessment, intervention and followup by the DCSSD, the children's right to protection from harm was not upheld. Immediate response to CPRs, proper assessments and interventions as well as sporadic unscheduled visits and regular followup would have increased the likelihood of the DCSSD seeing firsthand what was truly going on in the lives of these children.

In an interview with the ACY, the zone manager commented on the working conditions in the community at the time:

> *…we weren't able to carry out the expectations that were laid upon us… we had social workers with caseloads of 70 and 80, and the fact was they were not seeing children in [Protective Intervention Programs] sometimes for months on end… The number of children in the [Protective Intervention] program and the number of children in care [in this community] is completely disproportionate with the size of the population… we were kidding ourselves if we thought we were keeping kids safe… we absolutely had to rely on all of the adults that are involved in the lives of children… to ensure the safety of children* (Transcript of ACY Interview, 2016, pp. 45-52).

When asked about the current working conditions, the zone manager responded that there are currently ten (10) social workers in the office:

> *And many workers leave because they, they look at the fact that they're defeated almost before they start. They know what they're capable of doing but if your caseload is 1 [social worker] to 40 [children], 1 to 50, 1 to 60 and right now [the regional director] is hoping with the [file] closures it is going to go 1 to 33… I don't know what it would be if we could comply [with the standards]… I never experienced it. I know they're still not experiencing it. I don't know what that would be like* (Transcript of ACY Interview, 2016, pp. 61-63).

In addition, DCSSD Quality Assurance Indicator Reports (2016) confirm significantly lower percentages of completed Safety Assessments, Risk Assessments and Family Centered Action Plans per month in the Labrador region as compared to all other regions in the Province. For example, as of July 2016 the percentage of completed Safety Assessments in the Labrador region was approximately 59% compared to an average of 95% in all other regions; the percentage of completed Risk Assessment Instruments in the Labrador region was approximately 67% compared to an average of 90% in all other regions; and, the percentage of completed Family Centered Action Plans in the Labrador region was approximately 34% compared to an average of 63% in all other regions. The ACY maintains that these numbers are unacceptable and the situation in Labrador must be rectified immediately by the DCSSD.

Based on the findings of this investigation, a recommendation would typically result that the DCSSD needs to ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to complete comprehensive assessments, interventions and followup in accordance with the *RMDM*; however, this recommendation was already made by the ACY in the investigative report *"A Tragedy Waiting to Happen"*, released in 2015. As per *The Advocate's Report on the Status of Recommendations 2015*, and based on the response from the DCSSD, the Advocate has determined that this recommendation is partially implemented. The Advocate will continue to monitor the status of this recommendation until it is implemented.

It is incumbent upon the Department of Children, Seniors and Social Development to "ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to

complete comprehensive assessments, interventions and followup in accordance with the Risk Management Decision-Making Model Manual (2013)".

CHALLENGES TO SERVICE PROVISION

Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services)

Alex and Ben lived in a remote community in Labrador. Some of the residents in this community, like those in other similar communities, struggle with high levels of addictions and family violence issues stemming from colonization and intergenerational trauma. The location of the community, paired with these issues, create unique challenges to service provision. In an interview with the ACY, the zone manager noted that family violence was, and still is *"a significant issue"* in this particular Labrador zone (Transcript of ACY Interview, 2016, p. 89). Additionally, it was documented in meeting notes from 2014 by a DCSSD program consultant that one of the clinical program supervisors involved with this family described the working conditions in the community as *"intolerable"*. In an interview with the ACY, the clinical program supervisor confirmed her statement and commented further:

> *…you can ask people to do what is the right thing to do, but if it is humanly impossible for them to do that you're just creating more and more stress with no acknowledgement of that… I had a lot of respect for most of the workers there because I saw them… burning out, and crying. And that's very hard as a supervisor to see because you just wonder what can I do? I can't pull bodies out of the wall… there was really no respect being given by the province to the state of affairs in our offices* (Transcript of ACY Interview, 2016, pp. 45-48).

The challenges to service provision identified by service providers in this region point to a clear deficiency within the DCSSD; the Department has failed to address the unique needs of the Labrador region.

A further challenge to service provision in the Labrador region is the absence of traditional custom adoption in existing DCSSD legislation, policies and procedures. *"Traditional adoption"*, also known as custom adoption, is defined by the Adop-

tion Council of Canada as *"a form of adoption specific to Aboriginal peoples, taking place within the Aboriginal community and recognizing traditional customs"*. There are examples in DCSSD documentation which indicate that Alex was traditionally adopted on two (2) separate occasions. Additionally, there is a notarized traditional adoption document in the DCSSD file, assigning all rights and obligations for Alex to Nan and Pop. The family's protective intervention file was closed three (3) months after this traditional adoption document was signed, based on the DCSSD assessment that Nan and Pop were acting as protective parents. The zone manager wrote in a case note that she supported *"…that the risk for [Alex] has been significantly reduced and [he] is being parented by protective parents who are fully aware of and capable of carrying out their responsibility for [his] ongoing safety and well being"*.

Although the traditional adoption document obtained by Nan and Pop to assume permanent care of Alex was notarized by a lawyer, the DCSSD were not involved in his adoption. While the DCSSD have policies in place regarding kinship care, as per the *Protection and In Care Policy and Procedure Manual* (2011), and formal adoption by a relative as per the *Adoption Act* (SNL 2013), the *Department of Child, Youth and Family Services Review of the Adoption Act: Discussion Guide* (2013) states: *"While there is presently no ability under the Adoption Act to recognize a custom adoption in Newfoundland and Labrador, there has been an expressed desire to have an Aboriginal custom adoption clearly recognized"* (pp. 4-5).

Currently in Canada, provincial statutory legislation for custom adoption exists only in British Columbia, the Northwest Territories, Nunavut, and the Yukon (Poitras & Zlotkin, 2013). The *Labrador Innu Land Claims Agreement-In-Principle* (2011), which is applicable to this community, indicates in Section 30.11 that adoptions and child welfare are subjects of negotiation for Innu self-government; however, this agreement-in-principle has been in negotiations since 2008 and is not a legally binding document. The *Department of Child, Youth and Family Services Highlights of the Adoption Act Review Consultations* (2013) states that it was suggested to the DCSSD during public consultations that the Province *"should continue to explore the ability to recognize the practice of custom adoption, also known as traditional adoption, in legislation"*, through consultation with Aboriginal governments and organizations (p. 2). The ACY recommends that traditional custom adoption be effectively integrated into existing DCSSD legislation, policies and procedures to ensure safety and permanency planning for all children and youth throughout the Province.

RECOMMENDATION 6

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services), in consultation with Aboriginal governments, organizations and communities, propose changes to legislation that will recognize traditional custom adoption, and ensure the same standard of safety and permanency planning for all children and youth in the Province.

Challenges to service provision were also experienced by the relatives of Alex and Ben. Approximately one month after Ben's death, one of his relatives wrote a letter to the Minister of the DCSSD, expressing disappointment with the Department's handling of this case. In an interview with the Advocate, the relative commented further on her letter:

> *…if action was taken I think [Ben] would still be with us today because a lot of times when people call CYFS down here they don't seem to want to take action. You have to go in over and over again until action is taken… I personally feel that CYFS is just there to work and… not be empathetic to the children that are… in troubled homes* (Transcript of ACY Interview, 2016, pp. 13-14).

The Minister of the DCSSD advised the relative via letter that he would be willing to meet with her during his visit to the community in early 2014. In an interview with the Advocate, the relative confirmed that the Minister visited the community at that time; however, a meeting did not occur (Transcript of ACY Interview, 2016).

Article 2(1) of the UNCRC (1989) states:

> *States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.*

Every child and youth deserves appropriate and effective service delivery regardless of place of residence. However, when service provision is compromised as a result of contextual factors, those factors cannot be ignored. These factors also cannot be used to excuse ineffective and inappropriate service delivery. Government departments and agencies cannot be complacent in their provision of services to the

Labrador region. Government departments and agencies cannot accept lower standards for the children and youth residing in these communities. Traditional practices, such as custom adoption, should be respected by government departments and agencies; however, this cannot be done at the expense of the rights and safety of children in the Province, or without official legislation, policies and procedures in place. A needs assessment of the Labrador region must be completed, and government departments and agencies have to determine how they can meet the needs identified to ensure that every child and youth in Newfoundland and Labrador is receiving an acceptable standard of service provision regardless of where they live.

In interviews with the Advocate, several relatives of Ben expressed their dissatisfaction with the handling of this case by the government departments and agencies involved. One of them pleaded with the Advocate: *"…the system failed [Ben]… I struggle every day of my life with a broken heart. I ask you to help the children. Don't let them suffer like me"* (Transcript of ACY Interview, 2016, p. 36).

Based on the findings of this investigation, a recommendation would typically result that the DCSSD needs to complete comprehensive needs assessments of the services being provided in every remote and isolated community in the Province to identify existing deficiencies; and, develop and implement strategies to address the identified deficiencies in a timely manner. However, this recommendation was already made by the ACY in the investigative report *"A Tragedy Waiting to Happen"*, released in 2015. As per *The Advocate's Report on the Status of Recommendations 2015*, and based on the response from the DCSSD, the Advocate has determined that this recommendation is partially implemented. The Advocate will continue to monitor the status of this recommendation until it is implemented.

> ***It is incumbent upon the Department of Children, Seniors and Social Development, "in collaboration with local governments and other service providers, [to] complete comprehensive needs assessments of the services being provided in every remote and isolated community in the Province to identify existing deficiencies; and develop and implement strategies to address the identified deficiencies in a timely manner".***

Standard 3 of the *Standards for Cultural Competence in Social Work Practice* (Newfoundland and Labrador Association of Social Workers, 2016) states: "*Social workers seek to understand the values, beliefs, traditions and historical context of clients and incorporate this knowledge into social work assessments and interventions*"

(p. 5). For many years, the Labrador region has faced challenges that have been recognized by government departments and agencies; however, these challenges have not been adequately addressed. The DCSSD must take comprehensive action now to address these challenges in order to prevent further tragedy.

RECOMMENDATION 7

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services), in consultation with Aboriginal governments, organizations and communities:

(a) dedicate additional human resources of management and staff to the Labrador region to focus on ensuring that every child and youth throughout the Province receives the same standard of service.

(b) demonstrate improved service standards in the Labrador region through consistent monthly Quality Assurance Indicator Reports that equal those in all other regions.

Conclusion

The purpose of this investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services (renamed the Department of Children, Seniors and Social Development in August 2016), the Department of Health and Community Services (DHCS), the Department of Justice (renamed the Department of Justice and Public Safety in October 2014), the Labrador-Grenfell Regional Health Authority (LGRHA), and the Royal Canadian Mounted Police (RCMP) met the needs of Alex and Ben and whether their right to services was upheld. It was evident throughout the course of this investigation that, at times, the needs of these children were not met, their rights were not respected and their right to services was not upheld. Despite the involvement of professionals from the Department of Children, Seniors and Social Development (DCSSD), the DHCS, the Department of Justice and Public Safety (DJPS), the LGRHA, and the RCMP, the best interests of the children were not at the forefront of service provision.

Alex and Ben lived in a small community in Labrador, and while service providers worked and lived in close proximity to each other, collaboration and communication amongst these professionals was severely lacking. The RCMP failed to report serious child protection concerns to the DCSSD. The DCSSD failed to complete comprehensive assessments, with each child protection intervention for this family being treated in isolation of previous interventions. Previous file information was not reviewed by DCSSD staff upon receipt of new CPRs to ensure previous interventions had been adhered to by the children's caretakers prior to a new protection measure being put into place. Furthermore, DCSSD documentation was often incomplete and response to child protection concerns was delayed. Followup with this family was CPR-driven and case planning was nonexistent, largely due to a lack of resources and a lack of provincial DCSSD support for employees in the Labrador region.

There were also contextual issues identified in this community that need to be addressed, such as the prevalence of addictions and family violence concerns, and traditional custom adoption practices. Every child and youth in Newfoundland and Labrador has a right to receive services provided by the provincial government, and this right to services must be upheld regardless of where in the Province they live. Contextual issues can no longer be used by service providers as justification for acceptance of a lower standard of service provision for children and youth living in the Labrador region.

When Ben was born, despite the previously documented child protection concerns, he was left in the primary care of Mom and Boyfriend #2, without super-

vision from other relatives. Ultimately, Ben died while in receipt of services from government departments and agencies. Article 6(1) of the *UNCRC* (1989) declares that every child *"has the inherent right to life"*. Tragically, Ben's right to life was stolen at only four (4) months of age. His death could have been prevented if government departments and agencies had been working collaboratively and effectively to protect his rights and interests.

The Advocate for Children and Youth (ACY) has made 183 recommendations since 2006 in previous reports to government departments and agencies to improve and standardize services to children and youth throughout the Province. It has been over seven (7) years since the creation of the Department of Child, Youth and Family Services on March 9, 2009. It has been over four (4) years since the devolving of Child, Youth and Family Services from all four (4) Regional Health Authorities to the Department of Child, Youth and Family Services, with Labrador being the last in March 2012. The Department of Child, Youth and Family Services was renamed the Department of Children, Seniors and Social Development on August 17, 2016. It is incumbent upon the new Department of Children, Seniors and Social Development to implement change now before another child or youth suffers.

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their voices are heard. It is in keeping with this legislative duty that the ACY reports on an investigation and makes recommendations based on its findings. The goal is to prevent any reoccurrence of a similar matter. After completing a review or investigation under the *Child and Youth Advocate Act* (SNL 2001), the Advocate may, under section 15(1)(g), *"make recommendations to government, an agency of the government or communities about legislation, policies and practices respecting services to or the rights of children or youth"*. Overall, there are six (6) recommendations previously made in investigative reports by the ACY that are applicable to this case and highlighted throughout this report. The Advocate has determined that these recommendations are "Implemented" or "Partially Implemented", based on the responses from relevant government departments and agencies. However, despite actions taken by departments and agencies to address the previous recommendations, it is evident in this investigation that they continue to be an issue in practice. Additionally, seven (7) new recommendations have resulted from the completion of this investigation. Pursuant to Section 24(1) of the Act, the Advocate will continue to monitor and follow up on these recommendations until they are all appropriately addressed by the applicable government department or agency.

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Appendices

Appendix A

List of Acronyms used in this Report

Acronym	Official Title
ACY	Advocate for Children and Youth
COO	Chief Operating Officer
CPR	Child Protection Report
CRMS	Client Referral Management System
CSW	Community Service Worker
CYCP	Children and Youth Care and Protection
CYFS	Child, Youth and Family Services
DCSSD	Department of Children, Seniors and Social Development
DHCS	Department of Health and Community Services
DJPS	Department of Justice and Public Safety
FCAP	Family Centered Action Plan
LGRHA	Labrador-Grenfell Regional Health Authority
MOU	Memorandum of Understanding
RCMP	Royal Canadian Mounted Police
RMDM	Risk Management Decision-Making Model
RMS	Risk Management System
RNC	Royal Newfoundland Constabulary
SNL	Statutes of Newfoundland and Labrador
UNCRC	United Nations Convention on the Rights of the Child

Appendix B

Investigative Documents and Interviews

Investigative Documents:

Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services)

- Family's Protective Intervention File (2010 – 2014)

Department of Health and Community Services

- Labrador-Grenfell Regional Health Authority
  - Hospital File for "Alex" (2010 – 2014)
  - Hospital File for "Ben" (2013)
  - Community Clinic File for "Alex" (2010 – 2014)
  - Community Clinic File for "Ben" (2013)

Department of Justice and Public Safety (formerly the Department of Justice)

- Royal Canadian Mounted Police Records (2009 – 2014)

Investigative Interviews:

Investigative interviews were completed by the ACY with:

- Staff from the Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services)
- Relatives of Alex and Ben

Appendix C

Previous Recommendations

Overall, there are six (6) recommendations previously made in investigative reports by the ACY that are applicable to this case and highlighted throughout this report. The Advocate has determined that these recommendations are "Implemented" or "Partially Implemented", based on the responses from relevant government departments and agencies. However, despite actions taken by departments and agencies to address the previous recommendations, it is evident in this investigation that they continue to be an issue in practice.

1. ***It is incumbent upon the Department of Justice and Public Safety to "ensure that all Royal Newfoundland Constabulary and Royal Canadian Mounted Police employees are educated on their [legislative] duty to report" on an ongoing basis.***

2. ***It is incumbent upon the Department of Children, Seniors and Social Development, the Department of Health and Community Services, and the Department of Justice and Public Safety to "jointly develop and implement initiatives such as a multi-disciplinary committee in communities throughout all regions of the Province to ensure collaboration, communication and information sharing among service providers".***

3. ***It is incumbent upon the Department of Children, Seniors and Social Development to "ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to adhere to the documentation standards" on an ongoing basis.***

4. *It is incumbent upon the Department of Children, Seniors and Social Development to "ensure compliance with policy that all children in a family are physically and critically observed during a referral and during every home visit. Where appropriate, children must be interviewed – alone, if necessary".*

5. *It is incumbent upon the Department of Children, Seniors and Social Development to "ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to complete comprehensive assessments, interventions and followup in accordance with the Risk Management Decision-Making Model Manual (2013)".*

6. *It is incumbent upon the Department of Children, Seniors and Social Development, "in collaboration with local governments and other service providers [to] complete comprehensive needs assessments of the services being provided in every remote and isolated community in the Province to identify existing deficiencies; and develop and implement strategies to address the identified deficiencies in a timely manner".*

Appendix D

New Recommendations

Pursuant to Section 24(1) of the *Child and Youth Advocate Act* (SNL 2001), the Advocate will continue to monitor and follow up on the recommendations arising from this investigation until they are all appropriately addressed by the applicable government department or agency.

Recommendation 1

The Department of Justice and Public Safety (formerly the Department of Justice) ensure that the Royal Canadian Mounted Police and the Royal Newfoundland Constabulary review their current policy and process for completing and delivering Child Protection Reports (CPRs) to the Department of Children, Seniors and Social Development (DCSSD) (formerly the Department of Child, Youth and Family Services) to ensure:

(a) all members understand and comply with their legislative duty to report to the DCSSD any information that a child or youth is or may be in need of protective intervention.
(b) timely delivery of, and confirmation of receipt of CPRs by the DCSSD.

Recommendation 2

The Department of Children, Seniors and Social Development (DCSSD) (formerly the Department of Child, Youth and Family Services):

(a) review and revise legislation, policies and procedures as necessary to ensure direct and timely reporting to the DCSSD when a child is or may be in need of protective intervention, including the reporting of any unexplained deaths or critical incidents of children or youth, regardless of whether there are other minors in the household.
(b) ensure the provision of ongoing education regarding any revisions to their legislation, policies or procedures, both to the general public and to all government departments and agencies.

Recommendation 3

The Department of Children, Seniors and Social Development (DCSSD) (formerly the Department of Child, Youth and Family Services) and the Department of Justice and Public Safety (formerly the Department of Justice) ensure compliance with Policies 1.3 and 1.5 of the *Protection and In Care Policy and Procedure Manual* (2011), and Section 3.2 of both the *Memorandum of Understanding* (Royal Canadian Mounted Police, 2016) and the *Memorandum of Understanding* (Royal Newfoundland Constabulary, 2015), which require that:

(a) a joint decision be made by the DCSSD and the RCMP or the RNC (as applicable) as to the most appropriate means of investigation when a child has been physically or sexually abused.
(b) a joint investigation of alleged physical or sexual abuse of a child be conducted by the DCSSD and the RCMP or the RNC (as applicable).

Recommendation 4

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services) ensure compliance with sections 7(a) and 7(b) of the *Child, Youth and Family Services (CYFS) Documentation Guide* (2015) which contains protocol for documenting contact with supervisors and zone managers.

Recommendation 5

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services) review and revise their current policy and procedure pertaining to the verification of child protection concerns and the determination of a child's need for protective intervention, to ensure that:

(a) When a child or youth discloses physical or sexual abuse they receive a thorough medical examination.
(b) Any siblings of a child or youth who died under suspicious circumstances receive a thorough medical examination.

Recommendation 6

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services), in consultation with Aboriginal governments, organizations and communities, propose changes to legislation that will recognize traditional custom adoption, and ensure the same standard of safety and permanency planning for all children and youth in the Province.

Recommendation 7

The Department of Children, Seniors and Social Development (formerly the Department of Child, Youth and Family Services), in consultation with Aboriginal governments, organizations and communities:

(a) dedicate additional human resources of management and staff to the Labrador region to focus on ensuring that every child and youth throughout the Province receives the same standard of service.
(b) demonstrate improved service standards in the Labrador region through consistent monthly Quality Assurance Indicator Reports that equal those in all other regions.

ADVOCATE

CHILDREN YOUTH

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