THE ADVOCATE'S REPORT ON THE STATUS OF RECOMMENDATIONS

2014

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Message from the Advocate

I am very pleased to present "The Advocate's Report on the Status of Recommendations 2014". This is our first report and will continue to be updated and released publicly on an annual basis. As the first report, it includes all seven (7) investigations and four (4) reviews completed since 2006, including the resulting 173 recommendations. I have determined the status of each recommendation based on information reported by departments and agencies as of November 2014.

It is important to note that three (3) of the investigations, *Turner Review and Investigation, Lost in Transition,* and *An Investigation into Janeway Psychiatry Unit J4D Programs and Services* were completed prior to my appointment in September 2010. In reviewing the recommendations included in these reports, I have determined that there are a total of fourteen (14) recommendations which are no longer applicable in the *Turner Review and Investigation.*

This has been a very intensive process between my office and the various government departments and agencies. I would like to take this opportunity to acknowledge the ongoing cooperation that we receive from those involved and the commitment to enhancing services to children and youth of Newfoundland and Labrador.

Overall, the majority of these recommendations have been implemented and work continues to be done on completing the outstanding recommendations. These are commendable achievements which should lead to enhanced services being provided to children and youth throughout Newfoundland and Labrador.

However, it is of great importance that all government departments and agencies ensure that there are ongoing efforts to enable managers and staff to provide a standardized practice throughout our province. It is only through consistent and quality practices that our children and youth will receive the services they truly deserve.

Carol A. Chafe

Carol A. Chafe
Advocate for Children and Youth

Executive Summary

The mandate of the Advocate for Children and Youth (ACY) is to ensure that the rights and interests of children and youth are protected and advanced and that their views are heard and considered. The Office also provides information to stakeholders involved about the availability, effectiveness, responsiveness, and relevance of services to children and youth. The goal of any investigation or review is to help diminish the likelihood of similar situations in the future.

Under the authority of the *Child and Youth Advocate Act (SNL 2001)*, the Advocate has the ability to receive, review and investigate any matter relating to a child or youth. In doing so, the Advocate may make recommendations to government departments and agencies regarding legislation, as well as policies and practices that relate to the rights of children and youth. The Advocate also has the responsibly to inform the general public of these recommendations.

Since 2006, the ACY has completed a total of seven (7) investigations: *Turner Review and Investigation; Lost in Transition; An Investigation into Janeway Psychiatry Unit J4D Programs and Services; The Child Upstairs… Joey's Story; Turning a Blind Eye; Out of Focus; and Sixteen.* Four (4) case reviews were also completed: *Justice Complaint - Emergency Intake; Youth in Adult Holding Facilities: Case 1; Youth Corrections - Decisions Regarding Open Custody Placements; and Youth in Adult Holding Facilities:* Case 2.

These eleven (11) reports included a total of 173 recommendations, which have been made to various government departments and agencies including:

- **Department of Child, Youth and Family Services;**
- **Department of Health and Community Services;**
- **Department of Justice;**
- **Eastern Regional Integrated Health Authority; and**
- **Royal Newfoundland Constabulary.**

Some of these recommendations were made to, and required action by, multiple departments and agencies, resulting in a total of 184 responses.

In 2011, the Advocate established a follow-up process to ensure that all recommendations made in the Advocate's reports are implemented. This process involves communication between the Advocate and the relevant government departments and agencies. Updates are provided to the Advocate regarding the status of each recommendation. Once information is received, it is reviewed by the Advocate to

determine if the steps taken by the departments and agencies complete the recommendation or if additional information is required. This process continues until the Advocate determines that the recommendation has been completed.

The ACY reviewed all seven (7) sets of recommendations made in the investigations as well as recommendations made in the four (4) case reviews. Analysis of correspondence between the Advocate and the respective departments and agencies was also completed. This report provides an overview of the recommendations made in each investigation or review, as well as the status of each recommendation as of November 2014. In some instances, comments are provided to explain why a particular recommendation has yet to be implemented. Appendix B highlights the total number of recommendations made to each department or agency and the percentage of recommendations in each status category.

As of November 2014, the status of the 173 recommendations, based on 184 responses from the departments and agencies, are as follows:

- 66% - Implemented
- 14% - Implemented Through Alternative Measures
- 9% - Partially Implemented
- 3% - Not Implemented – Response Inadequate and Inappropriate
- 8% - No Longer Applicable

Recommendations resulting from future investigations and reviews will be highlighted in the Advocate's Report on the Status of Recommendations and released publically on an annual basis.

Introduction

Reviews and investigations are carried out pursuant to Section 15(1)(c) of *the Child and Youth Advocate Act (SNL 2001)*. The Advocate for Children and Youth (ACY) may review or investigate a matter on behalf of a child or youth, or group of them, whether or not a complaint has been made and may conduct an investigation if advocacy, mediation, or another dispute resolution process has not resulted in an outcome satisfactory to the Advocate.

The process for reviews and investigations is based on a comprehensive framework that may include: review of documents; interviews of individuals; analysis of facts; release of findings and recommendations to government, agencies and the public; and follow up respecting the recommendations. As necessary, the Advocate can subpoena individuals to be interviewed.

Upon completion of a review or investigation, the Advocate may make recommendations to the government departments and agencies involved, with the goal of preventing any reoccurrence of a similar matter. To ensure that government departments and agencies involved are held accountable for the recommendations made by the Advocate, a follow-up process was established in 2011. This report, the first Advocate's Report on the Status of Recommendations, outlines the monitoring activity by the Advocate as of November 2014 of the recommendations included in seven (7) investigations and four (4) case reviews completed since 2006.

With regard to confidentiality, Section 13 of *the Child and Youth Advocate Act (SNL 2001)* outlines the information the Advocate may disclose in a report. To meet the requirements of confidentiality, identification of those involved in the investigations or reviews is not provided, with the exception of *the Turner Review and Investigation*. Additionally, this report contains various acronyms in use throughout the system; official agency names and terminology are detailed in Appendix A.

Methodology and Terminology

In 2011, the Advocate for Children and Youth (ACY) initiated a follow-up process to ensure that all recommendations included in the Advocate's reports are implemented. This process involves communication between the Advocate and the relevant government departments and agencies. Once information is received, it is reviewed by the Advocate to determine if the steps taken by the departments and agencies complete the recommendation or if additional information is required. This process continues until the Advocate determines that the recommendation has been completed. Initially, the Advocate requested an update on a quarterly basis regarding all outstanding recommendations since 2006. The process has since evolved and the Advocate now requests an update annually to be published in an annual status report, the Advocate's Report on the Status of Recommendations.

For this first Advocate's Report on the Status of Recommendations, the relevant departments and agencies provided information regarding the status of each recommendation made by the Advocate since 2006. Conclusions made by the Advocate regarding the status of each recommendation are based on written responses received from government departments and agencies and any additional documents provided. The status of each recommendation has been classified by the Advocate into one of five (5) categories:

Implemented

The recommendation has been completed.

Implemented Through Alternative Measures

Alternative steps taken by the department or agency completes the recommendation.

Partially Implemented

Some action has occurred by the department or agency; however, there are still outstanding items that need to be addressed.

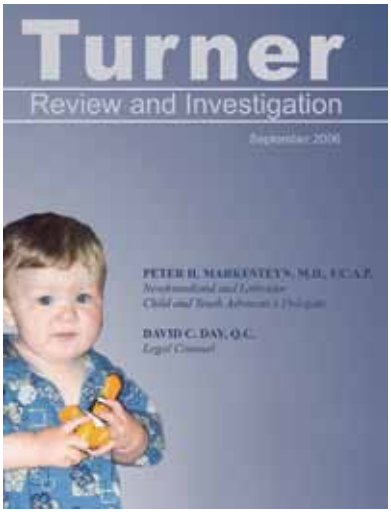
Not Implemented - Response Inadequate and Inappropriate

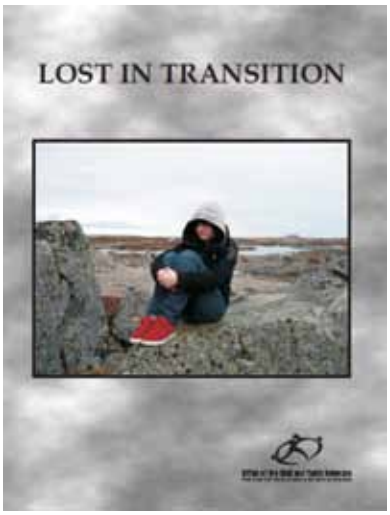
No action taken by the department or agency. As per Section 24 of *the Child and Youth Advocate Act (SNL 2001),* the Advocate may report this to Cabinet and may mention the report in the next annual report to the House of Assembly.

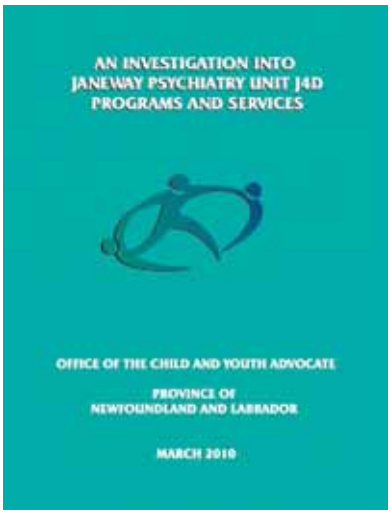
No Longer Applicable

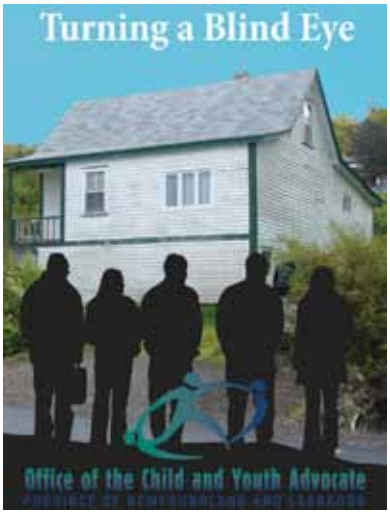
The Advocate has determined that the recommendation is no longer applicable.

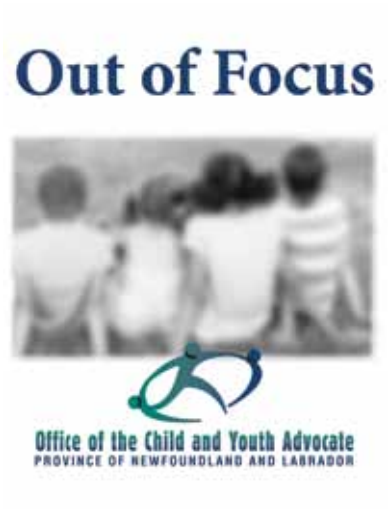
Investigations

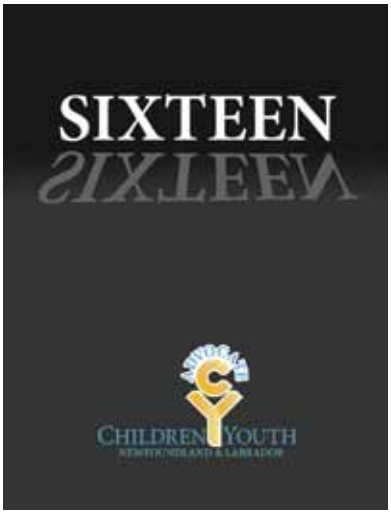


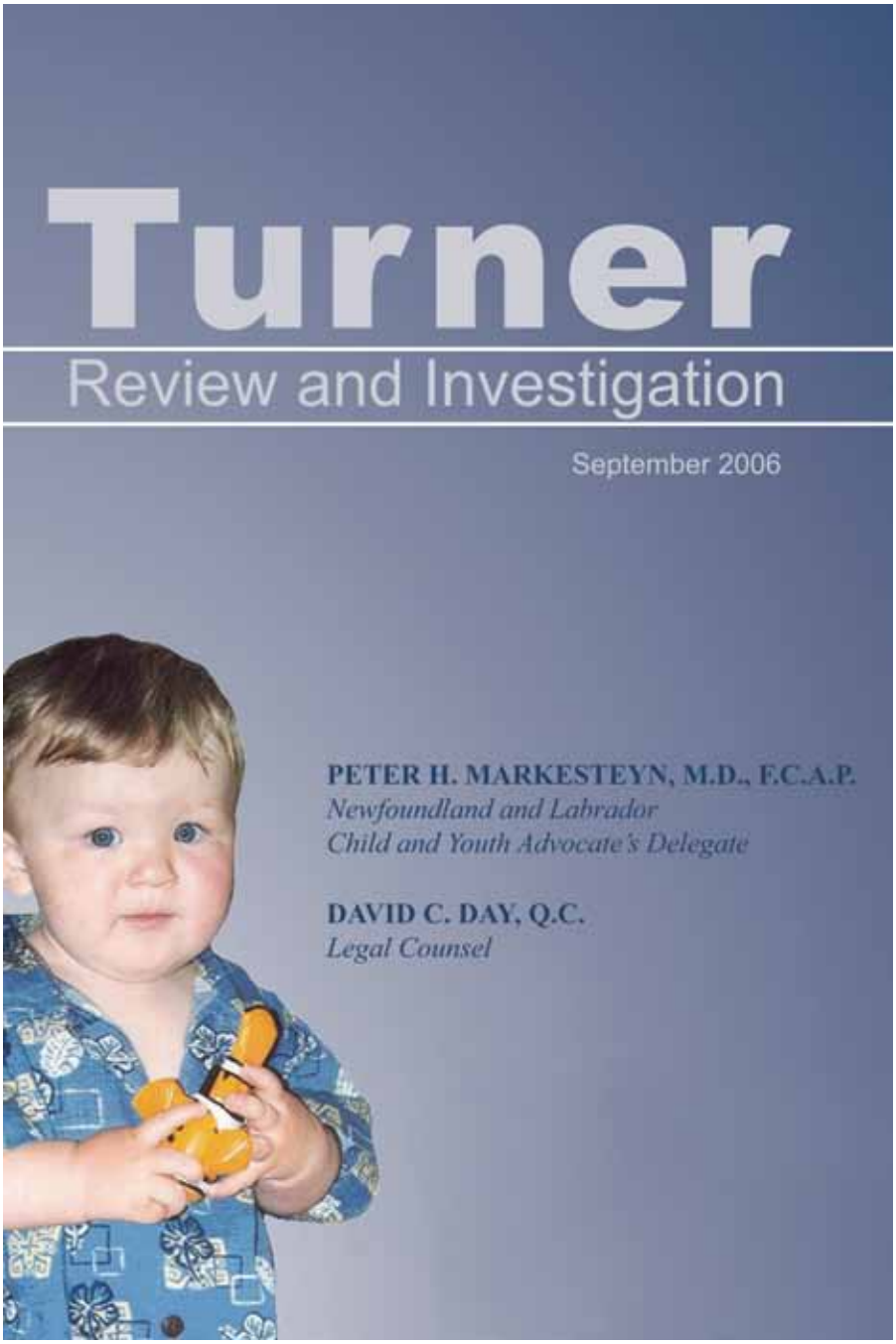











Turner
Review and Investigation
September 2006
PETER H. MARKESTEYN, M.D., F.C.A.P.
Newfoundland and Labrador
Child and Youth Advocate's Delegate
DAVID C. DAY, Q.C.
Legal Counsel

Turner: Review and Investigation
September 2006

Sometime after 3:00 a.m. on August 18, 2003, Dr. Shirley Turner committed suicide and murdered her thirteen (13) month old son, Zachary, when she entered the Atlantic Ocean with Zachary secured to her, drowning them both. When these deaths occurred, Dr. Shirley Turner was the subject of a legal proceeding in the Supreme Court of Newfoundland to extradite her from Newfoundland, Canada to Pennsylvania, United States of America, for trial on criminal charges. The charges alleged that approximately twenty one (21) months earlier on November 5, 2001 at Keystone State Park, Pennsylvania, Dr. Turner had murdered Zachary's father, Dr. Andrew Bagby, by shooting him five (5) times. The Review was conducted by Dr. Peter H. Markesteyn, at the request of the Child and Youth Advocate in 2003.

The findings and conclusions of the Turner Review were generated by Dr. Markesteyn following an investigation which included: determining the facts of, and surrounding, the death of Zachary Turner; and determining if Zachary's death was preventable. Between the occurrences of these senseless deaths, Dr. Turner frequently resorted to fables and fabrications to mislead and manipulate justice, community, health and financial service providers with whom she had contact.

The investigation of this tragedy resulted in an opportunity to make recommendations and changes to legislation, policy, standards and practices. The recommendations included proposed changes to the delivery of justice, community, health and financial services including changes to the operation of the Offices of the Medical Examiner and the Child and Youth Advocate. Dr. Markesteyn recommended that advocacy be used to deliver more focused, coordinated and proactive services. He also stated that if his recommendations were accepted, they may help prevent the deaths of other children and benefit all children at risk in Newfoundland and Labrador.

The Turner Review and Investigation resulted in a total of fifty-eight (58) recommendations to the Provincial Government of Newfoundland and Labrador. As a result of these recommendations, a five (5) member Ministerial Committee was established to review the recommendations following the release of the report. The Ministerial Committee on the Turner Recommendations is chaired by the Minister of the Department of Child, Youth and Family Services.

Status of Recommendations

Provincial Government of Newfoundland and Labrador

Implemented	31
Implemented Through Alternative Measures	11
Partially Implemented	2
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	14

RECOMMENDATIONS MADE TO THE PROVINCIAL GOVERNMENT OF NEWFOUNDLAND AND LABRADOR

Recommendation 6.1
Implemented

That either by legislation or directive from the Minister of Justice for Newfoundland, provision be made for informing potential sureties of their obligations should they enter into a Recognizance, and for qualifying them to serve as sureties (including provision of documentation verifying their financial capacity to serve as sureties); and that the legislation or Ministerial directive designate who will be responsible for discharging these duties.

Recommendation 6.2
Implemented

That before legislation is enacted or a Ministerial directive is issued, the Province shall consult with all Newfoundland Courts and obtain their views on the processes which will most probably facilitate informing potential sureties of their obligations under, and qualifying them to enter into, a Recognizance.

Recommendation 6.3
No Longer Applicable

That the Child and Youth Advocate, after having determined who is legally entitled to conduct a Judicial Review (acting along with the authority of the Federal Government), do so in order to fully examine how the justice system

functioned in relation to Dr. Shirley Turner and hence affected the rights and interests of Zachary Turner.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Advocate has no legal jurisdiction as bail reform falls under federal responsibility. ***The recommendation is no longer applicable.***

Recommendation 6.4
No Longer Applicable

That the Child and Youth Advocate report her findings to the House of Assembly and the Newfoundland public.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Advocate has no legal jurisdiction in this area. ***The recommendation is no longer applicable.***

Recommendation 7.1
Implemented Through Alternative Measures

That Section 14 of the *Child, Youth and Family Services Act* be amended, in order to ensure better protection of the child, by providing:

A child is in need of protective intervention where the child is, or is at risk of being

(a) physically harmed by the action or lack of appropriate action by the parent of a child;

(b) sexually abused or exploited either by the child's parent, or through lack of appropriate action by the parent of a child;

(c) emotionally harmed by the conduct of a parent of a child;

(d) physically harmed by a person and the parent of a child does not protect the child;

(e) sexually abused or exploited by a person and the parent of a child does not protect the child;

(f) emotionally harmed by a person and the parent of a child does not protect the child;

(g) in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;

(h) abandoned;

(i) left with no living parent or a parent is unavailable to care for the child;

(j) exposed to domestic or other violence

or,

(k) where the child

i. has been left without adequate supervision appropriate to the child's developmental level; or

ii. has allegedly, or whose parent has allegedly, killed or seriously injured another person or has caused serious damage to another person's property;

or

iii. on more than one occasion caused, or whose parent has caused, injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or living thing;

(l) the child is living in circumstances in which the child's safety, health or well-being otherwise is, or is at risk of, being endangered.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that changes to Section 14 in the *Child Youth and Family Services Act* were achieved through the proclamation of *the Children and Youth Care and Protection Act.*

Recommendation 7.2
Implemented Through Alternative Measures

That Section 15(4) be amended to add "to suspect or believe that a child is, or may be, in need of protective intervention."

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that *the Children and Youth Care and Protection Act* states that "a person who has information that a child is or may be in need of protection" must report it.

Recommendation 7.3
No Longer Applicable

That where the Advocate's Office is contacted by someone already receiving services under the *Child, Youth and Family Services Act*, the Advocate shall consider initiating a case conference with those mandated under the *Act*.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Advocate routinely engages in case conferencing with Child, Youth and Family Services related to children and youth under the authority of paragraph 15(d) of the *Child and Youth Advocate Act*. Accordingly, no changes were required to legislation or policies. ***The recommendation is no longer applicable.***

Recommendation 7.4
Implemented

That the policy manual be amended to include clear directions with respect to interpretation of "least intrusion" within the context that the best interests of the child are the paramount consideration under the Act. The amendments must provide clarification as to when the practice becomes a form of negligence and contributes to a child being "in need of protective intervention."

Recommendation 7.5
No Longer Applicable

That policy with respect to Section 10 Family Services be drafted and disseminated through in-service training to all personnel.

Comments: The response is accepted as adequate and appropriate as Section 10 Family Services is no longer applicable to DCYFS legislation. The Ministerial Committee reported that policy was developed to reflect the *Children and Youth Care and Protection Act* which removes Family Services as a separate intervention and includes it as part of services provided after the need for protective intervention is determined. ***The recommendation is no longer applicable.***

Recommendation 7.6
Implemented

That the Province develop and deliver mandatory, multi-disciplinary education and training (including but not limited to) from police, health care professionals, educators, lawyers and caregivers, the focus of which is investigation and assessment of the need for protective intervention on behalf of the child or children.

Recommendation 7.7
Implemented

That the investigation and assessment of the need for protective intervention, at all times, only be carried out by someone who has successfully completed the education and training proposed in Recommendation 7.6.

Recommendation 7.8
Implemented

That the definition of parental social history be expanded and the collection of a full social history, as outlined above, be mandatory not only for all child protection investigations and assessments, but also in long-term family services cases.

Recommendation 7.9
Implemented

That whenever a child comes to the attention of CYFS, if and when it is discovered that the child and/or family are involved with more than one professional or agency, a case conference involving all parties be a regular part of policy.

Recommendation 7.10
Implemented

That Social Work education and in-service training include coverage of the ability to override confidentiality, where a child's safety is at issue.

Recommendation 7.11
Implemented Through Alternative Measures

That the Director in Region of Child, Youth and Family Services be responsible for both line and legislated authorities, to ensure effective and efficient formal lines of accountability and communication.

Comments: The response is accepted as adequate and appropriate the Ministerial Committee reported that the creation of a line department with a new organizational structure addresses this issue throughout the province.

Recommendation 7.12
Implemented

That where there is an open file related to a matter under the *Child, Youth and Family Services Act,* all activities and/or discussions pertaining to it shall be recorded on that file, no matter at which level they occur.

Recommendation 7.13
Implemented

That when a child comes to the attention of CYFS as possibly in need of protection, the responsible worker be proactive in thoroughly and expeditiously seeking out and documenting all relevant sources of information.

Recommendation 7.14
Implemented

That policy be clearly established that part of the manager/supervisor's mandate and responsibility is to assist the worker carrying a file to establish long-term as well as short-term goals. The goals must be translated into specific tasks, with projected time lines attached, to enable periodic reviews of outcomes.

Recommendation 7.15
Implemented

That when a worker responsible for a child entitled to any service under the *Child, Youth and Family Services Act* is on leave, or absent for whatever reason, another worker must be assigned and the persons responsible for the child's care be informed of the name of that person to ensure constant monitoring of the child's safety and security.

Recommendation 7.16
Implemented

That mandatory in-service training which incorporates skills in caseload management and time management be developed and delivered to supervisory and direct service personnel.

Recommendation 7.17
Implemented

That all assessment workers be provided with ongoing and regularly scheduled in-service training on the meaning, the importance and the implementation of Policy Reference No. 02-02-03 (Coordinated Response).

Recommendation 7.18
Partially Implemented

That <u>all prior records</u> of child abuse and neglect, currently held on card indexes, be transferred to CRMS as soon as possible and be easily accessible to all CYFS staff.

Comments: In June 2012, the Ministerial Committee reported that this recommendation is implemented and ongoing due to the nature of the initiative. In March 2013, the Ministerial Committee reported that when the Department of Child, Youth and Family Services (DCYFS) was formed, 70,000 historical records were transferred to the storage facility. Since then, another 20,000 records have been

transferred and 15,000 records are searchable in the Client Referral Management System (CRMS). All records are searchable manually; however, the electronic transfer of files is expected to take three (3) to five (5) years to complete.

In March 2014, the Ministerial Committee reported that the DCYFS continues to make progress on the organization and management of index cards. Additionally, 185,000 index cards are stored at the records centre and 90% have been organized alphabetically for searching capability.

In November 2014, the Ministerial Committee provided an update indicating that approximately 225,000 index cards are now stored at the records centre and approximately 14,000 remaining index cards will be processed by the end of the fiscal year. Upon completion of the alphabetizing process, focus will move towards electronic transfer of records that is estimated to take three (3) to five (5) years to complete.

Completion of this recommendation is pending the completion of the electronic transfer of all records.

Recommendation 7.19
Partially Implemented

That all child abuse and neglect records include sufficient identifying information such that a name change will not result in their being overlooked.

Comments: In June 2012, the Ministerial Committee reported that this recommendation is implemented and ongoing due to the nature of the initiative. In March 2013, the Ministerial Committee reported that issues with child abuse and neglect records will be addressed through the new case management system which will be in place in 2015/2016. Currently, a report in CRMS can be used to follow up with social workers when identifying information is not complete.

In March 2014, the Ministerial Committee reported that the ISM project is a computerized case management system that will replace CRMS. The new system will support clinical practice and help ensure that standards are monitored.

In November 2014, the Ministerial Committee reported that all business requirements for the ISM project have been developed, a vendor has been identified, and the Office of the Chief Information Officer is in the process of finalizing the contract with the successful proponent.

Completion of this recommendation is pending the implementation of the ISM project.

Recommendation 7.20
Implemented

That all reports be founded on fact to promote evidence-based practice.

Recommendation 7.21
Implemented Through Alternative Measures

That a multi-disciplinary committee be struck, including representation from NLASW and the Province, to consult with the Memorial University School of Social Work (within three months of the release of these Findings) to investigate the feasibility of establishing a postgraduate diploma in child welfare and child protection.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the Ministerial Committee. These steps include: in-house training for social workers; the establishment of the DCYFS training unit; and collaboration between the DCYFS and Memorial University School of Social Work to enhance clinical supervision skills.

Recommendation 7.22
Implemented Through Alternative Measures

That the Memorial University School of Social Work give a seat on its Academic Council to the Province.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the Ministerial Committee including collaborative projects between the DCYFS and Memorial University School of Social Work.

Recommendation 7.23
Implemented

That caseload management and time management be included in course work at the Memorial University School of Social Work.

Recommendation 7.24
Implemented

That training on legislation, policy and procedures, and other appropriate in-servicing be updated semi-annually, and be the responsibility of the Provincial Director to ensure province-wide equity of opportunity.

Recommendation 7.25
Implemented

That regular performance evaluations be provided to all personnel using child-centered criteria to fit with the monitoring duties of the Provincial Director under section 5 of the *Child, Youth and Family Services Act*.

Recommendation 7.26
Implemented

That record keeping, beyond what may already be required by law or policy, be a fundamental obligation at all levels. Records to include purpose of the event, strategies used to achieve objectives, decisions made, directions given, those responsible for implementing actions, time lines, plans for follow-up and evaluation, and whether objectives have been achieved.

Recommendation 7.27
Implemented

That mandatory in-service training be developed in the theory and practice of documentation and record keeping.

Recommendation 7.28
Implemented

That there be a group supervision as well as individual supervision beyond what is already required by law or policy.

Recommendation 7.29
Implemented

That the *Child, Youth and Family Services Act* be amended to authorize the Supreme Court of Newfoundland and the Provincial Court of Newfoundland to receive, hear, decide and make orders resulting from applications for psychological and psychiatric assessments, and for health care treatment of persons having, or being considered by CYFS or the Court to have, custody of or access to children, as well as children themselves, where established to be relevant from the perspective of a child's best interests in either a CYFS investigation or in a proceeding under the *Act*.

Recommendation 7.30
Implemented

That reports of the course and results of assessment or treatment be provided to CYFS, the ordering Court and the persons assessed or treated, or their caregivers.

Recommendation 8.1
No Longer Applicable

That the Departments of Psychology and/or Psychiatry at Memorial University of Newfoundland (MUN) complete a psychological autopsy on Dr. Shirley Jane Turner.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that this recommendation has been assessed and not implemented as the mental health provider is no longer in the province therefore a meaningful psychological autopsy cannot be completed. ***The recommendation is no longer applicable.***

Recommendation 8.2
Implemented

That issues in Forensic Psychiatry be addressed not only in the education and training of general psychiatrists, but also be part of a continuing medical education program.

Recommendation 8.3
Implemented

That lectures in "Physicians and the Law" be offered at Memorial University's Faculty of Medicine, both at the undergraduate and postgraduate levels, such lectures to include coverage of child protection issues.

Recommendation 10.1
No Longer Applicable

That the decision to call a Medical Examiner's inquest in Newfoundland - a public inquiry into any death under its jurisdiction - lie with the Chief Medical Examiner and, when made, shall not be countermanded by the Provincial Government.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that issues of public safety and protection fall under the

Minister of Justice and Attorney General, including the authority to call an inquiry and any recommendation made by the Chief Medical Examiner respecting an inquiry has been followed. ***The recommendation is no longer applicable.***

Recommendation 10.2
No Longer Applicable

That the Chief Medical Examiner be appointed at arm's length from the Government of the Province and only be dismissed "for cause."

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Office of the Chief Medical Examiner operates independent of government and the position of the Chief Medical Examiner is at arm's length. ***The recommendation is no longer applicable.***

Recommendation 10.3
No Longer Applicable

That an investigation be conducted to determine the feasibility of appointing the Chief Medical Examiner with a non-tenured position at Memorial University, partially or wholly funded by the University; for which purpose, the portion of the budget of Memorial University provided by the Provincial Government would include funding adequate - in the judgment of the Department of Justice and Memorial University - for the operation of the Office of the Chief Medical Examiner.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Chief Medical Examiner is an employee of MUN and is positioned at arm's length from government. ***The recommendation is no longer applicable.***

Recommendation 10.4
Implemented Through Alternative Measures

That the Office of the Medical Examiner conduct an investigation into the death of all **children under two years old.**

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Provincial Government created the Child Death Review Committee which was established pursuant to amendments to the *Fatalities Investigations Act* in March 2014. The Child Death Review Committee will review cases involving deaths of children (under 19) which have been provided by the Chief Medical Examiner in accordance with sections 5-8 of the *Fatalities Investigations Act.*

Recommendation 10.5
Implemented

That, in order to reduce or eliminate any further speculation surrounding the circumstances of both Dr. Turner's and Zachary's deaths, full toxicological analyses be done on all the still preserved body fluids of both decedents.

Recommendation 10.6
Implemented Through Alternative Measures

That the Medical Examiner's Office establish and conduct Child Death Reviews, chaired by the Chief Medical Examiner, with multi-disciplinary membership including the Child and Youth Advocate.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Provincial Government created the Child Death Review Committee which was established pursuant to amendments to the *Fatalities Investigations Act* in March 2014. The Child Death Review Committee will review cases involving deaths of children (under 19) which have been provided by the Chief Medical Examiner in accordance with sections 5-8 of the *Fatalities Investigations Act.* While the Chief Medical Examiner is not the chair of the committee and the Child and Youth Advocate is not a member, the Advocate determined that these two aspects of the recommendation are no longer applicable.

Recommendation 10.7
Implemented Through Alternative Measures

That the Chief Medical Examiner be given the legislative authority to make recommendations to respective Ministers of the Crown (with opportunities to follow-up on these recommendations).

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Provincial Government created the Child Death Review Committee which was established pursuant to amendments to the *Fatalities Investigations Act* in March 2014. The Child Death Review Committee will review cases involving deaths of children (under 19) which have been provided by the Chief Medical Examiner in accordance with sections 5-8 of the *Fatalities Investigations Act.*

Recommendation 10.8
No Longer Applicable

That the Office of the Chief Medical Examiner seek accreditation by the National Association of Medical Examiners.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that due to the Royal College of Physicians and Surgeons Canada's new training standards in forensic pathology, there is no advantage for the Office of the Chief Medical Examiner to seek accreditation by the National Association of Medical Examiners. ***The recommendation is no longer applicable.***

Recommendation 12.1
Implemented

That the four regional integrated health authorities created by the *Regional Integrated Health Authorities Order* be specifically listed in the Schedule to the *Act*.

Recommendation 12.2
Implemented

That an amendment of the Schedule to the *Act* include the Chief Medical Examiner and any other agency of the Provincial Government likely to possess information relevant to the Advocate's responsibilities under the *Act*.

Recommendation 12.3
No Longer Applicable

That an amendment of the *Act* provide that the Chief Medical Examiner be obligated to perform, or cause to be performed, any feasible medical or laboratory analysis or other scientific procedure requested by the Advocate which the Advocate determines to be relevant to the Advocate's mandate under the *Act*.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported these amendments fall outside the Advocate's mandate and the Advocate does not have the expertise to make such a request. ***The recommendation is no longer applicable.***

Recommendation 12.4
Implemented Through Alternative Measures

That section 21 of the *Act* be amended to authorize the Advocate to require information by written interview instead of depending on voluntary participation.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that amendments to subsection 21(1.2) of the *Child and Youth Advocate Act* were passed by the House of Assembly in May 2008 to allow the Advocate to examine persons on oath or affirmation.

Recommendation 12.5
Implemented Through Alternative Measures

That the *Act* be amended to provide for addition of the following section:

(1) For the purposes of a review or an investigation, or a review and investigation, subject to subsection (4), the Child and Youth Advocate may

(a) summon by subpoena and enforce attendance of any witnesses;

(b) summon by subpoena and enforce production by witnesses of any records and other things, and provisions of answers to written questions.

(2) Where the Advocate exercises a subpoena power under subsection (1), a person or other legal entity who fails or refuses to;

(a) attend;

(b) answer questions;

(c) produce the records or other things in the person's custody or possession, or provide answers to written questions requested by subpoena;

is liable, on application by the Advocate or his or her Delegate to a Judge of the Trial Division of the Supreme Court of Newfoundland and Labrador, to be committed for contempt as if in breach of an order, judgment or other process of the Supreme Court of Newfoundland and Labrador.

(3) The Advocate shall issue a subpoena provided for in subsection (1) in the manner authorized by the *Public Investigations Evidence Act.*

(4) The Advocate shall not exercise the powers prescribed by subsection (1) unless the Advocate is unable, under section 21 or voluntarily, to obtain evidence, records and other things that the Advocate determines to be necessary to a review or investigation.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that amendments to subsection 21 of the *Child and Youth Advocate Act* were passed by the House of Assembly in May 2008 to grant the Advocate special investigatory powers to include the power to summon a witness.

Recommendation 12.6
Implemented Through Alternative Measures

That amendment of section 21 of the *Act* provide that, should the Advocate encounter any refusal or delay in response to an information request for documents or other things, verbal testimony, or written answers, the Advocate may apply for an information disclosure order from a Judge of the Provincial Court of Newfoundland on not less than seven days written notice of the application to the information source. And, that the Judge be given discretion to order payment by respondents to an application of some or all of the actual fees and disbursements incurred by the Advocate in making the application (depending on the outcome of the application).

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that no legislative amendments to the *Child and Youth Advocate Act* were necessary as failure to comply with a summons under section 21 of the legislation is already considered an offence and penalty subject to fine or term of imprisonment pursuant to section 31.

Recommendation 12.7
Implemented

That amendment of the *Act* provide that during a review or investigation by the Advocate, all information (oral and written) on which the Advocate relies for reports the Advocate may or must make under the *Act* to any department or scheduled agency of the Provincial Government or a community or community member, be received under oath or on affirmation.

Recommendation 12.8
No Longer Applicable

That regulations be enacted under the *Act* which prescribe forms to be employed by the Advocate in requesting and receiving information, e.g., documents and written interview answers.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported regulations are not required as the Advocate already has the ability to prescribe its own forms to be employed by the Office as they pertain to procedures pursuant to subsection 30(2). ***The recommendation is no longer applicable.***

Recommendation 12.9
Implemented

That the *Act* be amended throughout to express the mandate, powers and duties of the Advocate in terms of children, youth and families, including parents and other caregivers.

Recommendation 12.10
No Longer Applicable

That the *Act* be amended to provide that any question respecting the Advocate's jurisdiction to review or investigate any matter under the *Act* may be resolved by the Advocate's application to a judge of the Provincial Court of Newfoundland for a declaratory order determining the question of jurisdiction.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the Department of Justice did not proceed with this recommendation as no legislative amendments were needed to allow the Advocate to make application to the Supreme Court, Trial Division to seek declaratory relief on this issue. ***The recommendation is no longer applicable***

Recommendation 12.11
No Longer Applicable

That section 15(1)(c) of the *Act* be amended to enable the Advocate to dispense with advocacy, mediation or other dispute resolution process, and any other precursor to investigating a matter where, in the Advocate's opinion, those mechanisms are impracticable.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that the steps the Child and Youth Advocate may take are clearly outlined in sections 3 and 5 of the *Child and Youth Advocate Act*. ***The recommendation is no longer applicable.***

Recommendation 12.12
No Longer Applicable

That section 24 of the *Act* be amended to state that the types of steps the Advocate may propose include, although not be confined to:

(a) enactment of new legislation and amendment of existing legislation;

(b) development of policies, standards and practices, and alterations to existing polices, standards and practices;

(c) development of new programs and reform of existing programs;

(d) review, modification and reversal of particular program services delivery decisions;

(e) rectification of omissions in program services delivery;

(f) provision for reasons for decisions;

(g) allocation and reallocation of program service centres and providers;

(h) development of professional and non-professional employee training, and modification of existing training;

(i) conduct of additional investigations;

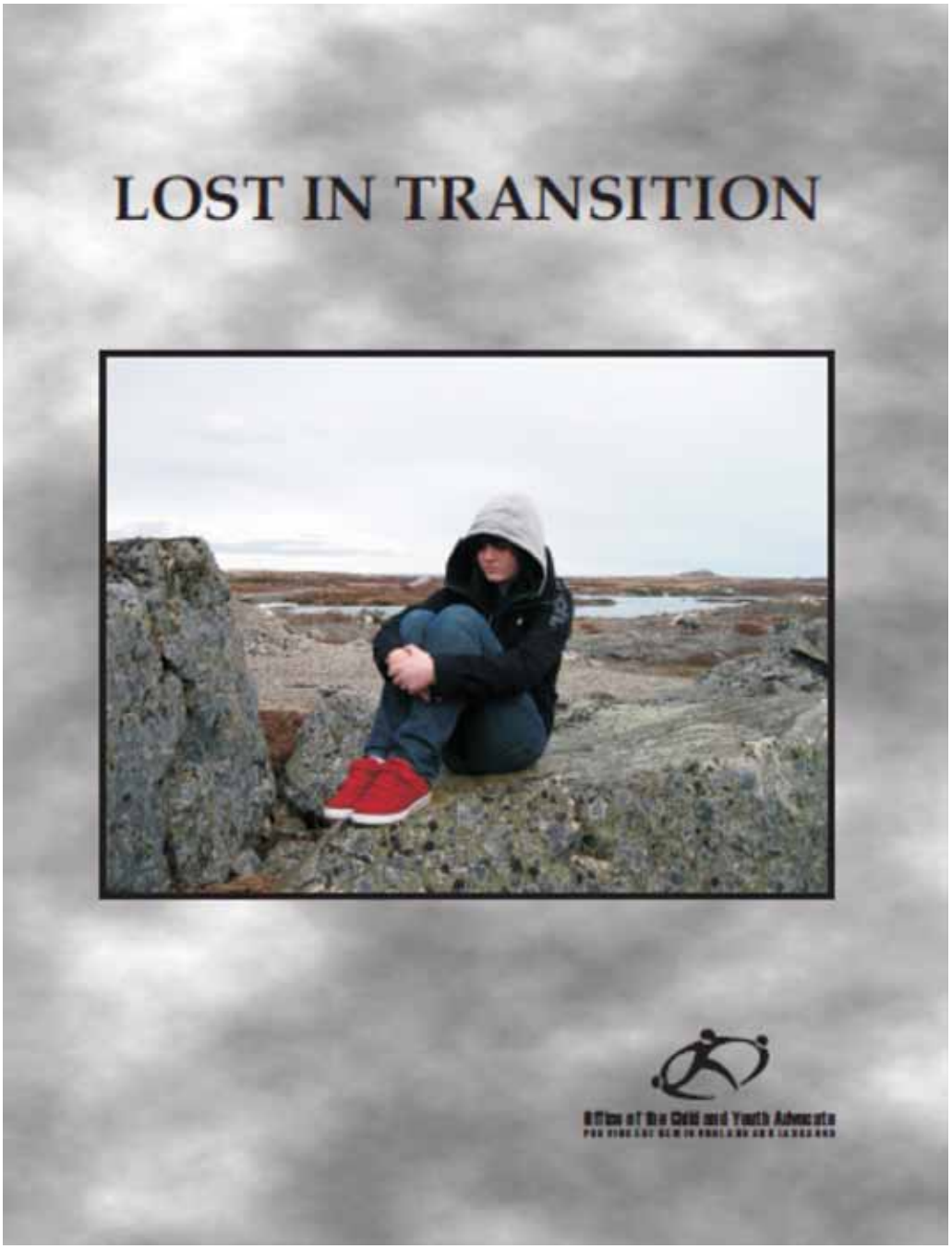
(j) "no name/no blame" monitoring and auditing of professional and non-professional program services delivery personnel; and

(k) resolution of circumstances which are unreasonable, unjust, oppressive or discriminatory.

Comments: The response is accepted as adequate and appropriate as the Ministerial Committee reported that steps the Advocate may take are outlined in Section 3 and Section 5 of the legislation and this amendment would not enhance achievement of the mandate. ***The recommendation is no longer applicable.***

Recommendation 12.13
Implemented

That section 17(1) of the *Act* be amended by deleting "*Young Offenders Act*" and substituting "*Youth Criminal Justice Act.*"


LOST IN TRANSITION

Lost in Transition: A Review of the Transitioning of Children and Youth in Care May 2009

RD had been in foster care since he was three (3) months old. He had been moved in and out of care many times, but had been happy in his placement for four (4) years. However, the foster parents and Child, Youth and Family Services (CYFS) social workers frequently disagreed on issues pertaining to his care.

One day RD's social worker came to his foster home, under the pretext of taking him to McDonald's for lunch and a visit with his sister. Instead, she took him to the CYFS office where she informed him that he would not be returning home. He was told he would be moving immediately to a new foster home. He had no prior notice that this change was occurring. He was told that his belongings would be packed and sent to him. He would have to change schools, leave his friends and start over. RD was thirteen (13) years old.

Each year, children and youth who cannot be cared for by their parents or guardians are placed in the care of Child, Youth and Family Services. These children and youth, the most vulnerable in our society, are referred to as being "In Care".

The Child and Youth Advocate undertook this review after hearing a number of accounts by children and youth related to transitions they experienced while In Care. It was not possible to convey the trauma they had experienced; however, it was possible to give voice to their experiences and examine the circumstances which lead to failures to support them and make recommendations to improve the situation.

The review examined the movement or transitioning of children and youth In Care, and was motivated by reports of situations where children and youth had been moved from one placement to another with no prior notice or involvement. These moves often necessitated a change in schools, loss of friends and loss of established supports. In many cases, starting over involved a child or youth not having their personal belongings.

In order to gain a comprehensive and balanced picture of the circumstances surrounding transitioning of children and youth In Care, information was sought from a variety of sources. A review of existing policies and legislation helped to establish the expected standard of care for the In Care Program. Data collection involved engaging children and youth in discussions regarding their experiences. The perspective of caregivers, service providers, and regional and departmental decision makers was also obtained to help understand the challenges and identify the remedial actions required to address them.

Lost in Transition included a total of fifteen (15) recommendations made to the Department of Child, Youth and Family Services (DCYFS).

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	10
Implemented Through Alternative Measures	5
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Implemented

That sufficient resources be allocated to address the recruitment, retention and continuing education requirements of social workers assigned to the In Care Program within the province.

Recommendation 2
Implemented

That training be provided to caregivers in such areas as attachment, grief and loss to assist them to better understand the behaviour of the children and youth in their care.

Recommendation 3
Implemented Through Alternative Measures

That policy and strategies be developed to increase the recruitment and retention of caregiver placements. Such strategies and policy should include annual indexing of the rates paid to caregivers for cost of living increases.

Comments: The response is accepted as adequate and appropriate as the DCYFS reported that the rates paid to foster parents increased significantly in April 2010 with the varying rates established to recognize the costs of providing care to chil-

dren of differing ages in different regions of the province. In addition, it was reported that the continuum of care strategy will enhance placement options for children and youth in care and provide better support to existing and new homes.

Recommendation 4
Implemented Through Alternative Measures

That the *Child Youth and Family Services Act*, SNL. 1998, c. C-12.1, be amended to include provision for the mandatory reporting by the directors in the regions to the provincial director of Child, Youth and Family Services whenever the regions are unable to deliver services and programs to children and youth In Care in accordance with the standards established by policy and legislation.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the DCYFS. These reported steps include: regional managers maintaining oversight of their regions and responsibility to ensure that practice is consistent with policy and legislation; when issues are identified, regional managers bring them to the Assistant Deputy Minister; the Act requires the Provincial Director of In-Care and Protection to evaluate and monitor adherence to policies, programs and standards; and the Department is establishing a quality assurance division to develop and implement a quality improvement program.

Recommendation 5
Implemented

That regional managers complete file audits every 90 days to ensure compliance with program and recording policies.

Recommendation 6
Implemented

That a checklist of all required file documentation for children and youth In Care be developed in CRMS and a print out placed at the beginning of each file. The checklist should include a complete list of the documents required, e.g., Life Book, Plan of Care, Special Needs Assessment, ISSP, and a log of visits completed, updates to reports, etc.

Recommendation 7
Implemented

That policy be developed to include the recording in CRMS of the monthly visitation with the child or youth and monthly review of the Plan of Care.

Recommendation 8

Implemented Through Alternative Measures

That policy be developed which requires within 24 hours, an update to the Plan of Care in CRMS and in the file, whenever a transition occurs and such update shall include the reasons for the transition.

Comments: The response is accepted as adequate and appropriate as the DCYFS reported that documentation policy and guidelines came into effect July 2012 and are for use in all child protection and in care programs to ensure timely and effective documentation. The Documentation Guide (2012) states that case notes shall be completed as soon as possible but no later than twenty-four (24) hours after an investigation and no later than five (5) days for all other ongoing DCYFS involvement.

Recommendation 9

Implemented

That policy be developed which requires the participation of a child or youth in all decisions related to a transition. In situations where a child or youth has not participated in the transition planning, the social worker shall document, within 5 days, both in CRMS and in the file, the reasons why the child or youth did not participate.

Recommendation 10

Implemented

That policy be developed which contains clear guidelines regarding the supports to be provided to a child or youth and caregiver(s) pre-transition, transition and post-transition. The social worker shall document in CRMS and in the file the supports offered and/or provided to a child or youth or caregiver(s) during the transition process within 7 days of the offer of supports and/or receipt of the supports by the child, youth or caregiver(s).

Recommendation 11

Implemented Through Alternative Measures

That policy be developed which requires that all personal belongings of a child or youth who is transitioned accompany the child or youth and that, within 24 hours of the transition, the social worker shall document in CRMS and record in the file, verification that the personal belongings accompanied the child or youth or an explanation as to why this did not occur, including the plans to deliver these items to the child or youth.

Comments: The response is accepted as adequate and appropriate as the DCYFS reported that Policy 3.7 Placement Procedures has been recently amended to provide clear direction respecting a child or youth's personal belongings to accompany them following a transition. It was reported that the Documentation Guide (2012) states that case notes shall be completed as soon as possible but no later than twenty-four (24) hours after an investigation and no later than five (5) days for all other ongoing DCYFS involvement.

Recommendation 12
Implemented

That policy be developed that social workers document throughout the pre-transition, transition and post-transition phases the changes which will occur or have occurred in the life of the child or youth as a result of the transition. Documents shall include changes related to contact with family, loss of belongings, access to professional services, changes in schools and extracurricular activities, and separation from pets.

Recommendation 13
Implemented

That policy be developed to ensure access for children and youth In Care to alternative forms of support, services and therapy (such as animal, art and music therapy) and extracurricular activities.

Recommendation 14
Implemented Through Alternative Measures

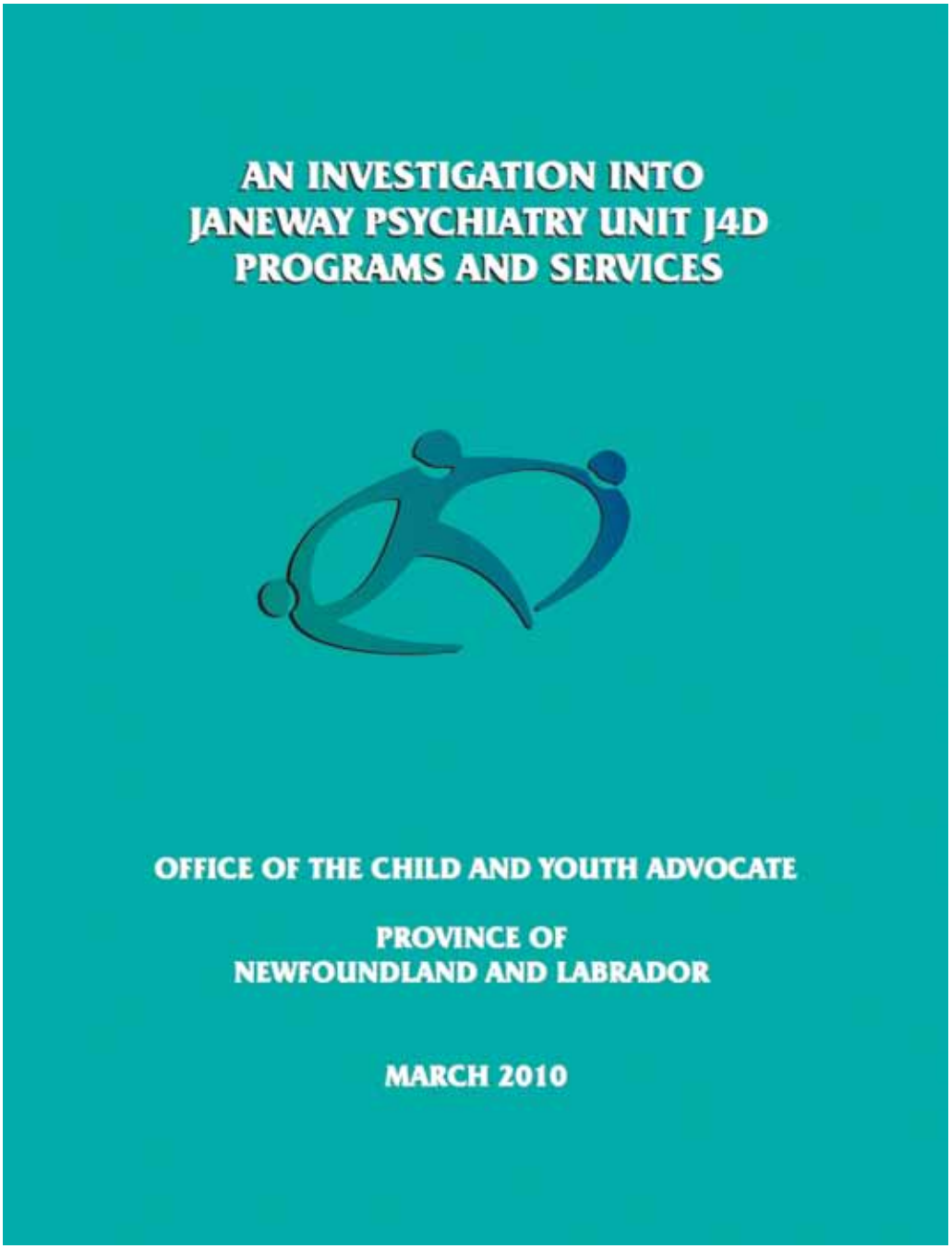
That policy be developed which requires social workers to identify children and youth who have an established relationship with a family pet. In such cases, social workers shall make every effort to ensure continued contact by the child or youth with the pet and shall document all such efforts and the access by the child or youth to the pet.

Comments: The response is accepted as adequate and appropriate as the DCYFS reported that the best interests principle as legislated in the new *CYCP Act* and supported in the DCYFS policies, highlights the importance of stability, continuity for children and youth, and the importance of maintaining connections to family, significant others, and community. Access to family and significant persons in the life of a child/youth are highlighted in the Plan for the Child and the In Care Progress Report. It is an expectation that all transitions for children/youth be carried out in the least intrusive manner, balancing the safety of the child/youth with the importance of stability and continuity.

Recommendation 15

Implemented

That policy be developed regarding the involvement of caregivers in decisions related to the pre-transition, transition and post-transition process.


AN INVESTIGATION INTO
JANEWAY PSYCHIATRY UNIT J4D
PROGRAMS AND SERVICES
OFFICE OF THE CHILD AND YOUTH ADVOCATE
PROVINCE OF
NEWFOUNDLAND AND LABRADOR
MARCH 2010

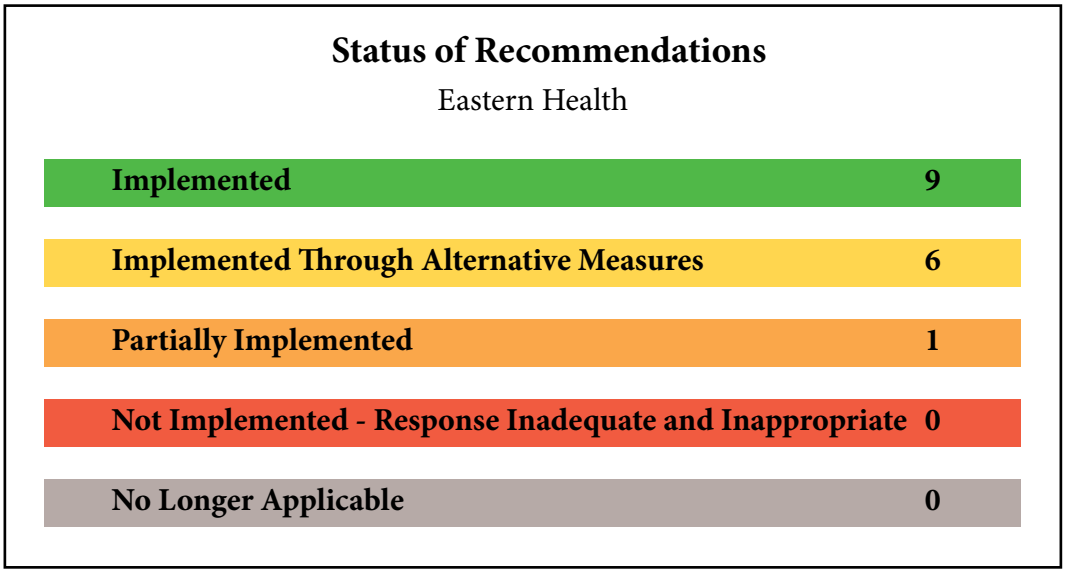
An Investigation into Janeway Psychiatry Unit J4D Programs and Services March 2010

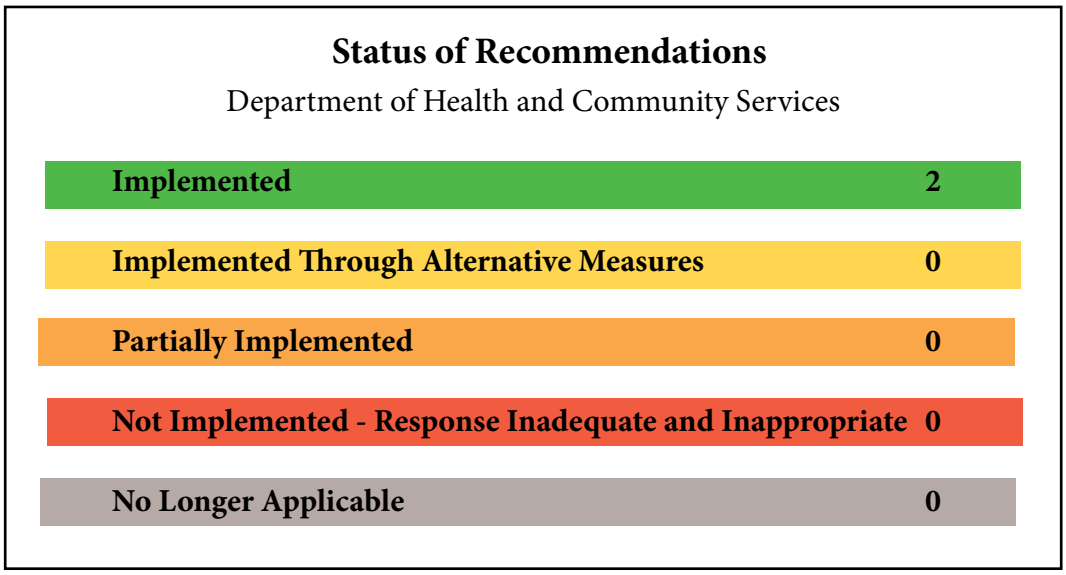
In 2008, the Child and Youth Advocate undertook this investigation after learning that the Eastern Regional Integrated Health Authority (Eastern Health) had made a decision to shut down the Janeway Psychiatry Unit J4D, the only inpatient facility in the province to service children and youth with mental health illnesses. This decision resulted in the transfer of two (2) adolescent inpatients from the inpatient mental health unit at the Janeway to the adult Waterford Hospital. The Royal Newfoundland Constabulary (RNC) and nursing staff provided safe escort of these certified patients.

The investigation covered a time period of January 1, 2008 to December 31, 2008. Analysis of files of all patients assessed by or admitted to Janeway Psychiatry Unit J4D for reasons of self-harm, suicide risk and/or behaviour which presented risk of harm to others was completed.

The Advocate gathered pertinent facts and highlighted necessary changes that would prevent the reoccurrence of similar events. The investigation included interviews with Eastern Health staff, patients and family members, and a documentation review. The analysis provided insight and perspective on how Unit J4D functioned during 2008 and revealed a unit in crisis and in need of intervention.

The Investigation Into Janeway Psychiatry Unit J4D Programs and Services included a total of eighteen (18) recommendations; sixteen (16) were made to Eastern Health and two (2) to the Department of Health and Community Services (DHCS).


Status of Recommendations
Eastern Health
Implemented 9
Implemented Through Alternative Measures 6
Partially Implemented 1
Not Implemented - Response Inadequate and Inappropriate 0
No Longer Applicable 0


Status of Recommendations
Department of Health and Community Services
Implemented 2
Implemented Through Alternative Measures 0
Partially Implemented 0
Not Implemented - Response Inadequate and Inappropriate 0
No Longer Applicable 0

RECOMMENDATIONS MADE TO EASTERN HEALTH

Recommendation 1
Implemented

That Eastern Health revise policies so that they are relevant to the patient population it serves.

Recommendation 2
Implemented

That Eastern Health ensure consistent interpretation and implementation of policies and procedures.

Recommendation 3
Implemented

That Eastern Health ensure:

(a) patients and families have a clear understanding of the treatment plan, their role in the plan, and who is responsible to monitor and implement the plan.
(b) patients and families receive written documentation at the end of each ICP meeting.

Recommendation 4
Implemented Through Alternative Measures

That Eastern Health designate a case manager within the treatment team to be responsible for coordinating, monitoring and managing a patient's individual treatment.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the Eastern Health. These reported steps include: utilizing the Collaborative Problem Solving Model; utilizing the Eastern Health Model of Nursing Care on J4D; the current patient care coordinator position fulfilling the coordinating role of patient care; and hiring additional child and youth care workers.

Recommendation 5
Implemented

That Eastern Health conduct a needs assessment to expand J4D's programming component and ensure that all elements add therapeutic value to a patient's individual treatment plan.

Recommendation 6
Implemented Through Alternative Measures

That Eastern Health establish a *communications liaison* position to manage all aspects of each patient's care on the Unit. This would include overseeing the admission process, education, policy and procedure adherence, team cohesiveness, family involvement, etc.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by Eastern Health. These reported steps include: utilizing the Collaborative Problem Solving Model; utilizing the Eastern Health Model of Nursing Care on J4D; the role of the current patient care coordinator position; the role of the advance practice nurse; and the development of a parent handbook.

Recommendation 7
Implemented

That Eastern Health immediately conduct a needs assessment to address the physical limitations of the Unit layout.

Recommendation 8
Implemented Through Alternative Measures

That Eastern Health create a secure outdoor space that J4D patients can access regardless of acuity levels.

Comments: The response is accepted as adequate and appropriate as Eastern Health reported they continue to explore the possibility of creating an outside space but there are limitations within the existing space. Eastern Health reported that every opportunity is taken to take the children off the unit and J4D patients can access the Maple Leaf Garden under staff supervision regardless of acuity levels.

Recommendation 10
Implemented Through Alternative Measures

That Eastern Health address salary issues to ensure that the Unit is staffed with appropriately trained and compensated individuals.

Comments: The response is accepted as adequate and appropriate as Eastern Health provided a summary of training available to staff and advised that salary issues must be addressed through the collective bargaining process.

Recommendation 11
Implemented Through Alternative Measures

That Eastern Health designate J4D as a specialized psychiatric Unit.

Comments: The response is accepted as adequate and appropriate as Eastern Health reported that J4D does provide specialized service in child and adolescent psychiatry. Eastern Health also reported that registered nurses working on J4D are encouraged to complete the Mental Health Nurse Certification Program available through the Canadian Nurses Association.

Recommendation 12
Implemented

That Eastern Health revise J4D's constant care procedure and establish this in policy to better ensure safety of patients and staff.

Recommendation 13
Partially Implemented

That Eastern Health establish a process to address inappropriate admissions.

Comments: In June 2012, Eastern Health reported that J4D has an admissions committee that reviews requests and evaluates appropriateness of admissions, its goals, and the ward milieu. Eastern Health was in the process of drafting admissions criteria which was to be shared with regional/provincial stakeholders. Eastern Health implemented a service to the Janeway Emergency Department whereby a nurse from J4D will go to the Emergency Room to assess individuals presenting with mental health concerns. The nurse will review community-based options with the youth if an admission is not necessary.

In March 2013, Eastern Health provided a copy of the draft Admissions Criteria Policy and reported they were seeking feedback on the draft from the other regions.

In November 2014, Eastern Health reported that it is anticipated that the admissions policy will be approved by the end of November 2014.

Completion of this recommendation is pending finalization of the Admission Policy.

Recommendation 15
Implemented Through Alternative Measures

That Eastern Health develop a list of approved facilities and establish a formalized process for out-of-Province placements within child and adolescent mental health.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps. Eastern Health reported the recent establishment of two (2) treatment centres in Grand Falls Windsor (for youth with addictions) and in Paradise (for youth with complex mental health needs). If it is determined that neither facility is able to meet the needs of a young person then a referral for services outside of the province may be considered. Eastern Health reported that a specific list has not been developed as each referral would be matched with the most appropriate out-of-province service.

Recommendation 16
Implemented

That Eastern Health develop a communications strategy to ensure better management of the Unit and a cohesive team approach.

Recommendation 17
Implemented

That Eastern Health develop a plan for intra-hospital transfers in the area of child and adolescent mental health.

Recommendation 18
Implemented

That Eastern Health provide all staff on J4D with opportunities to come to terms with the events that occurred on the Unit during 2008 and to move forward as professionals.

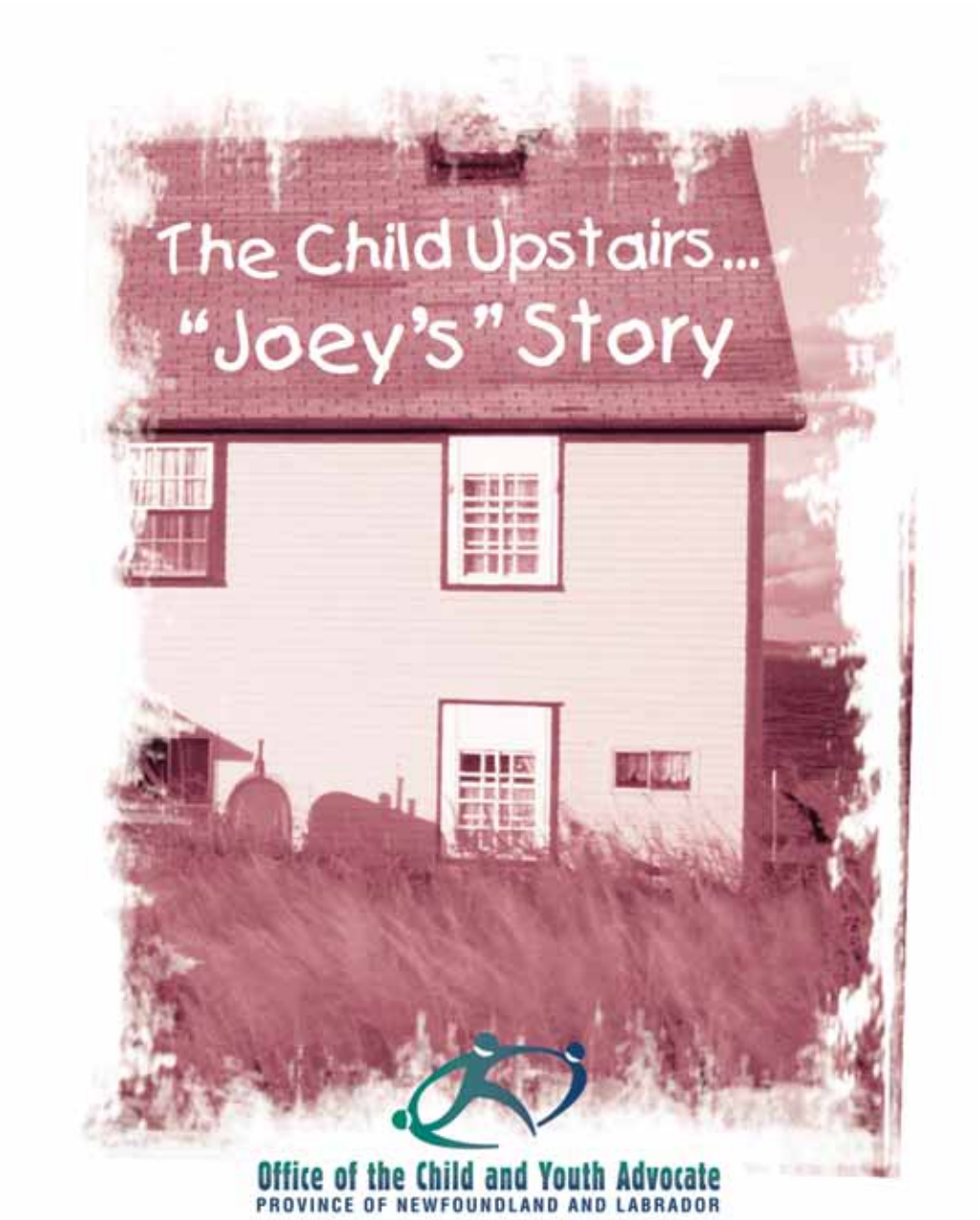
RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 9
Implemented

That the Provincial Government maintain child and adolescent mental health as a budget priority.

Recommendation 14
Implemented

That the Provincial Government, in consultation with youth-serving agencies, develop a strategy to address the gaps in community wraparound services.


The Child Upstairs...
"Joey's" Story
Office of the Child and Youth Advocate
PROVINCE OF NEWFOUNDLAND AND LABRADOR

The Child Upstairs… Joey's Story
August 2011

In 2006, the Child and Youth Advocate undertook this investigation after learning of a court sentence imposed on Joey's parents for failure to provide the necessities of life. While all four (4) children in this family were apprehended, it was Joey, the youngest, who was deemed to be in the most severe condition.

The events of this case span a thirteen (13) month period wherein several professionals had contact with the family on a number of occasions. If enhanced recordkeeping and information sharing had been cultivated, Joey's situation could have been preempted well before his admission to hospital.

The primary deficiencies identified in the system were:

- non-adherence to policy or lack of policies/protocols;
- lack of communication and collaborative practice between the stakeholders; and
- an ambiguous records management system and lack of documentation.

The Advocate gathered pertinent facts and highlighted necessary changes that would prevent the reoccurrence of such a case. This investigative report provided an in-depth overview of the case as well as recommendations including the development of definitive policies and protocols, systematic recordkeeping, required information sharing, and enhanced collaborative approaches. It was believed that addressing these critical issues would provide the necessary safeguards to ensure a child's safety.

The Child Upstairs… Joey's Story included a total of nine (9) recommendations; four (4) of these recommendations were made to more than one department and agency. Five (5) recommendations were made to the Department of Child, Youth and Family Services (DCYFS); one recommendation was made to both the Eastern Regional Integrated Health Authority (Eastern Health) and the Department of Health and Community Services (DHCS); and three (3) recommendations were made to all three (3) departments and agencies involved.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	5
Implemented Through Alternative Measures	0
Partially Implemented	1
Not Implemented - Response Inadequate and Inappropriate	2
No Longer Applicable	0

Status of Recommendations

Eastern Health

Implemented	4
Implemented Through Alternative Measures	0
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

Status of Recommendations

Department of Health and Community Services

Implemented	4
Implemented Through Alternative Measures	0
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Partially Implemented

All historical documentation held by CYFS must be inputted to the CRMS. The 'All Program Search' and cross referencing functions must operate at optimal levels.

Comments: In June 2012, the DCYFS reported that all inactive files were received at the records centre (except files from Labrador). As files are received, they are entered in CRMS which allows the file to be quickly located. A total of 91,000 inactive files were transferred and processed so they are searchable. In addition, the DCYFS reported that an inventory project involving child abuse and neglect records is ongoing and the plan was to have all information on index cards electronically searchable by 2014. It was reported that the 'All Program Search Function' in CRMS is available to social workers and a draft policy providing direction on the use of this function was being reviewed.

In March 2013, the DCYFS reported that it was expected that all files would be transferred and searchable by 2014. The alphabetizing of index cards was ongoing and additional index cards were located. Alphabetizing of index cards was 82% complete. The 'All Programs Search Function' policy was finalized February 2013 and was circulated to staff.

In March 2014, the DCYFS reported that work on the transferring of inactive files was completed. As new inactive files become due for storage, they are transferred from the regions to the records centre. A transfer schedule was developed to assist regions. Inventory capture is in progress; when a search is required, electronic and card indexes are reviewed to determine if a file exists. The DCYFS reported that given the volume of records, the inventory process is expected to take three (3) to five (5) years to complete.

In November 2014, the DCYFS provided an update indicating that approximately 225,000 index cards are now stored at the records centre and approximately 14,000 remaining index cards will be processed by the end of the fiscal year. Upon completion of the alphabetizing process, focus will move towards electronic transfer of records that is estimated to take three (3) to five (5) years to complete.

Completion of this recommendation is pending the completion of the electronic transfer of files.

Recommendation 2

Not Implemented Response Inadequate and Inappropriate

Policy must be developed by CYFS to direct that all children in a family be critically observed during a referral and during every home visit.

Comments: In June 2012, the DCYFS reported that new child protection legislation and new policies and procedures were implemented. Section 14 of the *Children and Youth Care and Protection (CYCP) Act* provides social workers with the authority to observe children, and requires those entrusted with a child's care to identify a child for an interview or observation, when requested. Previously, social workers only had the authority to interview children.

The DCYFS further reported that Risk Management System (RMS) standards and policy require that all children in a family be observed or interviewed during a protection investigation. The frequency of interviews or observations of children receiving ongoing protective intervention services is linked with risk to the child and interventions to mitigate the risk. Children may be observed or interviewed at home or in the community (school or child care agency). This means that children may not be interviewed or observed during every home visit.

While policy requires all children in a family be observed during an investigation, in March 2013 and November 2014 the DCYFS stated there is no plan to develop policy requiring every child be critically observed during every home visit. It was reported that the frequency of observations and interviews that are part of ongoing protection work is dependent on the identified level of risk and the interventions in place to mitigate the risk of harm.

This response to Recommendation 2 is not accepted and is considered inadequate and inappropriate as the DCYFS reported they do not intend to develop policy requiring all children in a family be critically observed during every home visit. It was evident in this investigation that had the child been critically observed during home visits, identification of neglect would have occurred earlier; therefore, the Advocate continues to recommend that all children in a family be critically observed during every home visit.

Recommendation 3

Implemented

CYFS must ensure proper completion of the Child Protection Report. The Report must be completed at the point of Intake to include all relevant referral information. The appropriate sections/subsections of the Act must be reflected in the Child Protection Reports.

Recommendation 4

Implemented

Staff education must be developed and implemented to ensure that:

(a) all new hires receive orientation in the area of child maltreatment including: intake, assessment, risk management, and communication;
(b) continuing education occurs in the areas of skill development, clinical documentation and child maltreatment for all social work staff, and
(c) all regional managers receive clinical supervision training.

Recommendation 6

Implemented

(a) Collaborative practice initiatives must be developed and advanced between the disciplines of social work and nursing.
(b) Policy and guidelines must reflect ongoing collaborative practice.

Recommendation 7

Implemented

Establish a quality assurance process to address critical incidents and sentinel events that occur within CYFS and PH Nursing Programs.

Recommendation 8

Implemented

(a) Protocol must be developed with the Department of Education regarding the legislated duty to report in cases of suspected child maltreatment, and
(b) All appropriate service providers with the Department of Education and PH Nursing must receive training on child maltreatment and their legislated duty to report.

Recommendation 9

Not Implemented Response Inadequate and Inappropriate

Protocol must be developed with CYFS and the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.

Comments: In June 2012, the DCYFS reported that protocol was developed with the Advocate for Children and Youth (ACY) regarding requests for information under Section 20 and Section 21 of the Child and Youth Advocate Act. The DCYFS

reported that there is no requirement in the legislation for the DCYFS to report critical incidents to the ACY. They reported there is an accountability framework within the DCYFS designed to support staff in decision making, ensuring consistency and to address any issues identified.

In March 2013, the DCYFS reported they do not plan to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. It was noted that the DCYFS will continue to adhere to the protocol agreed on by the ACY and the DCYFS that deals with requests for information under Section 20 and Section 21 of the *Child and Youth Advocate Act*.

In March 2014 and November 2014, the DCYFS provided responses which reflected previous responses from 2012 and 2013. The DCYFS reported that there is no requirement in the legislation for the DCYFS to report on ongoing internal processes to review critical incidents.

The response to Recommendation 9 is not accepted and is considered inadequate and inappropriate as the DCYFS does not intend to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. On September 8, 2014, as per Section 24 of the *Child and Youth Advocate Act (SNL 2001)*, the Advocate reported the noncompliance to this recommendation to Cabinet.

RECOMMENDATIONS MADE TO EASTERN HEALTH

Recommendation 5

Implemented

Policies and guidelines must be developed by PH Nursing to require that:

(a) all nurses refer families to the appropriate professionals when a child's weight falls below the medically acceptable percentile;

(b) all new hires in nursing receive training in child maltreatment and clinical documentation, and

(c) continuing education in child maltreatment and clinical documentation be provided for all PH nurses.

Recommendation 6

Implemented

(a) Collaborative practice initiatives must be developed and advanced between the disciplines of social work and nursing.

(b) Policy and guidelines must reflect ongoing collaborative practice.

Recommendation 7

Implemented

Establish a quality assurance process to address critical incidents and sentinel events that occur within CYFS and PH Nursing Programs.

Recommendation 8

Implemented

(a) Protocol must be developed with the Department of Education regarding the legislated duty to report in cases of suspected child mal treatment, and

(b) All appropriate service providers with the Department of Education and PH Nursing must receive training on child maltreatment and their legislated duty to report.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 5

Implemented

Policies and guidelines must be developed by PH Nursing to require that:

(a) all nurses refer families to the appropriate professionals when a child's weight falls below the medically acceptable percentile;

(b) all new hires in nursing receive training in child maltreatment and clinical documentation, and

(c) continuing education in child maltreatment and clinical documentation be provided for all PH nurses.

Recommendation 6

Implemented

(a) Collaborative practice initiatives must be developed and advanced between the disciplines of social work and nursing.

(b) Policy and guidelines must reflect ongoing collaborative practice.

Recommendation 7

Implemented

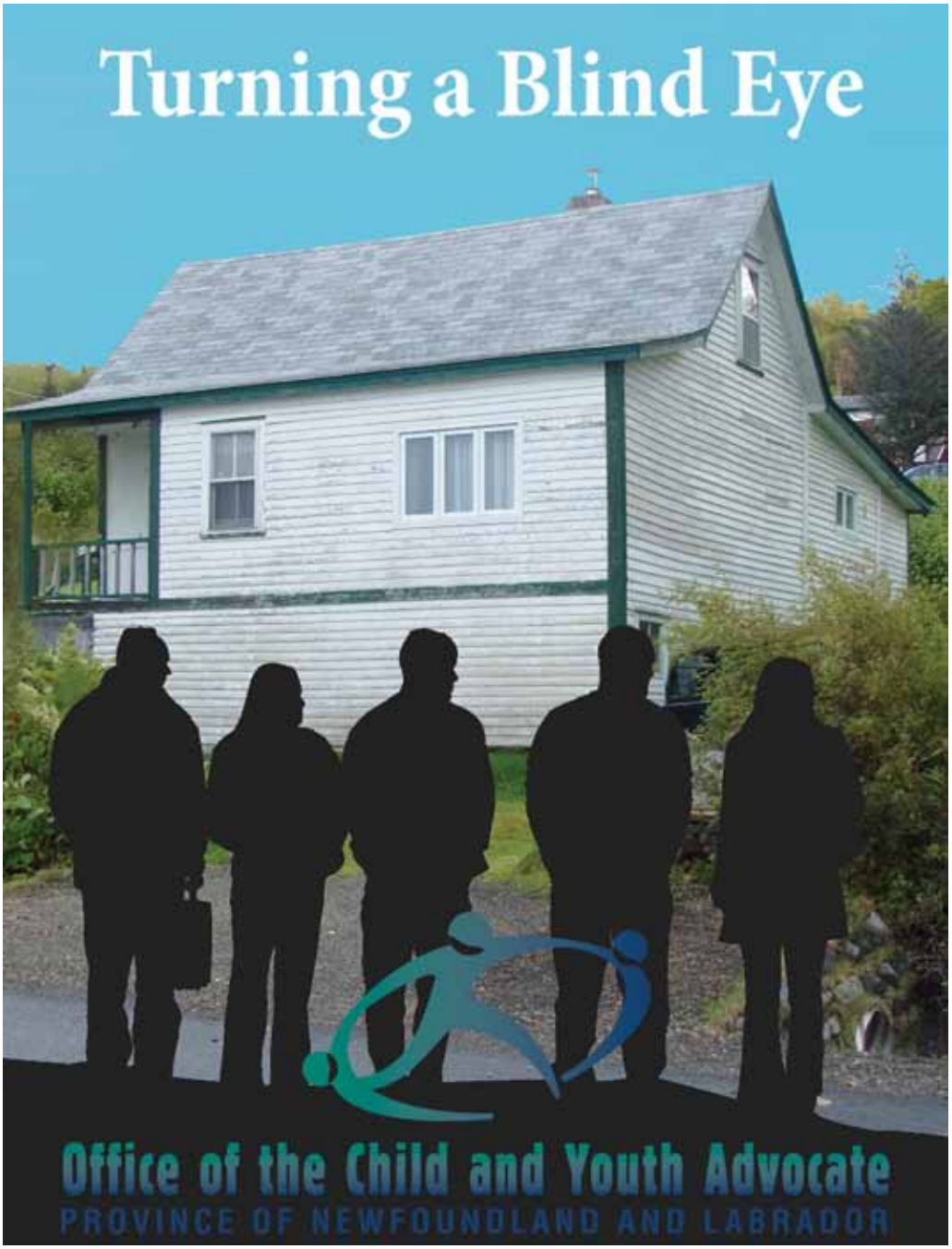
Establish a quality assurance process to address critical incidents and sentinel events that occur within CYFS and PH Nursing Programs.

Recommendation 8

Implemented

(a) Protocol must be developed with the Department of Education regarding the legislated duty to report in cases of suspected child maltreatment, and

(b) All appropriate service providers with the Department of Education and PH Nursing must receive training on child maltreatment and their legislated duty to report.


Turning a Blind Eye
Office of the Child and Youth Advocate
PROVINCE OF NEWFOUNDLAND AND LABRADOR

Turning a Blind Eye
July 2012

In 2005, the Child and Youth Advocate undertook this investigation following the conviction of a mother for numerous offences against her children, namely her two (2) girls, Jane and Mary. This woman was subsequently sentenced to several years in prison.

The events span a thirteen (13) year period wherein multiple professionals and agencies had contact with the family on a continuous basis. Comprehensive notes were logged during the early 1990s which ultimately led to the 1993 apprehension of Mom's three (3) children from her first relationship. Mom had no further contact with these children following a 1994 custody hearing. Based on the extensive interventions and services provided to this family, the oppressive living conditions of the six (6) children (from a second relationship) should have been preempted well before their removal in 2004. Three (3) of these children, including Jane and Mary, had been taken into care for the first time in 1995 and returned to their mother in 1997. Sadly, when extra vigilance, reviews, and analysis should have happened over the next several years, file documentation did not mirror the safeguards that were reportedly in place.

The primary deficiencies identified in the system were:

- non adherence to policy or lack of policies;
- lack of in-depth clinical reviews and analysis;
- lack of documentation and communication;
- lack of collaboration amongst the service providers; and
- staff changeover.

The Advocate gathered pertinent facts, analyzed data, and recommended necessary changes that would prevent the reoccurrence of such a situation. This investigative report provided an in-depth overview of the case. Overall, the recommendations included compliance with policy, detailed record keeping, debriefings and full case reviews with newly assigned staff, having experienced social workers assigned to high-risk cases, regular clinical reviews of cases, information sharing amongst stakeholders, and enhanced collaborative approaches.

Turning a Blind Eye included a total of twelve (12) recommendations. Nine (9) recommendations were made to the Department of Child Youth and Family Services (DCYFS); one recommendation was made to the Department of Health and Community Services (DHCS); and two (2) recommendations were made to both departments.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	8
Implemented Through Alternative Measures	1
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	2
No Longer Applicable	0

Status of Recommendations

Department of Health and Community Services

Implemented	3
Implemented Through Alternative Measures	0
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Implemented

The Department of CYFS must develop policy to ensure that regular reviews, updates and clinical analysis of high risk cases are conducted.

Recommendation 2
Implemented

The Department of CYFS must develop policy to ensure effective transfer of files occur with joint case review and direct communication between social workers.

Recommendation 3
Not Implemented Response Inadequate and Inappropriate

The Department of CYFS must develop policy to ensure that all children in a family are physically and critically observed during a referral and during every home visit.

Comments: In March 2013, the DCYFS reported that new child protection legislation and new policies and procedures were implemented. Section 14 of the *Children and Youth Care and Protection (CYCP) Act* provides social workers with the authority to observe children, and requires those entrusted with a child's care to identify a child for an interview or observation, when requested. Previously, social workers only had the authority to interview children.

The DCYFS further reported that Risk Management System (RMS) standards and policy require that all children in a family be observed or interviewed during a protection investigation. The frequency of interviews or observations of children receiving ongoing protective intervention services is linked with risk to the child and interventions to mitigate the risk. Children may be observed or interviewed at home or in the community (school or child care agency). This means that children may not be interviewed or observed during every home visit.

While policy requires all children in a family be observed during an investigation, in March 2013 and November 2014 the DCYFS stated there is no plan to develop policy requiring every child be critically observed during every home visit. It was reported that the frequency of observations and interviews that are part of ongoing

protection work is dependent on the identified level of risk and the interventions in place to mitigate the risk of harm.

This response to Recommendation 3 is not accepted and is considered inadequate and inappropriate as the DCYFS reported they do not intend to develop policy requiring all children in a family be critically observed during every home visit. It was evident in this investigation that had the children been critically observed during the many home visits, identification of abuse would have occurred earlier; therefore, the Advocate continues to recommend that all children in a family be critically observed during every home visit.

Recommendation 4
Implemented

The Department of CYFS must ensure proper completion of the Child Protection Report. The Report must be completed at the point of Intake to include all relevant and accurate referral information. The appropriate sections/subsections of the *Act* must be reflected in the Child Protection Reports.

Recommendation 5
Implemented

The Department of CYFS must develop policy to ensure that the Risk Management System is applied consistently for identifying, assessing, responding to, and documenting the risk of maltreatment towards a child.

Recommendation 6
Implemented

The Department of CYFS must develop policy to ensure that whenever a home support service provider is contracted, a written standard of expectations must be outlined and there must be written protocols to ensure accountability. Such services must be monitored and assessed on a regular and definitive basis.

Recommendation 7
Implemented

The Department of CYFS must develop and implement staff education to ensure:

- **(a) all new hires receive orientation in the area of child maltreatment including: intake, assessment, risk management, and communication;**
- **(b) continuing education occurs in the areas of skill development, clinical documentation and child maltreatment for all social work staff;**

(c) all social workers must receive training in policies and procedures, and
(d) all program managers must receive case management and clinical supervision training.

Recommendation 8
Implemented Through Alternative Measures

The Department of CYFS must ensure service notes are inputted into CRMS as per the prescribed standard. The standard reads: Client documentation related to a 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. Historical data must also be available to social workers.

Comments: The response is accepted as adequate and appropriate as the DCYFS reported that new documentation policy guidelines were issued July 2012 that have revised timeline standards. These guidelines require case notes to be completed as soon as possible but not later than twenty-four (24) hours after an investigation and no later than five (5) days for all other ongoing DYCFS involvement. The DCYFS further reported that supervisory and quality audits provide monitoring of files. Historical information is available to social workers either electronically or paper copy.

Recommendation 10
Implemented

The Department of CYFS and the Department of Health and Community Services must ensure that provincially:

(a) collaborative practice initiatives are developed and advanced between the disciplines of social work, nursing, medicine, and education.

(b) policy and guidelines reflect ongoing collaborative practice.

Recommendation 11
Implemented

The Department of CYFS and the Department of Health and Community Services must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS and PH Nursing programs, province wide.

Recommendation 12

Not Implemented Response Inadequate and Inappropriate

Protocol must be developed with CYFS and the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.

Comments: In March 2013, the DCYFS reported that protocol was developed with the Advocate for Children and Youth (ACY) regarding requests for information under Section 20 and Section 21 of the *Child and Youth Advocate Act.* The DCYFS reported that there is no requirement in the legislation for the DCYFS to report critical incidents to the ACY. They reported there is an accountability framework within the DCYFS designed to support staff in decision making, ensuring consistency and to address any issues identified.

The DCYFS reported they do not plan to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. It was noted that the DCYFS will continue to adhere to the protocol agreed on by the ACY and the DCYFS that deals with requests for information under Section 20 and Section 21 of the *Child and Youth Advocate Act.*

In March 2014 and November 2014, the DCYFS provided responses which reflected previous response from 2013. The DCYFS reported that there is no requirement in the legislation for the DCYFS to report on ongoing internal processes to review critical incidents.

The response to Recommendation 12 is not accepted and is considered inadequate and inappropriate as the DCYFS does not intend to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. On September 8, 2014, as per Section 24 of the *Child and Youth Advocate Act (SNL 2001)*, the Advocate reported the noncompliance to this recommendation to Cabinet.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 9

Implemented

The Department of Health and Community Services must ensure that the four Regional Integrated Health Authorities develop and implement policy to provide:

(a) all new hires in PH Nursing with training in child maltreatment, clinical documentation, and their legislated duty to report, and

(b) continuing education in child maltreatment and clinical documentation for all PH nurses.

Recommendation 10
Implemented

The Department of CYFS and the Department of Health and Community Services must ensure that provincially:

(a) collaborative practice initiatives are developed and advanced between the disciplines of social work, nursing, medicine, and education.

(b) policy and guidelines reflect ongoing collaborative practice.

Recommendation 11
Implemented

The Department of CYFS and the Department of Health and Community Services must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS and PH Nursing programs, province wide.

Out of Focus

Office of the Child and Youth Advocate
PROVINCE OF NEWFOUNDLAND AND LABRADOR

Out of Focus
September 2012

In 2009, the Child and Youth Advocate undertook this investigation following a house fire which claimed the lives of five (5) people, including two (2) children, William from Family A and Hannah from Family B. Both of these children were on active Child Youth and Family Services (CYFS) child protection caseloads.

The events span a thirteen (13) year period wherein many social workers and support workers had contact with the families on a regular basis. Except for relatively short and temporary placements that were voluntary, William remained in the care of his mother throughout this period. Olivia, Steven, and Hannah, the three (3) children from Family B, had been removed from their mother's care in March 2005 due to issues of neglect but were returned to her three (3) months later. Sadly, when vigilance, reviews, and analysis should have happened during the course of contact with these families, file documentation does not reflect that the necessary safeguards were in place.

The primary deficiencies identified in the system were:

- non adherence to policy or lack of policies;
- lack of in-depth clinical reviews and analysis;
- lack of documentation and communication;
- lack of collaboration amongst the service providers; and
- staff changeover.

The Advocate gathered pertinent facts, analyzed data and recommended necessary changes that would prevent the reoccurrence of such a situation. This investigative report provided an in-depth overview of the case. Overall, the recommendations included: compliance with policy; detailed recordkeeping; debriefings and full case reviews with newly assigned staff; having experienced social workers assigned to high-risk cases; regular clinical reviews of cases; information sharing, and enhanced collaborative approaches.

Out of Focus included a total of thirteen (13) recommendations made to the Department of Child, Youth and Family Services (DCYFS).

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	11
Implemented Through Alternative Measures	0
Partially Implemented	1
Not Implemented - Response Inadequate and Inappropriate	1
No Longer Applicable	0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Implemented

The Department of CYFS must develop policies to ensure:

(a) the appropriate assignment of high-risk cases;

(b) systematic reviews of cases;

(c) regular file updates, and

(d) clinical analysis of all cases.

Recommendation 2
Implemented

The Department of CYFS must develop policy to ensure effective transfer of files which would include joint case review and direct communication.

Recommendation 3
Implemented

The Department of CYFS must ensure proper and total completion of the Child Protection Report. The Report must be completed at the point of Intake to include all relevant referral information. The appropriate sections/subsections of the Act must be reflected in the Child Protection Reports.

Recommendation 4
Partially Implemented

The Department of CYFS must 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.

Comments: In March 2013, the DCYFS reported that new child protection legislation and new policies and procedures were implemented. Section 14 of the *Children and Youth Care and Protection (CYCP) Act* provides social workers with the authority to observe children, and requires those entrusted with a child's care to identify a child for an interview or observation, when requested. Previously, social workers only had the authority to interview children.

The DCYFS further reported that Risk Management System (RMS) standards and policy require that all children in a family be observed or interviewed during a protection investigation. The frequency of interviews or observations of children receiving ongoing protective intervention services is linked with risk to the child and interventions to mitigate the risk. Children may be observed or interviewed at home or in the community (school or child care agency). This means that children may not be interviewed or observed during every home visit.

In November 2014, the DCYFS reported they are reviewing a file audit process to monitor compliance with the physical and critical observation of children as per policy and standards of the *Risk Management Decision-Making Model* (2013).

Completion of this recommendation is pending the review of the file audit process.

Recommendation 5
Implemented

The Department of CYFS must ensure compliance with policies that require the completion of forms related to the assessment and case management of a child in need of protective intervention.

Recommendation 6
Implemented

The Department of CYFS must ensure compliance and consistency in the application of the Risk Management System when identifying, assessing, responding to, and documenting the risk of maltreatment towards a child.

Recommendation 7

Implemented

The Department of CYFS must ensure strategies and services employed to reduce risk are: appropriate; regularly monitored, and systematically evaluated on a regularly basis.

Recommendation 8

Implemented

The Department of CYFS must ensure service notes are inputted into CRMS as per the prescribed standard. Historical data must also be available to social workers.

Recommendation 9

Implemented

The Department of CYFS must develop and implement staff education to ensure:

(a) all new hires receive orientation in the area of child maltreatment including: intake, assessment, risk management, and communication;

(b) continuing education and training occurs in the areas of policies and procedures, skill development, clinical documentation, and child maltreatment for all social work staff;

(c) all social workers must receive training in policies and procedures, and

(d) all program managers receive ongoing case management and clinical supervision training.

Recommendation 10

Implemented

The Department of CYFS must ensure that provincially:

(a) collaborative practice initiatives are developed and advanced between the disciplines of social work, health, justice, and education, and

(b) policy and guidelines are reflective of collaborative practice.

Recommendation 11

Implemented

The Department of CYFS must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS programs, province wide.

Recommendation 12
Implemented

The Department of CYFS must develop protocol with the RCMP/RNC to ensure that when officers attend a residence where children are present and in a risk situation, information must be relayed immediately to the local CYFS office.

Recommendation 13
Not Implemented Response Inadequate and Inappropriate

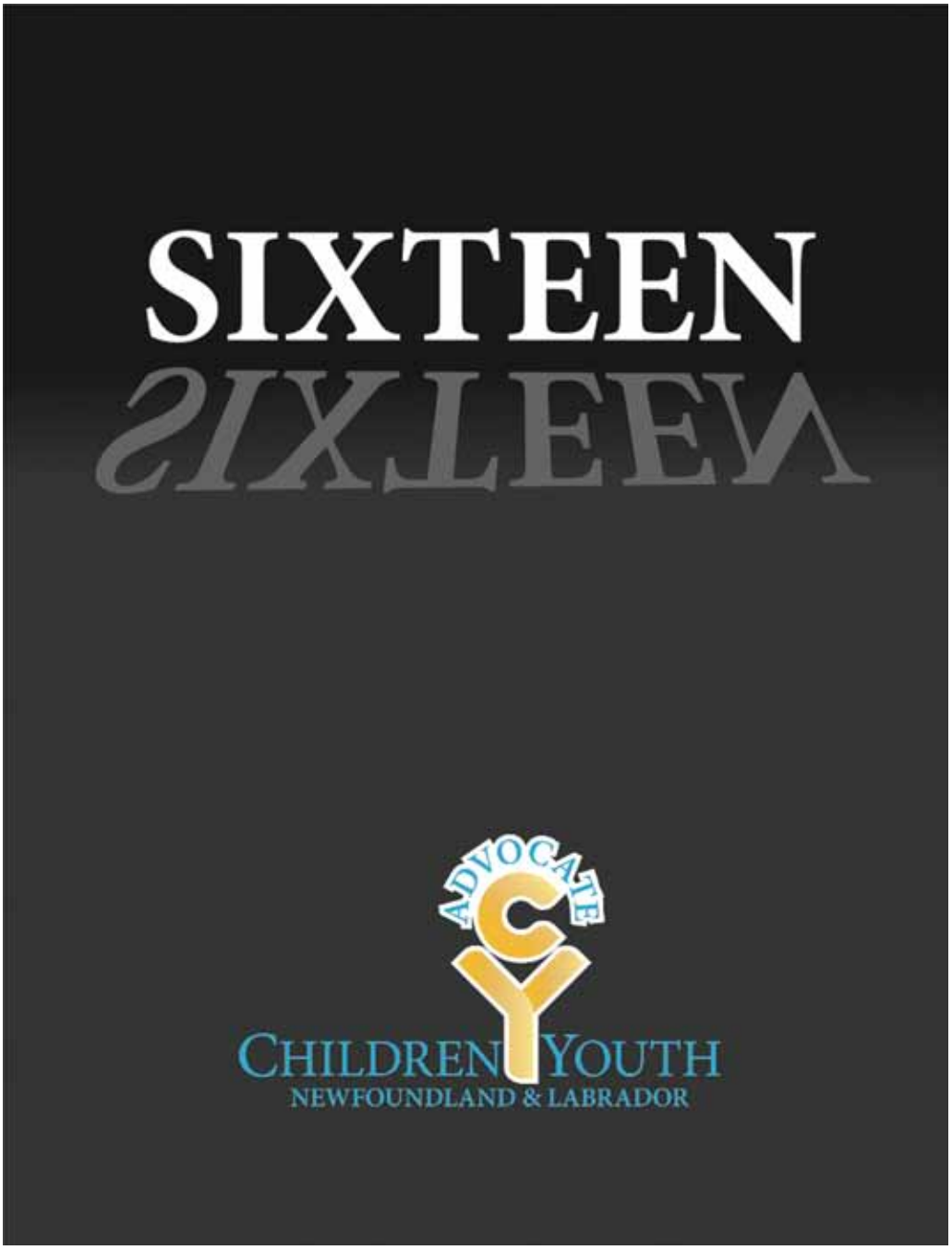
The Department of CYFS must develop protocol with the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.

Comments: In March 2013, the DCYFS reported that protocol was developed with the Advocate for Children and Youth (ACY) regarding requests for information under Section 20 and Section 21 of the *Child and Youth Advocate Act*. The DCYFS reported that there is no requirement in the legislation for the DCYFS to report critical incidents to the ACY. They reported there is an accountability framework within the DCYFS designed to support staff in decision making, ensuring consistency and to address any issues identified.

The DCYFS reported they do not plan to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. It was noted that the DCYFS will continue to adhere to the protocol agreed on by the ACY and the DCYFS that deals with requests for information under Section 20 and Section 21 of the *Child and Youth Advocate Act.*

In March 2014 and November 2014, the DCYFS provided responses which reflected previous response from 2013. The DCYFS reported that there is no requirement in the legislation for the DCYFS to report on ongoing internal processes to review critical incidents.

The response to Recommendation 13 is not accepted and is considered inadequate and inappropriate as the DCYFS does not intend to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. On September 8, 2014, as per Section 24 of the *Child and Youth Advocate Act (SNL 2001)*, the Advocate reported the noncompliance to this recommendation to Cabinet.


SIXTEEN
ADVOCATE
CHILDREN YOUTH
NEWFOUNDLAND & LABRADOR

Sixteen
October 2013

In December 2011, the Advocate initiated this investigation following a fire that resulted in the arrest of a sixteen (16) year old male. At the time of the fire, this youth, John, was a client of the Youth Services Program and Community Youth Corrections Program under the Department of Child, Youth and Family Services (DCYFS). During 2010 and 2011, John had involvement with services from multiple government departments and agencies. The purpose of the investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services; the Department of Justice; the Department of Health and Community Services (DHCS); and the Eastern Regional Integrated Health Authority (Eastern Health) met John's needs and whether his right to services was upheld.

The report provided an in-depth overview of the case. The events focused on the years 2009 to 2011 during which the majority of services by various government departments and agencies were provided. In 2011, after having an active file with the DCYFS for eight (8) months, John was removed from his mother's care several weeks before his 16th birthday. When John turned sixteen (16) he signed a Youth Services Agreement (YSA) and left a supervised residential setting and moved to a shelter. After residing in two (2) different shelters, John moved to a bedsitting room where he resided for seven (7) months until the date of the fire.

During the investigation, the Advocate for Children and Youth (ACY) gathered pertinent facts, analyzed information and recommended changes necessary to prevent the occurrence of a similar situation. Some issues identified are specific to certain departments and agencies involved, while others permeate multiple departments and agencies. The prominent theme throughout this investigation was the lack of collaboration among all departments and agencies.

Primary deficiencies that were identified throughout the delivery of services from the Department of Child, Youth and Family Services include:

- lack of collaboration with other departments and agencies;
- lack of opportunities for the voice of the child to be heard;
- non adherence to documentation policies;
- lack of documentation policies at the management level;
- lack of a comprehensive assessment;
- inefficient on-call services;
- delayed transfer of files within DCYFS programs;

- lack of appropriate training for social workers assigned to work in areas beyond their everyday assignment;
- misinterpretation of policy at the front line and management level;
- lack of planning for transitioning out of temporary custody;
- lack of incorporation of informed consent in Youth Services Agreements;
- inadequate and inappropriate Supportive and Residential Services available through the Youth Services Program;
- disjointed service delivery relationship with Choices for Youth;
- inappropriate dual case assignment of one social worker to fulfill the role of both the Youth Services Worker and the Youth Corrections Worker; and
- incorrect use of the YLS-CMI assessment tool.

Primary deficiencies that were identified throughout the delivery of services from the Department of Justice and the Royal Newfoundland Constabulary (RNC) include:

- lack of collaboration with other departments and agencies;
- nonadherence to RNC documentation policies; and
- nonadherence to RNC record keeping policies.

Primary deficiencies that were identified throughout the delivery of services from the Department of Health and Community Services and Eastern Health include:

- lack of collaboration with other departments and agencies;
- lack of opportunities for the voice of the child to be heard;
- lack of proactive engagement with the client;
- inadequate assessment; and
- inadequate access to mental health services.

Sixteen included a total of thirty (30) recommendations. Nineteen (19) recommendations were made to the Department of Child, Youth and Family Services; three (3) were made to the Department of Justice; five (5) were made to the Department of Health and Community Services; and one was made to Eastern Health. In addition, one recommendation was made to both the Department of Justice and the Department of Health and Community Services and one recommendation was made to both the Royal Newfoundland Constabulary and Eastern Health.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	14
Implemented Through Alternative Measures	1
Partially Implemented	3
Not Implemented - Response Inadequate and Inappropriate	1
No Longer Applicable	0

Status of Recommendations

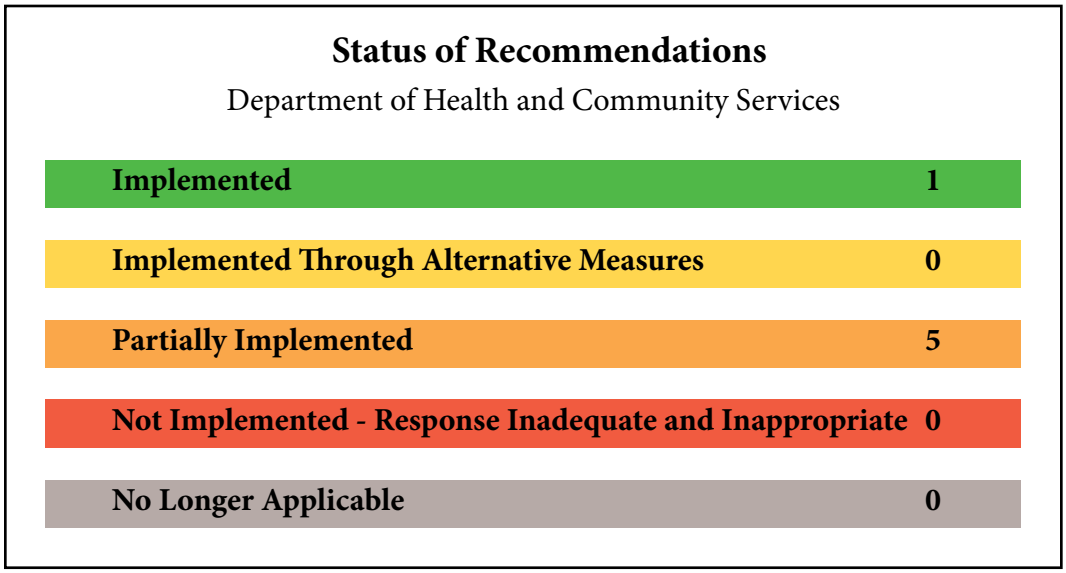
Department of Justice

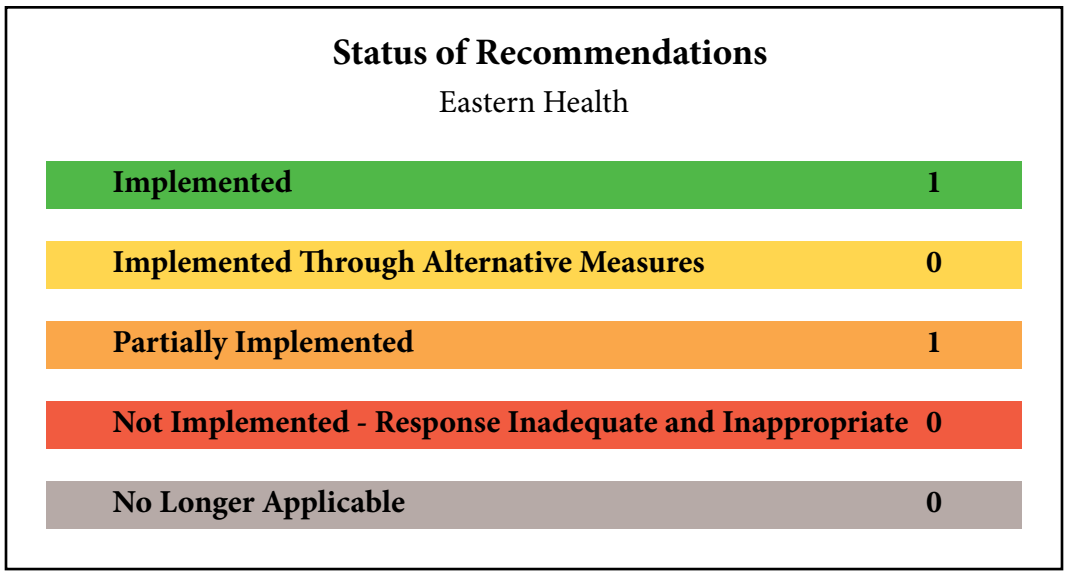
Implemented	2
Implemented Through Alternative Measures	0
Partially Implemented	2
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

Status of Recommendations

Royal Newfoundland Constabulary

Implemented	0
Implemented Through Alternative Measures	0
Partially Implemented	1
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0


Status of Recommendations
Department of Health and Community Services
Implemented 1
Implemented Through Alternative Measures 0
Partially Implemented 5
Not Implemented - Response Inadequate and Inappropriate 0
No Longer Applicable 0


Status of Recommendations
Eastern Health
Implemented 1
Implemented Through Alternative Measures 0
Partially Implemented 1
Not Implemented - Response Inadequate and Inappropriate 0
No Longer Applicable 0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Implemented

The Department of Child, Youth and Family Services develop and implement an auditing protocol to examine file documentation to ensure strict adherence to the documentation standards outlined in the Child, Youth and Family Services Documentation Guide (2012) and the Risk Management Decision-Making Model Manual (2013).

Recommendation 2
Partially Implemented

The Department of Child, Youth and Family Services develop and implement a policy that ensures all Managers document all consultations and any decisions made pertaining to a child or youth.

Comments: In February 2014, the DCYFS reported that the Documentation Guide (2012) directs staff regarding information that should be recorded in the file and states that the social worker document the purpose for the consultation with the supervisor, date and time of consultation, and any decisions and direction given by the supervisor. Once the documentation is complete, the social worker must advise the supervisor that the consultation has been recorded. The supervisor will then review the entry to confirm it reflects the decisions and direction provided. The DCYFS reported that the Documentation Guide (2012) was being reviewed to provide direction on documentation of consultations and decisions made by supervisors and zone managers.

In November 2014, the DCYFS reported that an updated draft of the Documentation Guide (2012) has been prepared and is under review.

Completion of this recommendation is pending the review of the Documentation Guide (2012) and implementation of policy ensuring managers document all consultations and any decisions made pertaining to a child or youth.

Recommendation 3
Implemented

The Department of Child, Youth and Family Services ensure that social workers working in the Protective Intervention Program complete comprehensive assessments in accordance with the Risk Management Decision-Making Model

Manual (2013), ensuring that when a referral is screened in for a Protection Investigation:

(a) the social worker completes the Safety Assessment form within 24 hours of interviewing the child and parents as per Standard #3; and

(b) the social worker, in consultation with a supervisor, completes the Protective Investigation within thirty (30) days after the report is received as per Standard #4.

Recommendation 4

Partially Implemented

The Department of Child, Youth and Family Services review and revise current on-call services standards throughout the province to ensure that:

- **(a) there is sufficient human resources to meet the demand for these services;**
- **(b) all social workers providing on-call services provide those services from a DCYFS location or have sufficient portable technology to ensure appropriate and timely access to information; and**
- **(c) social workers who are not regularly assigned to on-call services only provide this service if they have completed on-call training within the previous twelve (12) months.**

Comments: In February 2014, the DCYFS reported they were in the process of completing a review of the on-call system and that upon completion, an alternate model may be proposed.

In November 2014, the DCYFS reported that regional baseline data was collected on the number and types of after-hours calls processed and a jurisdictional review of on-call practices was conducted to inform the development of options for a provincial on-call project. Options are currently being developed for a provincial on-call model; however, additional analysis is required. A new model for on-call services has not yet been selected.

Completion of this recommendation is pending the selection and implementation of the new on-call system.

Recommendation 5

Implemented

The Department of Child, Youth and Family Services ensure the provision of complete and comprehensive assessments of all children and youth, regardless of age, to determine the need for protective intervention based on the Risk Management Decision-Making Model (2013).

Recommendation 6

Implemented

The Department of Child, Youth and Family Services ensure that all social workers comply with Policy no.: 2.16 Plan for the Child and Policy no.: 3.9 Planning: In Care Progress Report of the Protection and In Care Policy and Procedure Manual (2011) and utilize the Plan for the Child and In Care Progress Report to prepare for the transitioning of children who are in care and approaching the age of sixteen (16).

Recommendation 7

Implemented

The Department of Child, Youth and Family Services develop and implement a policy to ensure that children in care who express their intention to receive Residential Services through the Youth Services Program to live independently:

(a) undergo a life skills assessment prior to any transition to independent living; and

(b) be provided with training to assist with the demands and responsibilities of independent living.

Recommendation 8

Implemented

The Department of Child, Youth and Family Services ensure that all levels of management and frontline social workers are trained in, and demonstrate a clear understanding of, their applicable program areas and respective policies in order to provide accurate and consistent case management, direction and supervision.

Recommendation 9

Implemented

The Department of Child, Youth and Family Services ensure that within thirty (30) days of receiving a Child Protection Report, a determination is made as to whether or not a child is in need of protective intervention and the file is closed or transferred to Ongoing Protective Intervention Services as required by Standard #4 of the Risk Management Decision-Making Model (2013).

Recommendation 10

Implemented

The Department of Child, Youth and Family Services develop and implement a policy to ensure that, when a child or youth is being transferred from one program area to another, a meeting is held between the sending and receiving staff persons prior to the transfer of the client's file.

Recommendation 11

Implemented

The Department of Child, Youth and Family Services develop and implement a policy to ensure that social workers are trained in and comply with the rules of informed consent when completing Youth Services Agreements with youth.

Recommendation 12

Implemented

The Department of Child, Youth and Family Services develop and implement a policy to ensure that when signing or re-signing a Youth Services Agreement, all young people receiving services from the Youth Services Program:

(a) must be fully informed and demonstrate a clear understanding of what the YSA entails; and

(b) must have a guardian, support person or legal representative present during the signing of the Youth Services Agreement.

Recommendation 13

Implemented Through Alternative Measures

The Department of Child, Youth and Family Services research and review the feasibility of creating a provincial youth services coordinator position. This person would be solely responsible for meeting (face-to-face, or via telephone

or video conference) with all youth transitioning into the Youth Services Program. This person will ensure that all youth receive consistent assessment of competency by an expert physician, and the necessary education and guidance required in signing and re-signing a Youth Services Agreement.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the DCYFS. The DCYFS reported they can achieve consistency and focus with the five (5) life skills coordinators in the Supporting Youth with Transitions Program. The life skills coordinators provide intervention and assist youth to develop life skills needed to transition to adulthood. In addition, the DCYFS reported that a youth's social worker receives policy direction from the supervisor, zone manager and provincial youth services consultant. The social worker also facilitates access to services in the community, including mental health and addiction counselling. Policies 3.17 and 5.9 provide direction regarding assessing a youth's mental capacity to determine the ability to self-protect and understand the consequences of having their continuous custody order set aside.

Recommendation 14
Implemented

The Department of Child, Youth and Family Services review and revise as necessary the Residential and Supportive Services provided under the Youth Services Program to ensure that youth have access to:

(a) sufficient funding for safe and affordable housing options; and

(b) services that support the crucial areas that Reid and Dudding (2006) identified as contributing to successful outcomes: relationships, education, housing, life skills, identity, youth engagement, emotional healing and financial support.

Recommendation 15
Implemented

The Department of Child, Youth and Family Services in collaboration with Choices for Youth:

(a) update and revise the 2004 MOU between the St. John's Regional Health and Community Services Board and Choices for Youth to reflect the cur rent partner organizations and agreement of services; and

(b) ensure that all staff working in the Youth Services Program and Supportive Housing Program are trained in and demonstrate a clear understanding of their specific roles and responsibilities with respect to case management.

Recommendation 16

Not Implemented Response Inadequate and Inappropriate

The Department of Child, Youth and Family Services ensure that when a youth is in receipt of services from multiple programs within the DCYFS, he or she is assigned a separate worker for each program area (i.e. Assessment, Long-Term Protection, Youth Services, Corrections). This will ensure the provision of expert services, clear communication and the avoidance of any potential conflict of interest in meeting the needs of youth.

Comments: In February 2014, the DCYFS asked the Advocate to consider the Department's new organizational model, which involves social workers having a solid understanding and ability to work in all program areas. The DCYFS indicated that a goal of the model is to reduce the number of cases per social worker, which results in more direct contact with clients, more consistency for clients, and a more focused approach. The DCYFS reported that as part of the new organizational model, training will be provided to all front line staff in all program areas. The model provides for increased clinical supervision by having six (6) social workers per supervisor, which will reduce caseloads and lead to better service for clients. The DCYFS reported that it would be contrary to this new organizational model to have multiple social workers dealing with one client.

Upon consideration, the Advocate determined that while the recommendation has not been implemented, the response regarding the overall model was adequate and appropriate with the exception of the dual assignment of a youth services and youth corrections client to one social worker. The Advocate sought further information to determine if the new organizational model supports this dual assignment of a youth services and youth corrections client to one social worker.

In November 2014, the DCYFS reported that under the new model, one social worker may provide services from the Youth Services and Youth Corrections programs to one client. This response is not accepted and is considered inadequate and inappropriate as the dual assignment of a youth services and youth corrections client to one social worker has the potential to present a conflict of interest in meeting the needs of youth. It was evident in this investigation that the youth felt he could not confide issues to his youth services worker as this worker was also his youth corrections worker; therefore, the Advocate continues to recommend that these services be provided by separate social workers.

Recommendation 17
Implemented

The Department of Child, Youth and Family Services:

(a) develop and implement a training module to train social workers in the use of the YLS-CMI tool; and

(b) educate all applicable social workers in the completion of the YLS-CMI assessments to ensure reliability and validity of service provision.

Recommendation 26
Partially Implemented

The Department of Child, Youth and Family Services:

(a) develop and implement a policy requiring the completion of an Individualized Support Services Plan for all children in care who are receiving services from multiple agencies;

(b) ensure that a Youth Services Plan as per Policy no.: 5.3 of the Protection and In Care Policy and Procedure Manual is completed for any youth who is simultaneously receiving services from the Youth Services Program and from one or more other agencies; and

(c) ensure that an Individualized Support Services Plan as per Policy 8.3 of the Community Youth Corrections Standards and Practices Manual is completed for any youth who is simultaneously receiving services from the Community Youth Corrections Program and from one or more other agencies.

Comments: Recommendation 26(a) and 26 (b) are considered implemented.

With regards to Recommendation 26(c), in February 2014 the DCYFS reported that the ISSP (Policy 8.3) of the Community Youth Corrections Standards and Practices Manual was being reviewed to ensure best practice in case planning for youth receiving services from the Community Youth Corrections Program and from one or more other agencies. In November 2014, the DCYFS indicated efforts to complete this recommendation are ongoing.

Completion of this recommendation is pending the review and revision of the ISSP policy in the Community Youth Corrections Standards and Practices Manual.

Recommendation 29
Implemented

The Department of Child, Youth and Family Services ensure that all children and youth:

(a) are provided with opportunities to express their views freely in all matters affecting them; and
(b) have their views considered in the development of their permanency plans.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF JUSTICE

Recommendation 18
Implemented

The Department of Justice develop and implement a protocol to ensure that notification is provided to a youth corrections social worker when a youth on his or her caseload is arrested and/or detained under the Youth Criminal Justice Act.

Recommendation 19
Partially Implemented

The Department of Justice ensure that the Royal Newfoundland Constabulary:

(a) uphold record keeping standards as outlined in General Order 169 Police Note Books;
(b) uphold record keeping standards as outlined in General Order 188 Criminal Reporting Procedures;
(c) uphold 13.0 Information Required in Reports Concerning Young Persons outlined in General Order 176 Youth Criminal Justice Act/ Youth Investigations; and
(d) keep complete electronic records of all shift daily rosters.

Comments: In June 2014, the Department of Justice reported that the RNC had provided a response to this recommendation and that the Department was satisfied with same. The RNC reported that managers have been directed to inspect notebooks for compliance with policy. In addition, new policy is in draft that will further support proper note taking.

The RNC also reported that the Criminal Reporting Procedure Policy was up-

dated December 2013 to reflect best practices and the recommendation made in the "Sixteen" report. Platoon commanders are to ensure that duty rosters are entered on Computer Aided Dispatch (CAD) at the start of each shift and reflected in quarterly reports.

In October 2014, the RNC reported that the new police notebook policy has been completed and approved; however, it has not been implemented yet as the timing of the release of this policy will coincide with the distribution of the newly designed police notebooks. In November 2014, the RNC reported that the new policy will be distributed to all officers in November 2014 and notebooks will be distributed in December 2014. Training for officers will also take place.

Completion of this recommendation is pending the implementation of the new police notebook policy.

Recommendation 20
Implemented

The Department of Justice ensure that all Royal Newfoundland Constabulary and Royal Canadian Mounted Police employees are educated on their duty to report pursuant to Section 11 of the *Children and Youth Care and Protection Act (2010).*

Recommendation 28
Partially Implemented

The Department of Justice and the Department of Health and Community Services review the findings reported by the Royal Newfoundland Constabulary and Eastern Regional Integrated Health Authority as per Recommendation 27(c) and ensure implementation throughout the province.

Comments: In June 2014, the Department of Justice reported that the RNC and Eastern Health have developed a new *Mental Health Care and Treatment Act* template form, which has been sent for printing. The Department of Justice indicated they are satisfied with the steps taken and have requested the RNC provide updates as more information about implementation becomes available.

The RNC provided an update to the Department of Justice in November 2014. Completion of this recommendation is pending the review of the findings reported by the RNC and the implementation throughout the province.

RECOMMENDATIONS MADE TO THE ROYAL NEWFOUNDLAND CONSTABULARY

Recommendation 27

Partially Implemented

The Royal Newfoundland Constabulary and the Eastern Regional Integrated Health Authority:

(a) review and revise the Mental Health Care and Treatment Act Template form to ensure it is meeting the needs of youth presenting at Emergency Rooms by police escort;

(b) develop and implement a policy to ensure that when a youth requiring police services due to mental health issues presents at a hospital, communication between medical personnel and the police is acknowledged by the signatures of both the police officer and the hospital official (i.e. the nurse or physician) on the Mental Health Care and Treatment Act Template form and the signed form is placed in each file;

(c) report the findings of Recommendation 27(a) and 27(b) to the Department of Justice and the Department of Health and Community Services for implementation throughout the province.

Comments: In October 2014, the RNC reported that the new *Mental Health Care and Treatment Act* form has been developed and was distributed to all officers in June 2014. The Routine Order that provides direction to officers regarding use of the new form was also distributed at this time. In November 2014, the RNC reported the findings of Recommendation 27(a) and 27(b) to the Department of Justice.

While the response from the RNC indicates that work on this recommendation is complete, Eastern Health reported that an algorithm to guide the process of emergency presentations to the emergency room by youth with mental health issues is being developed and will be shared with emergency room staff and police agencies. As this is a joint recommendation, completion of this recommendation is pending completion and implementation of the algorithm, including sharing of the algorithm with the RNC.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 21
Implemented

The Department of Health and Community Services ensure that all health care professionals in the four (4) Regional Integrated Health Authorities are educated on their duty to report pursuant to Section 11 of the *Children and Youth Care and Protection Act (2010).*

Recommendation 22
Partially Implemented

The Department of Health and Community Services ensure that when youth meet with medical professionals in any of the four (4) Regional Integrated Health Authorities:

(a) they are provided with the opportunity to meet privately and confidentially upholding their right to privacy as per Article 16 of the United Nations Convention on the Rights of the Child; and

(b) if the safety of the youth or professionals is a concern that alternative measures are taken (the use of handcuffs and/or a windowed room for observation) to accommodate a private and confidential meeting while ensuring safety.

Comments: In March 2014, the DHCS reported that the Janeway Emergency Department was expanded to provide private space for mental health and addictions assessments with a psychiatric nurse. This initiative was communicated to the other regions. In May 2014, the Department reported they would finalize plans to address this recommendation with each region at a follow-up meeting with clinical chiefs and directors responsible for mental health and addictions.

In November 2014, the DHCS reported that there is a designated room for the mental health team to see a patient privately in the Janeway Emergency Department. Central Health executive of Mental Health and Addictions Services and Emergency and Medicine Services are in the process of identifying safe alternative spaces for interviews in all emergency rooms. The Department advised that private and safe rooms already exist in James Paton Memorial Centre and Central Newfoundland Regional Health Centre. In addition, it was reported that Western Health has safe rooms on all sites except one and Labrador Grenfell Health has safe rooms in Happy Valley-Goosebay, Labrador City and a private room available in St. Anthony.

Completion of this recommendation is pending identification of safe alternative spaces in emergency rooms throughout the province.

Recommendation 24
Partially Implemented

The Department of Health and Community Services review the findings reported by the Eastern Regional Integrated Health Authority as per Recommendation 23(c) and ensure implementation throughout the entire province.

Comments: In March 2014, the DHCS advised that Eastern Health has reported that there is no current need for short term beds in pediatric emergency. A psychiatric nurse is available to assess patients in the Janeway Emergency Department when required. Children and youth who present with mental health issues are treated and admitted or discharged, depending on their assessment and plan of care. If the plan involves an observation period, it will be carried out in the Pediatric Emergency Room. The DHCS reported that Eastern Health is reviewing the SAVRY and HEADS-ED assessment tools to determine their appropriateness.

In November 2014, the DHCS reported that assigned nurses at the Janeway Emergency Room Department will be trained in the use of the HEADS-ED assessment tool by the end of 2014. Western Health is currently using Individual Support Services Plan and Central Health is using the Canadian Triage Acuity Scale. All regions are collaborating in the use of a consistent tool. The Department reported they will work with the four (4) Regional Health Authorities to determine the next steps once Eastern Health has fully implemented the tool.

Completion of this recommendation is pending the implementation of the HEADS-ED tool in all regions of the province.

Recommendation 25
Partially Implemented

The Department of Health and Community Services ensure that when youth present with concurrent disorders to any of the four (4) Regional Integrated Health Authorities, they are provided with a comprehensive assessment, diagnosis and treatment plan addressing both their mental health issues and addictions issues.

Comments: In March 2014, the DHCS reported that all regions have an integrated mental health and addictions program. The Department was in the process of finalizing provincial treatment guidelines for individuals with concurrent disorders, including youth. The DHCS planned to provide sessions on these guidelines, the new addictions treatment standards, and withdrawal management guidelines. Training was to be provided to mental health and addictions staff in the four (4) regions in 2014 and will give staff an opportunity to review the guidelines and provide

feedback before final approval. The DHCS advised they will ensure that work on this recommendation will be completed and communicated to all regions.

In November 2014, the DHCS reported that the development of provincial guidelines for individuals with concurrent disorders was completed. There is a plan to develop e-modules in 2015 to support knowledge translation of these standards.

Completion of this recommendation is pending the completion of the knowledge translation and implementation phase in 2015.

Recommendation 28
Partially Implemented

The Department of Justice and the Department of Health and Community Services review the findings reported by the Royal Newfoundland Constabulary and Eastern Regional Integrated Health Authority as per Recommendation 27(c) and ensure implementation throughout the province.

Comments: In March 2014, the DHCS reported that the *Mental Health Care and Treatment Act* template forms for the RNC and the RCMP are available in the Janeway Emergency Department. The forms are generated by the RNC and the RCMP and have been in use for several years. Eastern Health was reviewing the form to determine if revisions are needed. The DHCS reported that Eastern Health, in collaboration with the RNC and the RCMP, will develop an algorithm to guide the assessment process within the Janeway Emergency Department for patients presenting with mental health and addictions issues.

In November 2014, the DHCS reported that Eastern Health in collaboration with the RNC and RCMP reviewed and revised the *Mental Health Care and Treatment Act* template forms. In addition, Eastern Health is working on an algorithm to guide the process of emergency presentations by youth with mental health issues. Once finalized, the process and algorithm will be shared with the emergency room staff, police and agencies province-wide.

Completion of this recommendation is pending sharing of the template and algorithm with emergency room staff and police agencies province-wide.

Recommendation 30
Partially Implemented

The Department of Health and Community Services ensure that all children and youth:

(a) are provided with opportunities to express their views freely in all matters affecting them; and

(b) have their views considered in the development of their treatment plans.

Comments: In March 2014, the DHCS reported they are facilitating a recovery network of mental health and addictions leaders, community agencies, and youth and adult correctional services. The network will oversee a transformation of mental health and addictions services for youth and adults. A recovery-focused system ensures that opportunities are provided for youth to express their views freely in all matters affecting them and have their views considered in the development of treatment plans.

In November 2014, the DHCS reported that the four (4) Regional Health Authorities continue to ensure their philosophy, values, and guiding principles of the organization reflect a client-focused system. Additionally, it was reported that all regions are collaborating in the use of a consistent tool and the DHCS will work with the Regional Health Authorities to determine the next steps.

Completion of this recommendation is pending additional information regarding the use of a consistent tool within the Regional Health Authorities.

RECOMMENDATIONS MADE TO EASTERN HEALTH

Recommendation 23

Implemented

The Eastern Regional Integrated Health Authority:

(a) research and review the feasibility of creating short-term beds in the pediatric emergency room for youth that present with mental health concerns and require intensive evaluation;

(b) research and review the feasibility of utilizing a structured professional judgment tool (e.g. the SAVRY tool) for the assessment of adolescents that present with mental health concerns; and

(c) report the findings of Recommendation 23(a) and 23(b) to the Department of Health and Community Services.

Recommendation 27

Partially Implemented

The Royal Newfoundland Constabulary and the Eastern Regional Integrated Health Authority:

(a) review and revise the *Mental Health Care and Treatment Act* Template form to ensure it is meeting the needs of youth presenting at Emergency Rooms by police escort;

(b) develop and implement a policy to ensure that when a youth requiring

police services due to mental health issues presents at a hospital, communication between medical personnel and the police is acknowl edged by the signatures of both the police officer and the hospital official (i.e. the nurse or physician) on the *Mental Health Care and Treatment Act* Template form and the signed form is placed in each file;

(c) report the findings of Recommendation 27(a) and 27(b) to the Department of Justice and the Department of Health and Community Services for implementation throughout the province.

Comments: In March 2014, Eastern Health reported the *Mental Health Care and Treatment Act* template forms for the RNC and the RCMP are available in the Janeway Emergency Room. These forms are generated by the RNC and the RCMP and have been in use for several years. Eastern Health reported their intentions to review the form to determine if revisions are needed and a meeting was scheduled for April 2014. Eastern Health reported that in collaboration with the Child Health Program, the RNC and the RCMP, an algorithm will be developed to guide the assessment process within the Janeway Emergency Room for patients presenting with mental health and addictions issues. This will include reference to the *Mental Health Care and Treatment Act* template forms and was to be completed by May 2014. Eastern Health reported ongoing consultation with the Mental Health and Addictions Division of the DHCS regarding the provision of mental health and addictions services to children and youth.

In November 2014, Eastern Health reported that the *Mental Health Care and Treatment Act* form for both the RNC and RCMP was reviewed and revised. It was also reported that an algorithm to guide the process of emergency presentations to the emergency room by youth with mental health issues is being developed and will be shared with emergency room staff and police agencies.

Completion of this recommendation is pending completion and implementation of the algorithm and reported findings to the DHCS.

Reviews

Justice Complaint Emergency Intake

Justice Complaint Emergency Intake

In 2011, the Child and Youth Advocate became aware of a case involving a fifteen (15) year old who had been arrested. The youth was arrested for assaulting a parent and was placed in the custody of Youth Corrections. After appearing in court, the youth was released from custody on an undertaking with conditions to keep the peace, abide by a curfew, and to have no contact with the parent that had been assaulted. The third condition left the youth without the option of returning home to the parent's care.

Justice staff concluded that the youth could not return home and did not have a caregiver willing or able to provide care, resulting in the youth being a child in need of protective intervention. The Department of Child, Youth and Family Services (DCYFS) was contacted and advised of the youth's situation as well as the need for the DCYFS to take custody of the youth. Justice staff was advised by the DCYFS that they did not have the authority to take the youth into care and would not be picking up the youth from the holding cells.

The youth reappeared before a judge and asked to be referred to the DCYFS under Section 35 of the *Youth Criminal Justice Act,* which gives the court the authority to refer a young person to a child welfare agency for assessment to determine if they are in need of child welfare services. The judge made an order under this section and directed the DCYFS to address the situation immediately. The youth remained in the holding cells until later that evening when the DCYFS took the youth into their care.

The Advocate decided to review the circumstances of this case to determine if the youth was treated unjustly and to assess the role of the DCYFS in this case. The review included discussions with the parties involved and a review of policies, procedures and legislation. The purpose of this review was to examine the actions of the DCYFS in regards to the placement of the youth after court.

The review revealed that:

- the youth was unlawfully held at court after release, as there was no other safe option;
- the DCYFS who has the obligation to intervene was reluctant and advised that they did not have the authority to take the youth into their care;
- the youth was held at court due to a child protection concern;
- the DCYFS believed that their response was appropriate;
- the DCYFS was actively involved with the youth's family and was aware that the family could not assist with placement;

- the DCYFS should not have been reluctant to become involved (resulting in the court filing a Section 35 order); and
- the youth was a child in need of protection and the response by the DCYFS should have come sooner.

This review included a total of one recommendation made to the Department of Child, Youth and Family Services (DCYFS).

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	**1**
Implemented Through Alternative Measures	**0**
Partially Implemented	**0**
Not Implemented - Response Inadequate and Inappropriate	**0**
No Longer Applicable	**0**

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Implemented

CYFS collaborate with the Department of Justice, along with Pre-Trial Services, Legal Aid and the Sherriff's Office to develop a Memorandum of Understanding/Joint Policy regarding CYFS role in Youth Court. This Memorandum of Understanding/Joint Policy should include a step-by-step process of roles and responsibilities of each of the agencies involved.

Youth in Adult Holding Facilities: Case 1

Youth in Adult Holding Facilities: Case 1

In 2011, the Child and Youth Advocate received information that a youth had been held at an adult holding facility for longer than the allotted maximum time stipulated in *Standards of Care for the Operation of Police Lockups as Designated Places of Temporary Detention* and *Secure Custody for Young Persons (Standards of Care)*. In a span of approximately two (2) weeks, the youth had been held in an adult holding facility twice; once for approximately eight (8) days and again for approximately five (5) days. Additionally, concerns were raised that the meals the youth received while detained were limited and did not meet nutritional guidelines. It was also alleged that access to shower facilities was not provided daily. These allegations pointed to a direct contravention of the *Standards of Care*, which have been put in place to protect the rights of young offenders.

In completing this review, the *Standards of Care* were reviewed, as well as all Royal Canadian Mounted Police (RCMP) file information pertaining to this youth's detentions in the holding facility. Advocate's staff met with the youth at the Newfoundland and Labrador Youth Centre (NLYC) to discuss this experience at the holding facility. Discussions with other professionals from the RCMP and the NLYC also occurred.

The Advocate was unable to substantiate the complaints made by the youth regarding the two (2) detainments at the holding facility. In fact, it appeared that staff at the holding facility did the best they could to maintain the *Standards of Care* for the youth during these detentions. However, it was glaringly obvious that the amount of time the youth was held was well in excess of the ninety-six (96) hours allotted in the *Standards of Care*. This was a major concern and was unacceptable.

This review included a total of six (6) recommendations to the Department of Justice.

Status of Recommendations

Department of Justice

Implemented	**6**
Implemented Through Alternative Measures	**0**
Partially Implemented	**0**
Not Implemented - Response Inadequate and Inappropriate	**0**
No Longer Applicable	**0**

RECOMMENDATIONS MADE TO THE DEPARTMENT OF JUSTICE

Recommendation 1
Implemented

The NLYC ensure there is a process in place whereby the Community Social Worker is notified when a youth leaves the NLYC to travel to court and will be held in a police lockup.

Recommendation 2
Implemented

The NLYC ensure there is a process in place whereby before a youth leaves the facility they are informed who they can contact and how to contact those people if they have any concerns during their time in the police lockup.

Recommendation 3
Implemented

The NLYC ensure there is a process in place whereby daily contact is made by a facility employee with a youth who is being held in a police lockup awaiting court or awaiting transfer back to the NLYC. Where possible, the daily contact should be made with the youth directly.

Recommendation 4
Implemented

The Department of Justice ensure that the *Standards of Care* are upheld whenever a youth is being held in a police lockup (adult holding facility).

Recommendation 5
Implemented

The Department of Justice ensure that a process is put in place by which a judge or the Crown Prosecutor be notified when the amount of time a youth has been held in a police lockup (holding facility) surpasses 96 hours.

Recommendation 6
Implemented

The Department of Justice conduct a review of the current facilities that have been designated to temporarily hold youth to ensure that when a youth is held there that the *Standards of Care* can be maintained to ensure a youth's rights are not violated and provide the findings of that review to the OCYA.

Youth Corrections Decisions Regarding Open Custody Placements

Youth Corrections - Decisions Regarding Open Custody Placements

In 2011, concerns were brought to the Advocate's attention regarding a youth who received a court sentence that included placement at an open-custody facility in St. John's. The youth was later told that they were no longer being placed in St. John's; they were being transferred to an open-custody placement in Corner Brook.

The youth had been in secure custody at the Newfoundland and Labrador Youth Centre (NLYC) for approximately one month. At sentencing, the judge was told about the youth's history and needs, and that a space was available for the youth in an open-custody facility in St. John's. Professionals involved drafted a plan to ensure that the youth's needs would be met and services would be provided in St. John's. The plan included assisting the youth to find housing and counselling and to enroll in school. The youth was to reside in an open-custody group home in St. John's that would be close to a supportive family, Choices for Youth and Community Youth Corrections.

The decision of placement of youth serving open custody sentences is made by the Director of Youth Corrections. In this case, the Director decided to place the youth in Corner Brook, even though a placement was available in St. John's. The decision was made because the placement in St. John's was needed for another youth who was being transferred from Corner Brook.

Section 83(2)(c) of the *Youth Criminal Justice Act (YCJA)* stipulates that the youth custody and supervision system should facilitate the involvement of the families of a young person. Section 85(5)(a)(ii) of YCJA stipulates that when making decisions the Director should take into account the needs and circumstances of the youth including proximity to family, school, employment and support services.

The purpose of this review was to examine the actions of the Department of Child, Youth and Family Services (DCYFS) regarding the open-custody placement of this youth and to determine the level of services available for the youth at this placement in Corner Brook. Legislation, policies and procedures were reviewed and discussions occurred with the youth, the parent of the youth, the judge, staff from the open-custody placement in Corner Brook and staff from Youth Corrections, Pre-Trial Services and Legal Aid.

This review included a total of two (2) recommendations to the Department of Child Youth and Family Services (DCYFS).

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	2
Implemented Through Alternative Measures	0
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF CHILD, YOUTH AND FAMILY SERVICES

Recommendation 1
Implemented

That the Department of Child, Youth and Family Services and the Department of Justice implement a process so that current information regarding Open Custody placements for youth is readily available to key players to ensure proper placements occur.

Recommendation 2
Implemented

That the Department of Child, Youth and Family Services continue to monitor the Open Custody Program and if placement problems continue, then conduct a review of the program.

Youth in Adult Holding Facilities: Case 2

Youth in Adult Holding Facilities: Case 2

In 2013, the Advocate for Children and Youth (ACY) became aware of a case involving a youth who had been detained in three (3) adult holding facilities for eleven (11) days. This well exceeded the allotted time stipulated by the *Standards of Care for the Operation of Police Lockups as Designated Places of Temporary Detention* and *Secure Custody for Young Persons (Standards of Care)*. The youth had been detained in three (3) different holding facilities during this eleven (11) day period; two (2) facilities were operated by the Royal Canadian Mounted Police (RCMP) and one facility was operated by the Royal Newfoundland Constabulary (RNC).

The *Standards of Care* state that a young person who is held in an adult holding facility by a court order can only be held for ninety-six (96) hours from the time of the first court appearance. After ninety-six (96) hours, the youth must be transferred to a youth facility. The *Standards of Care* also state that the police must contact the appropriate office or an on-call worker immediately when detaining a youth under a court order.

The primary issue that contributed to this youth remaining in the adult holding facilities for eleven (11) days was court delays. Weather conditions also contributed by preventing transportation of the youth to the Newfoundland and Labrador Youth Centre (NLYC). For the most part, the holding facilities that housed this youth did attempt to meet the standards listed in the *Standards of Care*. Meals and clean clothing were provided and visits were permitted from the youth's social worker, lawyer and parent. However, some issues were identified including reasonable access to showers; availability of toiletries, reading materials, and games; and access to daily exercise and time out of the locked cell. Issues were also identified with regards to the provision of necessary health services and the conduct of physical searches.

The purpose of the review was to determine the circumstances and chronology of this youth's detainments. One month after the Advocate initiated the review, the youth was again detained in an adult holding facility. This later detention was also included in the review. In completing the review, the *Standards of Care*, file information related to the youth's detainments and file information from the DCYFS was reviewed. Discussions with the youth's parent also occurred.

This review included a total of nine (9) recommendations made to the Department of Justice.

Status of Recommendations

Department of Justice

Implemented	8
Implemented Through Alternative Measures	1
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

RECOMMENDATIONS MADE TO THE DEPARTMENT OF JUSTICE

Recommendation 1
Implemented

The Department of Justice always ensure that the *Standards of Care* are upheld when a young offender is detained in an adult holding facility (i.e. police lockup). In particular, as a result of this review, the Department of Justice must ensure that:

(a) assignment of staff is adjusted or revised when a young offender is held in an adult holding facility (i.e. police lockup) to ensure timely access to showers and other entitlements; and

(b) books, magazines and appropriate games are obtained and provided to young offenders during their time in an adult holding facility (i.e. police lockup).

Recommendation 2
Implemented

The Department of Justice review and revise policies and protocols of all provincial policing agencies to ensure consistency in the monitoring and recording of activity of young offenders while in an adult holding facility (i.e. police lockup).

Recommendation 3
Implemented Through Alternative Measures

The Department of Justice explore and implement alternative processes to be used during strip searches of young offenders if the situation escalates and the risk of trauma is imminent.

Comments: The response is accepted as adequate and appropriate as the Department of Justice reported that strip searches are not completed on young offenders in designated lockups. Should the situation become such that clothing must be removed from a prisoner, then it is done for the concern of safety. The safety of persons in the Department's care is priority along with ensuring that potential risks are assessed. The unfortunate reality is that steps have to be taken to mitigate risks for the safety of all.

Recommendation 4
Implemented

The Department of Justice develop and implement protocol to ensure the presiding Judge of a court is officially notified at the beginning of each court appearance of the current amount of time a young offender has been held in an adult holding facility (i.e. police lockup); with particular emphasis on when the maximum time allotted by the *Standards of Care* has been exceeded.

Recommendation 5
Implemented

The Department of Justice review court processes to ensure adherence to the maximum period of time a young offender can be held in an adult holding facility (i.e. police lockup) as per Standard 2 of the *Standards of Care*. Additionally, the Department of Justice must identify and establish initiatives such as prioritizing youth on the court docket, videoconferencing, etc., to prevent violations of the *Standards of Care*.

Recommendation 6
Implemented

The Department of Justice establish a process whereby notification is provided to a representative of the Department when the amount of time a youth has been held in an adult holding facility has exceeded the maximum allotted by the *Standards of Care*. This person would be responsible for ensuring an immediate response to remedy the issue. Additionally, they should notify the ACY of all instances when a youth has been held in an adult holding facility in excess of 96 hours.

Recommendation 7
Implemented

The Department of Justice ensure that upon admission to an adult holding facility (i.e. police lockup) all young offenders are provided with the contact information for the Advocate for Children and Youth, and any requests to contact the Advocate are facilitated, as per Section 17 of the *Child and Youth Advocate Act*.

Recommendation 8
Implemented

The Department of Justice review and revise the protocol for handling suicide attempts to ensure the safety of young offenders with particular focus on:

(a) the provision of tear-resistant clothing to each adult holding facility (i.e. police lockup) for young offenders presenting with threats of self-harm or suicidal idealization; and

(b) the provision of "constant" monitoring of young offenders presenting with threats of self-harm or suicidal ideation.

Recommendation 9
Implemented

The Department of Justice establish a quality assurance process to review any critical incident to ensure any deficiencies are identified and addressed to prevent future harm.

Conclusion

From 2006 to 2013, the Advocate for Children and Youth (ACY) completed seven (7) investigations and four (4) reviews, which included 173 recommendations. Some of these recommendations were made to, and required action by, multiple departments and agencies, resulting in a total of 184 responses. This report provides the status of each recommendation as determined by the Advocate based on responses from the relevant departments and agencies. The Advocate will continue to follow up on recommendations that have yet to be implemented to ensure that all are completed. The Advocate's Report on the Status of Recommendations will be released publicly on an annual basis.

Appendices

Appendix A

List of acronyms used in this report

ACRONYM	OFFICIAL TITLE
ACY	Advocate for Children and Youth
CRMS	Client Referral Management System
CYCP Act	Children and Youth Care and Protection Act
CYFS	Child, Youth and Family Services
DCYFS	Department of Child, Youth and Family Services
DHCS	Department of Health and Community Services
Eastern Health	Eastern Regional Integrated Health Authority
ISM	Integrated Service Management
ISSP	Individual Support Services Plan
Janeway	Janeway Children's Health and Rehabilitation Centre
Ministerial Committee	Ministerial Committee on the Turner Recommendations
MOU	Memorandum of Understanding
MUN	Memorial University of Newfoundland
NLYC	Newfoundland and Labrador Youth Centre
RCMP	Royal Canadian Mounted Police
RFP	Request for Proposal
RMS	Risk Management System
RNC	Royal Newfoundland Constabulary
SAVRY	Structured Assessment of Violence Risk in Youth
Standards of Care	Standards of Care for the Operation of Police Lock ups as Designated Places of Temporary Detention and Secure Custody for Young Persons
YCJA	Youth Criminal Justice Act
YLS-CMI	Youth Level of Service Case Management Inventory
YSA	Youth Services Agreement

Appendix B

Status of Recommendations by Department and Agencies

Department/Agency	Implemented	Implemented Through Alternative Measures	Partially Implemented	Not Implemented Response Inadequate and Inappropriate	No Longer Applicable	TOTAL
Provincial Government of Newfoundland and Labrador (Ministerial Committee on the Turner Recommendations)	53.5% 31/58	19% 11/58	3.5% 2/58	0% 0/58	24% 14/58	58
Department of Child, Youth and Family Services	74% 51/69	10% 7/69	7% 5/69	9% 6/69	0% 0/69	69
Department of Health and Community Services	67% 10/15	0% 0/15	33% 5/15	0% 0/15	0% 0/15	15
Department of Justice	84% 16/19	5% 1/19	11% 2/19	0% 0/19	0% 0/19	19
Eastern Health	64% 14/22	27% 6/22	9% 2/22	0% 0/22	0% 0/22	22
Royal Newfoundland Constabulary	0% 0/1	0% 0/1	100% 1/1	0% 0/1	0% 0/1	1

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