NOT THERE YET

STATUS REPORT ON RECOMMENDATIONS

The Office of the Child and Youth Advocate • December 2017

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Designed by:

Nicole Greeley
Graphic Designer

Back Cover Artwork by:

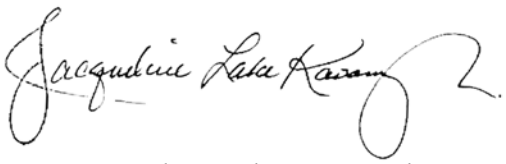
Young Artist: Tyler Young, Grey River

Message from the Child and Youth Advocate

I am very pleased to present the 2016 report on the status of recommendations. This report is issued annually and reports progress and status of Office of the Child and Youth Advocate's recommendations. This report points to success, with government departments and agencies implementing 90% of recommendations. This is good, and the efforts of the individuals and the departments involved to make this happen is appreciated. But numbers also tell another story in *Not There Yet*. Outstanding recommendations remain, and some are old. This work must be concluded in order for children and youth to experience the benefits of the recommended changes. However success is not only measured through numbers and statistics. It is also measured through long term quality change that stands the test of time. Where departments and agencies need to reassess their approach or focus on outstanding recommendations, my Office is prepared to meet and discuss this with them.

This report reflects status and progress for recommendations of both the Office of the Child and Youth Advocate as well as the Child Death Review Committee. Through a previous agreement with the Department of Justice and Public Safety, the Office of the Child and Youth Advocate agreed to capture and include progress of the Child Death Review Committee's recommendations in its annual report on recommendations. It should be noted that for all other purposes, the Office of the Child and Youth Advocate operates separate and distinct from the workings of the Child Death Review Committee.

This report demonstrates that when the Office of the Child and Youth Advocate issues a report with recommendations, progress is monitored on each and every recommendation until all are implemented. Each recommendation is carried forward each year until concluded. None drop off the radar. This is important for those young people who are the focus of investigations, and for them to know we stand by our recommendations until they are complete. It is also important for other young people and their families who will benefit in the future from the recommended changes and improvements. And it is important for the public to know that we monitor and are prepared to publicly report on these expectations. We believe that children, youth, and the general public expect and deserve nothing less.



Jacqueline Lake Kavanagh
Child and Youth Advocate

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1. Introduction

In carrying out its mandate, the Office of the Child and Youth Advocate (OCYA) conducts investigations and reviews, and subsequently identifies findings and makes recommendations in the interest of improved responses to children and youth in Newfoundland and Labrador. The Office is authorized under Section 24 (1) of the *Child and Youth Advocate Act* to request progress reports from relevant departments and agencies regarding any recommendations.

The Office has made a total of 190 recommendations to various government departments and agencies to December 31, 2016. However, seven of those were made in the investigative report, *A Stolen Life*, released on November 30, 2016. As the reporting period ended December 31, 2016, updates on recommendations were not sought for this report. Those seven recommendations are not reflected in the statistics and responses, but are detailed at the end of this report. Notwithstanding *A Stolen Life*, 90% of OCYA's recommendations to December 31, 2016 have been implemented, two percent (2%) have been partially implemented, one percent (1%) has not been implemented, and seven percent (7%) are no longer applicable.

Under an agreement with the Department of Justice and Public Safety, the OCYA also monitors and reports on progress for the Child Death Review Committee (CDRC) recommendations. The CDRC is separate from the OCYA and is legislated under the *Fatalities Investigations Act*. The CDRC reviews deaths of children under 19 years of age which the Chief Medical Examiner refers. Between October 2014 and December 2016 the CDRC made 31 recommendations. 74% of those recommendations have been implemented, 6% have been partially implemented, 10% have not been implemented, and 10% are no longer applicable.

Definitions

The status of each recommendation has been divided into one of four categories:

Implemented

The recommendation has been completed.

Partially Implemented

The department or agency has made some progress on the recommendation; however, outstanding items remain to be addressed.

Not Implemented

There has been no substantive progress on the recommendation.

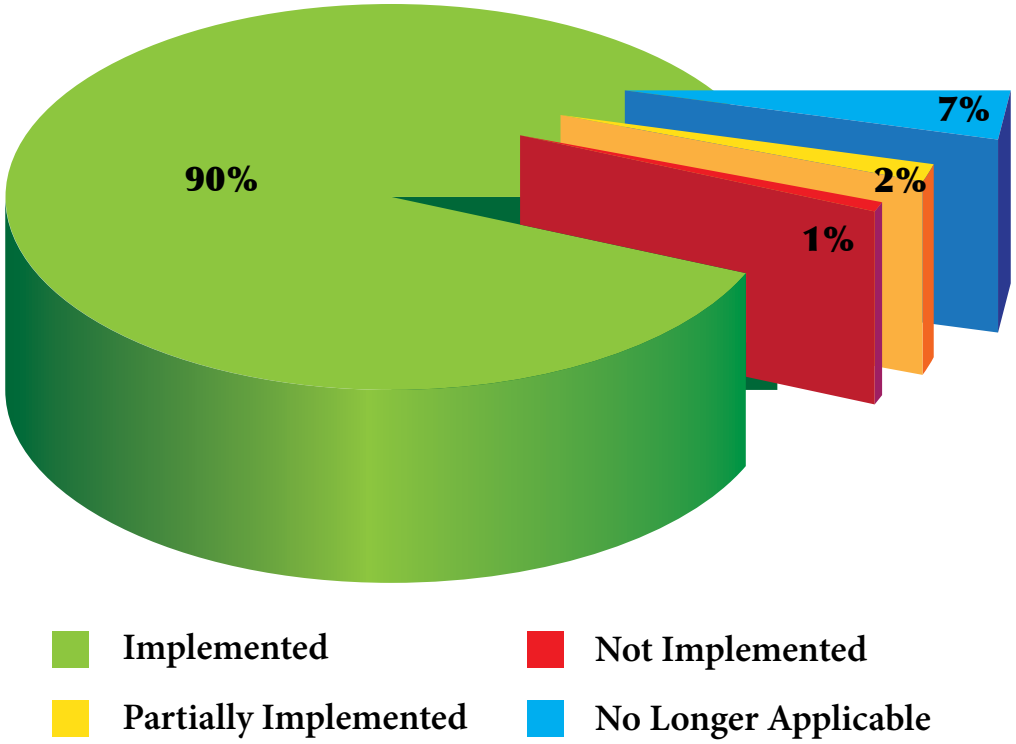
No Longer Applicable

Recommendations may meet this category when changes have occurred since the recommendation was made, such as legislative or policy changes, or restructuring of government departments and agencies.

This report is structured to identify the recommendations which are partially implemented or not implemented, and to provide a brief description of the explanation which the department or agency provided.

2. Office of the Child and Youth Advocate Status of Recommendations

INVESTIGATIONS	IMPLEMENTED	PARTIALLY IMPLEMENTED	NOT IMPLEMENTED	NO LONGER APPLICABLE	TOTAL # OF RECOMMENDATIONS
Turner Review and Investigation (2006)	43	1		14	58
Lost in Transition (2009)	15				15
An Investigation into Janeway Psychiatry Unit J4D Programs and Services (2010)	18				18
The Child Upstairs …Joey's Story (2011)	9				9
Turning a Blind Eye (2012)	12				12
Out of Focus (2012)	13				13
Sixteen (2013)	29	1			30
A Tragedy Waiting to Happen (2015)	7	1	2		10
REVIEWS					
CSSD Emergency Intake (2011)	1				1
Youth Corrections – Decisions Regarding Open Custody Placements (2011)	2				2
Youth in Adult Holding Facilities: Case 1 (2011)	6				6
Youth in Adult Holding Facilities: Case 2 (2013)	9				9
TOTAL	164	3	2	14	183



Notwithstanding *A Stolen Life*, 90% of the Office of the Child and Youth Advocate's recommendations to December 31, 2016 have been implemented, two percent (2%) have been partially implemented, one percent (1%) has not been implemented, and seven percent (7%) are no longer applicable.

2. a. Recommendations Partially Implemented

i. *Turner Review and Investigation* (2006)

Recommendation 7.19

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

The Department of Children, Seniors and Social Development (CSSD) is finalizing the Integrated Service Management system, which will replace the current Client Referral Management System. This is intended to ensure the implementation of this recommendation. Implementation of the new system is anticipated by Winter 2018.

Completion of this recommendation is pending the implementation of the Integrated Service Management system.

ii. *Sixteen* (2013)

Recommendation 16

CSSD ensure that when a youth is in receipt of services from multiple programs within CSSD, 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.

CSSD continues to pilot 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. CSSD is currently conducting an evaluation of this pilot. Once the results of the evaluation are provided, the Office of the Child and Youth Advocate will assess whether the requirements of the recommendation have been satisfied.

iii. *A Tragedy Waiting to Happen* (2015)

Recommendation 8

CSSD 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).

The Government of Newfoundland and Labrador committed $305,800 in Budget 2017 to train child protection staff in the new Structured Decision Making model, which will replace the Risk Management Decision-Making model. This new model is intended to modernize the approach to child protection decision-making by providing staff with the most up to date and efficient tools available to support their practice. The new model is anticipated to be implemented by Winter 2018.

Completion of this recommendation is pending the implementation of the Structured Decision Making model. The Office of the Child and Youth Advocate has requested a presentation on this model.

2. b. Recommendations Not Implemented

i. *A Tragedy Waiting to Happen* (2015)

Recommendation 9

CSSD, the Department of Health and Community Services, and the Department of Justice and Public Safety 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.

Recommendation 10

The Department of Health and Community Services and CSSD, 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**

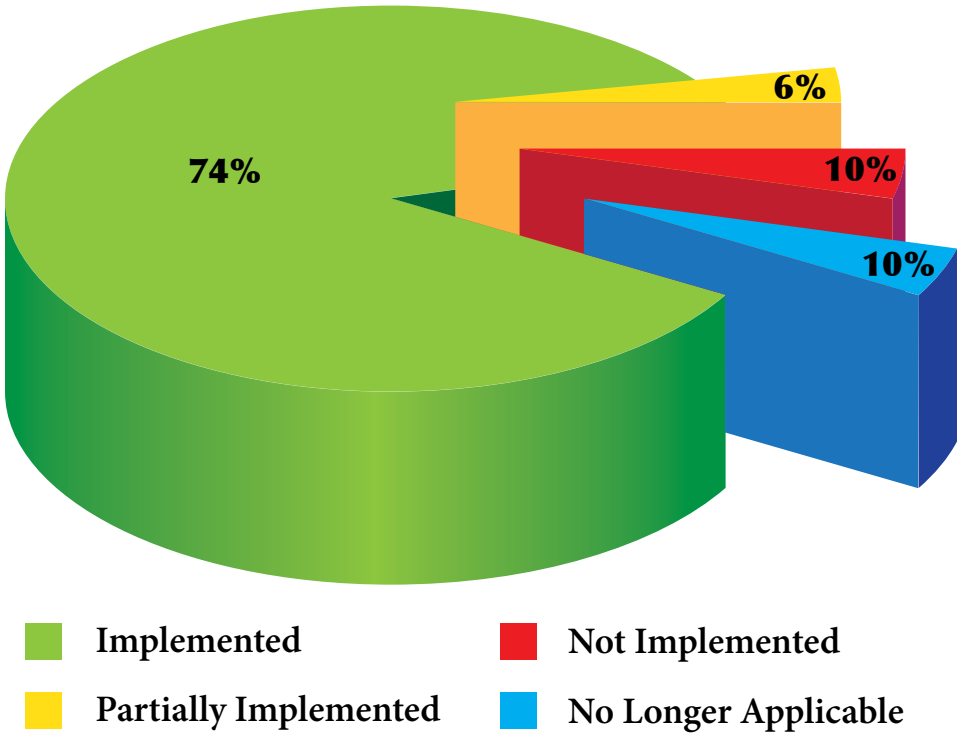
(b) **Develop and implement strategies to address the identified deficiencies in a timely manner.**

In 2015 an interdepartmental committee was established to address recommendations nine (9) and ten (10). Thus far, the committee has largely focused on developing an inventory of existing multidisciplinary committees across the province in order to identify where new committees are needed, or where committee mandates require revision for the purpose of enhancing collaboration among service providers. Policies and protocols regarding communication and collaboration have been reviewed and have been revised where needed. Service provision and service outcomes have been identified departmentally to identify geographical areas with the greatest need.

At the time of this report, and notwithstanding the above-referenced reviews, CSSD indicated the committee has not reported on substantive actual changes to improve collaboration, communication and information sharing among service providers. The Department has expressed an interest in further discussions with the Office of the Child and Youth Advocate regarding the committee's activities to date and expectations to conclude these recommendations.

3. Child Death Review Committee Status of Recommendations

CASE NUMBER	IMPLEMENTED	PARTIALLY IMPLEMENTED	NOT IMPLEMENTED	NO LONGER APPLICABLE	TOTAL # OF RECOMMENDATIONS
14ME0060	1				1
SP1362014	1	1			2
FP15014	3				3
14ME0159				1	1
FP315	1				1
FP20114	2				2
14ME3005	1				1
ME4010	1				1
15ME4006	2				2
15ME0010	1				1
15ME0066	1				1
15ME4016			3		3
15ME1517				2	2
15ME1039	1				1
15ME4035	1				1
15ME0146	3				3
15ME0195	1				1
15ME3030	3				3
15ME0196		1			1
TOTAL	23	2	3	3	31



Between October 2014 and December 2016 the Child Death Review Committee made 31 recommendations. 74% of those recommendations have been implemented, 6% have been partially implemented, 10% have not been implemented, and 10% are no longer applicable.

3. a. Recommendations Partially Implemented

i. *Case # SP 136-2014*

Recommendation 2

The Department of Children, Seniors and Social Development and Public Health review their processes for identifying Sudden Infant Death Syndrome (SIDS) risk factors and screen families who are considered to be at a higher risk, and provide educational and supportive services aimed towards prevention.

Each Regional Health Authority has a community health nursing position dedicated to parent and child health. Community health nurses screen all postnatal families to determine their immediate needs. They 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. All families receive a *You and Your New Baby* kit in the immediate postnatal period, which includes various preventative resources.

In 2017, the Department of Children, Seniors and Social Development and the Department of Health and Community Services worked with the Regional Health Authorities to adapt the *Best Start Sleep Well, Sleep Safe* resource for use throughout the province. All new parents receive this information on safe sleep in the early post-natal period. The Public Health and Regional Services Divisions began working with the Regional Health Authorities to review all resources on safe sleep being provided to new parents in both acute care and in the community, for the purposes of streamlining resources and improving consistency and continuity. This work is still in progress and will be completed in early 2018.

CSSD has issued a memorandum to all regional staff with information on risk and protective factors, external resource links with safe sleep brochures and videos, and information on preventing SIDS. The CSSD Training Unit is developing the training curriculum and is consulting with Memorial University of Newfoundland to develop the module for online delivery. A draft of the child development module has been developed, which contains the SIDS related information. The timeline for implementation of this module is Spring-Summer 2018.

ii. *Case # 15ME0196*

Recommendation 1

Eastern Health develop a transition system giving immediate access to adult services for youth who require ongoing service upon leaving the children's mental health service.

Eastern Health responded that it fully supports the implementation of this recommendation. However, transition from the child to the adult system has been a challenge for the Eastern Health Mental Health and Addictions program for quite some time. The program includes a policy on continuity of care, where child psychiatrists continue services until adult services are available, and priority waitlist for youth transitioning to adult services.

Eastern Health was part of a national research project led by the Centre for Addictions and Mental Health that focused on transitional aged youth. The results will be used to help Eastern Health further improve services. The Child Central Intake and Adult Central Intake teams are working together to communicate and prioritize youth at transition. Eastern Health is also participating in the implementation of the *Towards Recovery* mental health and addictions action plan which includes recommendations to support integration of best practices when transitioning youth to the adult system.

Subsequent to the reporting period for this report, the OCYA recognizes that Eastern Health recently introduced the Doorways walk-in counseling service, which operates from eight sites across the region and offers a single session therapy for individuals 12 years and older, no referral required. The Mental Health and Addictions program now includes a stepped model of care which involves matching individuals to the level and intensity of care that best meets their needs. It is hoped that this model will provide more timely access to services.

3. b. Recommendations Not Implemented

i. *Case # 15ME4016*

Recommendation 1

Labrador-Grenfell Health establish an Assertive Community Treatment team for youth with serious mental health problems and those at high risk for suicide.

Recommendation 2

Labrador-Grenfell Health meet with Innu health and social service officials to review services to youth at risk for suicide and strengthen community responses.

Recommendation 3

Labrador-Grenfell Health in consultation with appropriate Innu officials, create a mental health service that can be accessed in communities in Labrador.

At the time of this report, substantive progress has not been made on these recommendations. Labrador-Grenfell Health has indicated that implementation of Recommendation 1 is not feasible. The lack of progress, or lack of alternative approach is very concerning, as these recommendations result from reviews conducted after a child's death.

Two developments independent of Labrador-Grenfell Health are worth noting. In July 2017, the Government of Newfoundland and Labrador and Innu leadership entered into a Memorandum of Understanding that outlines their mutual intent to pursue an Inquiry into the treatment, experiences and outcomes of Innu in the child protection system. The results of this Inquiry may provide further direction and recommendations on how to best address the mental health needs of Innu children and youth in a culturally responsive way. Additionally, the Government of Newfoundland and Labrador released *Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador.* This offers an opportunity for a new vision and approach to mental health services for Indigenous children and youth. If Recommendation 14 of *Towards Recovery* is implemented (Assertive Community Treatment teams) full consideration should be given to ensure Labrador is included in this development.

4. Report: *A Stolen Life* (2016)

The Office of the Child and Youth Advocate released this investigative report on November 30, 2016. As the reporting period ended December 31, 2016, there was no significant progress to report given the short time frame. The relevant departments and agencies will be asked to provide detailed updates on each recommendation, which will be included in the 2017 Recommendations Report.

Recommendation 1

The Department of Justice and Public Safety ensure that the RCMP and the RNC review their current policies and processes for completing and delivering Child Protection Reports to CSSD to ensure:

(a) **All members understand and comply with their legislative duty to report to CSSD any information that a child or youth is or may be in need of protective intervention.**

(b) **Timely delivery of, and confirmation of receipt of Child Protection Reports by CSSD.**

Recommendation 2

CSSD:

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

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

Recommendation 3

CSSD and the Department of Justice and Public Safety ensure compliance with Policies 1.3 and 1.5 of the *Protection and In Care Policy and Procedure Manual* (2011), and Section 3.2 of both the *Memorandum of Understanding* (RCMP, 2016) and the *Memorandum of Understanding* (RNC, 2015), which require that:

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

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

Recommendation 4

CSSD ensure compliance with sections 7(a) and 7(b) of the *Child, Youth and Family Services Documentation Guide* (2015) which contains protocol for documenting contact with supervisors and zone managers.

Recommendation 5

CSSD review and revise their current policy and procedure pertaining to the verification of child protection concerns and the determination of a child's need for protective intervention, to ensure that:

(a) **When a child or youth discloses physical or sexual abuse they receive a thorough medical examination.**

(b) **Any siblings of a child or youth who died under suspicious circumstances receive a thorough medical examination.**

Recommendation 6

CSSD, in consultation with Aboriginal governments, organizations and communities, propose changes to legislation that will recognize traditional custom adoption, and ensure the same standard of safety and permanency planning for all children and youth in the province.

Recommendation 7

CSSD, in consultation with Aboriginal governments, organizations and communities:

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

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

5. Conclusion

Government departments and agencies have made significant progress on the recommendations outlined in this report. Notwithstanding this progress, three percent (3%) of the Office of the Child and Youth Advocate's recommendations, and 16% of the Child Death Review Committee's recommendations remain outstanding. These need to be concluded and without further delay.

The Office of the Child and Youth Advocate released the investigative report *A Stolen Life* on November 30, 2016. The reporting period ended December 31, 2016. Given the short time frame, updates on recommendations were not sought for this report. The relevant departments and agencies will be asked to provide detailed updates on the seven recommendations from *A Stolen Life*, to be included in the 2017 Recommendations Report. Significant progress is anticipated.

The Office of the Child and Youth Advocate will be diligent in following all recommendations, and as per Section 24 of the *Child and Youth Advocate Act*, the Office will continue to follow up with any new or outstanding recommendations until they are all appropriately addressed. The 2017 review process will also assess all previously concluded recommendations to ensure there has been no slippage. Departments, personnel and economic conditions have changed over the years. The Office of the Child and Youth Advocate is committed to ensuring that valuable progress in responding to children and youth is not lost or reversed.

Appendix A: Office of the Child and Youth Advocate
Status of Recommendations

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Appendix B: Child Death Review Committee
Status of Recommendations

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15ME1517				2	2
15ME1039	1				1
15ME4035	1				1
15ME0146	3				3
15ME0195	1				1
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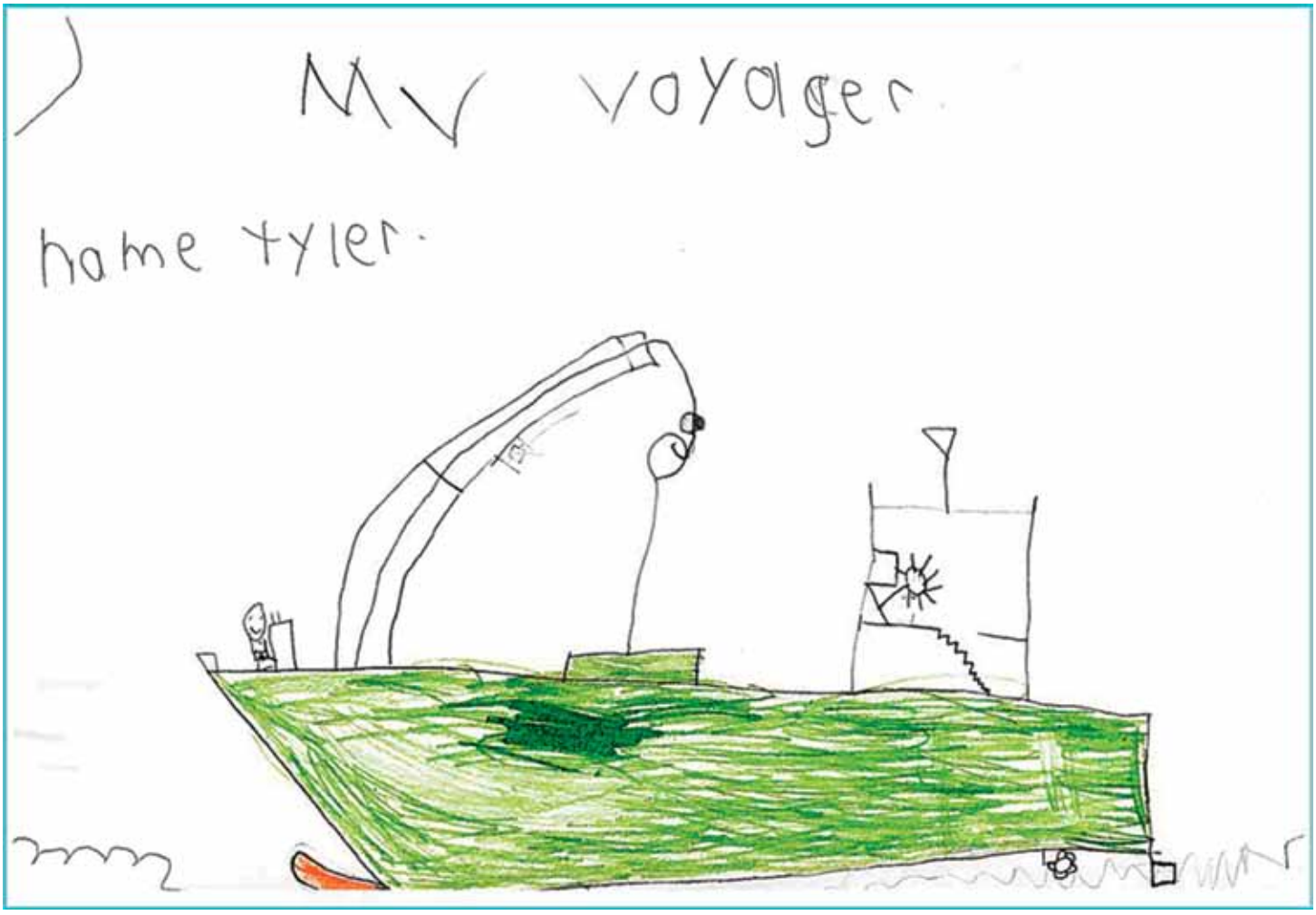

Young Artist: Tyler Young, Grey River

ADVOCATE
CHILDREN YOUTH
NEWFOUNDLAND & LABRADOR

www.childandyouthadvocate.nl.ca
(709) 753-3888 • Toll Free: 1-877-753-3888
193 LeMarchant Road, St. John's, NL A1C 2H5