THE ADVOCATE'S REPORT ON THE STATUS OF RECOMMENDATIONS

2015

PUBLICATION INFORMATION

The Advocate's Report on the Status of Recommendations 2015
was published by The Advocate for Children and Youth
Newfoundland and Labrador
193 LeMarchant Road
St. John's NL, A1C 2H5

Printed by:

The Queen's Printer
Government of Newfoundland and Labrador

Date printed:

March, 2016

Designed by:

Nicole Greeley
Graphic Designer

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2015

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Message from the Advocate

I am very pleased to present "The Advocate's Report on the Status of Recommendations 2015". This is our second report and will continue to be updated and released publicly on an annual basis. This report includes all eight (8) investigations and four (4) reviews completed since 2006, including the resulting 183 recommendations. I have determined the status of each recommendation based on information reported by departments and agencies as of October 2015.

It is important to note that there were six (6) recommendations for the Department of Child, Youth and Family Services (DCYFS) categorized as "Not Implemented – Response Inadequate and Inappropriate" in the 2014 report. Through continuing consultation with the DCYFS and their ongoing commitment, two (2) have now been implemented and four (4) partially implemented.

Unfortunately, three (3) of those four (4) have not progressed due to the halting of the intensive work that took place from January to June 2015 on the proposed amendments to the *Child and Youth Advocate Act (SNL 2001)*. It is my hope that progress will be made on this very important matter in the near future.

In addition to reporting on recommendations made to government departments and agencies by my office, this year recommendations made by the Child Death Review Committee (CDRC) are also highlighted. The CDRC reviews cases involving the deaths of children (under 19 years of age) which have been provided by the Chief Medical Examiner (CME). These deaths are referred to the CME's office as specifically outlined in Sections 5 through 8 of the *Fatalities Investigations Act (SNL 1995)*. In consultation with the Deputy Minister of the Department of Justice and Public Safety, I agreed to coordinate the follow-up process and report on the status of recommendations made by the CDRC. As of August 2015, the Department of Justice and Public Safety provided me with nine (9) individual case reviews completed by the CDRC. Of the nine (9) case reviews, six (6) had a total of ten (10) recommendations, while three (3) had no recommendations. In consultation with the CDRC, I have determined the status of each recommendation based on information reported by departments and agencies as of October 2015.

This has been an 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

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 responsibility to inform the general public of these recommendations.

Since 2006, the ACY has completed a total of eight (8) 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; Sixteen;* and *A Tragedy Waiting to Happen.* 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 twelve (12) reports included a total of 183 recommendations.

In addition to reporting on recommendations made to government departments and agencies by the ACY, this year recommendations made by the Child Death Review Committee (CDRC) are also highlighted. The CDRC reviews cases involving the deaths of children (under 19 years of age) which have been provided by the Chief Medical Examiner (CME). These deaths are referred to the CME's office as specifically outlined in Sections 5 through 8 of the *Fatalities Investigations Act (SNL 1995)*. In consultation with the Deputy Minister of the Department of Justice and Public Safety, the Advocate agreed to coordinate the follow-up process and report on the status of recommendations made by the CDRC. As of August 2015, the Department of Justice and Public Safety provided the ACY with nine (9) individual case reviews completed by the CDRC. Of the nine (9) case reviews, six (6) had a total of ten (10) recommendations, while three (3) had no recommendations.

While all previous recommendations made by the ACY are mentioned in this report, this year the ACY only provides the status of recommendations that were classified by the Advocate as partially implemented or not implemented in *The*

Advocate's Report on the Status of Recommendations 2014, as well as the status of new recommendations made since 2014. The eight (8) investigations and four (4) case reviews reported on this year by the ACY included a total of twenty one (21) outstanding recommendations and ten (10) new recommendations, and the six (6) individual case reviews completed by the CDRC included a total of ten (10) new recommendations, for an overall total of forty one (41) recommendations. These recommendations 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 and Public Safety;**
- **Labrador-Grenfell Regional Integrated Health Authority;**
- **Eastern Regional Integrated Health Authority;**
- **Royal Newfoundland Constabulary;**
- **Child Death Review Committee; and**
- **Department of Education and Early Childhood Development.**

Some of these recommendations were made to, and required action by, multiple departments and agencies, resulting in a total of forty five (45) responses this year.

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 outstanding and new recommendations made in investigations, as well as new recommendations made by the CDRC. 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 case review, as well as the status of each recommendation as of October 2015. In some instances, comments are provided to explain why a particular recommendation has yet to be implemented. Appendix B and Appendix C highlight the total number of recommendations made by the ACY and the CDRC to each department or agency and the percentage of recommendations in each status category.

As of October 2015, the status of all 183 recommendations made by the ACY since 2006, based on 218 responses from the departments and agencies, is as follows:

- 69% Implemented
- 13% Implemented Through Alternative Measures
- 11% Partially Implemented
- 0% Not Implemented – Response Inadequate and Inappropriate
- 7% No Longer Applicable

Additionally, as of October 2015, the status of ten (10) new recommendations made by the CDRC, based on eleven (11) responses from the departments and agencies, is as follows:

- 36% Implemented
- 19% Implemented Through Alternative Measures
- 36% Partially Implemented
- 0% Not Implemented – Response Inadequate and Inappropriate
- 9% 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 publicly 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.

In addition to reporting on recommendations made to government departments and agencies by the ACY, this year recommendations made by the Child Death Review Committee (CDRC) are also highlighted. The CDRC reviews cases involving the deaths of children (under 19 years of age) which have been provided by the Chief Medical Examiner (CME). These deaths are referred to the CME's office as specifically outlined in Sections 5 through 8 of the *Fatalities Investigations Act (SNL 1995)*. In consultation with the Deputy Minister of the Department of Justice and Public Safety, the Advocate agreed to coordinate the follow-up process and report on the status of recommendations made by the CDRC. This report, the second Advocate's Report on the Status of Recommendations, outlines the monitoring activity by the Advocate as of October 2015 of the outstanding and new recommendations included in eight (8) investigations and four (4) case reviews completed by the ACY, and new recommendations included in six (6) individual case reviews completed by the CDRC.

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 second Advocate's Report on the Status of Recommendations, the relevant departments and agencies provided information regarding the status of any recommendations determined to be partially implemented or not implemented in the last report, as well as the status of new recommendations made by the Advocate since 2014. In addition, this report highlights the status of recommendations made by the Child Death Review Committee (CDRC) in individual case reviews completed since 2014. 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.

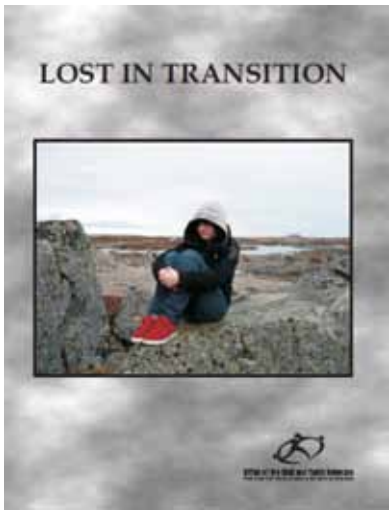
Not Implemented – Response Inadequate and Inappropriate

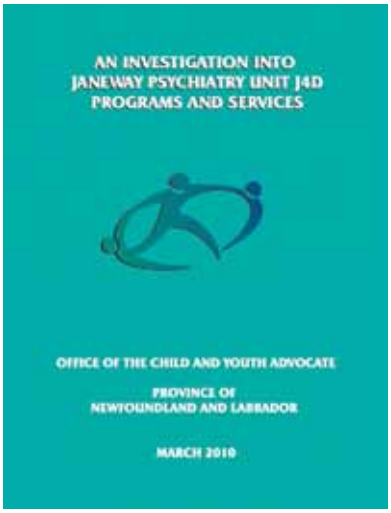
No action taken by the department or agency. As per Section 24 of the *Child and Youth Advocate Act (SNL 2001)*, the Advocate may report this to Cabinet and may mention the report in the next annual report to the House of Assembly.

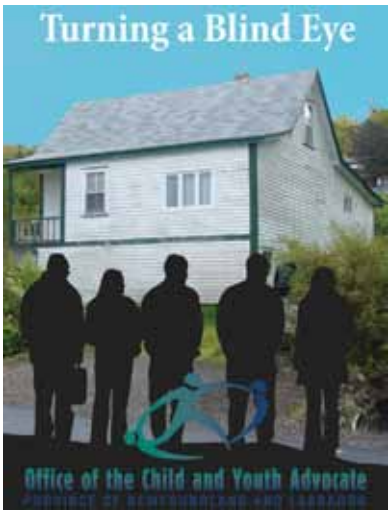
No Longer Applicable

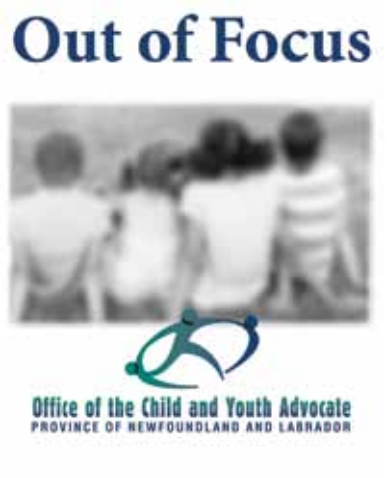
The Advocate has determined that the recommendation is no longer applicable.

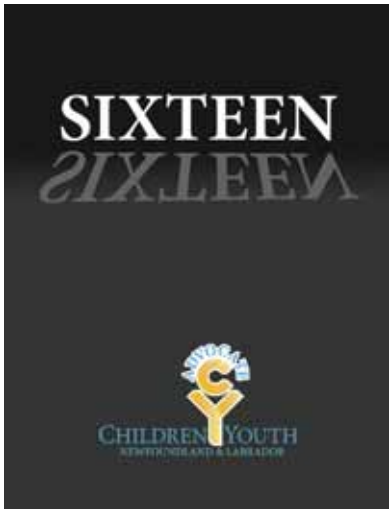
Investigations

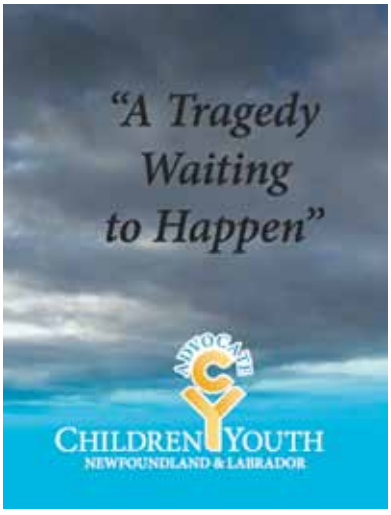


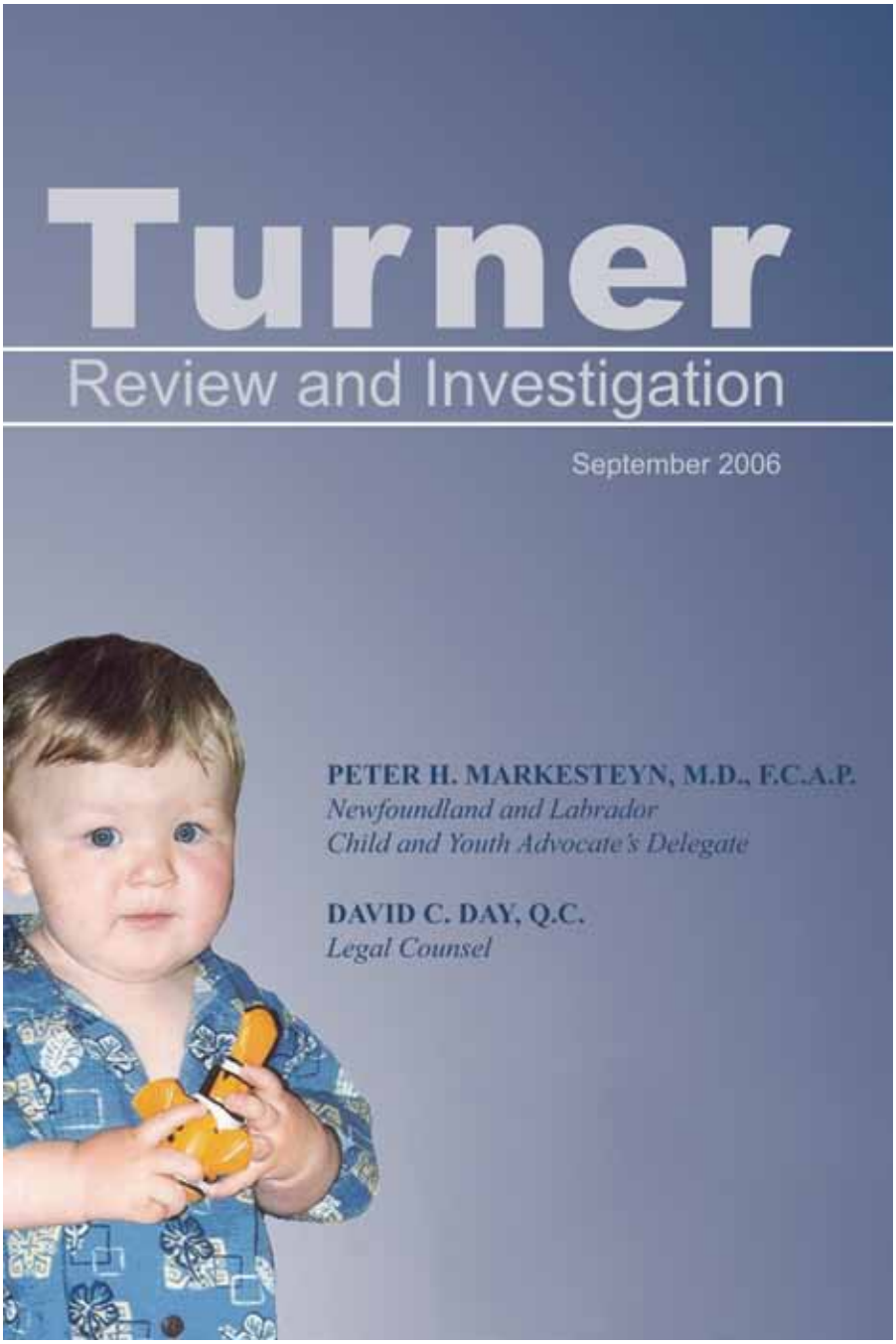











Turner
Review and Investigation
September 2006
PETER H. MARKESTEYN, M.D., F.C.A.P.
Newfoundland and Labrador
Child and Youth Advocate's Delegate
DAVID C. DAY, Q.C.
Legal Counsel

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. As of October 2015, there are two (2) recommendations requiring further action.

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 7.18
Partially Implemented

That all prior records 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.

In October 2015, the Ministerial Committee reported that the alphabetizing of the 225,000 index cards is nearing completion with approximately 800 cards left to organize. Since 2012, all incoming case files at the records centre are recorded in CRMS so that staff conducting a search can see that an archived file exists at the record centre. All historical files at the records centre are currently searchable through electronic means, either through a review of spreadsheets or a search in Total Records and Information Management (TRIM). The DCYFS is in the process of transferring all historical records (including those on index cards) to TRIM. In addition to completing record checks in CRMS, DCYFS staff will continue to contact the records centre to complete a search of its electronic databases.

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.

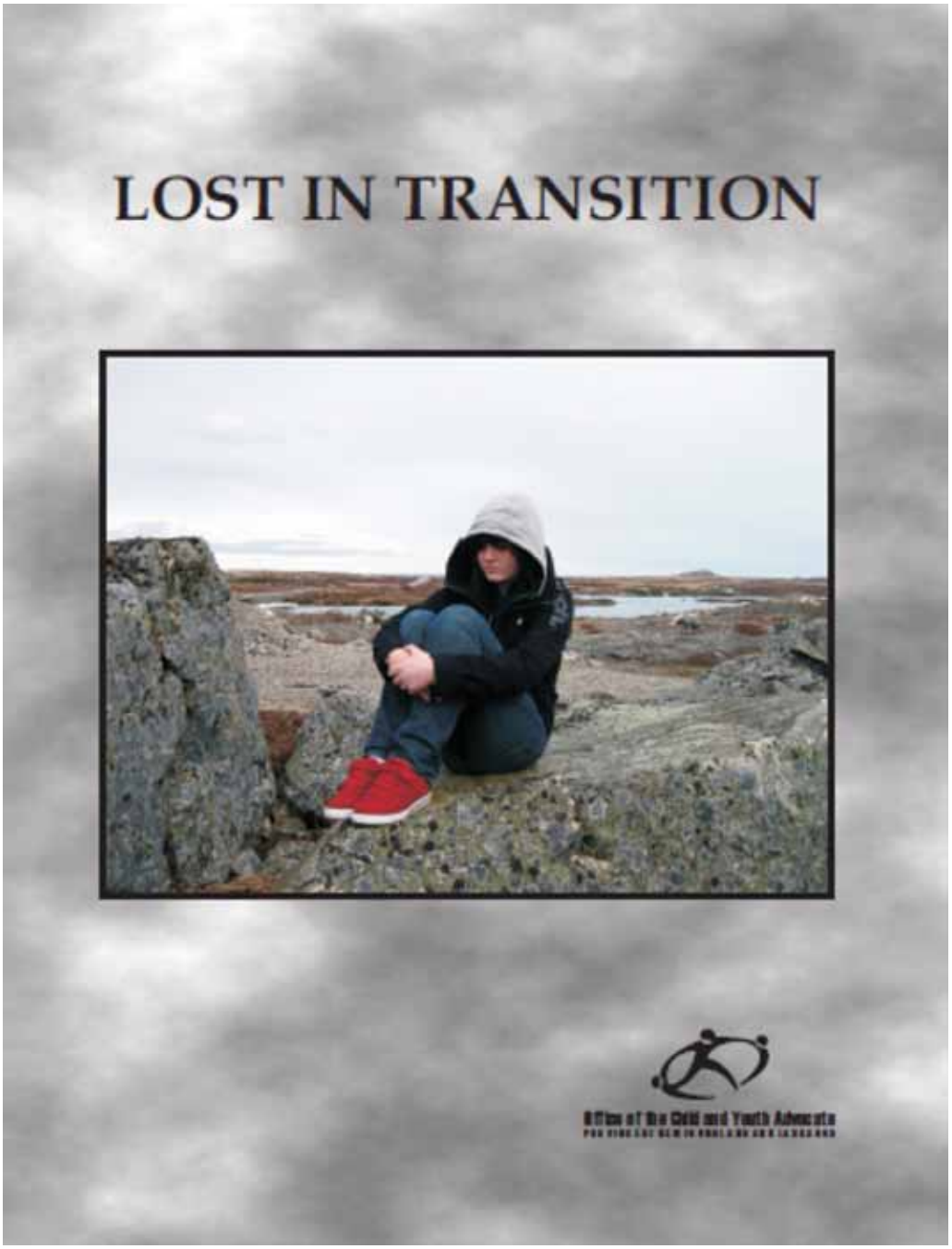
Comments: In June 2012, the Ministerial Committee reported that this recommendation is implemented and ongoing due to the nature of the initiative. In March 2013, the Ministerial Committee reported that issues with child abuse and neglect records will be addressed through the new case management system 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 Integrated Service Management (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.

In October 2015, the Ministerial Committee reported that the ISM project is currently underway and it is anticipated that implementation will occur in early 2017.

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


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.

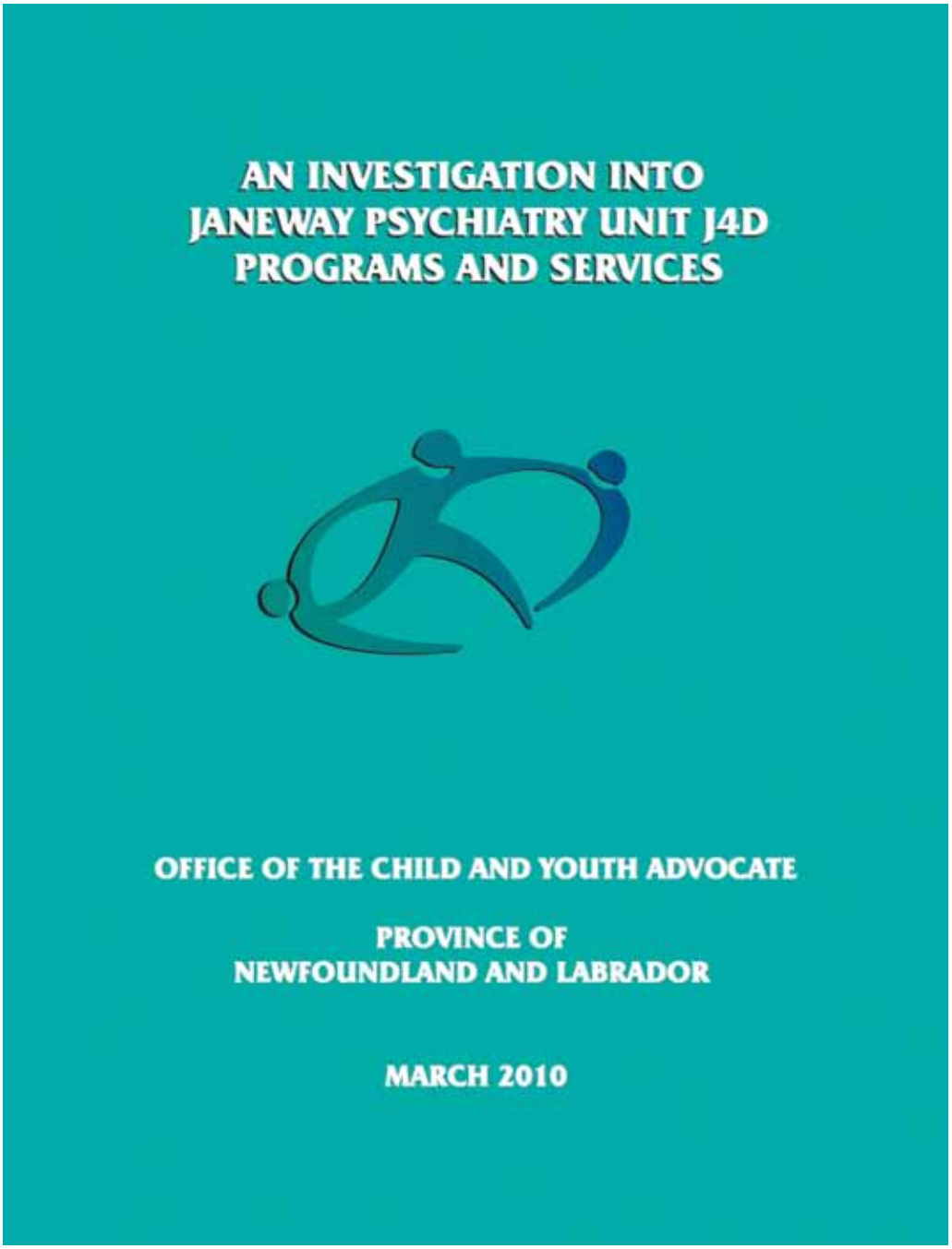
In order to gain a comprehensive and balanced picture of the circumstances surrounding transitioning of children and youth In Care, information was sought from a variety of sources. A review of existing policies and legislation helped to establish the expected standard of care for the In Care Program. 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. All recommendations were implemented as of *The Advocate's Report on the Status of Recommendations 2014.*

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**


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). In *The Advocate's Report on the Status of Recommendations 2014,* there was one outstanding recommendation which was classified by the Advocate as partially implemented. As of October 2015, all eighteen (18) recommendations have been implemented.

Status of Recommendations

Eastern Health

Implemented	10
Implemented Through Alternative Measures	6
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

Status of Recommendations

Department of Health and Community Services

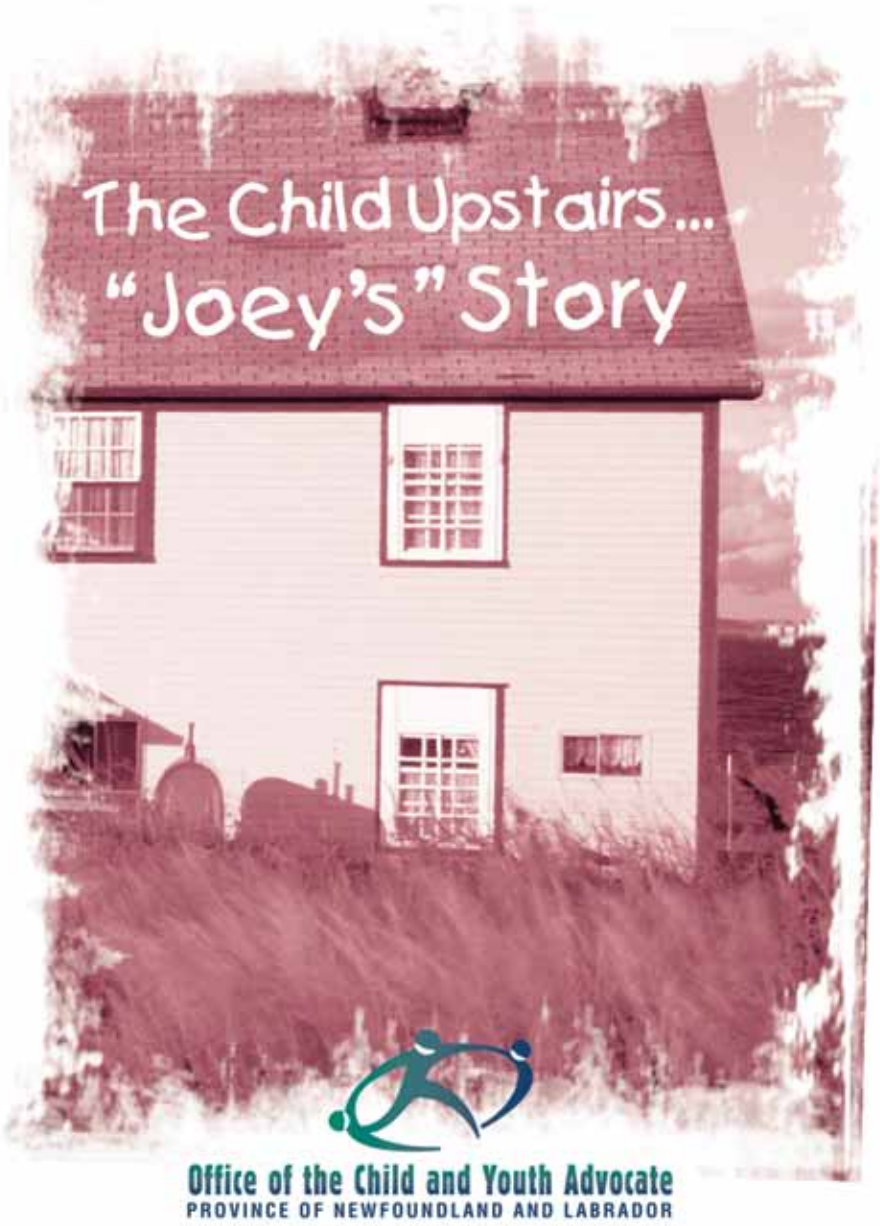
Implemented	2
Implemented Through Alternative Measures	0
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

RECOMMENDATIONS MADE TO EASTERN HEALTH

Recommendation 13

Implemented

That Eastern Health establish a process to address inappropriate admissions.


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 record-keeping and information sharing had been cultivated, Joey's situation could have been pre-empted 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 record-keeping, 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. As of October 2015, there are two (2) recommendations requiring further action.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	6
Implemented Through Alternative Measures	0
Partially Implemented	2
Not Implemented - Response Inadequate and Inappropriate	0
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.

In October 2015, the DCYFS reported that the alphabetizing of the 225,000 index cards is nearing completion with approximately 800 cards left to organize. Since 2012, all incoming case files at the records centre are recorded in CRMS so that staff conducting a search can see that an archived file exists at the record centre. All his-

torical files at the records centre are currently searchable through electronic means, either through a review of spreadsheets or a search in Total Records and Information Management (TRIM). The DCYFS is in the process of transferring all historical records (including those on index cards) to TRIM. In addition to completing record checks in CRMS, DCYFS staff will continue to contact the records centre to complete a search of its electronic databases.

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

Recommendation 2
Implemented

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.

Recommendation 9
Partially Implemented

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.

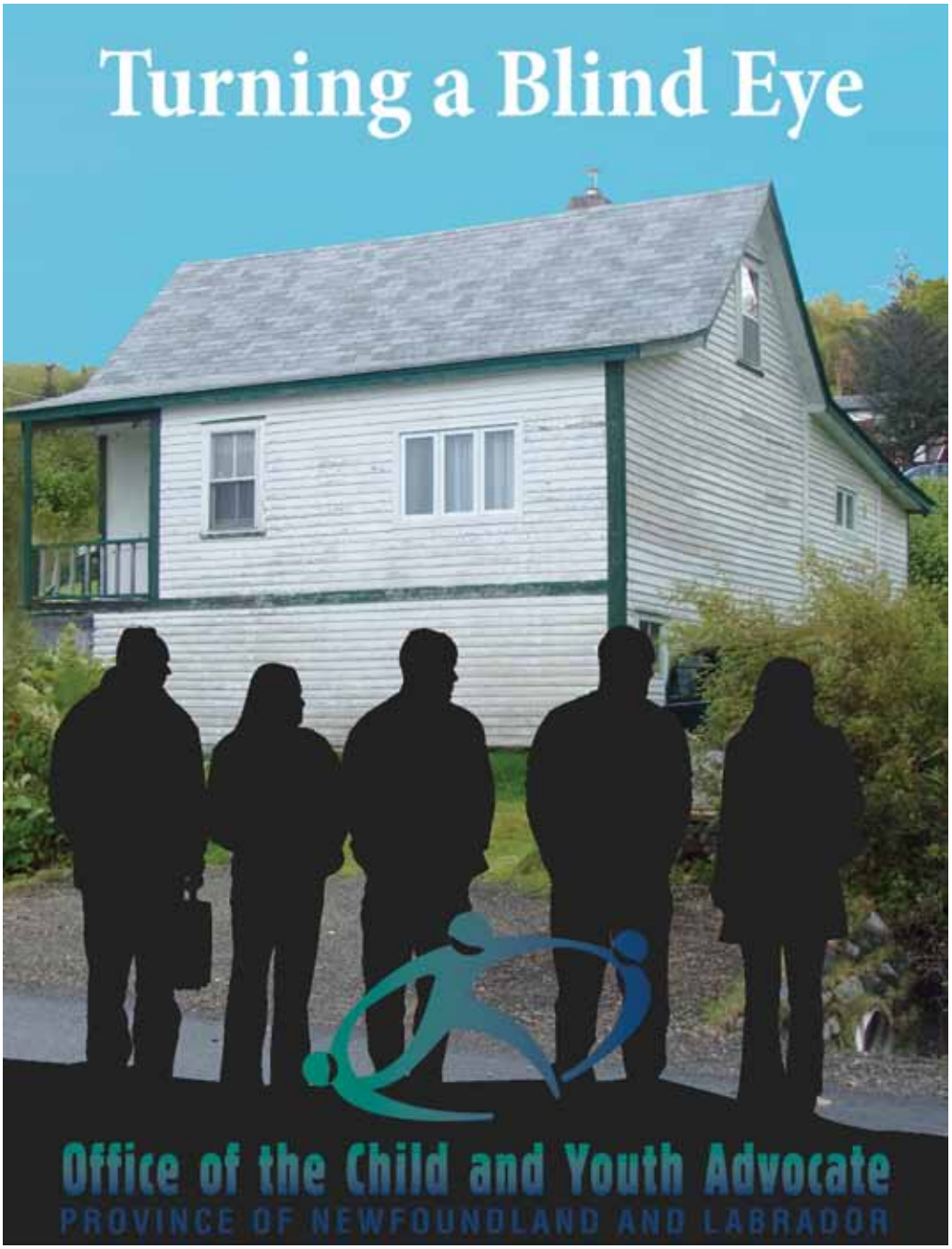
In March 2013, the DCYFS reported they do not plan to develop a protocol with the ACY to report critical incidents and sentinel events occurring with children and youth. It was noted that the DCYFS will continue to adhere to the protocol agreed on by the ACY and the DCYFS that deals with requests for 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. This response was not accepted and was considered inadequate and inappropriate. 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.

In the Fall of 2014, the Advocate made a formal request to the Honorable Paul Davis, Premier of Newfoundland and Labrador, that the *Child and Youth Advocate Act (SNL 2001)* be amended to include mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident, or when a death of a child or youth occurs. From January to June 2015, the ACY worked in collaboration with the Department of Child, Youth and Family Services; the Department of Health and Community Services; the Department of Education and Early Childhood Development; and, the Department of Justice and Public Safety to come to an agreement on the proposed amendments. The proposed amendments, developed in consultation with the Advocate, set out parameters for reporting including a definition of *"critical incident"* and the notification timeframe. As of October 2015, there has been no further progress on these amendments.

Completion of this recommendation is pending the completion of these amendments to the *Child and Youth Advocate Act (SNL 2001).*


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 pre-empted 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. As of October 2015, there is one recommendation requiring further action.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	9
Implemented Through Alternative Measures	1
Partially Implemented	1
Not Implemented - Response Inadequate and Inappropriate	0
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 3
Implemented

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.

Recommendation 12
Partially Implemented

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 their 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. This response was not accepted and was considered inadequate and inappropriate as the DCYFS did 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.

In the Fall of 2014, the Advocate made a formal request to the Honorable Paul Davis, Premier of Newfoundland and Labrador, that the *Child and Youth Advocate Act (SNL 2001)* be amended to include mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident, or when a death of a child or youth occurs. From January to June 2015, the ACY worked in collaboration with the Department of Child, Youth and Family Services; the Department of Health and Community Services; the Department of Education and Early Childhood Development; and, the Department of Justice and Public Safety to come to an agreement on the proposed amendments. The proposed amendments, developed in consultation with the Advocate, set out parameters for reporting including a definition of *"critical incident"* and the notification timeframe. As of October 2015, there has been no further progress on these amendments.

Completion of this recommendation is pending the completion of these amendments to the *Child and Youth Advocate Act (SNL 2001).*

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). As of October 2015, there is one recommendation requiring further action.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	12
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 4
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.

Recommendation 13
Partially Implemented

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.

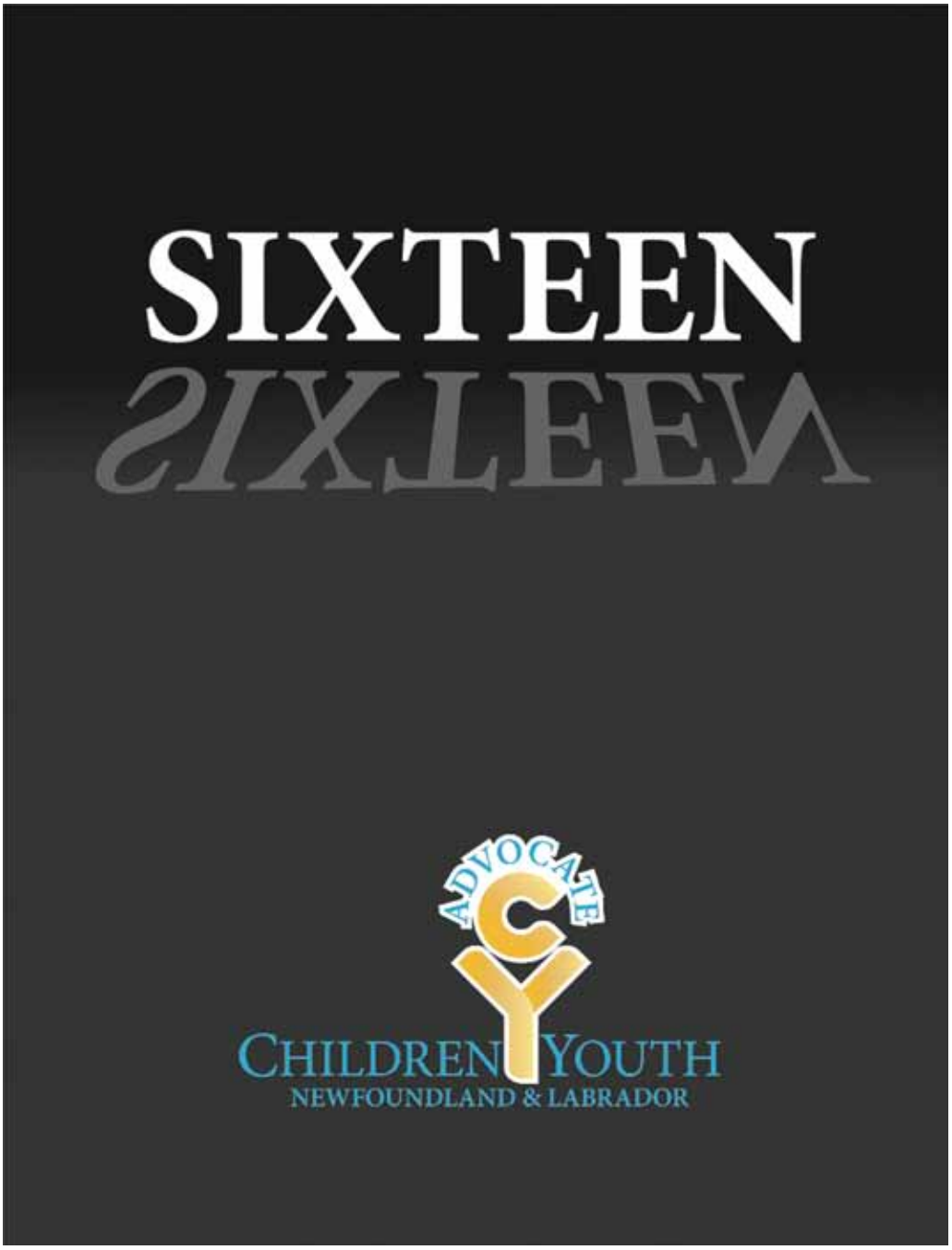
Comments: In March 2013, the DCYFS reported that protocol was developed with the Advocate for Children and Youth (ACY) regarding requests for information under Section 20 and Section 21 of the *Child and Youth Advocate Act*. The DCYFS reported that there is no requirement in the legislation for the DCYFS 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 their 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. This response was not accepted and was considered inadequate and inappropriate as the DCYFS did 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.

In the Fall of 2014, the Advocate made a formal request to the Honorable Paul Davis, Premier of Newfoundland and Labrador, that the *Child and Youth Advocate Act (SNL 2001)* be amended to include mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident, or when a death of a child or youth occurs. From January to June 2015, the ACY worked in collaboration with the Department of Child, Youth and Family Services; the Department of Health and Community Services; the Department of Education and Early Childhood Development; and, the Department of Justice and Public Safety to come to an agreement on the proposed amendments. The proposed amendments, developed in consultation with the Advocate, set out parameters for reporting including a definition of *"critical incident"* and the notification timeframe. As of October 2015, there has been no further progress on these amendments.

Completion of this recommendation is pending the completion of these amendments to the *Child and Youth Advocate Act (SNL 2001).*


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 (DCYFS); 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;
- non-adherence to RNC documentation policies; and
- non-adherence 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. As of October 2015, there are four (4) recommendations requiring further action.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	16
Implemented Through Alternative Measures	1
Partially Implemented	2
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

Status of Recommendations

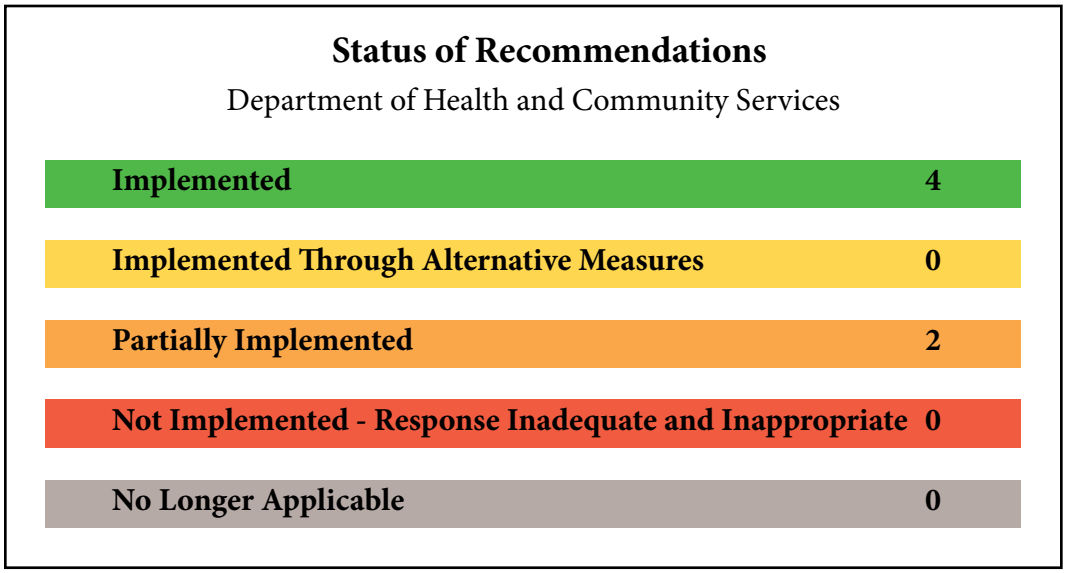
Department of Justice

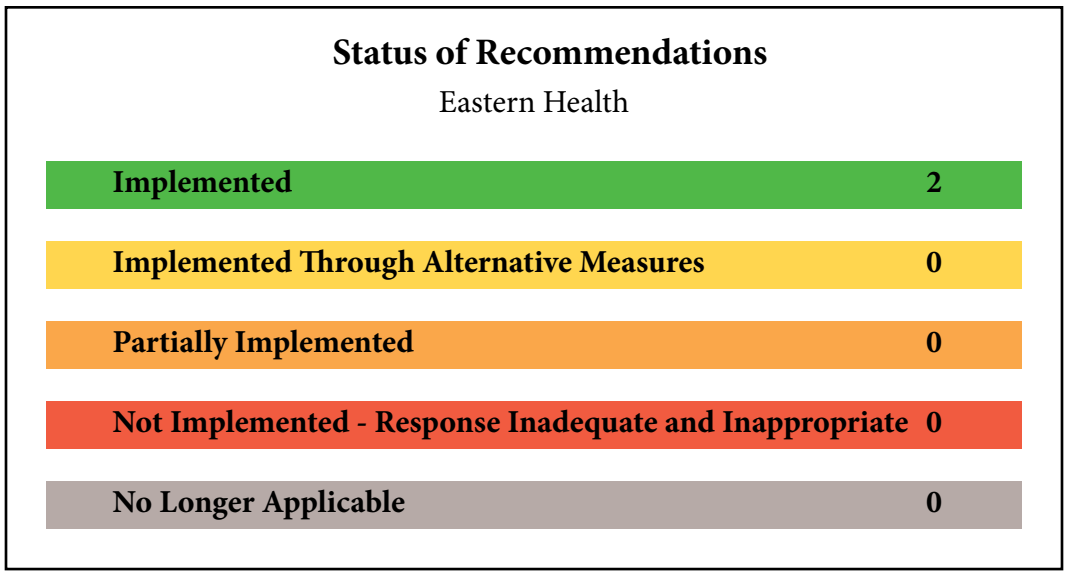
Implemented	4
Implemented Through Alternative Measures	0
Partially Implemented	0
Not Implemented - Response Inadequate and Inappropriate	0
No Longer Applicable	0

Status of Recommendations

Royal Newfoundland Constabulary

Implemented	1
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 2
Not Implemented - Response Inadequate and Inappropriate 0
No Longer Applicable 0


Status of Recommendations
Eastern Health
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 2
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.

Recommendation 4
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.

Recommendation 16
Partially Implemented

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 by the Advocate 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 continued to recommend that these services be provided by separate social workers.

In October 2015, the DCYFS reported that, effective October 31, 2015, they are piloting for one year the assignment of two social workers where a youth is involved in both the Youth Services and Community Youth Corrections Programs and where staffing resources allow for the assignment of two social workers. In instances where a youth is assigned a social worker for each program area, the social workers will be expected to collaborate and share information to ensure the youth has access to services necessary for his/her rehabilitation and a successful transition to adulthood. The DCYFS will develop indicators to measure the pilot which will be completed at the end of the pilot period.

Completion of this recommendation is pending the completion and evaluation of the one year pilot, and the resulting decision proposed by the DCYFS.

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: Recommendations 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.

In October 2015, the DCYFS reported that revisions to the Community Youth Corrections Standards and Practices Manual have been drafted and are currently undergoing a legal review before finalization. The revised manual will include Policy 9.7 on Service Planning, which establishes a new standard for the completion of a written service plan for community based youth corrections. The new policy on service planning will replace the ISSP planning process referenced in the current policy manual, and includes a *Youth Corrections Service Plan* form. The revised policy states that a *Youth Corrections Service Plan* is developed by the community social worker if the young person is in the community or by the open custody social worker when the young person is in custody if there are two (2) or more additional service providers involved with the young person and there is no other active formal planning process in place that has resulted in the development of a planning document that addresses various aspects of a young person's life.

Upon consideration, the Advocate determined that, while the establishment of a new standard for the completion of a written service plan for community based youth corrections is adequate and appropriate, Recommendation 26(c) requires the

completion of an ISSP *(Youth Corrections Service Plan)* for any youth who is simultaneously receiving services from the Community Youth Corrections Program and from one or more other agencies.

Completion of this recommendation is pending the finalization of revisions to the Community Youth Corrections Standards and Practices Manual, and implementation of those revisions, including the requirement that a *Youth Corrections Service Plan* be completed for any youth who is simultaneously receiving services from the Community Youth Corrections Program and from one or more other agencies.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF JUSTICE

Recommendation 19
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.

Recommendation 28
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.

RECOMMENDATIONS MADE TO THE ROYAL NEWFOUNDLAND CONSTABULARY

Recommendation 27
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.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 22
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.

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.

In October 2015, the DHCS provided a response which reflected their 2014 response. Eastern Health has reviewed the SAVRY and HEADS-ED assessment tool. The HEADS-ED tool was considered for implementation in the Janeway Emergency Department; however, the tool itself is still in the research phase. Therefore, implementation of the HEADS-ED has not occurred and mental health nurses in the Janeway Emergency Room continue to use the Psychiatric Nursing Assessment Form. Western Health and Central Health continue to use the same tools as reported by the DHCS in November 2014. All regions continue to collaborate in the use of a consistent tool. The DHCS will work with the (4) Regional Health Authorities to determine next steps once Eastern Health has fully implemented the HEADS-ED tool.

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

Recommendation 25
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.

Recommendation 28
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.

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.

In October 2015, the DHCS reported that the Recovery Approach training has been developed. The training supports the ongoing education of staff who work with individuals with mental health and addictions issues to fully shift a more hopeful, compassionate and recovery-focused system. The two part training includes an online course and skills-based workshop. The DHCS is currently working with the four (4) Regional Health Authorities to arrange the dissemination among all staff in corrections and mental health and addictions settings.

Recommendation 30 was intended to benefit all children and youth in the province, not just those experiencing mental health and addictions issues. Completion of this recommendation is pending a response from the DHCS that will ensure that all children and youth throughout the province are provided with opportunities to express their views freely in all matters affecting them, and have their views considered in the development of their treatment plans.

RECOMMENDATIONS MADE TO EASTERN HEALTH

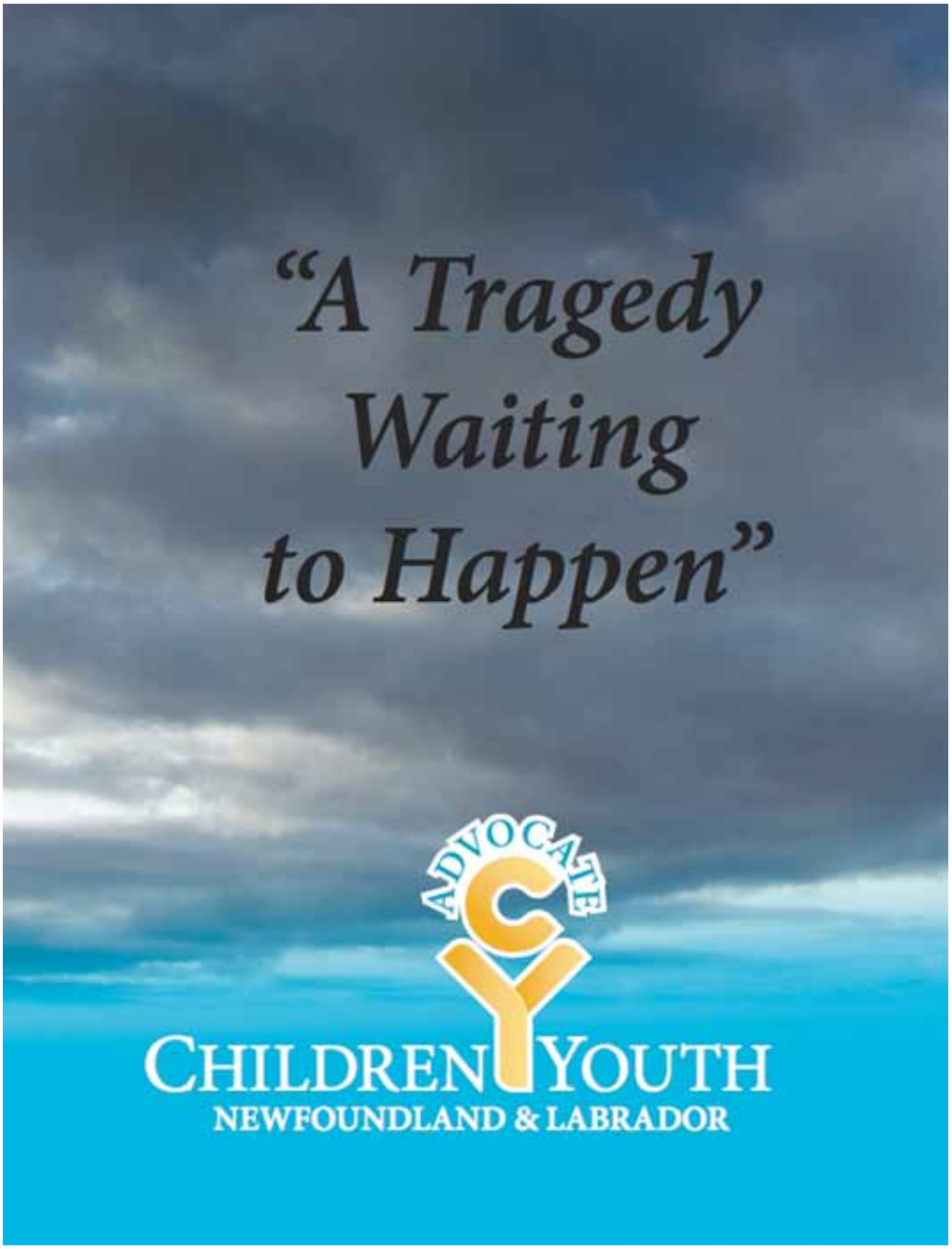
Recommendation 27
Implemented

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.


"A Tragedy
Waiting
to Happen"
ADVOCATE
CHILDREN YOUTH
NEWFOUNDLAND & LABRADOR

A Tragedy Waiting to Happen
March 2015

In January 2013, the Advocate for Children and Youth (ACY) initiated an investigation into the circumstances surrounding a family who had been receiving government services when a fire claimed the lives of two (2) of the three (3) children and one adult. The purpose of this investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services (DCYFS), the Department of Health and Community Services (DHCS), the Labrador-Grenfell Regional Health Authority (LGRHA), and the Department of Justice met the children's needs and whether their right to services was upheld.

The investigative report provides an overview of the events of this case as they occurred over an eight (8) year period. During this time frame, the family had multiple contacts with service providers from the local community health clinic, Child, Youth and Family Services (CYFS), the Royal Canadian Mounted Police (RCMP) and Public Health Nursing provided by the Department of Health and Social Development (DHSD) with the Nunatsiavut Government. The three (3) children remained in their mother's care throughout the duration of the investigative period.

In completing this investigation, the ACY gathered pertinent facts, analyzed the information obtained and recommended changes that are necessary to prevent the reoccurrence of a similar situation. While some of the recommendations are specific to certain departments and agencies, others are relevant to all departments and agencies involved. As with other reports released by the ACY in recent years, the prominent themes throughout this investigation are lack of documentation, non-adherence to documentation policies, lack of comprehensive assessment and lack of collaboration among all service providers involved.

Primary issues identified in the delivery of services provided by the Department of Child, Youth and Family Services to this family include:

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

Primary issues identified in the delivery of services provided by the Department of Health and Community Services and the Labrador-Grenfell Regional Health Authority to this family include:

- failure to report child protection concerns;

- inappropriate medication prescribing/dispensing and lack of comprehensive nursing assessment;
- lack of supervisory oversight;
- lack of collaboration, communication and information sharing; and
- challenges to service provision.

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

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

A Tragedy Waiting to Happen included a total of ten (10) recommendations. Two (2) recommendations were made to the Department of Child, Youth and Family Services (DCYFS); two (2) recommendations were made to the Labrador-Grenfell Regional Integrated Health Authority (LGRHA); and three (3) recommendations were made to the Department of Health and Community Services (DHCS). In addition, one recommendation was made to both the DCYFS and the Department of Justice and Public Safety (DJPS); one was made to the DCYFS, the DJPS and the DHCS; and one was made to both the DCYFS and the DHCS. As of October 2015, there are eight (8) recommendations requiring further action.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	**1**
Implemented Through Alternative Measures	**0**
Partially Implemented	**4**
Not Implemented - Response Inadequate and Inappropriate	**0**
No Longer Applicable	**0**

Status of Recommendations

Department of Justice and Public Safety

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

Status of Recommendations

Labrador-Grenfell Health

Implemented	0
Implemented Through Alternative Measures	0
Partially Implemented	2
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	4
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

The Department of Justice and Public Safety (formerly the Department of Justice) and the Department of Child, Youth and Family Services ensure that the new Memorandum of Understanding that is currently in the process of being drafted is completed in a timely manner and encompasses both Provincial policing agencies (the Royal Canadian Mounted Police and the Royal Newfoundland Constabulary).

Comments: In October 2015, the DCYFS and the DJPS reported that a formal review of the Memorandum of Understanding (MOU) with the Royal Newfoundland Constabulary (RNC) and the Royal Canadian Mounted Police (RCMP) was completed and a revised MOU between the DCYFS and RNC was signed and operationalized in June 2015. The MOU between the DCYFS and the RCMP is an intergovernmental agreement that requires approval which is currently being sought by the DCYFS.

Completion of this recommendation is pending the approval and operationalization of the MOU between the DCYFS and the RCMP.

Recommendation 7
Implemented

The Department of Child, Youth and Family Services ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to adhere to the documentation standards outlined in the *Child, Youth and Family Services Documentation Guide (2012)* and the *Risk Management Decision-Making Model Manual (2013).*

Recommendation 8
Partially Implemented

The Department of Child, Youth and Family Services ensure that all social workers throughout all regions of the Province have appropriate resources and support to enable them to complete comprehensive assessments, interventions and followup in accordance with the *Risk Management Decision-Making Model Manual (2013).*

Comments: In October 2015, the DCYFS reported that they have undertaken a number of initiatives to stabilize their workforce and provide the supports necessary for social workers to perform their job responsibilities. Since the creation of the Department in 2009 and the transition of staff to the Department from the health authorities, the DCYFS has revised and created new policies for all program areas and streamlined the delivery of key programs and services across the province. In addition to improving service delivery to clients, enhanced policies and procedures help to ensure staff understand the expectations of each program area which is a key component of ensuring they are successfully fulfilling their job responsibilities.

In terms of enhanced knowledge and skill development in the areas of protective intervention services, social workers are required to complete Pre-Core training before they assume responsibility for their caseload. Pre-Core includes information on completing comprehensive assessments, interventions and followup in accordance with the Risk Management Decision-Making Model (RMDM). The knowledge acquired through this training is further enhanced through the social worker's mandatory participation in the CORE training which is comprised of eight (8) additional modules.

To ensure staff working in the protection program have access to current clinical resources available to support their work, the Department will be implementing a new decision model (Structured Decision Making) to replace the current Risk Management Decision-Making Model (RMDM). The new model will modernize the approach to child protection decision-making and provide staff with the most up to date and efficient tools available to support their decision making and practice. The new model will be implemented concurrently with the new Integrated Service Management (ISM) system, planning for early 2017.

Completion of this recommendation is pending implementation of the Structured Decision Making model and the ISM system.

Recommendation 9
Partially Implemented

The Department of Child, Youth and Family Services, the Department of Health and Community Services and the Department of Justice and Public Safety (formerly the Department of Justice) jointly develop and implement initiatives such as a multi-disciplinary committee in communities throughout all regions of the Province to ensure collaboration, communication and information sharing among service providers.

Comments: In October 2015, the DCYFS reported that an interdepartmental working committee has been established with representation from the DCYFS, the

DHCS, and the DJPS, including representatives from the RNC and the RCMP. The committee began meeting in September 2015, and will meet monthly to discuss and implement initiatives to improve communication and collaboration in client specific case matters. The committee is in the process of gathering relevant data available within each department or agency and are having discussions with regional staff to identify areas of the province where multi-disciplinary committees are already in place. The DCYFS will establish an internal subcommittee, if required, to further discuss and implement strategies and initiatives identified by the interdepartmental committee.

The DCYFS has also undertaken a review of program specific policies and procedures to ensure the importance of collaborative practice is appropriately reflected in all program areas. The review showed that there is a strong emphasis in policy on collaboration with service providers to ensure the safety and well-being of children and youth.

Completion of this recommendation is pending the identification and establishment of committees at the community level to ensure collaboration, communication and information sharing among service providers.

Recommendation 10
Partially Implemented

The Department of Health and Community Services and the Department of Child, Youth and Family Services, in collaboration with local governments and other service providers:

(a) complete comprehensive needs assessments of the services being provided in every remote and isolated community in the Province to identify existing deficiencies; and

(b) develop and implement strategies to address the identified deficiencies in a timely manner.

Comments: In October 2015, the DCYFS reported that an interdepartmental working committee with representation from the DCYFS, the DHCS, the DJPS, the RNC and the RCMP has been established and began meeting in September 2015 to discuss and identify needs in remote and isolated communities. The committee is currently gathering data available from government departments to identify several communities that may benefit from a coordinated approach to addressing community needs relating to the well-being of children and families. In addition, the DCYFS reported that regular updates will be provided to the ACY with regards to the work of the committee.

Completion of this recommendation is pending the completion of a comprehensive needs assessment, in collaboration with local governments and other service providers, of the services being provided in every remote and isolated community in the province, as well as the development and implementation of strategies to address the identified deficiencies in a timely manner.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF JUSTICE AND PUBLIC SAFETY

Recommendation 1
Partially Implemented

The Department of Justice and Public Safety (formerly the Department of Justice) and the Department of Child, Youth and Family Services ensure that the new Memorandum of Understanding that is currently in the process of being drafted is completed in a timely manner and encompasses both Provincial policing agencies (the Royal Canadian Mounted Police and the Royal Newfoundland Constabulary).

Comments: In October 2015, the DCYFS and the DJPS reported that a formal review of the Memorandum of Understanding (MOU) with the Royal Newfoundland Constabulary (RNC) and the Royal Canadian Mounted Police (RCMP) was completed and a revised MOU between the DCYFS and RNC was signed and operationalized in June 2015. The MOU between the DCYFS and the RCMP is an intergovernmental agreement that requires approval which is currently being sought by the DCYFS.

Completion of this recommendation is pending the approval and operationalization of the MOU between the DCYFS and the RCMP.

Recommendation 9
Partially Implemented

The Department of Child, Youth and Family Services, the Department of Health and Community Services and the Department of Justice and Public Safety (formerly the Department of Justice) jointly develop and implement initiatives such as a multi-disciplinary committee in communities throughout all regions of the Province to ensure collaboration, communication and information sharing among service providers.

Comments: In October 2015, the DJPS reported that representatives from the DJPS, the DCYFS, the DHCS, the RNC and the RCMP met to discuss and examine mechanisms to best respond to this recommendation. The group is in the process of obtaining information from the regions with regards to interdisciplinary committees already in place with a view to identifying communities that need better sharing of information and better capacity to come together for complex matters. The representatives have begun meeting to continue moving implementation of this recommendation forward.

Completion of this recommendation is pending the identification and establishment of committees at the community level to ensure collaboration, communication and information sharing among service providers.

RECOMMENDATIONS MADE TO THE LABRADOR-GRENFELL REGIONAL HEALTH AUTHORITY

Recommendation 2
Partially Implemented

The Labrador-Grenfell Regional Health Authority consult with the Association of Registered Nurses of Newfoundland and Labrador, to review and revise as necessary, the practice of prescribing, administering and dispensing of medications by registered nurses in all community clinics within the region.

Comments: In October 2015, the LGRHA reported that consultation occurred with the DHCS to formulate and update an action plan for this recommendation. Subsequently, consultation between the LGRHA and the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) occurred to review policies and procedures and discuss how the ARNNL could support professional practice in the region.

In September 2015, the Provincial Advisory Committee of Nurse Administrators discussed the review and revision by the ARNNL of nursing practices regarding prescribing, administering and dispensing medications in all community clinics in the province. The ARNNL had planned site visits to the community clinics and health centres in October 2015 to educate regional nurses on a variety of professional practice standards, such as the practice of prescribing, administering and dispensing of medications and documentation. In addition, the LGRHA reported that a community clinics leadership team is participating with the ARNNL and the Pharmaceutical Board on a Dispensing Medications Standards Committee to update the standards. The ARNNL has two ongoing committees which provide oversight for professional practice (Nursing Practice Committee and Advisory Committee on

Nursing Administration). The Nursing Practice Committee reviews a variety of professional practice issues including medication standards and dispensing. Currently, the LGRHA, ARNNL and the pharmacy board have a working group to review the dispensing standards. In addition, the LGRHA has hired a Regional Director of Professional Practice that will also review nursing professional practice to ensure they are aligned with standards as set out by the ARNNL.

Completion of this recommendation is pending the review of the practice of prescribing, administering and dispensing of medications by registered nurses in all community clinics within the region and the completion of any necessary revisions to standards of practice.

Recommendation 4
Partially Implemented

The Labrador-Grenfell Regional Health Authority ensure that comprehensive nursing assessments are being conducted in all community clinics in the region in accordance with the *Labrador-Grenfell Health Community Clinic Services Policy and Procedures Manual* and the *First Nations and Inuit Health Clinical Practice Guidelines for Nurses in Primary Care.*

Comments: In October 2015, the LGRHA reported a variety of orientation and educational initiatives in place with regards to clinical practice guidelines. The LGRHA provides orientation to new registered nurses through a combination of one-on-one and group sessions, educational material, and self-directed learning modules. The orientation program will be enhanced with additional training and education online, which will provide nursing staff with evidence-based clinical practice guidelines to enhance patient care services. A Clinical Nurse Education position has been posted for the community clinics to discuss clinical practice guidelines and policy updates.

LGRHA policies and procedures dictate that all registered nurses consult with a physician if care is outside their scope of practice or their prescriptive authority, or if further advice is required. Two teleconferences on the topic of Duty to Report were held in July 2014 and July 2015 with all community clinics. The LGRHA commits to providing further education, clarification and enhanced orientation to nursing staff so they fully understand and appreciate the importance of reporting instances when someone's well-being and safety is in question.

In addition, the LGRHA reported that random chart audits are conducted to ensure registered nurses are compliant with their scope of practice, their prescriptive authority, the dispensing of medication policy, and the documentation requirements as set out by the Health Authority and the ARNNL. These audits are based on

the standards contained in the *Labrador-Grenfell Health Community Clinic Services Policies and Procedures Manual,* the *Labrador-Grenfell Health Community Clinic Clinical Practice Guidelines,* and the *First Nations and Inuit Health Clinical Practice Guidelines for Nurses in Primary Care.* Information gathered from audits ensures that staff members are following policies and procedures. Depending on the nature of the findings from the random chart audit, appropriate action is taken to increase accountability and ensure standards are met. The LGRHA confirmed that random chart audits are completed by the Clinical Nurse Manager in each clinic on an annual basis. Based on the findings of *A Tragedy Waiting to Happen*, a review of the need to increase the frequency of random chart audits is occurring.

Completion of this recommendation is pending the review of the need to increase the frequency of random chart audits and the completion of subsequent necessary revisions.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 3
Partially Implemented

The Department of Health and Community Services consult with the Association of Registered Nurses of Newfoundland and Labrador, to review and revise as necessary, the practice of prescribing, administering and dispensing of medications by registered nurses in all community clinics throughout all four (4) regions of the Province.

Comments: In October 2015, the DHCS reported that in September 2015, the Provincial Advisory Committee of Nurse Administrators discussed the review and revision by the ARNNL of nursing practices regarding prescribing, administering and dispensing medications in all community clinics in the province. Further, a formal letter has been sent to the ARNNL on behalf of the committee requesting the review and endorsement of all medication prescribing and dispensing policies and practices. The DHCS reported that followup with the ARNNL will occur to ensure the work is being carried out and standards are being met.

The DHCS reported that at this time, in the regions of Eastern Health, Central Health and Western Health, registered nurses do not prescribe or routinely dispense medications. Central Health and Western Health both have policies that allow registered nurses to provide medication to patients from remote areas, which allow a short-term supply of medications to patients who have been seen in the emergency/outpatient department or discharged from a rural health centre when access to a pharmacist is not available.

Completion of this recommendation is pending the review of all medication prescribing and dispensing policies and practices and the completion of necessary revisions.

Recommendation 5
Partially Implemented

The Department of Health and Community Services ensure that comprehensive nursing assessments are being conducted in all community clinics throughout the Province in accordance with the policies, procedures and best practice guidelines of all four (4) Regional Health Authorities.

Comments: In October 2015, the DHCS reported that according to information provided to the Department by the four (4) Regional Health Authorities (RHAs), there are policies and procedures in place in all four (4) RHAs that ensure individuals receive comprehensive assessments when they present at a community clinic. The RHAs also use and reference the ARNNL's *RN Practice Standards* as well as *ARNNL Documentation Standards* readily available at the RHAs and online. Eastern Health recently released a reference document called *Foundation of Nursing Practice* which assists nursing professionals to articulate their accountabilities and legal obligations in the delivery of safe, competent and ethical care. This document has been shared with the other RHAs.

Eastern Health is currently completing a review of Community Health Nursing documentation guidelines. In the LGRHA, a new Clinical Nurse Educator position has been posted for the community clinics which will enhance regional nurse's education, orientation and support. In addition, the LGRHA reported in October 2015 that, based on the findings of *A Tragedy Waiting to Happen*, a review of the need to increase the frequency of random chart audits is occurring. The DHCS also reported that a standing agenda item has been created at the quarterly Provincial Senior Nurse's Council to allow each RHA to provide a status report on their monitoring and auditing processes to reinforce the importance of comprehensive nursing assessments throughout the province.

Completion of this recommendation is pending the review of Community Health Nursing documentation guidelines and the completion of subsequent revisions; and, the review of the need to increase the frequency of random chart audits and the completion of subsequent revisions.

Recommendation 6
Implemented

The Department of Health and Community Services ensure that all four (4) Regional Health Authorities:

(a) review the role of the Nurse-in-Charge at all community clinics in the region and identify areas for improvement;

(b) review and revise all policies, as necessary, regarding the role of the Nurse-in-Charge to address the identified areas for improvement; and

(c) provide education to all Nurses-in-Charge to ensure compliance with policies.

Recommendation 9
Partially Implemented

The Department of Child, Youth and Family Services, the Department of Health and Community Services and the Department of Justice and Public Safety (formerly the Department of Justice) jointly develop and implement initiatives such as a multi-disciplinary committee in communities throughout all regions of the Province to ensure collaboration, communication and information sharing among service providers.

Comments: In October 2015, the DHCS reported that the Department is participating in an interdepartmental working committee with representation from the DCYFS, the DJPS, and the DHCS to discuss and foster communication and collaboration. A Health and Community Services subcommittee is developed with representatives from the Department and the four (4) Regional Health Authorities (RHAs) and have met to further discuss this recommendation.

RHAs have provided updates regarding current practices and/or initiatives which support the recommendation; the committee has identified gaps and barriers and they are implementing a process to address them. All four (4) RHAs indicate that there are processes in place to ensure collaboration, communication and information sharing among professionals who are in the circle of care. These may include: information sessions regarding case management; the use of the model for coordination of services; utilizing linkages to multiple program areas; and, using the Client Referral Management System (CRMS) in the identification of mutual clients. Each region identified the need to implement more consistent practices in the provision of service delivery to children and youth. There is a strong commitment among partners to enhance collaboration, communication and information sharing to address barriers to good collaborative practice, which will be addressed in the committee's action plan.

The action plan includes: a regional review of all policies and practices in each program area with a view to gaps and possible strategies to strengthen collaborative practice; a review of the Model for Coordination of Services and the Individual Support Services Plan (ISSP) at each RHA; and, the development of multi-agency leadership teams at the RHAs with a mandate to guide and support collaborative practice at the front line level of service delivery.

Completion of this recommendation is pending the identification and establishment of committees at the community level to ensure collaboration, communication and information sharing among service providers.

Recommendation 10
Partially Implemented

The Department of Health and Community Services and the Department of Child, Youth and Family Services, in collaboration with local governments and other service providers:

(a) complete comprehensive needs assessments of the services being provided in every remote and isolated community in the Province to identify existing deficiencies; and

(b) develop and implement strategies to address the identified deficiencies in a timely manner.

Comments: In October 2015, the DHCS reported that the Department is focusing on a three-phased plan to identify communities at greatest risk throughout the province and to assess gaps in services, including data collection and analysis to assess communities at risk; a needs assessment of at-risk communities to determine gaps in service provision; and a strategy to address issues in the identified at-risk communities with an emphasis on effective referral, information sharing, case management and consultation.

The Health and Community Service Sub-Committee has begun a review of sources of data which may assist in the determination of at-risk communities. The DHCS will continue to work towards enhancing the system to ensure safe and protective health care for children and youth in the province.

Completion of this recommendation is pending the completion of a comprehensive needs assessment, in collaboration with local governments and other service providers, of the services being provided in every remote and isolated community in the province, as well as the development and implementation of strategies to address the identified deficiencies in a timely manner.

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. This recommendation was implemented as of *The Advocate's Report on the Status of Recommendations 2014.*

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**

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 made to the Department of Justice. All recommendations were implemented as of *The Advocate's Report on the Status of Recommendations 2014.*

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**

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 made to the Department of Child, Youth and Family Services. All recommendations were implemented as of *The Advocate's Report on the Status of Recommendations 2014.*

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**

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. All recommendations were implemented as of *The Advocate's Report on the Status of Recommendations 2014.*

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**

Child Death Review Committee

Individual Case Reviews

Child Death Review Committee
Individual Case Reviews

The Child Death Review Committee (CDRC) is a multi-disciplinary committee that was appointed by legislation in March 2014, and began reviewing cases in Fall 2014. The creation of the CDRC was a recommendation of the *Turner Review and Investigation,* and was established pursuant to amendments to the *Fatalities Investigations Act* in 2012. The committee meets monthly if there are child deaths to review. All child deaths investigated by the Chief Medical Examiner are reviewed by the committee. The reviews involve consideration of facts and information outlined in written reports.

The mandate of the CDRC is contained in the *Fatalities Investigations Act*. The committee is required to review the facts and circumstances of child deaths (under 19 years of age), including stillbirths and neonatal deaths. The committee monitors trends in these deaths and determines whether further evaluation is necessary or desirable in the public interest. After each review, the committee shall report to the Minister on its findings and submit to the Chief Medical Examiner all records relevant to the review. The committee's ultimate goal is to help prevent deaths and to improve the health and safety of children.

An important aspect of the committee's work is to ensure that the Advocate for Children and Youth (ACY) is regularly updated regarding cases under review. The committee worked with the Advocate on the development of a communications strategy to ensure the timely sharing of required information.

In this second Advocate's Report on the Status of Recommendations, in addition to reporting on recommendations made to government departments and agencies by the ACY, recommendations made by the CDRC are also highlighted. In consultation with the Deputy Minister of the Department of Justice and Public Safety, the Advocate agreed to coordinate the follow-up process and report on the status of recommendations made by the CDRC. As of August 2015, the Department of Justice and Public Safety provided the ACY with nine (9) individual case reviews completed by the CDRC. Of the nine (9) case reviews, six (6) had a total of ten (10) recommendations, while three (3) had no recommendations. Two (2) recommendations were made to the CDRC; four (4) were made to the DCYFS; and three (3) were made to the Department of Education and Early Childhood Development (EECD). In addition, one recommendation was made to both the DCYFS and the DHCS. As of October 2015, there are three (3) recommendations requiring further action.

CASE # 14ME0060

Case # 14ME0060 included a total of one recommendation made to the Child Death Review Committee. As of October 2015, this recommendation has been implemented.

Status of Recommendations

Child Death Review Committee

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 CHILD DEATH REVIEW COMMITTEE

Recommendation 1

Implemented

The Child Death Review Committee monitor trends in deaths by drowning to determine the need for increased education/prevention activities for children and youth and high risk groups within this population.

CASE # SP 136-2014

Case # SP 136-2014 included a total of two (2) recommendations; one was made to the Child Death Review Committee, and one was made to both the Department of Child, Youth and Family Services and the Department of Health and Community Services. As of October 2015, there is one recommendation requiring further action.

Status of Recommendations

Child Death Review Committee

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

Status of Recommendations

Department of Child, Youth and Family Services

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

RECOMMENDATIONS MADE TO THE CHILD DEATH REVIEW COMMITTEE

Recommendation 1
Implemented

The Child Death Review Committee monitor trends in deaths by SIDS to determine trends and potential risk factors.

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

Recommendation 2
Partially Implemented

CYFS and Public Health review their processes for identifying SIDS risk factors and screen families who are considered to be at a higher risk, and provide educational and supportive services aimed towards prevention.

Comments: In October 2015, the DCYFS reported that health promotion, education and supportive services regarding medical issues such as Sudden Infant Death Syndrome (SIDS) are outside the legislated mandate of the DCYFS. The DCYFS initiated discussions with the DHCS regarding their role and the DHCS agreed to lead the gathering of information regarding SIDS risk factors to inform implementation of the recommendation. Collaboration continues between the respective departments and the DHCS has provided the DCYFS with relevant information on SIDS risk factors. The DCYFS shall forward the information to regional staff in the

near future. In addition, The Training Unit has been engaged and will incorporate information into CORE Training as part of an upcoming review of the curriculum commencing in the spring 2016.

Completion of this recommendation is pending the distribution, in collaboration with the DHCS, of relevant information on the issue of SIDS risk factors to DCYFS regional staff, and the incorporation of information into the CORE Training Program.

RECOMMENDATIONS MADE TO THE DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

Recommendation 2
Partially Implemented

CYFS and Public Health review their processes for identifying SIDS risk factors and screen families who are considered to be at a higher risk, and provide educational and supportive services aimed towards prevention.

Comments: In October 2015, the DHCS provided a comprehensive summary of screening activities currently in place throughout the four (4) Regional Health Authorities (RHAs) for identifying SIDS risk factors and providing education and supportive services aimed towards prevention. In each of the RHAs there is a community health nursing position dedicated to parent and child health. Community Health Nurses (CHNs) screen all postnatal families to determine their immediate postnatal needs and/or need for long-term followup. After a review of the client's *Record of Parent Learning,* the *LBN Form*, the *BABIES Prenatal Screening Tool* and consideration of the CHN's previous knowledge/information of the client and family, then the CHN would initiate the *Priority Assessment for Follow-up*. CHNs also provide service to clients under the *Healthy Beginnings Program,* which includes telephone contact and home visits to further assess family risk factors for SIDS.

With regards to providing education and supportive services aimed towards the prevention of SIDS from a population-based approach, all families receive a *You and Your New Baby* kit in the immediate postnatal period, which includes various resources as a means of providing information to parents around the prevention of SIDS. In addition, in the spring of 2015, *Infant Safe Sleep Kits* were developed and distributed to CHNs throughout the regions.

In October 2015, the DCYFS reported that health promotion, education and supportive services regarding medical issues such as Sudden Infant Death Syndrome (SIDS) are outside the legislated mandate of the DCYFS. The DCYFS initiated discussions with the DHCS regarding their role and the DHCS agreed to lead the gath-

ering of information regarding SIDS risk factors to inform implementation of the recommendation. Collaboration continues between the respective departments and the DHCS has provided the DCYFS with relevant information on SIDS risk factors. The DCYFS shall forward the information to regional staff in the near future. In addition, The Training Unit has been engaged and will incorporate information into CORE Training as part of an upcoming review of the curriculum commencing in the spring 2016.

Completion of this recommendation is pending the distribution, in collaboration with the DHCS, of relevant information on the issue of SIDS risk factors to DCYFS regional staff, and the incorporation of information into the CORE Training Program.

CASE # FP 150-14

Case # FP 150-14 included a total of three (3) recommendations made to the Department of Child, Youth and Family Services. As of October 2015, all three (3) recommendations have been implemented.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	**1**
Implemented Through Alternative Measures	**2**
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

Children in the care of CYFS who reach the age of 16 and elect to sign out of care, should have an assessment of their ability to care for themselves as part of the transition preparation that are outlined in CYFS policy.

Recommendation 2
Implemented Through Alternative Measures

A safety and supervision plan should be developed for those children who have challenges that are likely to impact their safety.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the DCYFS in October 2015. The Youth Services Program provides support to young

people who voluntarily seek service. There is no mandate to provide supervision to youth under this program and all service planning occurs with youth agreement. The Youth Screening Assessment Tool (YSAT) and the Youth Services Plan (YSP) helps social workers identify youth who have challenges and develop plans with them, in consultation with other service providers and supports, to address safety needs relating to those challenges. The YSP is reviewed at least once per month. Despite efforts to engage youth in a higher level of support, youth can opt to seek financial supports only, which means the goals set out in the YSP may only reflect a youth's basic needs. In those circumstances, social workers continually try to engage youth in goal development to enhance other life areas.

Recommendation 3
Implemented Through Alternative Measures

A new guardian must be made aware of the child's capabilities and needs, including need for ongoing medical care, and be able to provide the necessary supervision.

Comments: The response is accepted as adequate and appropriate as the recommendation is being completed through alternative steps taken as reported by the DCYFS in October 2015. Due to the voluntary nature of the Youth Services Program, youth receiving residential services are living independently and they are not in the care of a manager, a parent or a guardian. In situations where the youth has identified a supportive adult or service provider, youth are encouraged to share relevant information about their capabilities or needs and/or provide informed consent for their social worker to do so. If consent is given by the youth, care providers, supportive adults, family members and/or service providers are consulted in the process of developing the YSP and regular contact is made to coordinate service and support.

CASE # 14ME0159

Case # 14ME0159 included a total of one recommendation made to the Department of Education and Early Childhood Development. As of October 2015, this recommendation has been classified as no longer applicable.

Status of Recommendations

Department of Education and Early Childhood Development

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

RECOMMENDATIONS MADE TO THE DEPARTMENT OF EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Recommendation 1

No Longer Applicable

The Department of Education initiate a school program to be delivered to high school students regarding the dangers of exposure to carbon monoxide.

Comments: The response is accepted as adequate and appropriate as the Department of Education and Early Childhood Development reported that educating students about the dangers of carbon monoxide occurs primarily through programs that already exist inside curriculum that deals with personal safety. These specific curriculum outcomes are encountered within courses at various grade levels.
The recommendation is no longer applicable.

CASE # FP3-15

Case # FP3-15 included a total of one recommendation made to the Department of Child, Youth and Family Services. As of October 2015, this recommendation requires further action.

Status of Recommendations

Department of Child, Youth and Family Services

Implemented	0
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

Partially Implemented

Child Youth and Family Services initiate collaboration with Community Health and the Innu to explore a culturally sensitive education campaign to increase community awareness of SIDS risk factors and safe sleeping arrangements.

Comments: In October 2015, the DCYFS responded that the enhancement of community awareness on medical issues such as SIDS is outside the legislative mandate of CYFS. The Innu Nation is responsible for Public Health services for the Innu communities of Sheshatshiu and Natuashish. The DCYFS suggested that it is therefore appropriate that the Innu Nation be provided with and respond to this recommendation. Given the Innu has the mandate for public health in Innu communities, the Department will advise the appropriate Innu leadership of this recommendation.

Completion of this recommendation is pending confirmation that the DCYFS has advised the appropriate Innu leadership of this recommendation.

CASE # FP201-14

Case # FP201-14 included a total of two (2) recommendations made to the Department of Education and Early Childhood Development. As of October 2015, there is one recommendation requiring further action.

Status of Recommendations

Department of Education and Early Childhood Development

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 EDUCATION AND EARLY CHILDHOOD DEVELOPMENT

Recommendation 1
Implemented

The province review its public education strategy on the dangers associated with alcohol use by junior high and high school age children, including through public messaging campaigns, the school system, and/or through its relationship with the Newfoundland and Labrador Liquor Corporation, and provide messaging and education about the danger of ingesting too much alcohol as well as the responsibility of those who provide alcohol to minors.

Recommendation 2
Partially Implemented

The Department of Education consider launching an awareness campaign with involvement from interested parents and/or family members of children who die from alcohol consumption.

Comments: In October 2015, the Department of Education and Early Childhood Development (EECD) reported that awareness of adverse health effects of alcohol use/abuse is explored inside Health and Family Studies curricula at both the junior high and high school levels. EECD will recommend a collaborative approach, in conjunction with the Mental Health and Addictions Division of the DHCS, regarding interest/ability to develop an awareness campaign reflecting best practices on this topic. EECD continues to work collaboratively with other government departments and advocates to integrate messaging that will support positive outcomes for students. EECD continues to collaborate with the DHCS as it relates to mental wellness (including consumption of drugs, alcohol and tobacco). EECD distributed information pertaining to e-health technologies and encouraged schools to avail of these opportunities. The resources are designed to support mental health wellness and act as early interventions for mental illness and substance use issues.

Completion of this recommendation is pending an update from EECD regarding interest/ability to develop an awareness campaign reflecting best practices on this topic in conjunction with the Mental Health and Addictions Division of the DHCS, and in collaboration with interested parents and/or family members of children who died from alcohol consumption.

Conclusion

From 2006 to 2015, the Advocate for Children and Youth (ACY) completed eight (8) investigations and four (4) reviews, which included 183 recommendations. Some of these recommendations were made to, and required action by, multiple departments and agencies, resulting in a total of 218 responses.

In addition to reporting on recommendations made to government departments and agencies by the ACY, this year recommendations made by the Child Death Review Committee (CDRC) are also highlighted. In consultation with the Deputy Minister of the Department of Justice and Public Safety, the Advocate agreed to coordinate the follow-up process and report on the status of recommendations made by the CDRC. As of August 2015, the Department of Justice and Public Safety provided the ACY with nine (9) individual case reviews completed by the CDRC. Of the nine (9) case reviews, six (6) had a total of ten (10) recommendations, while three (3) had no recommendations. These recommendations were also made to, and required action by, multiple departments and agencies, resulting in a total of eleven (11) 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 is 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
ARNNL	Association of Registered Nurses of Newfoundland and Labrador
CDRC	Child Death Review Committee
CHN	Community Health Nurse
CME	Chief Medical Examiner
CRMS	Client Referral Management System
CYFS	Child, Youth and Family Services
DCYFS	Department of Child, Youth and Family Services
DHCS	Department of Health and Community Services
DHSD	Department of Health and Social Development
DJPS	Department of Justice and Public Safety
Eastern Health	Eastern Regional Integrated Health Authority
EECD	Department of Education and Early Childhood Development
HEADS-ED	home, education, activities/peers, drugs/alcohol, suicidality, emotions/behavior, discharge resources
ISM	Integrated Service Management
ISSP	Individual Support Services Plan
Janeway	Janeway Children's Health and Rehabilitation Centre
LGRHA	Labrador-Grenfell Regional Integrated Health Authority
Ministerial Committee	Ministerial Committee on the Turner Recommendations
MOU	Memorandum of Understanding
RCMP	Royal Canadian Mounted Police
RHA	Regional Health Authority
RMDM	Risk Management Decision-Making Model
RNC	Royal Newfoundland Constabulary
SAVRY	Structured Assessment of Violence Risk in Youth
SIDS	Sudden Infant Death Syndrome
TRIM	Total Records and Information Management
YLS-CMI	Youth Level of Service Case Management Inventory
YSA	Youth Services Agreement
YSAT	Youth Screening Assessment Tool
YSP	Youth Services Plan

Appendix B

Status of Advocate for Children and Youth Recommendations by Department and Agency

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	77% 57/74	9.5% 7/74	13.5% 10/74	0% 0/74	0% 0/74	74
Department of Health and Community Services	70% 14/20	0% 0/20	30% 6/20	0% 0/20	0% 0/20	20
Department of Justice and Public Safety	86% 18/21	5% 1/21	9% 2/21	0% 0/21	0% 0/21	21
Eastern Health	73% 16/22	27% 6/22	0% 0/22	0% 0/22	0% 0/22	22
Royal Newfoundland Constabulary	100% 1/1	0% 0/1	0% 0/1	0% 0/1	0% 0/1	1
Labrador-Grenfell Health	0% 0/2	0% 0/2	100% 2/2	0% 0/2	0% 0/2	2

Appendix C

Status of Child Death Review Committee Recommendations by Department and Agency

Department/Agency	Implemented	Implemented Through Alternative Measures	Partially Implemented	Not Implemented Response Inadequate and Inappropriate	No Longer Applicable	TOTAL
Child Death Review Committee	100% 2/2	0% 0/2	0% 0/2	0% 0/2	0% 0/2	2
Department of Child, Youth and Family Services	20% 1/5	40% 2/5	40% 2/5	0% 0/5	0% 0/5	5
Department of Health and Community Services	0% 0/1	0% 0/1	100% 1/1	0% 0/1	0% 0/1	1
Department of Education and Early Childhood Development	33.3% 1/3	0% 0/3	33.3% 1/3	0% 0/3	33.3% 1/3	3

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