"A Tragedy Waiting to Happen"

CHILDREN YOUTH
NEWFOUNDLAND & LABRADOR

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Message from the Advocate

This investigation reveals the story of three (3) vulnerable children and how government services did not meet their needs. For reasons of confidentiality, these children will be known as "Kevin" - 8 years old, "Ryan" - 4 years old, and "Sally" - 3 years old. Over a period of eight (8) years, these children had numerous encounters with many professionals, yet they continued to live in an unacceptable, unsafe environment detrimental to their health and quality of life. These children deserved so much more but sadly they endured several years of living in harmful conditions. The end result was a house fire in which two (2) children and one adult died. I extend my deepest condolences to their family and friends.

While this is a public report, every effort has been made to ensure that the identities of those involved are kept confidential. I strongly request that members of the public and the media not focus on identifying the specific location of this case or the identity of the people involved. Rather, I ask that you focus on the lessons that can be learned from this tragic story.

The goal of any investigation is not to lay blame but to identify what went wrong and how to prevent it from happening again. This investigation identifies many missed opportunities and deficiencies in the system that resulted in the rights of these children not being respected and their right to services not being upheld.

I want to acknowledge those professionals who strive every day to do their best. I want to thank the professionals who "under oath" answered my questions with such honesty and with a passion for wanting change to improve the system, change that can ultimately prevent future harm.

This was a horrible tragedy, unfortunately – "A Tragedy Waiting to Happen". While this tragedy occurred in 2010, the actual investigation and the gathering of information took place in 2013 and 2014. The deficiencies identified throughout this investigation reflect the eight (8) year time frame from 2002 to 2010; however, through information gathered during interviews completed in 2014 of the professionals involved with this case, it is evident that these deficiencies still remain today. As before, we have identified similar deficiencies and recommendations that have been put forth in investigative reports previously released.

In February 2015, I publicly released the first *"Advocate's Report on the Status of Recommendations 2014"*, which identified the status of previous recommendations after comprehensive followup with the applicable government departments and agencies. Many recommendations have been reported by the departments and agencies as implemented as a result of education and training of staff as well as policy changes; however, it is evident that corresponding practice has not necessarily changed throughout the Province.

This investigative report in particular highlights the specific challenges of communities in Labrador, where factors such as environment, workload, and human resources issues have not permitted the necessary changes to occur. Therefore, I call on all governments involved – local, provincial and federal – to work together to make the necessary changes so that all children and youth receive quality services and such a tragedy never happens again!

Carol A. Chafe
Advocate for Children and Youth

Executive Summary

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.

This 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, nonadherence 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 comprehen sive 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.

Overall, there are 10 recommendations resulting from the completion of this investigation. The Advocate for Children and Youth will follow up on these recommendations until they are all appropriately addressed by the applicable government department or agency.

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

Introduction

On January 14, 2013, the Advocate for Children and Youth (ACY) served notice to the Deputy Ministers of the Department of Child, Youth and Family Services (DCYFS); the Department of Health and Community Services (DHCS); the Department of Justice; and to the Chief Executive Officer (CEO) of the Labrador-Grenfell Regional Health Authority (LGRHA) that she would be *"conducting an investigation into the circumstances surrounding [Kevin], [Ryan], and [Sally], children of [Mom]"* who were in receipt of services from these departments and agency. Details of initiating the investigation were outlined in written correspondence to all parties on the aforementioned date. The investigation was conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act*, Statutes of Newfoundland and Labrador 2001. An initial request for documentation was made to each department and agency on January 17, 2013. By February 27, 2013, the ACY had received the requested documentation. Throughout the process of the investigation, additional requests for information were made to the aforementioned departments and agency as well as the Eastern Regional Health Authority (Eastern Health) and the Department of Health and Social Development (DHSD) with the Nunatsiavut Government. The ACY commenced this investigation on May 20, 2013 and it was completed on July 22, 2014 following a careful examination of the services and interventions provided to this family over an eight (8) year period.

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their voices are heard. In doing so, the ACY may be required to review or investigate matters affecting those rights and interests. It is in keeping with this legislative duty that the ACY reports on the investigation and makes recommendations based on its findings. The goal is to prevent any reoccurrence of a similar matter. The purpose of this investigation was to determine whether or not the services provided by the DCYFS, the DHCS, the LGRHA and the Department of Justice met the needs of Kevin, Ryan and Sally and whether their right to services was upheld.

The ACY is legislated under Section 13(1) of the *Child and Youth Advocate Act* (SNL 2001), to protect the identity of the parties involved in the investigation. To meet the rigorous requirements of confidentiality under the legislation, this report will identify the parent as Mom and the grandparents as Nan and Pop. The children will be known as Kevin, Ryan and Sally. The investigation focuses on the time frame of 2002 to 2010, during which services were provided to this family by the aforementioned departments and agencies.

This investigative report contains various acronyms in use throughout the system; official agency names and terminology are detailed in Appendix A. The mandates guiding the provision of services by the departments and agencies involved with this family are outlined in Appendix B.

Methodology

Information was obtained from a variety of sources during the investigation in accordance with Section 21(1) of the *Child and Youth Advocate Act* (SNL 2001). Case files and documents were provided by the Department of Child, Youth and Family Services (DCYFS); the Department of Health and Community Services (DHCS); the Labrador-Grenfell Regional Health Authority (LGRHA); the Eastern Regional Health Authority (Eastern Health); the Department of Justice; the Royal Canadian Mounted Police (RCMP); and the Department of Health and Social Development (DHSD) with the Nunatsiavut Government.

The information spanned an eight (8) year period. All written correspondence and records were thoroughly reviewed by the ACY. In addition, policies, protocols and legislation that corresponded with the relevant time frames were reviewed.

In accordance with Section 21(1.2) of the *Child and Youth Advocate Act* (SNL 2001), witnesses were summoned to appear before the Advocate and answer questions under oath in recorded interviews. The Advocate interviewed employees of DCYFS and the LGRHA.

Appendix C provides a complete list of investigative documents reviewed and interviews conducted. The reference section of this report contains all literature, websites, policies, standards and legislation reviewed by the ACY for this investigation.

Prior to the completion of the investigative report, to ensure administrative fairness, departments and agencies involved were provided with the opportunity to review and provide feedback on a draft of the Case Summary and Mandates sections of the report. Departments and agencies included in this process were the DCYFS, the DHCS, the LGRHA, Eastern Health, the Department of Justice, the RCMP and the DHSD with the Nunatsiavut Government. Upon completion, a copy of the entire final report was provided to the aforementioned departments and agencies for their information. In addition, the report was shared with the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) as well as the Newfoundland and Labrador Association of Social Workers (NLASW).

Case Summary

Mom was eighteen (18) years old when she had her first child, Kevin. Four (4) years later she had her second child, Ryan, and the year after that, her third child, Sally. During the time frame of this investigation, Mom and her three (3) children resided with Nan and Pop. The care of the children was a responsibility shared by Mom and Nan. Throughout the time period covered by this investigation, there were repeated and persistent medical concerns for each of the three (3) children; in eight (8) years the three (3) children were seen at the community clinic a total of 281 times and received 101 prescriptions for antibiotics. In addition to medical concerns, there were also concerns regarding their care, safety and wellbeing.

2002

Kevin – Born

In the first few months of his life, Kevin experienced many illnesses. Most commonly he was diagnosed with respiratory infections as well as ear and eye infections. The community where Mom and Kevin resided had a community health clinic staffed by nurses. There was no doctor on-site; however, in an interview with the Advocate, the nurse-in-charge for the clinic during the time period of this investigation advised that a doctor would visit the clinic once a month (Transcript of ACY Interview, 2014). Doctors were also available for consult via telephone or videoconference. For severe medical issues, travel was required to another community to see a doctor at a hospital. As per the principles for delegation of function outlined by the Association of Registered Nurses of Newfoundland and Labrador (ARNNL) in the *Scope of Nursing Practice: Definition, Decision-Making & Delegation (2006)* document and the *Labrador-Grenfell Health Community Clinic Services Policy and Procedure Manual,* nurses employed at this community clinic had the authority to prescribe medications. As well, as per the ARNNL *Dispensing by Registered Nurses (1999)* document and the *Labrador-Grenfell Health Community Clinic Services Policy and Procedure Manual*, nurses employed at this community clinic had the authority to dispense medications.

At one month of age, Kevin made his first visit to the hospital where he was admitted under a doctor's care for three (3) nights. Notably it was his aunt who accompanied him to the hospital, not Mom. He was diagnosed as having a respiratory infection and was prescribed an antibiotic. Only one month later, Kevin became

sick again and questions arose regarding Mom's compliance with Kevin's prescribed treatment. After attempting medical interventions at the community clinic, it was decided that Kevin would have to travel to the hospital to be seen by a doctor; however, Mom refused to accompany him.

Child, Youth and Family Services (CYFS) was notified of Mom's unwillingness to travel with Kevin for medical treatment and a Child Protection Report (CPR) was completed. The assigned social worker and a community service worker (CSW) completed a home visit with Mom, Nan and Kevin immediately after receiving the CPR. Mom was noted to be defensive. Nan told the assigned social worker that while she does not like to travel, she would accompany Kevin to the hospital if Mom refused. The assigned social worker explained to Mom and Nan that because of the concerns expressed in the CPR and the concerns for Kevin's health, the family would now be on their *"[Child Welfare] protection caseload"*. After the visit, the CSW told the assigned social worker that Nan had expressed concerns about Mom's boyfriend, whom Nan thought had pressured Mom into not travelling to the hospital with Kevin. There is no indication from the assigned social worker's case notes what followup would occur now that CYFS was involved with the family.

Mom and Kevin left for the hospital that afternoon and upon arrival, Kevin was admitted for a respiratory infection. He remained in the hospital for six (6) nights. Inpatient notes kept during Kevin's admission reflect concerns the nursing staff had regarding Mom's ability to properly care for Kevin. A doctor noted that Kevin was only two (2) months old yet he had been admitted to hospital twice for respiratory problems. The doctor commented that Mom *"Does not care for babe satisfactorily"* and requested that an assessment be completed by CYFS.

The CYFS office in that community was notified of the doctor's referral and her additional request for a parenting assessment. The on-call social worker who received this information noted that she did not think an assessment was necessary at that point as Kevin was safe at the hospital and was going back to his hometown soon. This social worker noted that the CYFS office in Kevin's hometown could do an assessment regarding his safety and wellbeing when he returned home. She documented that she contacted the CYFS *"supervisor"* in Kevin's hometown and was told that there was no immediate response needed other than making a referral to that CYFS office. The name of the CYFS *"supervisor"* whom the on-call social worker consulted was not documented. The on-call social worker also contacted the assigned social worker in Kevin's hometown who advised that the CYFS office there was aware of the family and would continue to closely monitor Kevin's safety and wellbeing once he returned home. The on-call social worker relayed this information to a hospital supervisor and noted she would forward the completed CPR to the other CYFS office.

The CPR indicates concerns regarding Mom's parenting ability, basic parenting skills, and motivation to parent. Reportedly, Mom had to be prompted to change dirty clothing and bathe the baby. She was resistant to help and was defensive towards hospital staff. There was concern for Kevin's care when he returned home. It was recommended that the CYFS office in Kevin's hometown contact the doctor at the hospital for additional details. Upon receipt of this information, the assigned social worker in Kevin's hometown noted that she would follow up with Mom and Kevin when they returned home.

The day after Kevin was discharged from the hospital, the assigned social worker visited with the family. Nan was home with Kevin and she told the assigned social worker that she and Mom shared the responsibility of caring for Kevin. Nan reported that Kevin's health had improved since the trip to the hospital and he would receive followup at the community clinic. Despite the doctor's request, a formal assessment of Mom's parenting capacity, and subsequently Kevin's safety, was not completed as part of the assigned social worker's followup on this date. When asked in an interview with the Advocate, the assigned social worker indicated that Safety Assessments were not being completed at that time and the means were not available to do parenting assessments (Transcript of ACY Interview, 2014).

Shortly after being released from the hospital, Kevin developed a rash and was brought to the community clinic by Nan. It was noted that he had started taking an antibiotic two (2) days prior. He was assessed by a nurse as having an allergic reaction to the antibiotic. The nurse consulted with a doctor who ordered the medication be discontinued. At this time, the doctor inquired about the referral that had been made and subsequent followup. The nurse contacted the assigned social worker who reported that the referral had been received and contact had been made with the family. The nurse indicated she would relay this information to the doctor; however, there is no documentation to indicate that occurred.

Kevin travelled with Mom to the Janeway Children's Health and Rehabilitation Centre (Janeway) later that year for a surgical procedure. The assigned social worker in Kevin's hometown and a social worker at the Janeway had arranged assistance to orientate Mom to the hospital and its facilities. Despite this, it was reported to the assigned social worker by a friend of the family that Mom did not receive any support and Kevin's surgery was not going ahead as scheduled. The assigned social worker contacted the Janeway social worker to request immediate intervention; however, she learned that someone had indeed met with Mom and accompanied her to Kevin's appointment. Mom had been given pre-operative instructions for the day of Kevin's surgery but had not followed those instructions and as a result, Kevin's surgery was cancelled. The two (2) social workers discussed options for support as Kevin had another appointment in a few days. A support person was arranged to help Mom understand directions from hospital staff. Kevin's surgery was completed

and he was discharged home with an antibiotic. It is noted in a Discharge Summary by a doctor that Mom met with a dietitian during Kevin's admission as there were some concerns regarding his diet. The doctor noted that the importance of the use of proper formula was explained to Mom and she was given instructions on how to ensure Kevin was receiving nutritionally appropriate feedings.

In the two (2) weeks following his surgery, Kevin was seen at the community clinic four (4) times for post-operative checks. He was also seen by Public Health twice for weight checks. During this time, the assigned social worker documented her unsuccessful attempts to connect with the Janeway social worker, the clinic and the family to learn of Mom and Kevin's progress.

Over the next few weeks, concerns regarding Kevin's diet were noted by the community clinic and by Public Health. Test results showed that Kevin had low iron and Mom had been instructed to give him a supplement; however, it appeared that she was not adhering to those instructions. A doctor was consulted and the recommended regimen for the supplement was increased. A nurse at the community clinic relayed this information to a Public Health Nurse (PHN) who then met with Nan and Kevin. The PHN gave Nan the iron supplement and provided instructions on how to properly prepare Kevin's formula. The importance of the iron supplement as well as the regular use of an inhaler Kevin had been prescribed was stressed to Nan. The PHN told Nan that they would follow up regarding the use of both.

Kevin was seen at the clinic twice after this; once for an ear infection and again for an eye infection. He was prescribed two (2) different antibiotic medications to treat each ailment. One of the antibiotics was the same one that he had been assessed as having an allergic reaction to just over one month prior.

Once again, the assigned social worker noted her unsuccessful attempts to visit with the family and to connect with the Janeway social worker regarding Kevin's last hospital admission. A CSW did meet with the family and relayed to the assigned social worker that Nan was caring for Kevin the majority of the time and his health had improved. Public Health also followed up with the family regarding Kevin's prescribed iron supplement. Nan indicated they needed a refill of the supplement and this information was relayed to the community clinic.

When Kevin was four (4) months old, he became sick again. The community clinic nurse attempted to alleviate symptoms but Kevin had to be transported to a hospital in another community. An antibiotic was ordered; the same antibiotic that he had been thought to have an allergic reaction to when he was two (2) months old. Kevin was admitted to hospital for seven (7) nights with a respiratory infection.

The assigned social worker contacted the community clinic and was told that Kevin had been brought in by Mom who reported that he had become ill overnight.

When Nan arrived at the clinic later that day, she conversely relayed that Kevin had been sick all week. The assigned social worker was also told that Nan had made a comment that she was trying to take Kevin from Mom as Mom did not know how to care for him properly. It is noted that Mom had no hesitation about escorting Kevin to the hospital; in fact, she seemed scared about Kevin's illness. Once at the hospital, Mom told the doctor that Kevin had been unwell for several days. The assigned social worker noted that she would advise a CSW of the situation and request followup with Nan. This information did not result in the generation of a CPR. When asked in an interview with the Advocate, the assigned social worker stated that at that time, only referrals from outside sources would be documented as a CPR. She explained that the concerns expressed in this instance were by Nan, who would have been viewed as one of Kevin's primary caregivers; not an outside source (Transcript of ACY Interview, 2014). The Advocate was advised by the Deputy Minister of the Department of Child, Youth and Family Services in September 2014 that this was inaccurate and actually contravened the CYFS policies in place during 2002.

During Kevin's hospital admission, the nurses again documented concerns regarding the amount of encouragement and direction Mom needed in caring for Kevin. She was anxious to return home and the doctor had to explain to her that Kevin had to stay in the hospital until he was better. When Kevin was discharged, a note was made on his Discharge Care Plan: *"Please do not smoke in your home or around the baby!"* This form was signed by Mom that same day. Kevin was discharged with a prescription for an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past.

While Kevin was in hospital, the assigned social worker attempted to visit the family but no one was home at the time. The Public Health office contacted the community clinic to inquire about Kevin's lack of attendance at recent appointments and was informed about Kevin's illness and subsequent hospital admission.

Approximately one week after Kevin had been discharged from hospital, Mom presented at the community clinic with his antibiotic prescription; she had not gotten it filled. When asked why, she was unable to provide a reason. It is noted: *"She also stated that he was better now anyway"*. The nurse informed Mom that a doctor would have to be contacted regarding the unfilled prescription. When the nurse spoke with the doctor, direction was given to not fill the prescription due to a long break in treatment. The nurse called and then wrote a letter to the assigned social worker to relay concerns about Kevin's care, specifically, the unfilled prescription.

In her letter, the nurse outlined Kevin's recent visit to the clinic and subsequent hospital admission. She relayed the discrepancy in when Kevin had gotten sick as reported by Mom and by Nan. She also relayed that Mom had alleged she had tried to get an appointment for Kevin earlier but had been told by the nurse not to bring

him in right away. The nurse was questioned by her supervisor about this but the nurse said she had not spoken to Mom about an appointment. Mom was questioned about this as well and she reportedly *"scratched her head and stated that she must have dreamed it"*. In her letter, the nurse stated that it was not the practice of the clinic to postpone seeing sick children. The nurse went on to explain how Mom had failed to get Kevin's prescription filled upon discharge from the hospital. When questioned about this, Mom stated the pharmacy would not fill it and *"she shrugged her shoulders stating that he was better now"*. The nurse indicated that she contacted the pharmacy but could not substantiate Mom's claims. The nurse reported that she also spoke with a doctor at the hospital regarding the delay in filling the prescription and subsequently, Kevin's treatment was suspended. The nurse stated: *"This baby was seriously ill. With only partial treatment, when he gets sick again the illness may become more virulent and more difficult to treat."* The nurse went on to say that there seemed to be a lack of understanding or concern for Kevin as this was his third admission in four (4) months. She wrote: *"Close follow-up by our clinic and your department will ensure the health and safety of [Kevin]."* A CPR could not be found in the CYFS file pertaining to the information provided by the nurse, via telephone and letter. When asked in an interview with the Advocate, the assigned social worker said that the information relayed by the nurse should have been documented as a CPR; however, she could not confirm whether or not a CPR had been completed given one was not present in the file (Transcript of ACY Interview, 2014).

Two (2) days after this letter was written, a CSW completed a home visit with Mom and Nan, but only Nan would answer the CSW's questions. Nan said Kevin had asthma and it was noted that she was smoking as she said this. The CSW told Nan not to smoke around Kevin and Nan put the cigarette out. During this visit, the CSW inquired whether Nan would be willing to travel with Kevin to the hospital if Mom could not; she replied she would but only if the weather was favourable. Mom was feeding Kevin during the visit and he was noted to be healthy and alert. The CSW told Mom and Nan that she would be dropping by once in a while to see how Kevin was doing. It does not appear that the concerns expressed in the nurse's letter were addressed during this visit. The next documented followup by CYFS occurred nearly two (2) weeks later.

Kevin returned to the clinic with an ear infection soon after and was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. A few days later, he returned again and was assessed as having tonsillitis. His antibiotic prescription was changed to a different one; though, still in the same family of antibiotics. The next day, Kevin was brought to the clinic by Mom with a rash that appeared shortly after he took his medication. He was assessed as having an allergic reaction to the new antibiotic. Mom was advised to immediately

discontinue the medication and she was instructed to destroy any that remained at home and to start Kevin on a different antibiotic the following day.

Following a dispute with Nan, Mom moved into her brother's home with Kevin. The assigned social worker became aware of this when she attempted a home visit with the family. Notably she did not speak with Nan at that time or attempt to visit the brother's home to see Mom and Kevin. A Community Health Aide (CHA) also attempted a home visit to follow up with Kevin who was noted to be on the *"high priority [follow-up] list"* but received a hostile reception from Nan. The situation was discussed with one of the nurses at the community clinic and another visit was planned.

After learning that Mom was considering a move to another community with Kevin and her boyfriend, the assigned social worker completed a home visit with Nan. During this visit, Nan said that Mom was capable of caring for Kevin but she was worried Mom may *"go drinking"* or out with her boyfriend while in the community and Kevin would not be cared for properly. The assigned social worker advised Nan that CYFS could not prevent Mom from leaving town or remove Kevin from her care unless there were serious parenting concerns. Nan reiterated that Mom knew how to care for Kevin but she worried how well she would do in another community. The assigned social worker said that she could make a referral to the CYFS office in the other community for followup given Kevin's health issues. She asked Nan to let her know if Mom did leave town. Following this visit, the assigned social worker spoke with someone from the Public Health office about Kevin's attendance at an appointment that day. She also spoke with a relative of Mom's boyfriend, who relayed that he had not said anything about moving away. It does not appear that the social worker visited Mom at her brother's house to discuss the potential move.

According to documentation, approximately ten (10) days after moving in with her brother, Mom moved back in with her parents. Upon learning this, the assigned social worker completed a home visit that same day, this time with Mom and Kevin, who was reportedly doing well. Mom indicated that she no longer planned to move away and she told the assigned social worker that she relied on Nan to help care for Kevin. Mom said she would contact the assigned social worker if she needed any help. The next documented contact CYFS had with this family occurred nearly three (3) months later.

Kevin became ill again late in the year and according to his clinic notes, he was admitted to the pediatric ward of the community clinic for observation. He was discharged home the same day with an antibiotic. He was seen twice more at the clinic that year for a routine checkup and a viral infection that was treated with over-the-counter medication. Kevin was also brought to the Public Health office by Mom for

his immunization. At that time, the PHN discussed with Mom the importance of Kevin receiving his prescribed supplements and medications regularly. After this appointment, the PHN consulted with the community clinic to confirm the family had been picking up refills of Kevin's medication.

2003

Kevin – 1 Year Old

Early the next year, Kevin was brought to the community clinic and assessed as having an eye infection and an ear infection. He was prescribed an antibiotic medication for each ailment; one of which was the same antibiotic that he had been assessed as having an allergic reaction to at two (2) months of age. Kevin was also brought to the clinic several times during the year with respiratory problems that were alleviated with the administration of respiratory medication; similar to the medication contained in Kevin's inhaler. Follow-up appointments were scheduled but Kevin was not always brought in for same.

In a visit with the assigned social worker, Mom expressed concerns about the environment at her parent's home. She reported that both Nan and Pop smoke and Kevin was coughing a lot. She also relayed that she would like for Nan and Pop to become Kevin's caregivers but only if they would stop smoking in the home. Mom signed a document that permitted the sharing of information pertaining to Kevin's medical records between the assigned social worker and the nurses and doctors providing his care. The assigned social worker contacted the nurse-in-charge at the community clinic to seek information regarding Kevin's health and input on whether an air purifier would *"offer sufficient protection in a house where cigarettes are regularly smoked"*. The nurse-in-charge noted in her response that Kevin had been seen at the community clinic numerous times and had been transported four (4) times to hospitals in other communities. In all these cases, Kevin had significant respiratory distress. This nurse believed that no one should be smoking around Kevin and queried whether the family would see the purchase of an air purifier by CYFS as permission to smoke, *"since the air is being purified"*.

Following receipt of the response from the nurse-in-charge, the assigned social worker completed a home visit with Mom and Kevin. She noted that the home did not smell of smoke and Mom advised that her parents were trying to smoke outside or by the woodstove. Mom and the assigned social worker discussed Nan becoming Kevin's main caregiver and a meeting was scheduled to discuss this arrangement with Nan and Pop.

The following month, Kevin was brought to the clinic again with respiratory problems and was given medication to alleviate his symptoms. He was assessed as having a respiratory infection and was prescribed an antibiotic. Kevin was seen by a doctor at the clinic the next day and it was noted that he had been a *"wheezy baby for several weeks"*. It was also noted that he lived in a house with six (6) cigarette smokers and a woodstove. He was assessed as having asthma. Kevin was seen by the same doctor a few days later and was again observed as having respiratory problems. The doctor prescribed a steroid and an antibiotic medication.

Public Health documentation indicates that Kevin was not brought in for a scheduled immunization appointment; no explanation was provided. In addition, Mom relayed to a CHA that she had attempted to visit the clinic to have Kevin weighed but no one was available. The CHA advised that she had been away completing a course at the time of Mom's visit.

Approximately one week after her last visit, the assigned social worker met with Mom, Nan and Pop as planned to discuss a caregiver arrangement for Kevin. It was decided by all that Nan and Pop would assume full time care of Kevin under a Child Welfare Allowance (CWA) arrangement. The assigned social worker noted that the arrangement would last for at least three (3) months and her program manager verbally confirmed the arrangement. It does not appear that there was a discussion about the concerns expressed by Mom a few weeks prior regarding Kevin's exposure to cigarette smoke in the home.

Later that day, Kevin was brought to the community clinic by Mom in respiratory distress. He was given medication to alleviate symptoms and was assessed by a doctor. It was noted that Kevin was *"quite distressed"* and he was admitted to the clinic as an inpatient. He was given more medication and put on oxygen. A progress note written by the doctor the next day highlighted the environmental factors contributing to Kevin's history of respiratory problems: *"6 of 7 people in home smoke [and] they have a wood stove."* Kevin was not responding to the treatment provided by the clinic therefore it was determined that he would be transferred to a hospital in another community. The doctor and a woman, noted as his *"grandmother"*, accompanied Kevin to the hospital where he was diagnosed as having a respiratory infection and possibly pneumonia. He stayed in the hospital for two (2) nights and was noted to improve greatly upon admission.

While in hospital, Kevin's inpatient notes reiterated the suspected environmental factors contributing to his illness. A doctor wrote: *"Child lives [with] smokers [and] wood stove. It would be best if he did not. Wrote a letter to social services to this effect."* A handwritten letter of the same date addressed to *"Whom it May Concern"* from the doctor states:

> *Little [Kevin] has had several hospital admissions for chest infections. His health would be much improved if he did not live in a house full of wood [and] cigarette smoke. If at all possible, I am recommending he change his home environment for medical reasons.*

This letter was present in both Kevin's medical file and the family's CYFS file.

The assigned social worker was notified about Kevin's most recent hospital admission and was faxed the letter written by the doctor with concerns regarding Kevin's home environment. Upon receipt of this letter, the assigned social worker noted that she *"immediately"* wrote a letter to Nan and Pop, with whom Kevin was residing, regarding the necessity of ensuring that the home was smoke-free. The assigned social worker explained that the doctor concluded that the cause of Kevin's illness was his exposure to cigarette, and possibly woodstove, smoke. The assigned social worker urged Nan and Pop to *"take action to protect [Kevin] from further harm by not smoking in the house."* The letter advised that if Kevin continued to exhibit illness due to smoke inhalation then he could be removed from Nan and Pop's care. The letter was signed by the assigned social worker and a CSW. The assigned social worker documented that she would visit the family when Kevin returned to the community. A CPR pertaining to the information provided about Kevin's hospital admission, his diagnosis and the recommendation of the doctor was not present in the CYFS file. When asked in an interview with the Advocate, the assigned social worker indicated that the information should have been documented as a CPR; however, she could not confirm whether or not a CPR had been completed given one was not present in the file. She explained that there had been damage to the CYFS office in 2005 and some documentation had been lost as a result. She could not say for certain what documentation pertaining to this family may have been lost (Transcript of ACY Interview, 2014).

The assigned social worker visited the family the following week and Kevin was noted to be doing better. The assigned social worker noted that she had a *"frank"* discussion with Nan and Pop regarding their smoking. They told the assigned social worker that they had discussed it and there would be *"absolutely no smoking"* in the home. The assigned social worker noted that the air in the home smelled fresh and Nan and Pop were smoking outside. She also noted that Nan and Pop had all the necessary baby equipment and clothing. Support for babysitting hours was offered by the assigned social worker but Nan indicated Mom would care for Kevin when Nan and Pop were away.

A PHN met with Nan and Kevin's uncle to discuss Kevin's diet and nutrition. Nan reported using Kevin's iron supplement as directed. A referral was made to a child development team and Nan signed a form that authorized the hospital to provide Kevin's medical chart to the Public Health office. One week later, a CHA brought Nan the forms that she would need to complete for Kevin's referral to the child

development team. The CHA was supposed to return to collect the forms but it is unclear whether or not she did. The next documented contact Public Health had with this family was four (4) months later.

Kevin was brought to the community clinic the following month and assessed as having an ear infection and respiratory infection; he was prescribed an antibiotic. Regular use of his inhalers at home was also recommended. A few weeks later, he became ill again and his inhaler was not alleviating symptoms. He was assessed as having another respiratory infection and was sent to a hospital in another community for tests. The results were negative for pneumonia and Kevin was not admitted to the hospital; it was noted: *"mother not wanting admission"*. He was sent home with an antibiotic prescription; the same antibiotic that he had been assessed as having an allergic reaction to in the past.

Over the next two (2) months, the assigned social worker had one office visit with Nan. During this visit, there was a discussion about the CWA payment. Additionally, Nan advised that Mom was spending very little time at home and was considering moving away. The assigned social worker noted that Mom had missed two (2) scheduled appointments to discuss long-term plans for Kevin. When they finally met, Mom relayed to the assigned social worker that she was spending more time with Kevin who was present with her during the visit. He was noted by the assigned social worker to look very well and comfortable with Mom.

Kevin had four (4) clinic visits over the next two (2) months. He was assessed as having an ear infection at his first visit and was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. Three (3) weeks later, Kevin was brought to the clinic again with an ear infection and was prescribed a different kind of antibiotic. Kevin returned to the clinic again a few days later with what appeared to be a fungal infection; medication was prescribed for same. A few days later, he returned to the clinic with what appeared to be symptoms of an allergic reaction. The new antibiotic medication prescribed a few days earlier to treat his second ear infection was thought to be the cause. A doctor was consulted and ordered the medication be discontinued.

Mom moved back in with Nan and Pop midway through the year; however, the assigned social worker was advised that Nan would remain as Kevin's primary caregiver. Later, Nan requested a meeting with the assigned social worker and relayed that the family had decided that Mom would resume care of Kevin with the support of Nan and Pop. Consequently, Nan requested the CWA be discontinued and the assigned social worker completed the necessary forms. The assigned social worker noted that because Mom would be living in the same home as her parents, this was an acceptable arrangement. Nan was confident that Mom could provide the appropriate care to Kevin with Nan's supervision. The assigned social worker advised she would visit Mom the following week.

A home visit was completed the next week by the assigned social worker and a CSW to see how Mom was doing and to check on Kevin. Mom was noted to be doing well. Kevin was sleeping at the time of the visit and Mom reported that he had not had any asthma difficulties as of late. Nan was home, but *"passed out"*. According to Mom, *"[Nan] had been drinking last night and has not yet sobered up."* Two (2) days later, the assigned social worker had an office visit with Mom and Kevin. During this visit, Mom inquired about social assistance and the assigned social worker encouraged her to pursue an application for funding to get her own housing accommodations. Mom was observed to be affectionate and appropriate with Kevin. The assigned social worker noted that he had grown quite a bit and had a slight cough but looked *"quite healthy"*. Mom said things were good at home; Nan had not been drinking often and they were getting along.

Around this time, Kevin was brought to the community clinic by Nan and was assessed as having a respiratory infection. He was given medication to help alleviate symptoms. Nan was told that Kevin should continue to use his inhaler at home. A couple of weeks later, Mom brought Kevin to the clinic with a rash that was caused by fly bites. It was noted in Public Health documentation that same day that Kevin was not brought in for his immunization appointment. The week after that, Kevin was seen at the community clinic again with a respiratory infection and what was thought to be an eye infection. Medication was prescribed and a test was completed, which was positive for infection.

On this same date, a referral form was completed by a PHN requesting Kevin be seen by the visiting pediatrician due to multiple conditions that he had been presenting with over the past few months. In the follow-up section of the form, a doctor wrote:

> *I saw the boy and agree he is not getting TLC due to poor home environment. He is an alert, happy kid who would thrive under better circumstances. Keep an eye on him and try [and] give supportive care to mom [and] nan.*

It does not appear from file documentation, that these concerns were reported to CYFS.

A CHA noted her attempt to schedule an appointment to see Kevin; however, Nan reported Kevin was sick. The CHA advised Nan to bring Kevin to the community clinic without an appointment but there is no documentation to indicate that Nan did as suggested. Ten (10) days later, Kevin was seen by Public Health and received part of his immunization; the remainder was held until a doctor was present due to the possibility of an allergic reaction. It was documented during this appointment that Kevin was *"very quiet"* and had a *"sad appearance"*. Kevin was assessed as *"high risk"* for priority followup. A form for the child development team

was given to Mom to complete. Additionally, a report would be completed by the PHN and forwarded to this team. Kevin was seen by Public Health the following week to receive the rest of his immunization. He was also seen at the community clinic and noted to have a mild respiratory infection, which was treated with over-the-counter medication.

It appears from Public Health documentation that a PHN wrote a letter to the assigned social worker around this time to relay some concerns. It had been recommended to Mom and Nan on multiple occasions that Kevin be seen by a pediatrician and by a child development team due to health concerns. The forms required for the child development team were given to both Mom and Nan to complete; however, despite both women stating they would complete the forms and return them, they never did. In addition, a referral had been made to a visiting doctor to assess Kevin's various health problems. Concerns were relayed to the doctor regarding Kevin's *"apathetic behavior… and very 'sad' appearance"* during visits with Public Health professionals. The PHN noted in her letter that the doctor *"agreed in writing that [Kevin] is not getting TLC due to poor home environment"*, referencing a note written a month prior on a referral form. The doctor said that Kevin was a happy and alert child who would *"thrive under better circumstances."* In her letter, the PHN suggested that the first step to address these concerns was to provide supportive care and followup on a regular basis to Kevin and his family. The PHN did note that Public Health provided limited support and it was believed that the family, Nan in particular, was feeling *"threatened"* due to their ongoing concern for Kevin. The PHN requested that the assigned social worker respond, indicating how she may address this matter *"in relation to monitoring closely and providing supportive care."* There is no record of this letter contained in the CYFS file and when asked in an interview with the Advocate, the assigned social worker stated she had no recollection of receiving the letter (Transcript of ACY Interview, 2014).

Kevin was seen at the community clinic five (5) times over the next month. During the first visit, he presented with asthma symptoms and Nan was advised to continue using his inhalers at home. He was brought into the community clinic a second time with a mild abrasion to his foot and the third time with gastro symptoms. Ten (10) days later, he was assessed as having an ear infection and sinus infection, for which he was prescribed an antibiotic. One week after that, he saw a doctor who noted that there were *"some concerns about mother's parenting skills"*. The doctor noted Kevin's respiratory problems and referred him to a pediatrician. The doctor requested the pediatrician provide advice on the management of Kevin's condition.

Kevin travelled to another community to see the pediatrician a couple of weeks later. The pediatrician noted in his Consultation Letter to the referring doctor that Kevin had a history of respiratory illness and infections. Kevin was due for his im-

munization and a change was recommended regarding the use of his inhalers. The pediatrician also noted that *"Mom smokes but denies smoking around him. Nobody else smokes around him."* He wrote:

> *I strongly recommended to mom to stop smoking. I hope she is able to do that and that you would be able to reinforce it during her visits with you. I have suggested that she be assessed by you on a monthly basis and monitor his [inhaler].*

Kevin was brought to the community clinic by Nan a few days later and assessed as having a respiratory infection and an ear infection; he was prescribed an antibiotic. He returned the following week and was noted to have a respiratory infection, fungal infection and asthma symptoms. Mom reported that they had been out of Kevin's inhalers for *"some (?) time"*. Medication was administered to alleviate Kevin's asthma symptoms, he was prescribed medication to treat the fungal infection and Mom was advised to use his inhalers regularly at home.

The assigned social worker documented in one case note the multiple contacts she had with Mom over the period of a month. She had two conversations with Mom early in the month, both about Kevin's health. During one of these conversations, the benefits of Kevin being referred to a child development team were discussed. Mom had the application forms and she was supposed to bring them in for the assigned social worker to review but this did not happen. Later in the month, the assigned social worker received a call that Mom was refusing to travel with Kevin for a surgical appointment out of town. The assigned social worker completed a home visit that same day and learned that Nan had prevented the travel from occurring as she felt the surgery was unnecessary. The assigned social worker followed up with the clinic to determine the need for Kevin's travel and learned that his appointment had been postponed. A follow-up appointment was going to be scheduled to reassess Kevin and his suitability to travel.

Notes from the community clinic indicate that a request was made to obtain Kevin's medical records from the surgeon at the Janeway and the pediatrician who had seen Kevin recently. Followup was planned for after these files were obtained. A note written later in the file indicates records were received from the surgeon but not from the pediatrician. A few days later, Kevin was brought to the clinic by Mom with respiratory problems. He was given medication to alleviate what was believed to be asthma symptoms. Mom was again told to use Kevin's inhalers at home as per the recommended regimen.

The assigned social worker completed a home visit with Mom, Nan and Kevin. It was noted that all seemed well; Kevin was awake and responsive. The discussion

centred on Kevin's health. Mom told the assigned social worker she was undecided about the referral to the child development team as she and Nan did not like to travel and they thought Kevin was doing well. Mom reported that she and Nan were getting along better and were sharing the responsibility of caring for Kevin. The next documented contact CYFS had with this family was two (2) years later.

According to clinic documentation, an appointment was made for Kevin to see a surgeon at the Janeway early the following month; Mom would be travelling with Kevin to this appointment. On the day they were due to leave, the clinic was notified that Mom had decided not to go. The surgeon was notified by the clinic and reportedly said that Kevin needed the surgery. The clinic notes indicate that the assigned social worker was notified; however, information pertaining to this event or a corresponding CPR was not present in the CYFS file. The appointment was rescheduled and it was noted that both Mom and Nan would travel with Kevin.

Mom brought Kevin to the clinic on the day they were scheduled to leave for his appointment. Kevin was having respiratory problems and he was given medication to alleviate symptoms. The surgeon at the Janeway was contacted but advised that Kevin should still travel to the Janeway. Mom was instructed to have Kevin checked at the emergency department of the hospital in one of the communities they were travelling through along the way. When Kevin was seen in the emergency department it was noted that he had been sick for two (2) nights and he was assessed as having a respiratory infection. The doctor also noted that Mom had a black eye and requested that *"family services"* be consulted regarding the need for a *"parenting course"* for Mom when she returned to the community. The doctor made reference to Kevin being a *"high risk baby"* with potential concerns regarding *"domestic violence of parents"*. It was documented in Kevin's community clinic file that *"Social Services"* were notified of suggestions made by the doctor at the hospital; however, information pertaining to this event or a corresponding CPR was not present in the CYFS file.

Upon arrival at the Janeway, it was determined that Kevin had *"significant"* pneumonia; he was admitted and treated intensively over the following week prior to having surgery. Similar to his past admissions at another hospital, inpatient notes reflect concerns regarding Mom's care of Kevin. One day it was noted that Mom slept all morning until early in the afternoon despite being called by the nursing staff to get up. Kevin was not fed breakfast and the nursing staff had to feed him lunch. It does not appear from file documentation that these concerns were reported to CYFS. Kevin was noted to improve *"markedly"* upon admission and the surgery was eventually completed.

2004

Kevin – 2 Years Old

During the first two (2) months of 2004, Kevin was brought to the clinic four (4) times. The first time he was assessed as having an ear infection, possibly tonsillitis and asthma symptoms. He was given medication to alleviate his asthma symptoms and was prescribed an antibiotic. Instructions were given to Mom that Kevin's inhalers be used as previously ordered. Nan brought Kevin into the clinic for reassessment the next day. He was again assessed as having asthma symptoms and Nan was told to continue with his medications as directed. Mom brought Kevin in for his third visit; at that time he again had similar respiratory symptoms. It was noted in his file that he was not being exposed to cigarette smoke. He was assessed as having a respiratory infection but no medications were prescribed; however, regular use of Kevin's inhaler was again advised. Kevin was assessed as having an ear infection during his fourth visit and was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past.

During a visit with Public Health, it was noted that there was *"Good interaction between mother [and] child."* Dental health, toilet training, safety, nutrition and developmental milestones were discussed with Mom and she was noted to be receptive to same. An appointment was made for Kevin to receive his immunization when a doctor was present in the community.

The following month, a note contained in the Public Health file indicates that Kevin was due for followup but states: *"Caution since family noted on two [occasions] to be verbally abusive to staff [regarding] Home visiting."* A home visit was completed a short time later and it was noted that both Mom and Nan were very welcoming. Again, good interaction was noted between Mom and Kevin. The last Public Health notation for the year reflects a consult between the Public Health professional and the assigned social worker. During this consult, the assigned social worker advised that CYFS had been following Kevin for assistance with travel for health purposes as well as providing support when necessary. The assigned social worker was noted as saying that Kevin was very happy and content in his home environment. This conversation was not documented in the CYFS file.

A few days after his immunization, Kevin was brought to the community clinic with a rash. It was thought he was having a reaction to his recent immunization and medication was given to treat same. Kevin returned to the clinic over a week later and it was noted that his rash had not improved. Advice was given on how to treat the rash and a cream was provided. Mom was asked to advise the clinic of Kevin's condition in a few days but it was over a week before Kevin was seen again. At that time, it was noted that he was still sore from the rash and he also had a cold. Over-

the-counter medication was given to treat both ailments. Kevin's next visit to the clinic occurred two (2) months later. At that time, Mom reported that Kevin still had a rash and it appeared to be spreading. It was noted that the rash looked infected and a cream was prescribed.

Kevin was seen again at the clinic one month later due to swelling and redness of his face and eye that was believed to be the result of a fly bite that had become infected. He was prescribed an antibiotic that was of the same family of antibiotics that he had been assessed as having an allergic reaction to in the past. Upon followup, Kevin was also prescribed antibiotic eye drops. His symptoms resolved within a few days.

It was two (2) months before Kevin was seen again at the clinic. At that time, he had an ear infection and was prescribed the same antibiotic that he had been assessed as having an allergic reaction to in the past. He returned two (2) weeks later and it was noted that his ear infection was still present. He was also noted to have asthma symptoms and Mom reported they did not have any inhalers at home. Medication was administered to alleviate symptoms and Kevin's inhaler prescription was refilled. He was also prescribed another type of antibiotic.

Kevin was brought to the clinic by Nan a few weeks later and assessed as having a skin infection. He was again prescribed an antibiotic. A few weeks after that, he returned to the clinic with what appeared to be an infected knee. A test was completed and it was noted that good hygiene was stressed to his caregivers. Test results were positive for two (2) kinds of infection. Upon receipt of the results by the community clinic one week later, Kevin was prescribed an antibiotic; again the same antibiotic that he had been assessed as having an allergic reaction to in the past.

Kevin was seen at the clinic three (3) more times this year. The first time he was assessed as having an eye infection and was given antibiotic eye drops. It appears he returned to be reassessed by a doctor a few days later. On his third visit, he presented with respiratory problems and was given medication to alleviate same. Mom was again reminded to use Kevin's inhalers as needed at home.

2005

Kevin – 3 Years Old

Kevin was brought to the community clinic by Mom early in the year with another eye infection. A test was completed to confirm the infection and it was noted that treatment would be determined based on the results. Kevin was given a followup appointment with a doctor for the following week, although it does not appear this appointment occurred. The test results were positive for infection and it was

noted that these results would be brought to the attention of a doctor. Despite this, it appears Kevin's infection remained untreated for over a month. Six (6) weeks after Kevin initially presented at the clinic with an eye infection, he returned with Mom who reported that his condition was not improving. He was referred to a doctor for assessment the following week and antibiotic cream was prescribed. Kevin finally saw a doctor a few days later. The doctor noted that he examined Kevin's eyes but he did not note any detailed assessment or prescribe any treatment.

Over the next few months, Kevin was brought to the clinic numerous times with respiratory problems and illnesses. During one visit, Kevin was assessed as having a viral infection and Mom was told to continue using his inhalers at home as previously prescribed. At a later visit, Kevin was assessed as having a chest infection and tonsillitis. He was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. Mom was again advised that Kevin should be using his inhalers as previously recommended. A few days later, Kevin returned to the clinic and it was noted that he was *"pale", "miserable"* and his breathing was laboured. Despite reports that he was using his inhalers at home, it was noted: *"Not sure how compliant with the [medication] orders of 48hrs ago"*. A doctor was consulted and Kevin was given medication to help alleviate his symptoms. His condition improved and he was given an appointment to see a doctor the following day. It was noted: *"Stressed importance of continuing [medication]"*. Clinic notes from the visit with the doctor highlight concerns regarding the family's compliance with Kevin's treatment orders and doctor's recommendations:

> *Agree with non compliance of meds - states child doesn't like it, still coughing [and] miserable. Strong smell of smoke [off] mother [and] grandmother's clothes was asked to stop smoking by [doctor]. Again stressed the importance of not smoking.*

It does not appear from file documentation that these concerns were reported to CYFS.

A couple of weeks later, Kevin was brought to the clinic by Mom and was assessed as having another respiratory infection and asthma symptoms. He was given medication to help alleviate symptoms and was prescribed an antibiotic. Mom was again told to continue using his inhalers at home. It does not appear as though any information regarding Kevin's repeated illnesses and the family's suspected noncompliance to the recommended treatment plans were communicated to CYFS.

Over the next two (2) months, Kevin was seen at the community clinic with repeated ear infections. At his first visit, he was noted to have a *"serious"* infection and was prescribed an antibiotic. He returned a few weeks later and it was noted that the infection was still present. He was again prescribed an antibiotic. The following month, Kevin was seen for fly bites and inflammation of the throat, for which he

was prescribed over-the-counter medications. Kevin was also seen by Public Health each month for weight checks. It was noted that he was doing well.

Kevin's health started to decline over the remainder of the year. He began to present at the clinic with skin problems and infections. During one visit, he was initially assessed as having a rash and was prescribed an antibiotic ointment to treat same. A test that was completed during this visit was positive for infection. Kevin was brought back to the clinic by Mom one week later due to his symptoms not improving. He was then diagnosed as having a bacterial skin infection. He was prescribed an antibiotic that was of the same family of antibiotics he had been assessed as having an allergic reaction to in the past. Mom was advised during this visit of proper bathing and skin care practices. Following this, Kevin's symptoms appeared to resolve for a brief period of time.

The following month, Kevin was seen at the clinic six (6) times. During his first visit, he was assessed as having a respiratory infection, an infection in both eyes and a bacterial skin infection of his ear. A test was completed to confirm an infection was present in both eyes. He was given an antibiotic ointment for his eyes, an antibiotic cream for his ear and it was noted that *"Hygiene instructions stressed to mom."* He was seen twice over the next few days for followup and was noted to be improving. When the results from Kevin's tests came back, they were positive for infection in both eyes. He was prescribed an antibiotic and Mom was told to discontinue the previously prescribed ointment. He was seen a week later and was notably improved. Mom was advised that Kevin should continue with the prescribed medication until it was finished and again, good hygiene practices were stressed. Kevin's next two appointments were the result of respiratory problems. He was assessed as having a mild respiratory infection and medication was given to alleviate symptoms. Mom was again encouraged to use Kevin's inhalers as previously recommended.

The following month, Kevin's skin problems returned. Test results were positive for infections in one of his eyes, one of his ears and his bottom. It was noted that good hygiene practices were once again discussed with Mom; including daily baths, good hand washing and proper cleaning of Kevin's eyes. Medications were prescribed for each ailment and included an antibiotic that was of the same variety as those he had been assessed as having an allergic reaction to in the past. It was noted during a follow-up appointment a few days later that Kevin's symptoms were improving.

At Kevin's next visit, it was noted that he had been to the clinic multiple times for skin problems and that tests had been positive for bacterial infections many times. At the time of this visit, a large *"plaque like area"* was observed on his body and there were other abrasions noted on his bottom, ear, trunk and face. The assessment of his condition remained the same and treatment was noted as *"ongoing"*. Concerns

regarding Kevin's hygiene were raised and while good hygiene practices were again stressed to Mom, the nurse questioned Mom's adherence to such instructions. The nurse did note that she would follow up with a social worker regarding this issue.

A Consultation Request was completed by a nurse on behalf of a doctor requesting that *"Social Work"* see this family due to Kevin's repeated bouts of serious skin infections despite Mom being provided with information about the necessity of hygiene and cleanliness. It was noted that Kevin had been receiving *"potent antibiotics"* to address the infections. The medical professionals involved were now questioning neglect and the doctor felt this was a serious health risk. The request was addressed to a specific social worker, who was not the assigned social worker. This request was stamped as received by the CYFS office in Kevin's hometown the day after it was written; however, it does not appear as though the information resulted in the generation of a CPR and no action was taken to immediately address these concerns. In an interview with the Advocate, the assigned social worker indicated that the information contained in the Consultation Request would have warranted the completion of a CPR; however, she could not confirm if such a document had been completed given it was not present in the file (Transcript of ACY Interview, 2014).

Nearly two (2) weeks after the Consultation Request was received by CYFS, the assigned social worker and a CSW completed a home visit to Mom's house. This was the first documented contact CYFS had with this family in two (2) years. In her case note, the social worker stated that she only received the Consultation Request from the doctor the day before. Mom, Nan and Kevin were present during the visit. Nan was noted to be hostile towards the workers. Kevin was observed as looking healthy and there was no sign of a rash *"on visible skin"*; he was noted to be wearing a *"t-shirt [and] underwear shorts"*. The assigned social worker discussed the use of mild detergents and soaps as Kevin had a number of allergies and very sensitive skin. She did not document whether she discussed hygiene or cleanliness practices, which were the concerns identified in the Consultation Request. The assigned social worker encouraged Mom to contact her if she needed assistance with medical care, appointments, and/or child care.

The following day, CYFS documentation indicates that the assigned social worker contacted the nurse-in-charge at the community clinic to inquire whether the clinic had any immediate concerns regarding Kevin. The nurse-in-charge provided the dates Kevin had been at the clinic for skin problems; she listed four (4) dates within less than a two (2) month time span. She said that he had incidents of eczema and dry patchy skin on his abdomen, face, neck and ears and had been treated with a variety of creams and antibiotics. The nurse-in-charge suggested the infections

could be avoided or severity decreased if there were better hygiene practices, such as washing Kevin's hands frequently. She informed the assigned social worker that the clinic had discussed this with Mom. The assigned social worker asked the nurse-in-charge to inform her if there was a reoccurrence of skin problems with Kevin that they felt could be avoided.

On this same date, the assigned social worker completed a Safety Assessment and deemed Kevin *"safe"*. This meant that there was no immediate safety intervention required. The assigned social worker noted that a home visit was completed and Mom had been directed to bring Kevin to the clinic at the first sign of a skin rash or irritation. She documented her discussion with Mom regarding the use of milder detergents and soaps, noting that she had advised Mom that Kevin's hands should be washed frequently. The assigned social worker signed the Safety Assessment on this date and it was signed by her program manager two (2) weeks later. In her case notes, the assigned social worker stated that she and the CSW discussed having a follow-up visit with Mom in a few weeks. It is unclear whether this follow-up visit occurred.

Kevin was seen at the clinic twice more that year; once for respiratory problems and once for skin problems. When Kevin presented with respiratory problems, Mom reported he was not getting his inhalers regularly. Mom was advised that Kevin should be getting his inhalers as previously prescribed. After administration of medication similar to that in his inhalers, Kevin's symptoms resolved. During his next visit, he was assessed as having an infection in his eyes and a rash on his bottom. Good hygiene practices were again discussed with Mom, which included daily baths and proper washing instructions. Treatment included antibiotic ointment and tests were completed that were once again positive for infection. Despite the assigned social worker's request, it does not appear that CYFS was notified of Kevin's recurrent skin problems.

There was a referral form addressed to *"Social Services"* in the CYFS file dated late in the year. The referral noted concerns regarding Mom, who was pregnant but could not be located for transfer to a hospital. Her family advised that she was out *"drinking and partying all night"*. The referral source noted that they were concerned for the health and safety of Mom and the unborn baby. There is no other documentation in the CYFS file concerning this event. In an interview with the Advocate, the assigned social worker explained that this information would not have been accepted as a referral as it was in reference to an unborn child (Transcript of ACY Interview, 2014). The next documented contact CYFS had with the family occurred over two (2) years later.

2006

Kevin – 4 Years Old *Ryan – Born*

Kevin's skin problems continued into the next year. During his first clinic visit, the nurse noted: *"poor hygiene – clothes are not clean."* In addition, Nan stated that she had not been following the care instructions previously given. Nan was instructed on good hygiene and over-the-counter medication was prescribed. Again, despite the assigned social worker's request, it does not appear that CYFS was notified of the reoccurrence of Kevin's skin problems or of the family's lack of adherence to Kevin's treatment plan and recommended hygiene practices. When Kevin returned for followup, tests were completed and hygiene was again discussed with Nan. A few days later, the results of the tests came back and were positive for infection. Nan was contacted and asked to bring Kevin in for followup; however, this did not occur right away. When Kevin did present at the clinic, it was noted that *"poor hygiene"* was a concern. His rash had cleared somewhat, yet it was noted he *"still needs good washing"*. He was given ointment and good hygiene was listed as part of his treatment plan.

Mom's second child, Ryan, was born in 2006. When Ryan was first seen at the community clinic, Mom was advised regarding good hygiene practices. A PHN completed a post-natal visit with the family one week after Ryan was born. Both Mom and Nan were present but Mom was noted as hesitant and uncooperative; she did not show any affection towards Ryan. During the visit, Mom indicated that Nan was Ryan's primary caregiver; in fact, Nan was referenced as Ryan's adoptive parent by both Public Health and the community clinic in documentation throughout the year. The PHN noted that there was a family history of alcohol abuse; however, it does not appear as though this was discussed during the visit. Ryan's diet was discussed and a daily iron supplement was recommended; this was communicated to the clinic. Ryan was rated as *"high priority"* on the priority assessment due to difficult family interactions and development concerns due to possible exposure to alcohol in utero. Ryan was seen again by Public Health two (2) weeks later for a weight check.

At only one month of age, Ryan was assessed as having an eye infection. He was prescribed antibiotic ointment to treat same. It was also noted during this clinic visit that Ryan's formula was too strong and preparation instructions were provided to Nan. The nurse documented that a discussion needed to occur with a PHN regarding an iron supplement for Ryan. Notes in the community clinic file state that instructions were given: *"not to have anyone smoking around baby"*. Another home visit was completed by Public Health noted as a *"priority [followup] home visit"*.

Ryan's diet was discussed with Nan; Mom was noted as *"distant"*. A weight check was scheduled to occur in two (2) days but there is no documentation to indicate this occurred.

During Ryan's next community clinic visit, Mom was noted to smell of alcohol; it does not appear that this was reported to CYFS. An infection was still present in Ryan's eyes and tests were completed to confirm this. Ryan was having trouble keeping feedings down and was noted to have respiratory congestion. Nan and Pop arrived at the clinic to assist with Ryan's care and Mom left. The clinic offered to care for Ryan overnight but this offer was declined. Nan and Pop were instructed that Ryan was to avoid second-hand smoke and a recommendation was given regarding feeding. A few days later, Ryan was brought to the clinic again with similar problems. Additional recommendations regarding feedings were given and it was noted that he may have reflux. Ryan was scheduled to see a doctor but there is no documentation to indicate that occurred.

Ryan was seen again at the clinic a few weeks later and was again congested. A humidifier was recommended for the home. Almost a month later, he was assessed as having a fungal infection and was given medication for same. Mom was advised to give daily baths and to ensure the proper boiling of all parts of bottles. A PHN saw Ryan and completed a weight check during his visit at the community clinic. Kevin was also seen at the clinic around this time; he was assessed as having tonsillitis and was prescribed an antibiotic.

Ryan was seen twice at the community clinic the following month. During his first visit, he was congested and it was noted that he was not receiving the recommended iron supplement; Nan stated he did not like it. Again, Nan was told that Ryan had to avoid second-hand smoke and she was encouraged regarding the use of the iron supplement. When Ryan was seen again, he was assessed as having an ear infection and respiratory infection; he was prescribed an antibiotic for same.

The next month, Ryan was seen by Public Health. His diet was discussed with Mom and Nan; it was noted that they could not afford formula but had guidelines from a PHN on how to prepare a substitute. Ryan received his immunization on this date and it was noted that he would remain on *"priority [followup] for family interaction factors"*. A few days after receiving his immunization, Ryan was brought to the community clinic by Nan and Pop who thought he might be having an allergic reaction. He was examined but only minor symptoms were observed; medication was given to treat same.

Ryan was seen at the clinic three (3) times the following month. During the first visit, he presented with a cough and was assessed as having a viral illness. A few weeks later, Ryan was brought to the clinic by Nan with an ear infection and was

prescribed an antibiotic. He was seen again over one week later with stomach upset and a cough; it was noted that he might be teething.

A nurse at the community clinic referred Ryan to a pediatrician for an assessment regarding his growth and development. In her referral, the nurse noted that Ryan had *"many viral illnesses since birth"*. A few days after the referral was made, Ryan was seen at the clinic with a respiratory infection. He was again prescribed an antibiotic. It was noted that Mom was told during this visit that Ryan was scheduled to see the pediatrician in a few days. Despite this, Ryan was not brought in for his scheduled appointment. A few days later, he was brought to the clinic by Nan and it was learned that his last course of antibiotic medication had been discontinued prematurely; the reason for this disruption was not documented. Ryan was again assessed as having a respiratory infection and an ear infection. He was prescribed a *"double dose"* of an antibiotic.

Kevin was also experiencing health issues around this time. He was seen at the community clinic and assessed as having a respiratory infection. He was prescribed an antibiotic and Mom was encouraged regarding good hygiene practices.

One month after Ryan was last seen at the clinic, he returned with stomach upset and another ear infection; he was prescribed an antibiotic. During this visit, Nan and Pop reported they had been consuming alcohol; it does not appear this was reported to CYFS. A few days later, Ryan returned to the clinic with similar symptoms. It was noted in his file: *"Feed baby Formula not canned [milk]!!"* A CHA noted that she was due to see Ryan that same date but due to his illness, the appointment would be rescheduled. When Ryan was brought to the clinic for followup, Nan reported that the full course of antibiotic medication recently prescribed had been given. Ryan was seen by Public Health approximately one month later. He received his immunization and it was noted that the next home visit would occur in two (2) months.

Over the next three (3) months, while Ryan was still less than one year old, he was brought to the clinic four (4) times with illnesses that were treated with antibiotic medication. He was assessed as having a respiratory infection and ear infection during his first visit and was prescribed an antibiotic. Almost three (3) weeks later, he returned and was assessed as having an ear infection that was again treated with an antibiotic. Approximately one month later, Ryan was assessed as having an inflamed throat and was prescribed an antibiotic. A test completed during this visit was negative for infection. Finally, almost three (3) weeks later, Ryan was seen at the clinic again and was assessed as having a respiratory infection. Once again, an antibiotic was prescribed.

2007

Kevin – 5 Years Old Ryan – 1 Year Old Sally - Born

Kevin was seen by Public Health for his Preschool Health Check early in 2007. Two (2) referrals were made as a result of concerns identified during this appointment. The first referral was made to a dentist as Kevin had tooth decay and had never seen a dentist. The second referral was made to a *"regional nurse"* and noted that Kevin's immunizations were deferred due to a past reaction. It was recommended he be pre-medicated prior to any immunization and that his immunizations occur when a doctor visited the area. Kevin received his immunization a few days later and no reaction was noted. A note regarding the request from the PHN for medication that Kevin required prior to his immunization was incorrectly recorded in Ryan's community clinic file.

Almost two (2) months after his last round of antibiotic medication, Ryan was brought to the clinic and assessed as having another ear infection and once again, prescribed an antibiotic. He returned to the clinic the following month and was assessed as having stomach upset and a respiratory infection. The nurse noted: *"multiple courses of antibiotics"* and then listed the dates Ryan had been prescribed antibiotics. Over an eleven (11) month period he had been given nine (9) antibiotic prescriptions; twice in one month on two (2) different occasions. The nurse documented that she *"Explained to mom frequent use antibiotics"*; however, Mom insisted that Ryan be medicated again and an antibiotic was prescribed. When Ryan returned a few days later for followup, it was noted that he was *"still miserable"*. He still had an upset stomach and was now assessed as having an ear infection in addition to the respiratory infection. Over-the-counter medication was prescribed.

Around this time, Kevin was brought to the clinic with respiratory symptoms. He was reportedly out of his inhalers and a nurse noted that the last refill was picked up almost nine (9) months earlier. His inhaler prescription was refilled and a recommendation regarding his diet was made to the family. Kevin was seen at the clinic two months later. A very brief clinic note states he had a sore throat, fever and cough. He was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past.

Ryan was seen by Public Health for his immunization. During this appointment, it was noted that Mom *"appeared anxious [and] was uncomfortable [with] strangers [and] child."* The PHN noted they would see Ryan again when he was eighteen (18) months old.

Over the next three (3) months, Ryan was brought to the clinic multiple times with similar ailments. The first visit was the result of an ear infection. He was again prescribed an antibiotic and the nurse noted that he may need followup with an *"ENT"* (Ear Nose Throat Specialist), though it does not appear a referral was made. He was seen a few days later for followup. He was noted at that time to have stomach upset and was unable to keep the antibiotic down. The nurse noted that he might be teething and that he should continue with his antibiotic if he was *"willing to take"*. He did not return to the clinic for nearly two (2) months. At that time, he was noted to have a viral respiratory infection. A humidifier was recommended to help alleviate symptoms.

Nearly two (2) months later, Ryan was brought to the clinic by Mom and was assessed as having another ear infection, for which he was prescribed an antibiotic. Approximately one hour after leaving the clinic, Mom returned with Ryan stating that he had broken out in hives minutes after taking the prescribed medication. He was assessed by a nurse practitioner as having an allergic reaction to the antibiotic prescribed earlier that day and was given medication to reduce the symptoms of the reaction. He returned to the clinic a few days later for followup. It was noted that he had not received any other type of antibiotic following his allergic reaction to treat his ear infection and he was still unwell. A different antibiotic was prescribed and a test dose was administered while Ryan was still at the clinic. The nurse advised that Ryan should avoid second-hand smoke.

In 2007, Mom's third child, Sally, was born. A CHA visited the family upon their return home and no concerns were noted. Following this appointment, efforts were made by a PHN to visit with the family and connect with Mom via telephone. The PHN also tried to encourage Mom to attend weekly voluntary weight checks with Sally; however, Mom was not receptive to any of the efforts made by the PHN. It was noted that Mom did not attend the weight check appointments and she indicated that she did not want a PHN visiting. The PHN noted that she would continue to contact Mom regarding her noncompliance and highlight the importance of making sure Sally was healthy and gaining weight. Eventually, an appointment was made to have Sally immunized but she was not brought in for this appointment. Sally was seen for a *"well-baby check"* later in the month. The visit was documented in the community clinic file but was signed by a PHN as well as a nurse at the clinic. Sally was observed to have noisy breathing and a cough but was noted as a *"Healthy Baby Girl"*. Followup with the PHN was scheduled to occur in one month for a growth check and immunizations.

In the month Sally was born, both Kevin and Ryan were seen at the community clinic multiple times for similar ailments. Ryan initially presented with stomach upset and tests were completed as ordered by a doctor. Ryan was assessed as having low iron and a supplement was prescribed. A nurse at the clinic contacted Nan to

explain the need for this medication as well as the need for followup with the clinic. Nan said she would work with Mom to ensure this occurred. Ryan was brought to the clinic the next day with a respiratory infection and was prescribed an antibiotic. At that time, the nurse documented a discussion with Mom regarding Ryan's need for iron and ongoing followup. It was noted that Mom agreed with same. Ryan did attend a followup appointment and his low iron was noted as secondary to his diet. Counselling regarding his diet was provided and it was recommended he continue with his supplement. Ryan was also seen by Public Health that month. His diet was discussed with Mom and she was advised to give him a different kind of milk in a cup rather than a bottle; the nurse advised that Ryan should already be weaned off his bottle. Ryan was immunized and his next appointment was noted to be his Preschool Health Check.

Kevin was seen at the clinic this month for asthma symptoms as well as growing pains. Mom was advised that Kevin should be using his inhalers as previously recommended and that he should avoid second-hand smoke. He was noted to have had a growth spurt and over-the-counter pain medication was recommended to treat any pain.

The following month, Sally was assessed as having a head cold while Ryan was assessed as having an ear infection and tonsillitis; he was again prescribed an antibiotic. He also had some tests done and it was noted that his iron levels were improving. A doctor recommended that Ryan continue with his supplement, though a note in the clinic file indicates that refills of the supplement were not being picked up by the family. When Nan was contacted she reported that she misunderstood the directions given and thought the supplement could be discontinued after the last quantity given. Clarification was provided and the supplement was dispensed.

Sally was seen by Public Health a couple of times for weight checks. It appears these visits coincided with visits to the community clinic. It was noted by the PHN that Mom was not pleasant; however, she was bonding well with Sally. Mom was again encouraged to attend the weekly voluntary weight check appointments with Sally, though Mom indicated that she did not feel these appointments were necessary. Sally's priority assessment score was rated *"moderate priority"* with the PHN citing family interaction factors.

When Ryan was next seen for followup at the clinic, it was noted that he was taking his iron supplement but his diet had remained unchanged; *"still pop, junk food"*. A doctor noted that Ryan's low iron was resolving; it was recommended that Ryan continue with the supplement and followup occur as planned. The clinic note indicates that Ryan was being followed by Public Health; however, when Ryan was last seen by Public Health two (2) months prior, it was noted that he would not be seen again until his Preschool Health Check.

Sally was seen late in the year at the community clinic. She had a cough as well as a fungal infection. Medication was prescribed and Mom was advised that Sally should avoid second-hand smoke. A note in the Public Health documentation indicates Sally was not brought in for her scheduled checkup. The PHN noted she would reschedule the appointment.

2008

Kevin – 6 Years Old Ryan – 2 Years Old Sally – 1 Year Old

Early the next year, Ryan was seen at the community clinic and assessed as having a respiratory infection. He was prescribed an antibiotic and Nan was told that he should avoid second-hand smoke. He returned to the clinic a few days later and was seen by a doctor as followup to his low iron. He was noted as doing well and his diet was improving. The doctor wrote *"smokers in house"* on Ryan's file. It was recommended that Ryan continue with the iron supplement and another follow-up appointment was planned.

Sally was not brought in for her next scheduled appointment with Public Health. It was noted when she was brought in that the appointment was one and one half months overdue. During this visit, Sally was noted as congested. Mom reported that she had a cough for the past six (6) weeks and would see someone at the clinic later that day. The nurse listed the woodstove in the home as a safety factor but noted it was the only source of heat. Mom was noted as pleasant during the visit. Sally received her immunization and a follow-up appointment was scheduled. Sally was then brought to the community clinic where Mom reported she had a diaper rash. It does not appear from the clinic notes that Sally's cough was mentioned. A few weeks later, Sally was seen at the clinic again and was assessed as having an ear infection and a respiratory infection. She was prescribed an antibiotic. Sally was supposed to attend the clinic for some tests but it was noted that she was not brought in. Mom and Nan were contacted four (4) times requesting they bring her in but they did not do so.

Around this time, Nan contacted the police to report that Mom was intoxicated and causing problems in the home. When the police responded, they learned that Nan had been drinking, not Mom. They determined that no offense had occurred and advised Mom and Nan that they should work out family issues amongst themselves; there was no need for police intervention. It is not evident from the documentation whether or not the children were present in the home at that time.

One Friday evening, the police received a telephone call alleging that Mom was intoxicated at her home and was threatening to harm herself. The police responded and a referral was made to the clinic for Mom to be assessed and another referral

was made to CYFS, as children were present in the home while excessive drinking was occurring. Mom was brought to the clinic and was examined by a nurse. A doctor was also consulted.

The police referral was faxed to CYFS three (3) hours after the initial call had been received. It highlighted the current issue but also referenced ongoing concerns regarding the children being neglected as a result of alcohol abuse by Mom and other family members residing in the home. The police were noted to have attended this home over the past several weeks and on those occasions they found the residents, including Mom, to be intoxicated. Despite this, there does not appear to have been any previous referrals made to CYFS by the police about this family.

The information provided by the police was documented by CYFS in a CPR four (4) days following the actual incident. The assigned social worker who had previously been involved with this family was assigned to the CPR, though it appears she had not had any documented contact with the family since 2005. It was noted that previous concerns included alcohol abuse by Nan and Pop, poor physical hygiene and possible neglect of the children. The assigned social worker documented that the file was not active on the Client Referral Management System (CRMS), which was implemented in the region three (3) years earlier in 2005. The last entry in the paper file was noted to have occurred just before CRMS implementation. The assigned social worker noted that there were three (3) young children living in a home that was known to the police as a place where adults were frequently intoxicated from alcohol consumption. In addition, Mom most recently engaged in self-harming behaviors. The Response Priority was assessed as *"medium"*, meaning response to the referral had to occur within forty-eight (48) hours. Immediate action would include a home visit, completion of a Safety Assessment, consultation with the nurse or physician who saw Mom that night and consultation with a program manager.

Due to issues with CRMS, the assigned social worker's documented action in response to this CPR did not flow in chronological order. In an interview with the Advocate, the assigned social worker confirmed the issues she encountered with CRMS on those dates and clarified the chronology of events that followed from this CPR (Transcript of ACY Interview, 2014). A home visit was attempted on the same day the CPR was completed by CYFS; however, no one was home at the time. The assigned social worker completed a home visit with a CSW later in the day; Nan and Pop were home but Mom was reportedly asleep. The assigned social worker noted that she saw and spoke with Kevin and Ryan, and viewed Sally. It was noted that all appeared well with the children but there was an *"obvious cloud of cigarette smoke"* around the table where Pop was sitting and smoking. Nan expressed concern about the incident involving Mom and reported that she was providing much of the care for the three (3) children herself. The assigned social worker told Nan that she would return the next day to speak with Mom about the police referral.

Following the home visit, the assigned social worker contacted her program manager, who was located in another community, via email to inform him that she had seen the children and would attempt to see Mom the next day. She relayed information she had obtained from the clinic regarding their assessment of Mom. The assigned social worker also spoke to the PHN who advised that Sally was progressing well; however, Mom only brought Sally into the Public Health office when requested; she did not attend for voluntary *"weigh-ins"*. The assigned social worker noted that she would need to discuss *"next steps"* with the program manager and indicated that she thought a supervision order may be warranted. The program manager responded the following morning and noted that he would access CRMS to review the referral information and would discuss same with the assigned social worker at a later time. There is no documentation to indicate if this discussion occurred.

The assigned social worker attempted another home visit the next day. Mom and Nan were home with the three (3) children but they were getting ready to go to the clinic. The assigned social worker and Mom discussed other possible times to meet and decided to set up an appointment via telephone the next morning. Upon presentation at the clinic, Kevin was assessed as having asthma symptoms and Mom was instructed to continue with his inhalers as previously recommended. Sally was assessed as having a respiratory infection. She was given medication to alleviate symptoms and was prescribed an inhaler. It was noted on both children's files that Mom was told the children had to avoid second-hand smoke.

The assigned social worker completed a handwritten Safety Assessment that same day. She noted the date the referral was received by CYFS as the date the CPR was generated; not the date the police faxed their referral to CYFS. Numerous safety factors were identified in this assessment that highlighted the risk to the children including the parent's behaviour being out of control, insufficient supervision for the children, and the inability of the parent to supervise, protect or care for the children due to alcohol use and emotional state. Additionally, the living conditions of the home were noted as potentially hazardous, including the presence of the woodstove and cigarette smoke. As a result of this assessment, the children were deemed unsafe and subsequently required immediate safety intervention. Despite this, there was nothing documented under the Safety Response on the assessment. It was noted that a program manager was consulted; however, he did not sign the handwritten copy of this document. According to CRMS documentation, the Safety Assessment was added to CRMS nearly two (2) years later.

A CSW completed a home visit the following day in an attempt to schedule a meeting with Mom and the assigned social worker. Mom was again on her way to the clinic and would not confirm a meeting time. The CSW asked Mom to call the assigned social worker and provided the telephone number when Mom stated she

did not have it. Shortly after this, Mom and Sally arrived at the clinic for a follow-up appointment. Mom reported using Sally's inhalers as prescribed and Sally was noted as improving.

Mom called the assigned social worker that afternoon to request they speak via telephone rather than meet in person. The assigned social worker explained to Mom that they had to meet in person to discuss the referral and the resulting Safety Plan. They agreed on a time to meet; however, Mom arrived at the assigned social worker's office shortly after the telephone call. She stated she was going to be busy at the previously agreed upon time and wanted to meet now. The assigned social worker was meeting with another client so the meeting with Mom was deferred until the following morning; however, there is no documentation to indicate the meeting actually occurred at that time.

Ryan was seen at the clinic for followup tests for his low iron and at that time he was also assessed as having an ear infection. He was prescribed an antibiotic. Information provided during this visit indicates that Ryan was still being given a bottle despite Mom being told by a PHN four (4) months earlier that he should be weaned.

The CSW completed another home visit with Mom a week later. The visit appears to have occurred in the porch as Mom did not invite the CSW into the home. There was a discussion regarding alcohol consumption and breastfeeding. Mom was noted as anxious during the visit though the CSW documented that everything *"seemed okay"*; she could smell laundry fabric softener and it was quiet in the home.

The following week, the assigned social worker attempted to reach Mom via telephone twice; however, each time she was advised by Nan that Mom was sleeping. Messages were left both times asking Mom to call the assigned social worker as soon as possible. Mom called the assigned social worker back after the second message and they agreed to meet at the assigned social worker's office that afternoon. Mom prefaced the meeting by stating that she only had a half hour to talk as she had to go home and feed her baby. They discussed the police referral and the incident that led to same. Mom indicated that she had been sober since that night and was receiving counselling. She said all three (3) of her children had been sleeping at the time of the incident and Pop and her two (2) brothers were home and sober. The children only woke when the police banged loudly on the door and entered the home. Mom reported that Kevin and Ryan had been sleeping next to her in the living room until this time. Mom told the assigned social worker she did not want to share personal details with her as she had a counsellor for that and she had a lot of support from family and friends. They discussed the concern of cigarette smoke in the home and Mom told the assigned social worker that Nan refused to smoke outside in the winter but would sit in front of the woodstove to allow the smoke to *"escape through the chimney"*.

A Safety Plan was completed on this same date; almost three (3) weeks after the police made the original referral. The document identifies Mom's episode of self-harm while drinking as the safety factor. The desired outcome of the Safety Plan was that the children would not witness Mom drinking or behaving inappropriately. The plan noted that Mom had a good relationship with a counsellor; however, it is unclear from the assigned social worker's CRMS notes whether she verified this information. It also stated that Mom had support from her family and friends; specifically Nan. The assigned social worker documented that Mom reportedly quit drinking and had recognized the inappropriateness of the incident. As part of the plan, Mom had to attend counselling and abstain from drinking. The start dates listed for these steps to be taken by Mom pre-date the generation of a CPR by CYFS and any action taken on this referral by the assigned social worker. The Safety Plan was signed by Mom and the assigned social worker but not by the program manager. The assigned social worker documented all action taken in response to this CPR in an Investigative Summary and noted that Mom had agreed to ongoing contact with CYFS to monitor progress. The next documented contact CYFS had with this family was six (6) months later.

Later that month, Mom brought Kevin to the clinic with respiratory problems. Mom claimed he was using his inhalers at home. Medication similar to that in Kevin's inhalers was administered; subsequently Kevin's symptoms were alleviated. Mom was instructed to use Kevin's inhalers consistently and to ensure he avoided second-hand smoke. A few days later, Nan contacted the clinic to report that Ryan had stomach upset. After consultation with a doctor, it was decided to discontinue Ryan's iron supplement. He was seen at the clinic a few days after that and was assessed as having a respiratory infection and prescribed an antibiotic.

Sally's next visit to Public Health was noted as two (2) months overdue. The PHN noted that Sally was well cared for and there were no concerns regarding her hygiene. She had a slight diaper rash but Mom reported she had been seen at the community clinic a few days earlier for same; there are no notes in Sally's clinic file to indicate such a visit occurred. Mom was noted as very protective of Sally during this appointment. She expressed concerns that returning in six (6) weeks as recommended by the PHN was too soon. The PHN reassured Mom and expressed how important it was for Sally to be immunized especially given that she was already late for her immunizations. Sally was immunized at this time and another appointment was scheduled for six (6) weeks.

Kevin was brought to the clinic twice this month. During the first visit, he was assessed as having a respiratory infection and asthma symptoms. He was given medication similar to that in his inhaler to alleviate symptoms and was prescribed an antibiotic. Mom was advised to bring him back in the evening for a second dose of medication but he did not return. An appointment was also made for Kevin to see

a pediatric resident a few days later but there is no indication from the file that this appointment occurred. When Kevin returned to the clinic for his second visit that month, it was questioned whether or not he had a viral infection; over-the-counter medication was recommended.

Sally was not brought in for her first appointment with the community clinic that month. She did attend the clinic the following day with respiratory problems and was assessed as having two (2) types of respiratory infections. Medication was administered to alleviate symptoms and a doctor was consulted. A steroid medication was administered as ordered by the doctor and Sally was observed in the clinic afterwards; her symptoms were noted to improve following administration. Mom wanted to take Sally home; she was advised to use Sally's inhaler and instructed on what to do to help reduce Sally's symptoms when at home. Sally was also prescribed an antibiotic. She was scheduled to return to the clinic for a second dose of the steroid medication but a note in her file states she was not brought back.

That same month, Ryan was seen at the clinic and assessed as having an ear infection. He was prescribed antibiotic medication and Mom was advised that he had to avoid second-hand smoke. During this visit, Mom again made reference to Ryan taking a bottle, which Public Health had advised months before should be discontinued.

Over the next three (3) months, each of the children were seen at least once at the clinic. Kevin was seen for respiratory problems that were alleviated by medication administered during the visit. He was seen again for stomach upset and while tests were noted as necessary, the family did not return with the samples as requested. Ryan was assessed as having another ear infection and was prescribed an antibiotic. One month later, he returned to the clinic again with an ear infection and was again prescribed an antibiotic. Sally presented with congestion and was assessed as having a respiratory infection, though this time she was not prescribed an antibiotic. It was noted in Sally's clinic file that Mom, Nan and Pop smoked but not in the house. It was also documented that there was mould growing in the house.

Sally was not brought in for her next two (2) scheduled appointments with Public Health. When she did finally attend an appointment with Mom, it was noted that she was healthy with good hygiene. She was observed to be congested but Mom reported that Sally had asthma and was using an inhaler. Sally was immunized and no reaction was noted. Around this time, a Consultation Request was made to a doctor for Kevin. The request noted that Kevin had a long history of asthma and viral infections. The doctor was asked to assess Kevin's health and his current asthma medication. A Consultation Request was also made to a doctor for Ryan. The request noted that Ryan had frequent ear and respiratory infections. The doctor was asked to assess Ryan's nutritional and general health status.

Twice the following month, Mom contacted the police to report a person was intoxicated in her home and was refusing to leave. In both instances, the police attended the home and removed the person causing the disruption. It is not evident from the documentation whether or not the children were present in the home during either incident.

Around this time, a referral was made to CYFS regarding Mom and the care of her children. A CPR was completed by a social worker assistant who noted that he had been informed that Mom had been drinking heavily for a few days and was seen while intoxicated with Ryan, who was trying to get away from her. The referral source was unsure whether Mom had any babysitters for the children. A program manager was listed as the person assigned to this CPR. It was documented on the CPR that CYFS had confirmed knowledge of adults drinking to the point of intoxication in this home where three (3) young children resided. The Response Priority was assessed as *"low"*; meaning response to the referral had to occur within seventy-two (72) hours. The immediate action to be taken was a home visit to assess the situation with the children.

Documentation pertaining to this CPR was added to CRMS ten (10) months later. The missing documentation appears to have come to light when another program manager inquired as to the whereabouts in order to sign off on the referral. In his CRMS note, this program manager listed the date of his inquiry as the referral date, though his inquiry actually occurred ten (10) months later. He noted that he sent an email to the program manager who was listed as assigned to the CPR and copied the social worker assistant requesting information about the involvement of CYFS and outcome of this referral. He documented that a Safety Assessment and Safety Plan that had been completed months prior to this referral would have to be reviewed. The program manager noted on the CPR: *"This referral now coming to my attention as the result of a quality initiative in [community]. To [follow up] with staff [regarding] outcome of this referral in an email today."* This note was added in 2009. The program manager signed off on the referral and noted the completion date as 2008, even though he identified he was not aware of this referral until nearly a year later.

CRMS notes that outline the response to this CPR were entered ten (10) months after the referral. The notes belong to the social worker assistant, who generated the CPR. The assistant wrote: *"notes entered to best of this writer's recollection. [Home visit] was 10 months ago and this writer was [accompanying social worker] on another CSW's caseload more as a backup worker. Not primary worker."* According to the assistant, he and the assigned social worker completed a home visit on the same date the referral was received. Mom and her children were present during the visit; Mom was not drunk, though her eyes were noted as red. She was cooperative with the workers and answered their questions. The assistant noted that this was odd given Mom was often *"defiant and stubborn"*. Nan and another person were drinking dur-

ing the visit and Nan yelled at the workers to go away. The children were *"deemed okay"* and follow-up visits were to be arranged by the assigned social worker and the regular CSW. It does not appear as though the program manager who was listed as assigned to the CPR had any involvement with the resulting followup.

A Safety Assessment was completed by the assigned social worker. There were no safety factors identified in this instance and the children were deemed safe. The assigned social worker noted that Mom was sober and at home with the children when the assigned social worker visited the family and previous concerns regarding Mom's drinking were noted as being monitored by CYFS. It appears that the program manager who was originally assigned to this CPR was consulted and signed off on the assessment that same day. This Safety Assessment was added to CRMS fifteen (15) months later. There are no other notes in the CYFS file related to this CPR or to indicate that any other followup occurred. The next documented contact CYFS had with this family was one year later.

Later that same month, Mom's brother contacted the police to report that there were intoxicated people in the home causing problems. The police attended the residence and spoke to all involved, including Mom. It was noted that there were no further problems and no offenses had occurred. It is not evident from the documentation whether or not the children were present in the home at that time.

Over the next four (4) months, each child was brought to the clinic multiple times with various ailments. Kevin was seen three (3) times; once for an ear infection for which he was prescribed an antibiotic and another time for a minor food allergy. He also saw a doctor regarding his asthma symptoms. At the time, he was noted as stable and the doctor advised he continue with his inhalers. An electrocardiogram (ECG) was scheduled; however, it does not appear from documentation that it occurred as planned. Sally was also seen three (3) times; once for a fungal infection, once for a fever and another time for an ear infection, for which she was prescribed an antibiotic. Mom was again instructed that Sally had to avoid second-hand smoke. During this time, it was noted that Sally was not brought in for another appointment with Public Health. When she was finally seen, she was noted to have *"good/fair hygiene"* and she was immunized. Mom was noted as more pleasant and talkative at this visit than she had been prior.

Of the three (3) children, Ryan was seen the most at the clinic during this time period. He was noted to have had five (5) visits in four (4) months. He was seen for a minor dog bite, tonsillitis for which he was prescribed an antibiotic, stomach upset and an ear infection. He was prescribed an antibiotic for the ear infection and Nan was told that he had to avoid second-hand smoke. Ryan returned to the clinic for a recheck of his symptoms and it was noted that Nan had only given him the antibiotic medication for seven (7) of the prescribed ten (10) days. When questioned

about this, she stated that was what she had understood from the nurses. Ryan was assessed as having an unresolved ear infection and was again prescribed the same antibiotic.

Later in the year, Mom's brother went to the police station to report a dispute at his home. He reported that Mom and Nan were both drinking and he had gotten into a dispute with Mom, which led to a physical altercation. The police attended the residence and were provided *"sketchy details"* of the incident between Mom and her brother. To avoid further potential problems, the officer thought it best if the brother spent the night in police cells and returned home in the morning. It is not evident from the documentation whether or not the children were present in the home at that time.

2009

Kevin – 7 Years Old Ryan – 3 Years Old Sally – 2 Years Old

The children continued to have numerous clinic visits in 2009. Kevin was seen twice in the first six (6) months of the year; both visits were the result of respiratory problems. He was noted to have a respiratory infection with asthma symptoms during his first visit and was noted to have a viral illness the second visit. His inhalers were recommended to treat both ailments.

Ryan was seen eight (8) times over the six (6) months. Initially, he was assessed as having a viral infection but when he returned a few days later for a recheck, he was assessed as having an ear infection. An antibiotic was prescribed; the same antibiotic that he had been assessed as having an allergic reaction to in the past. He returned for another recheck a few days later and was noted to be improving. He was seen at a later time with a fever and earache for which over-the-counter medication was recommended. It was noted that Ryan was not brought in for his next two (2) appointments. When he was seen again, he was assessed as having another ear infection. It was less than a month since his last infection and he was again prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. Approximately one week later, Mom returned to the clinic requesting a medication refill for Ryan's antibiotic. She reported that Nan had not been giving the right dosage of medication to Ryan. Mom was given the refill. The next time Ryan was seen, he was assessed as having a respiratory infection for which he was prescribed an antibiotic. He was seen twice more; once for followup to his respiratory infection and later for stomach upset. According to his Public Health file, he was being discharged from that caseload as he was now attending school.

Sally was seen seven (7) times over the six (6) month period. During her first visit of the year, Sally was assessed as having a respiratory infection and was prescribed

an antibiotic. She was assessed as having an ear infection and inflammation of the mouth at her next appointment. She was prescribed a solution to treat the inflammation and over-the-counter pain medication. Good hygiene was identified as part of her treatment plan. When she returned for followup, it was noted that there was no improvement in her condition. A test was conducted but her treatment remained the same. Sally was not brought in for her scheduled follow-up appointment two (2) days later. It was noted that the clinic received her test results seven (7) days after her last appointment but it was another five (5) days before she was seen at the clinic for followup. The test indicated a serious infection of Sally's mouth with a noted *"fecal contaminant"*. It is unclear whether the clinic contacted the family immediately upon receipt of the test results to request Sally be brought in for reassessment and treatment. When Sally did finally present at the clinic, she was assessed as having a respiratory infection and inflammation of the mouth. She was prescribed an antibiotic. Nearly two (2) months later, she was seen and assessed as having an ear infection and respiratory infection. She was again prescribed an antibiotic. Sally returned a few days later and similar symptoms were observed. She was given medication to help alleviate respiratory symptoms and a steroid medication. Mom was instructed to use Sally's previously prescribed inhaler. Sally's antibiotic prescription was changed to another variety during this appointment. Following this, it was documented that Sally was not brought in for her next three (3) scheduled appointments with the clinic. A Consultation Request was made to a doctor for Sally. The doctor was asked to assess Sally due to recurrent and repeated episodes of ear and respiratory infections. When Sally saw the doctor, it was thought she may have asthma. She was prescribed a steroid medication and Mom was advised to use Sally's inhalers at home. The doctor noted that Mom was single, unemployed and a smoker.

Sally was seen twice by Public Health in the first half of the year; once for what appeared to be a weight check. She was seen six (6) months later and it was noted she looked healthy and had good hygiene. Sally was immunized at that time. This was the last documented contact Public Health had with Sally.

Early in the year, the police received a complaint from Mom who reported that Pop was intoxicated and causing problems in the home. The police attended and Pop was detained. Mom was also noted by the police to be intoxicated. Mom declined pressing charges. It is not evident from the documentation whether or not the children were present in the home at that time.

Approximately three (3) months later, the police received another complaint from Mom. She reported that her brother was intoxicated, had stolen her money and had tried to choke her. Mom said she had left the home with no shoes on her feet to call the police; she was currently at a community centre. In Mom's words, her brother was *"going crazy"*. She told the police she was afraid to return to the home as her brother was still there. It was documented that Mom said three (3) children

were also in the home. The police attended the community centre but learned that Mom had returned to the home. They then went to the residence where they met with Mom who was noted to be intoxicated. Her brother was noted to be in bed; he was also intoxicated. He was arrested but when the police returned to get a statement from Mom, she refused to provide one. In the conversation with the police officer, she indicated that this house belonged to her parents and that she was there looking after them. Her brother lived there too but she noted that *"her residence was elsewhere."* It was not documented whether the police asked Mom where she lived and there is no mention of the whereabouts of the three (3) children. It does not appear as though a referral was made to CYFS as a CPR could not be found in the police file or the CYFS file.

In the next six (6) months of the year, while clinic visits continued, the police and CYFS also had increased involvement with the family. On one occasion, Mom was seen by the police to be staggering down the road and was arrested for being drunk in public. A couple of weeks later, Mom contacted the police to report a man was intoxicated in her home and would not leave. The police attended the residence and arrested the man; however, Mom did not want to press charges. It is not evident from the documentation whether or not the children were present in the home at that time.

Around this time, a CRMS note appeared in the CYFS file stating: *"Reviewing 2008 referral as prompted by CRMS system."* This note was entered by the assigned social worker who had been involved with this family since 2002. There are no other entries in CRMS until a month later, and at that time it appeared a new social worker was responsible for this family's file.

Kevin was seen at the clinic five (5) times during the second half of the year. First, he was seen for a minor injury to his foot. Over-the-counter pain medication was recommended and when he returned for followup, he was noted as improved. He was seen again a couple of months later and it was thought that due to his symptoms, he might have a heart murmur. Tests were ordered and an appointment was made for Kevin to see a doctor. When he saw the doctor the following week, it was noted that Kevin had not had an ECG that had been ordered the year prior and there was no evidence in the file that he had ever had a pulmonary function test. The doctor referred Kevin for tests and referred him to a pediatric cardiologist. The doctor noted that Kevin's asthma was poorly controlled and his inhaler use had to be reviewed. The doctor prescribed a different kind of inhaler medication that was to be used daily. On the date Kevin was due to travel to have the required tests and see the pediatric cardiologist, Mom contacted the clinic reporting that he was too sick to travel. Upon presentation to the clinic, Kevin was noted as having stomach upset and the clinic noted they would reschedule his tests and appointment. A test was completed on his throat and it was positive for infection. He was prescribed an

antibiotic for same. The following week, Kevin had one of the tests completed that had been ordered by the doctor earlier that month. The other test and his appointment with the pediatric cardiologist would not occur until the following year.

During the same six (6) month period, Ryan was seen at the clinic five (5) times. He was assessed as having an ear infection at the first appointment and was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. He was not seen again for three (3) months. At that time, he was assessed as having a throat infection. Tests were completed and were positive for infection. He was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. He returned to the clinic two (2) weeks later and was noted to still have a sore throat. Another test was completed and showed the same results as the test completed two (2) weeks prior. During this visit, Ryan was also noted to have a rash on his face. He had a flu shot the day before and it was questioned if he was having an allergic reaction. Antibiotic medication was prescribed and as required, a report regarding the reaction was made to the Public Health Agency of Canada. Mom brought Ryan back to the clinic for followup a couple of weeks later; however, she was not able to see a nurse right away. Mom claimed Ryan was *"very difficult"* and *"he is scared of the nurse"*; she did not want to wait and left without Ryan being seen. Ryan was not brought in for his next scheduled appointment at the clinic. A note in his file one week later indicates Ryan was referred to the clinic by a PHN for medication to treat a skin infection on his face. There are no notes in the Public Health documentation to indicate what lead to this referral or how long Ryan had this condition. It is also not clear from the clinic notes whether Ryan's condition was a continuation of the reaction he had to the immunization that was administered a few weeks prior.

Sally was seen at the clinic five (5) times over the same six (6) month period. She was assessed as having a viral respiratory infection at her first visit and over-the-counter medication was recommended. She was not brought in for the next two (2) scheduled appointments. The next time she was seen, she was again assessed as having a respiratory infection and was prescribed an antibiotic. She was scheduled to return for followup a few days later but she did not return for over a week and at that time it was due to a minor injury she had sustained. It was noted that Sally was not brought in for her next scheduled appointment. Later the following month, Sally was seen at the clinic and it was noted that she was still being bottle fed. Sally's mouth was inflamed and some tooth decay was noted. Dental hygiene practices were reviewed with Mom and she was advised to stop bottle feeding Sally. The nurse noted that during this visit, Mom smelled strongly of alcohol. Despite this, it does not appear as though CYFS was notified. Sally was seen two (2) months later and was assessed as having a respiratory infection. It was noted that she had an inhaler but Mom had not been giving it to her; Mom said she understood that she was not

to do so unless recommended by a nurse or doctor. Sally was prescribed an antibiotic and the nurse advised that she had to avoid second-hand smoke. The last note in Sally's clinic file for the year indicates she was not brought in for another scheduled appointment.

CYFS became involved with the family again mid-way through 2009. CRMS notes written by a CSW indicate that a home visit took place with a new social worker. Nan and Pop were home at the time of this visit and when the workers asked for Mom, they were told she was in another room. The new social worker asked to see Mom but was told that Mom did not want to speak to the workers. The new social worker insisted that she speak with Mom and finally, she came out of the room. She was noted to be *"ignorant"* towards the workers but she answered their questions. The new social worker asked Pop about his drinking habits, which upset Nan, who then asked the workers to leave. The workers gave Mom an appointment to meet with them to talk further; however, the date and time of the appointment are not noted in CRMS.

Two (2) days later, there were two (2) notes entered into CRMS; one by the CSW and the other by the new social worker. The CSW noted that an office visit occurred with Mom on this date. It was documented during this visit that the new social worker explained that she and the previously assigned social worker had to *"share client list"* and Mom was on the new social worker's list. The new social worker further explained to Mom that she had read her file and there were concerns about the children being home when all the adults were drinking. The new social worker advised Mom that there was not to be any alcohol use when the children were home and Mom was not to return to the home intoxicated; Mom agreed to same. The new social worker told Mom that CYFS would be doing unannounced visits to check on them and she relayed that Mom could drop by the CYFS office for a visit whenever she was able. The CSW's CRMS notes were added three (3) days after the office visit. In an interview with the Advocate, the previously assigned social worker clarified that the two (2) social workers were not sharing their client lists; rather, they divided the caseload between them and Mom's file was reassigned to the new social worker (Transcript of ACY Interview, 2014).

The newly assigned social worker's CRMS notes of the same date seem to encompass a home visit and an office visit; both captured within the same note with the same date for both visits. It is unclear whether the home visit referred to in the newly assigned social worker's note is the same home visit the CSW documented as occurring two (2) days prior. The newly assigned social worker wrote that she completed a home visit with a CSW. Mom was sleeping and her parents were angry that the workers were waking her up to talk. The newly assigned social worker noted that the home visit occurred in the afternoon and there were concerns that Mom was intoxicated; though it was noted Mom appeared sober during the visit.

The newly assigned social worker informed Mom that they were visiting because of a prior referral; however, it is unclear what referral the newly assigned social worker was referring to in this instance. The newly assigned social worker noted that Mom came to the office later for a visit and said everything was okay at home but her parents were upset that the workers were there. The newly assigned social worker's note outlining both visits was added to CRMS almost one month later. There is no documentation in the CYFS file to indicate that a formal file transfer occurred between the previously assigned and newly assigned social workers.

Approximately two (2) weeks later, Mom contacted the police to report that her brother was intoxicated and causing problems at the residence. Police attended the home but Mom's brother had already left. They searched the area but were unable to locate him. Mom declined pressing charges; it was noted she was also intoxicated. One month later, the police received a complaint from Nan that Mom was intoxicated and causing problems in the home. Nan requested that the police remove Mom until she was sober. The police attended the home and Mom was arrested and detained, though no charges were laid. It is not evident from the documentation whether or not the children were present in the home during either incident.

Nearly six (6) weeks after the last complaint, the police received another one from Nan that Mom was causing problems in the residence and refusing to leave; Nan requested that the police attend the home. The police did attend and spoke with Mom who left without incident; no charges were laid. It is not evident from the documentation whether or not the children were present in the home at that time.

Two (2) notes were added to CRMS late in 2009 by the previously assigned social worker that indicated she was adding documentation to CRMS that pertained to referrals that were received in 2008. This was being done *"as part of CRMS clean-up project."*

The following month, CRMS notes indicate the newly assigned social worker consulted with her program manager who directed she *"assess situation at the [family] home"*. It is unclear from the file what prompted this consultation as there are no other CRMS notes around this date and there is no referral on file. The newly assigned social worker completed a home visit during which Mom reported she was unaware that Nan had taken Kevin to a store while drunk. It was noted that Mom was not drunk at the time of this visit but she said she would take the children to a family member's home and not return until her parents were sober. Nan was present during the visit; it was noted she was drunk and swore at the assigned social worker. The newly assigned social worker consulted with her program manager after the visit and he advised that because Mom was sober and being responsible they could *"close the case."* There are no CRMS notes in the file to indicate that the newly assigned social worker confirmed that Mom and the children left the home as Mom stated they would.

2010

Kevin – 8 Years Old Ryan – 4 Years Old Sally – 3 Years Old

The family continued to have frequent contact with the community clinic, the police and with CYFS through 2010. The children continued to have similar health problems as in previous years. Kevin was noted to have quite a few more clinic visits this year in comparison to the previous two (2) years.

Early in the year, Kevin travelled to a hospital in another community to have a pulmonary function test. A few days after the test was completed, Kevin was seen by a doctor at the community clinic. During this visit, the doctor noted the two (2) inhalers Kevin was currently using for his chronic asthma and inquired about a third medication that had been prescribed by another doctor three (3) months prior. Despite a note in the clinic file stating that the new medication had been dispensed, Mom stated she was never told about it. The doctor noted that there was a woodstove in Kevin's home and Nan reportedly blew smoke into the stove. The doctor wanted Kevin to start the new medication previously referenced and recommended some tests be repeated when Kevin saw the pediatric cardiologist. The doctor developed an Asthmatic Action Plan for Kevin on this date, which directed how and when to use certain asthma medications. As part of this plan, the doctor directed that Kevin discontinue using one of the inhalers he had been using for years. In a Consultation Letter, the doctor outlined her visit with Kevin. She wrote: *"Mom is aware that [smoking] can be an aggravating factor in his asthma"*. The doctor noted her recommendation for Kevin to have tests repeated and for a pediatric cardiologist to see Kevin to evaluate the suspected heart murmur and to provide input on the management of Kevin's asthma.

On the day Kevin was supposed to travel to have the repeated tests, Mom reported she was not aware of the appointment and refused to go. Kevin was rebooked for the following month but again, he did not travel as planned. There is no explanation documented as to why Kevin missed this appointment. Nearly two (2) weeks later, Kevin's uncle travelled with him to have the scheduled test. The results of this test required that another test be completed a few weeks later.

The following month, it was noted in Kevin's clinic file that Mom cancelled scheduled travel for Kevin to attend an appointment with the pediatric cardiologist. She insisted that Kevin was sick and stated she would attend the next scheduled appointment. A few weeks after that, Mom contacted the clinic to cancel travel for Kevin who was due to have recommended tests repeated. There is no reason for the cancellation documented in the clinic note. It appears that Kevin had the test done a few days later.

In addition to these appointments, Kevin was brought to the community clinic with other ailments a total of ten (10) times in three (3) months in 2010. He was seen for a burn that he had gotten when he rubbed against the woodstove after getting out of the bath. The burn was treated and he was reassessed the following day. He was not in any pain and Mom was instructed on how to apply dressings. Kevin returned two (2) days later and was assessed as having a respiratory infection. A doctor was consulted and an antibiotic was prescribed. Kevin returned the next day for followup and was noted to have improved. Mom was instructed to continue with his antibiotic and ensure the use of Kevin's inhalers. Kevin returned again for a recheck a few days later; he was noted as feeling better. The next time Kevin was seen at the clinic he presented with respiratory problems and was again assessed as having a respiratory infection. Mom reported that he was using his inhalers as prescribed. He returned for followup the next day with similar symptoms. Regular use of his inhalers was again recommended. When Kevin returned for his third visit in as many days, he still had respiratory problems and medication was given to alleviate symptoms. He was seen by a doctor who, despite Mom's claims, noted that Kevin was not taking his inhalers as prescribed. Kevin was assessed as having an asthma attack and pneumonia. An antibiotic and multiple asthma medications were prescribed. Kevin was reassessed the following day and was noted to be doing better. Kevin returned to the clinic two (2) weeks later, for a checkup. At that time, Kevin was noted as a *"well child"*.

In 2010, Ryan was seen at the community clinic six (6) times in a seven (7) month period. He was assessed as having an inflamed throat during his first visit. A test was completed and was positive for infection. He was prescribed an antibiotic. The following month, Ryan was brought to the clinic by Mom and assessed as having an ear infection. He was prescribed an antibiotic; the same antibiotic that he had been assessed as having an allergic reaction to in the past. A few months later, Ryan was brought to the clinic by Nan and was assessed as having a viral infection. He returned in a few days for reassessment and it was determined then that he had an ear infection. He was prescribed an antibiotic. The next month he was again assessed as having an inflamed throat. He was prescribed an antibiotic that was of the same family of antibiotics that he had been assessed as having an allergic reaction to previously. Approximately one week later, Nan contacted the clinic requesting a refill of Ryan's antibiotic. She reported that Ryan had *"upset medication"* when she was trying to give it to him. A refill was dispensed to Nan. The following month, Ryan was brought to the clinic by Mom after he reportedly stabbed himself in the finger with his uncle's EpiPen. Poison Control was contacted and Ryan was observed at the clinic for nearly two (2) hours. Mom was advised to ensure all medications and cleaning supplies were out of the reach of the children.

Sally was also seen six (6) times within a seven (7) month period in 2010. During Sally's first visit that year, she was noted to have poor hygiene and the nurse commented: *"child malodorous"*. Despite this, it does not appear that CYFS was notified of same. Sally was assessed as having inflamed throat and mouth. Oral hygiene was discussed with Mom and she was again advised that she must discontinue bottle feeding Sally. A test was positive for a throat infection and Sally was prescribed an antibiotic. Three (3) months later, Sally was seen at the clinic and assessed as having tonsillitis. She was prescribed an antibiotic. She returned the next day to be reassessed. Mom reported she was not getting better, though she was taking her antibiotic as prescribed. During this appointment, Sally was assessed as having a respiratory infection in addition to the tonsillitis. Mom was instructed to continue with Sally's antibiotic. It was noted that good hygiene practices and proper nutrition were discussed and reviewed with Mom. Two (2) days later, they returned to the clinic and Mom reported that Sally now had an upset stomach. Mom again reported that Sally was taking her antibiotic as prescribed and it was decided that the dose of medication would be increased. Sally was supposed to return the following day for reassessment but it was noted that she was not brought in for her appointment. Sally was seen at the clinic a few weeks later and Mom reported she had been unwell for a month. She was again assessed as having a respiratory infection. The clinic note for this visit indicates that Mom was questioned as to whether Sally was getting her antibiotic medication as prescribed. Mom stated that Sally was indeed getting her medication. Sally was prescribed an antibiotic again. A few days later, Sally returned to the clinic. It was noted that she had frequent respiratory infections and ear infections. There were smokers in the home but they were noted to smoke outside. Sally was assessed as potentially having asthma and was prescribed two (2) kinds of inhalers. Sally was also assessed as having an ear infection during this visit. It was noted she was already taking an antibiotic and it was recommended that she finish this medication as prescribed.

Early in the year, Nan contacted the police reporting that Mom was causing a disturbance in the home. The police attended the residence and found Nan to be intoxicated. The police spoke with both women and Mom agreed to leave the home; she would stay with a relative. Nan indicated that she did not want to press charges. A few weeks later, the police were contacted by Mom who reported that Pop was drunk and causing problems in the home. The police went to the house and spoke with Mom, who reported that everything was okay now; Pop had gone to sleep. Mom indicated that she did not want to press charges. It is not evident from the documentation whether or not the children were present in the home during either incident.

A couple of weeks later, on a Saturday, it was noted in both Ryan's and Sally's community clinic files that the children were not brought in for their scheduled

appointments. Both files contained a note written later that same day that summarized contact one of the nurses had with the family and subsequent concerns for the children's wellbeing. The nurse noted in both files that Mom was intoxicated when she called the clinic looking for over-the-counter pain medication for the children. Mom refused to bring the children into the clinic to be assessed. Pop then arrived at the clinic requesting medication for the children and it was noted that he smelled of alcohol. He was asked by clinic staff to bring the children in for assessment, which he did not do. A nurse noted in both files that medication was not dispensed as there was *"[no] sober adult in the home"*. It was noted that CYFS was contacted but they did not intervene. The police were also contacted and they did visit the home. The nurse noted in both children's files that following the visit, the police reported back to the clinic that the children did not appear ill as they were *"up running around [and] jumping on couch."*

CRMS notes indicate that the assigned social worker received a call at home that Saturday evening from the community clinic with information about the family. It was reported that Mom was supposed to have brought the children to a medical appointment that day but she did not do so. It was reported that Mom had contacted the clinic via telephone and she sounded drunk during this conversation. It was also reported that while on the telephone, screaming and yelling could be heard in the background. Pop presented at the clinic later in the evening asking for medication but it was explained to him that medication was not permitted to be given to inebriated people and because Pop smelled of alcohol, he was refused the medication. The children were reportedly sick with infections but because they were not brought to the clinic for assessment, medication could not be dispensed. Despite the concerns noted about the children's caregivers and the children's health, it does not appear as though this information resulted in the generation of a CPR. The assigned social worker documented in her CRMS notes that after receiving this information, she consulted with her program manager who directed that no action be taken. The assigned social worker's notes were added to CRMS two (2) and one half weeks later.

According to police documentation, Mom contacted the police that Saturday evening as well and said something about her children but she was *"so intoxicated she could not be understood"*. The police attended the home and noted that all persons present were intoxicated. It was also noted that there were three (3) young children in the residence and they were *"O.K."* The police officer who attended wrote: *"[Nan] was passed out, [Mom] was so intoxicated that she could just keep her eyes open and could not be understood. [Pop] was also intoxicated."* It was noted that staff from the community clinic had also contacted the police that evening to advise that the children had missed appointments that day and they were reportedly sick and needed medication. The police noted that they were told the grandparents had gone to the clinic while intoxicated and demanded medication. The staff would not pro-

vide same as the children had to be present and assessed in order for medication to be dispensed. The police documentation indicates that according to clinic staff, the children never did attend. After visiting the home, the police advised clinic staff that they had responded to the residence and *"the children were in good health but that all persons, that had care of the children, were highly intoxicated."* The clinic staff advised the police that they had contacted CYFS but had learned that they would not visit the home. The police officer noted in his report that a fax was sent to CYFS and concluded by stating that the *"children were fine and seemed to be in good health"*.

The fax sent by police to CYFS contained a referral that outlined the events of the evening including the response and observations made by the police. The referral lists three (3) children; however, one of the names is incorrect. The officer documented the details of the incident and noted that the police felt CYFS should be aware of the situation *"as there was no person in the residence that was in a sober condition and able to care for the children."* This fax appears to have been sent a few hours after the initial call from Mom was received. Despite the risk to the wellbeing and safety of the children, it does not appear that the police officer contacted CYFS in a more direct and immediate manner, e.g. by calling a social worker, to relay these concerns and request immediate followup.

CRMS notes indicate that the assigned social worker received the faxed referral from the police on Sunday morning; however, the referral was not present in the family's file. It was located in a CYFS critical incident report that was completed four (4) months later for the regional director. It does not appear as though the information provided by the police in their referral resulted in the generation of a CPR by CYFS.

Five (5) days after CYFS was initially contacted by the clinic requesting they attend the home to ensure the safety and wellbeing of the children, the assigned social worker received an email with additional concerns regarding the family. The email reported regular alcohol consumption in the family's home; the children being left for days at a time with no sober caregiver; and an allegation that Mom recently said she did not care about her children and they could be taken away. The home was allegedly smoke-filled and it was noted that Kevin had asthma. There are no corresponding CRMS notes on file pertaining to this email and it does not appear as though the information presented in the email resulted in the generation of a CPR.

The day after this email was received the assigned social worker completed a home visit with a CSW. This home visit occurred nearly one week after serious concerns about the safety and wellbeing of the children had been expressed to CYFS, via telephone and formal referral. Contrary to the police report, Mom claimed she was not drinking the night the police attended her home. Mom stated that her parents were intoxicated as well as one of her brothers; however, her other brother was

sober and she denied being intoxicated herself. The assigned social worker asked Mom what her plan was for when she drank as the children could not be present if she were intoxicated. Mom said she would stay sober or bring the children to a *"sober home"* and she provided the names of two (2) people who she said did not drink. The assigned social worker also told Mom that she had to take the children to a *"sober caretaker"* when Nan and Pop were drinking. Mom was asked to come to the CYFS office the following week to review her *"plan"*. Nan was present during this visit and appeared agitated; she said the workers had no right to be there. The note for this visit was added to CRMS two (2) and one half weeks later.

Early the following week, Mom attended the CYFS office for a meeting with the assigned social worker. Mom informed the assigned social worker that she was going to start Alcoholics Anonymous (AA) that evening and she would attend three (3) times a week. The assigned social worker noted that she and Mom discussed the issues identified in the Safety Plan. Mom told the assigned social worker that she would get her brother to watch the children when she drank as he did not drink, smoke or do drugs. Mom said she would talk to Nan about not smoking in the house when she was drunk; Nan was noted as the only family member who smoked. The assigned social worker was noted to have discussed the hazard of the woodstove in the middle of the living room with three (3) small children in the house and all three (3) caretakers intoxicated. The assigned social worker told Mom that a fire could happen and that the children could die as a result. She also stressed the danger of Nan smoking while drinking and potentially passing out with a lit cigarette. Mom again said she would take the children to a *"sober home"* when they were drinking and she signed the Safety Plan on this date. The assigned social worker consulted with her program manager after the office visit and he signed off on the Safety Plan via fax. The CRMS note pertaining to this visit was added over one week later.

The Safety Plan listed multiple safety factors as a result of this incident, such as there being no sober caretaker watching the children; that intoxicated people were smoking in the home; and that the children had not been brought elsewhere when Mom and the grandparents were drinking. Mom's willingness to cooperate and to provide a sober caretaker to protect her children; her awareness of the danger of intoxicated people smoking and the potential threat of fire; her acknowledgement of the dangers of second-hand smoke and her *"close family"* were all listed as strength and protective factors on the Safety Plan. As part of the plan, Mom was expected to protect the children when she or her family members were drinking by bringing them to a "sober home" and by ensuring there was no smoking occurring in the home while people were drinking. For each of these steps, an expected completion date was noted, which was three (3) months later. Despite this, there are no CRMS notes indicating any followup occurred on that date. The next documented contact CYFS had with this family occurred seven (7) weeks later.

Around this time, a risk management coordinator wrote an email to one of the CYFS program managers and copied the regional director of CYFS. In this email, the risk management coordinator explained that she was currently working in a risk management role with the Labrador-Grenfell Regional Health Authority (LGRHA) and she had been notified of an incident that occurred one week earlier and was requesting the program manager's assistance with same. The coordinator outlined how a call had been received recently at the community clinic from Mom, who was noted as intoxicated and was requesting medication for her children. Mom was asked to bring her children in for assessment but she refused to do so. The coordinator noted in her email that the children were in the home that evening with three (3) intoxicated adults and were without any other supervision. A person at the community clinic was concerned about the welfare of the children and called CYFS for assistance; however, she was told that CYFS would not intervene *"unless the children were in danger"*. The caller reiterated to the CYFS staff person that she was calling due to fear for the children's safety. When CYFS would not help, this person contacted the police and asked that they attend the home and check on the children. The police did so and found Mom was intoxicated, Nan was passed out, and Pop was *"trying to sober up"*. There were no other sober adults in the home at this time. The coordinator noted that it was her understanding that the police also made a referral to CYFS that evening. She continued her email by saying that the refusal of CYFS to provide assistance when contacted by clinic staff concerning the safety of three (3) children was a significant issue that required attention. She asked the program manager for his immediate attention concerning this matter to ensure other similar incidents did not occur in the future. It is unclear from the documentation whether the program manager or the regional director responded to this email or addressed any of the concerns expressed by the risk management coordinator.

The day after this email was sent, a letter was written to the regional director of CYFS from a different CYFS program manager concerning the aforementioned incident. This program manager was the one with whom the assigned social worker consulted on the night in question, not the program manager who was the addressee on the email. In this letter, the program manager explained that he had received a telephone call from the assigned social worker on a Saturday night to consult regarding a *"referral"* the assigned social worker had received from the community clinic. The program manager stated that according to the assigned social worker, the referral source was requesting that CYFS make a visit to a home because the children living there might be ill and *"there was alcohol being consumed at the house"*. The program manager was informed that the grandfather had attended the clinic earlier in the day to request medication but because alcohol could be smelled on his breath, medication was not dispensed. An appointment was made to see the children at the clinic in the afternoon; however, this appointment was not kept.

The program manager stated in his letter that his position after receiving the details from the assigned social worker was that there was no emergency situation at the home and therefore the assigned social worker did not need to visit the home that evening. The program manager instructed the assigned social worker to follow up on the referral on Monday, after the weekend. The program manager noted that the referral source was not happy with this decision and proceeded to call the police to investigate the conditions at this home. The police did attend the home that evening and *"found drunken adults there"*. The program manager noted in his letter that the police did not contact CYFS that night; rather, he said they sent a referral on Monday. This was not correct as the fax received by CYFS notes the date and time the fax was sent and the assigned social worker noted in CRMS that she received the fax Sunday morning. The program manager outlined in his letter that the assigned social worker had been working with the family since this incident to ensure Mom took appropriate action to have her children properly supervised when she drank. He did not specify that the initial contact with Mom following this incident occurred nearly one week later. Additionally, the program manager noted he was told that Mom was attending AA and he noted that they would continue to work with the family in order to help them make better choices in the care of the children. He concluded by stating: *"In regard to my response being a risk management issue I can only repeat that I did not think this referral required an immediate response from the social worker."*

Three (3) weeks after the last incident involving the police, another complaint was received where it was alleged that Mom had been assaulted by her brother. The police attended the home and spoke with Mom. She reported that her brother had pulled her hair and hauled her across the floor. Mom was noted to be *"highly intoxicated"* at the time the police were present and she was unable to provide a statement. The police spoke with Mom the following week but she stated she no longer wanted to press charges and she would not provide a statement. It is not evident from the documentation whether or not the children were present in the home at that time.

The CYFS file contained an email sent the following month to the assigned social worker with information that Mom was reportedly *"loaded drunk on Friday night and again on Saturday afternoon."* Additionally, the email noted that Nan was *"loaded drunk on Friday night as well."* There are no CRMS notes in the CYFS file pertaining to this information and it does not appear as though this information resulted in the generation of a CPR or any action on part of the assigned social worker. One week later, the assigned social worker documented a very brief note in CRMS stating that her program manager had directed her to *"close the intake."* There was not enough information in the note to ascertain any further details; it was unclear what intake the assigned social worker and the program manager were referring to and what the reason for closure would have been.

The following day, CRMS notes indicate that the assigned social worker placed a telephone call to Mom regarding *"the report"* that she was intoxicated *"Friday night"*. The only other reference in the CYFS file to a report about Mom being intoxicated on a Friday night was in the email sent to the assigned social worker eight (8) days earlier. During this telephone call, Mom told the assigned social worker that her brother was present and was sober at the time. Mom also reported that *"her parents were drunk not her"*. Following this telephone conversation, the assigned social worker noted that she consulted with her program manager via email, though this email was not present in the CYFS file. The assigned social worker relayed to her program manager that Mom reported she was sober, as was her brother. The assigned social worker did not document any direction given by her program manager as a result of this consult. These notes were added to CRMS over three (3) weeks later.

Later that same day, the assigned social worker consulted with her program manager again regarding a discussion she had with two (2) concerned individuals. During this discussion, it was reported that Mom was often drunk and leaving her children with Nan. She was spending her child support on alcohol and was not feeding her children. The concerned individuals said they had spoken to Mom about this but she *"did not care"*. The program manager said he would refer this matter to another social worker who would follow up. It is unclear why this information was being transferred to another social worker when the assigned social worker received the information. It does not appear that this information resulted in the generation of a CPR. Additionally, there is no indication in the file that this other social worker followed up on this information or was even notified of same.

Three (3) weeks later, a letter was written to Mom from the assigned social worker who advised that Mom's file would be transferred to a new social worker, effective immediately. The new social worker was the worker the program manager had said would follow up on the concerns expressed three (3) weeks earlier. The letter to Mom provided the newly assigned social worker's telephone number and office location. There is no documentation to indicate that a formal file transfer occurred between the two (2) social workers.

The following month, a fire occurred in the family's home that claimed the lives of Pop, Ryan and Sally.

Findings and Analysis

The purpose of this investigation was to determine whether or not the services provided by the Department of Child, Youth and Family Services (DCYFS), the Department of Health and Community Services (DHCS), the Labrador-Grenfell Regional Health Authority (LGRHA), and the Department of Justice met the needs of Kevin, Ryan and Sally, and whether their right to services was upheld. This section of the report identifies areas for improvement in connection with each relevant department or agency involved, thus informing the recommendations put forth by the Advocate for Children and Youth (ACY). The areas for improvement will be illustrated through examples that were found throughout the investigative process.

Many of the areas for improvement and the resulting recommendations identified during this investigation were similar to those identified in other investigations previously completed by the ACY. In February 2015, the ACY released the first *"Advocate's Report on the Status of Recommendations 2014"*, in which the ACY identified the status of all previous recommendations after comprehensive followup with the applicable government departments and agencies. Many of the recommendations that would be relevant to this current investigation have been reported by the departments and agencies as implemented through education and training of staff as well as policy changes; however, it is evident that corresponding practice has not necessarily changed throughout the Province.

The events that are the subject of this investigation took place during the time frame of 2002 to 2010; however, interviews completed with service providers involved with the case took place in 2014. At that time, the Advocate learned that many of the issues with service provision that were present during the time period of 2002 to 2010 are still present today, despite education and training initiatives and policy changes. In fact, the information gathered during the interviews completed by the ACY identified additional challenges, specific to communities in Labrador. Therefore the recommendations presented in this investigation will focus on ensuring that the departments and agencies involved further enable their service providers to meet policy standards, which will also address the recommendations put forth in previous investigative reports completed by the ACY.

FAILURE TO REPORT CHILD PROTECTION CONCERNS

The primary consideration for any decision made concerning a child under the Child, Youth and Family Services Act (SNL 1998) is the best interest of the child. In keeping with this mandate, Section 15(1) of the Act states: *"Where a person has information that a child is or may be in need of protective intervention, the person shall immediately report the matter to a director, social worker or a peace officer."* This directive assigns a duty to all citizens, including professionals, to report any instance where a child may be in need of protection. Despite this, there were instances during the period of this investigation when issues pertaining to the safety and wellbeing of Kevin, Ryan and Sally were not reported to the appropriate authorities for investigation or action.

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

Department of Health and Community Services Labrador-Grenfell Regional Health Authority

Throughout the period of this investigation, there were numerous concerns documented about the health, safety and wellbeing of Kevin, Ryan and Sally in their clinic and hospital files. Staff at these facilities questioned Mom's ability to properly care for her children; they noted times when Mom, Nan and Pop presented at the clinic with the children after consuming alcohol; and when it was suspected, or evident, that the children's treatment plans were not being adhered to by Mom and Nan. Many of these concerns were not reported to CYFS for assessment and followup.

During one of Kevin's hospital admissions in 2002, inpatient notes reflected many concerns about Mom's caregiving ability and parenting skills. These notes highlighted the encouragement and direction Mom required in caring for Kevin and her apparent lack of understanding regarding the seriousness of Kevin's condition. She repeatedly expressed her desire for Kevin to be discharged so they could return

home even after a doctor had explained to her that Kevin had to stay in the hospital until he was better. While staff at the hospital documented their concerns for Kevin's safety and wellbeing, it does not appear that these concerns were reported to CYFS.

At only one month of age, Ryan was brought to the clinic by Mom who was noted by a nurse to smell of alcohol. Later in the year, when he was seven (7) months old, Ryan was brought to the clinic by Nan and Pop who reported to that same nurse that they had been consuming alcohol before coming to the clinic. In 2009, Sally was brought to the clinic by Mom who was noted in Sally's clinic file to smell strongly of alcohol. Though it was documented in the children's files that alcohol had been, or was suspected of having been, consumed by their caretakers while the children were in their care, this information was not reported to CYFS.

During the period of this investigation, the health of the three (3) children was an ongoing concern. Each of the children presented at the clinic with repeated and persistent infections and illnesses despite plans being put in place to treat these conditions. Consequently, questions arose among clinic staff regarding Mom and Nan's compliance with the children's treatment plans including adherence to instructions regarding the children's hygiene or prescribed medication orders.

In 2005, a Consultation Request was sent to CYFS by a nurse on behalf of a doctor asking that the family be seen due to Kevin's repeated bouts of skin infections. This request noted that Kevin had been receiving *"potent antibiotics"* and neglect was suspected. As part of her response to this request, the social worker contacted the nurse-in-charge at the community clinic to inquire about any concerns the staff there had regarding Kevin and his health. Upon conclusion of this conversation, the social worker requested that the nurse-in-charge notify CYFS if Kevin experienced a reoccurrence of skin problems that clinic staff felt could be avoided or prevented. Despite this request, the clinic staff did not always report such information to CYFS. Just one month following this conversation between the social worker and the nurse-in-charge, Kevin presented at the clinic again with an infection and a rash. It was noted in the clinic file that good hygiene was discussed with Mom again; however, it does not appear a referral was made to CYFS. One month later, Kevin was brought to the clinic again and it was noted that his skin problems were continuing and spreading. A nurse wrote in the clinic file: *"poor hygiene – clothes are not clean"*. Kevin returned to the clinic again a few days later with continuing symptoms and a test was completed. The results of this test were positive for infection and Nan was contacted to bring Kevin in for followup; however, she did not do so right away. When Kevin was brought into the clinic, a nurse noted that poor hygiene was again a concern, in fact it was documented that he *"still needs good washing"*. It does not appear that information regarding either of these visits, the presence of another infection, or the lack of immediate followup by Nan, was reported to CYFS.

In 2009, Sally had a serious infection in her mouth with a noted *"fecal contaminant"*. Good hygiene practices were again stressed to Mom. The following year, Sally was seen at the clinic and a nurse commented: *"child malodorous"* and made note of Sally's poor hygiene. It does not appear from the documentation that CYFS was notified at either time. Given these persistent skin problems could have been prevented with good hygiene practices, CYFS should have been notified.

In addition to hygiene practices, Mom and Nan's compliance with ensuring the children received prescribed medication was also questioned. It appeared that the family was not adhering to the instructions provided by the medical professionals, many of whom documented this observation in the children's clinic and hospital files.

Kevin was prescribed inhalers early in his life to manage his asthma symptoms and both Mom and Nan were instructed to use them regularly. Yet throughout the period of this investigation, Kevin presented at the clinic repeatedly with respiratory problems and asthma symptoms that often were alleviated upon the administration of medication that was similar to that in his inhalers. During one of these visits, Mom reported that Kevin was not being given his inhalers as previously prescribed. She was advised, as she had been many times before, that Kevin should be getting his inhalers regularly to manage his symptoms. Yet when Kevin presented with asthma symptoms again at a later date, it was learned that he was out of his inhalers and the nurse noted in his clinic file that the last refill had been picked up nine (9) months earlier. Similarly, upon being diagnosed with low iron, Ryan was prescribed an iron supplement. Nurses and doctors advised Mom and Nan repeatedly of the importance of Ryan continuing with the iron supplement given his condition; however, it was noted in his clinic file that refills were often not picked up by the family. During one visit with the clinic, Nan reported not giving Ryan the supplement because he did not like it. When a nurse from the clinic was asked in an interview with the Advocate about not reporting concerns such as these to CYFS, she indicated that at times it was a struggle for balance: *"… you had to worry whether you had prejudiced your relationship… Because, you know, you still want them to come to that door"* (Transcript of ACY Interview, 2014, pp. 43 - 44). This nurse said that she understands that you have to do what is right for the child but if the family feels threatened or afraid then they may not return to the clinic: *"You don't want that because then there's nobody getting care"* (Transcript of ACY Interview, 2014, p. 44).

The family's compliance with the children's antibiotic medication prescriptions was also questioned by clinic staff. On a few occasions, Mom and Nan admitted that they had not been giving the medication as prescribed. In 2006, Ryan was prescribed an antibiotic for a respiratory infection. When he was brought to the clinic by Nan a few days later for reassessment, it was learned that the antibiotic had been discontinued prematurely and as a result, he was prescribed a *"double dose"* of the

same antibiotic. This happened again two (2) more times; once in 2008 when Nan reported that Ryan had not received the antibiotic for the prescribed amount of time and again in 2009 when Mom reported that Nan had not been giving Ryan the right dosage of antibiotic. In addition to the times when Mom or Nan would report noncompliance, there were many other times when noncompliance to prescribed antibiotic medication was suspected by a nurse or doctor and this was documented in the children's files, though not reported to CYFS.

By not providing prescribed medications as recommended or adhering to treatment instructions provided by medical professions, the family was not ensuring the children's health needs were being met. The nurses and doctors involved had a duty to report the family's noncompliance, suspected or otherwise, to CYFS given that the children endured years of serious infections and illnesses with repeated courses of antibiotics to treat these conditions.

Based on the findings of this investigation, a recommendation would typically result that all health care professionals in the Province be educated on their legislative duty to report; however, this recommendation has already been put forth. In the investigative report *"Sixteen"*, released in 2013, the ACY recommended that:

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

As per *The Advocate's Report on the Status of Recommendations 2014* and based on the response from the Department of Health and Community Services, the Advocate has determined that this recommendation is implemented; therefore, it will not be put forth again. However, it is incumbent upon the Department of Health and Community Services and the four Regional Health Authorities to ensure that all health care professionals are educated about their legislative duty to report on an ongoing basis.

Department of Justice
Royal Canadian Mounted Police

In addition to concerns noted by medical staff, there were also concerns for Kevin, Ryan and Sally that were observed by the police that were not reported to CYFS. In 2008, the police responded to a report that Mom was intoxicated and had threatened to harm herself. In this instance, the police did send a referral to CYFS noting concerns for the children due to alcohol abuse by Mom and other family members residing in the home; however, the officer who completed the report indicated that

these concerns had been ongoing for some time. In the report, the officer wrote: *"Over the past several weeks the [community] detachment of the RCMP have attended this household and individuals including the mother [have] been intoxicated."* Despite this, there are no other documented reports made to CYFS by the police in the weeks prior to this referral. As the police were aware of concerns regarding the safety and protection of these children prior to this incident, those concerns should have been formally reported to CYFS at the time of each occurrence.

In 2009, Mom contacted the police alleging that her brother was intoxicated and had physically assaulted her. Mom told the police that she had left the home with no shoes to call them and was afraid to return as she said her brother was *"going crazy"*. It was documented that Mom said three (3) children were still in the home. When the police arrived, they found both Mom and her brother to be intoxicated. Mom's brother was arrested and removed from the home. Despite Mom referencing three (3) children being present in the home, there was no mention of any children in the police report. There was also no documentation to indicate that CYFS was notified of this incident despite Mom being intoxicated and fleeing the home without the children due to physical violence.

On a Saturday night in 2010, the police attended the family's home after receiving two (2) telephone calls; one from the community clinic and another from Mom where she was *"so intoxicated she could not be understood"*. When the police arrived, they found all residents to be intoxicated. A referral was made to CYFS stating that there was *"no person in the residence that was in a sober condition and able to care for the children"*. Despite these very serious concerns, this referral was delivered to CYFS via fax and it does not appear that the police officer contacted a social worker in a more direct manner, i.e., via telephone, to request immediate followup to ensure the safety of the children. Given the high risk situation the children were in that evening, a more immediate and appropriate response was warranted from the police. At the time of this incident, the RCMP's policy for notifying CYFS stated that a referral should be forwarded to CYFS within three (3) working days. This policy was changed in 2012 and is now consistent with previous recommendations made by the ACY. It now directs that upon submission of a referral to CYFS, a telephone call will be made to the local CYFS office advising of the submitted referral. The policy goes on to state: *"After normal business hours the on-call Child Protection Worker will be contacted and advised of the report"* (B Division Operation Manual, RCMP, 2012). Upon receipt of these policies in 2014, the Advocate learned that the Memorandum of Understanding (MOU) in place that guides the sharing of information between the RCMP and the DCYFS has not been updated. The MOU still states that a referral should be made to the appropriate department within three (3) working days. The Deputy Minister of the Department of Justice acknowledged this in his

correspondence of February 2014 and indicated that the RCMP is in the process of drafting a new MOU in partnership with the DCYFS.

There were times when it was not evident from police documentation whether or not the children were present when the police attended the family's home to investigate allegations of physical violence or intoxicated adults causing problems in the home. If the children had been present during these incidents, referrals should have been made to CYFS. When questioned about this in October 2014, a staff sergeant with the RCMP advised the Advocate that all RCMP members are required to document and report to CYFS if children are present during such incidents. In addition, the staff sergeant followed up with the applicable RCMP officers and reported to the Advocate via email that *"the members did say that during the majority of their dealings with this [family], the children were typically in the care of [relatives] at another location."*

In the investigative report *"Sixteen"*, released in 2013, the ACY recommended that:

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

As per *The Advocate's Report on the Status of Recommendations 2014* and based on the response from the Department of Justice and Public Safety, the Advocate has determined that this recommendation is implemented. The ACY now recommends that:

RECOMMENDATION 1

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).

INAPPROPRIATE MEDICATION PRESCRIBING/DISPENSING AND LACK OF COMPREHENSIVE NURSING ASSESSMENT

Department of Health and Community Services
Labrador-Grenfell Regional Health Authority

In certain geographical areas of Newfoundland and Labrador, registered nurses may be required to perform competencies outside the approved scope of nursing practice. Prescriptive authority is one of these non-delegated competencies. In certain practice settings, a nurse is able to initiate select treatments without a client-specific medical order but in accordance with the policies and procedures outlined by the Regional Health Authority. Similarly, in areas where there is limited or no access to a pharmacist, registered nurses are required to dispense prescribed medications as part of their scope of practice. As per the ARNNL *Dispensing by Registered Nurses (1999)* document and the *Labrador-Grenfell Health Community Clinic Services Policy and Procedure Manual,* nurses employed at the clinic in the community where this family resided had the authority to prescribe and dispense medications. Unfortunately, the prescribing and dispensing of certain medications to the children of this family was, at times, excessive and inappropriate.

Mom's first child, Kevin, was born in 2002. During the eight (8) year period of this investigation, Kevin was seen at the community clinic 172 times and received 54 prescriptions for antibiotic medications. Ryan was born in 2006 and Sally in 2007. From the time of their births until their deaths in 2010; Ryan was seen at the clinic 77 times and received 35 antibiotic prescriptions while Sally was seen 32 times and received 12 antibiotic prescriptions. In total, the children were seen at the clinic 281 times and received 101 prescriptions for antibiotics. For the most part, the children presented with repetitive and persistent infections of their eyes, ears, throat, mouth and skin, for which antibiotics were prescribed. When asked in an interview with the Advocate about the excessive amount of antibiotic medication being prescribed to the children of this family, one nurse stated: "*We prescribe more antibiotics than we should sometimes because sometimes that's all you can do*" (Transcript of ACY Interview, 2014, p. 65).

Antibiotics are important in treating bacterial infections, preventing the spread of diseases and minimizing serious complications of diseases (Mayo Clinic Staff, 2014). However, the frequent and inappropriate use of antibiotics can result in bacterial resistance or antibiotic resistance. In addition, whenever children take antibi-

otics *"they run the risk of side-effects, such as stomach upset and diarrhea or even a possible allergic reaction"* (The Nemours Foundation, 2014).

In addition to the frequent visits and numerous prescriptions for antibiotic medication, a major concern noted throughout this investigation was the prescribing of antibiotic medication to Kevin and Ryan for which they had been assessed as being allergic to previously. At two (2) months of age, Kevin was brought to the clinic by Nan with a rash that was present on his chest, back, arms and legs. It was noted that he had started taking an antibiotic two (2) days prior. He was assessed by a nurse as having an allergic reaction to the antibiotic. The nurse consulted with a doctor who ordered that the antibiotic be stopped. Despite this, Kevin was prescribed the same antibiotic once the following month and twice the month after that. Almost three (3) months after the allergic reaction, Kevin presented at the clinic with a rash all over his body. Mom reported that Kevin had broken out in the rash shortly after taking an antibiotic that had been prescribed the day before. Kevin was assessed as having an allergic reaction to the antibiotic, which was in the same family of antibiotics as the one that he had been assessed as having a reaction to in the past. Mom was instructed to discontinue giving Kevin that antibiotic and to destroy any that remained at home. Despite both of these episodes, Kevin continued to be prescribed the first antibiotic and others in the same family of antibiotics, a total of twelve (12) times up to 2007.

Similarly, Ryan presented at the clinic when he was seventeen (17) months old with a rash on his face, back and chest. Mom reported that Ryan broke out in the rash minutes after taking an antibiotic that had been prescribed earlier that day. He was assessed by a nurse practitioner on this date as having an allergic reaction to the antibiotic; yet, he continued to be prescribed that antibiotic and others in the same family of antibiotics, a total of seven (7) times up to 2010.

The medication allergies were noted on the front page of both children's files indicating the date the allergy occurred and in Ryan's case, the symptoms he experienced. When asked in an interview with the Advocate about the prescription of medication to which Kevin and Ryan were allergic, a nurse could not provide an explanation. She did state that if a file was marked with an allergy, that medication should not be given again (Transcript of ACY Interview, 2014). According to Perry and Potter's *Clinical Nursing Skills and Techniques*, which is the leading nursing skills reference book providing comprehensive coverage of over 200 evidence-based skills, *"A client should never be given a medication to which he or she is known to be allergic"* (Perry & Potter, 2006).

In interviews with the Advocate, nurses from the clinic were asked whether or not there was a requirement to review a patient's chart for previous visits, diagnoses and treatments prior to seeing that patient for a new assessment. One nurse indi-

cated that while there were times when that was applicable, it was *"not necessarily all the time"* (Transcript of ACY Interview, 2014, p. 5). Another nurse stated that while a patient's chart would be pulled for their appointment, it was up to the individual nurse whether or not they would review it prior to seeing the patient: *"Well, it's up to you, you can take the chart and go in the room and sit and browse through it, and then call them in and have them walk in with you. That's your prerogative"* (Transcript of ACY Interview, 2014, p. 15).

According to the First Nations and *Inuit Health Clinical Practice Guidelines for Nurses in Primary Care* (2011): *"A health history is the most important part of a health assessment as it is key to reaching an accurate diagnosis."* The guidelines state that a thorough history should include certain components such as the history of present illness or concern; treatments tried; previous occurrences for each symptom; past medical history; and any known allergies including the type of any reactions. With respect to medication administration, Perry and Potter (2006) state: *"Nursing assessment relating to medication therapy involves client assessment and medication review. The nurse determines if a client has a history of medication allergies."* Arguably, an even higher standard of practice with respect to nursing assessments would be expected for nurses who are not only administering, but prescribing and dispensing, medications to patients.

The children's clinic files were continuous running records; therefore, information about their previous visits, illnesses, treatments and allergies was readily available to the nurses who assessed and treated them. Furthermore, both Kevin and Ryan had an allergy alert marked on the front of their files, which indicated an allergy to the antibiotics they continued to be prescribed. A review of the children's files or completion of a health history and comprehensive nursing assessment upon each presentation to the clinic would have highlighted the repetitive bouts of poor hygiene and excessive antibiotic prescriptions each of the children were receiving. At that point, the nursing staff should have consulted with the appropriate medical professionals to determine a plan of action to treat the overall issues, rather than the presenting symptom. In addition, it is likely that had a comprehensive nursing assessment and health history been completed upon each visit the children had at the clinic, they would not have been prescribed medication they had been assessed as having an allergic reaction to previously.

Article 24(1) of the UNCRC (1989) states:

> *States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*

In total, Kevin, Ryan and Sally were brought to the clinic 281 times and received 101 prescriptions for antibiotics. When these numbers were presented by the Advocate to a nurse during an interview, the nurse stated they were *"astronomical"* (Transcript of ACY Interview, 2014, p. 87). Though the children were assessed and given treatment for their illnesses upon each presentation to the clinic, it appears that there was no comprehensive assessment of their health problems. Having one child present at a health clinic as many times as any one of these children did would be alarming but in this case, there were three (3) children from the one family presenting regularly at a small community clinic with similar and persistent illnesses. At some point, the frequent visits and volume of antibiotics being prescribed to the children should have warranted more than a symptom-focused assessment to identify and treat the presenting symptom or illness. The episodic approach taken when assessing the children's health impacted the children's right to receive quality health care.

RECOMMENDATION 2

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.

RECOMMENDATION 3

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.

RECOMMENDATION 4

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.*

RECOMMENDATION 5

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.

LACK OF SUPERVISORY OVERSIGHT

Department of Health and Community Services
Labrador-Grenfell Regional Health Authority

Throughout the time period of this investigation, there appeared to be a lack of supervisory oversight occurring at the community clinic. Each nurse who saw the children appeared to complete their assessments independently of one another and rarely was it noted that they consulted with each other or with the nurse-in-charge for advice or feedback. This lack of communication among staff at the clinic contributed to the lack of awareness and understanding of the children's repetitive and persistent health problems and the lack of action taken to address these issues.

The community clinic employs one Regional Nurse II, who is designated as the nurse-in-charge of the clinic, which has twenty (20) staff (Transcript of ACY Interview, 2014). The description for this position states that the nurse-in-charge is the *"administrator, primary health care worker and clinical preceptor of student experience"* (Regional Nurse II Position Description, LGRHA, 2002 & 2007). The nurse-in-charge is responsible for administering and supervising the operations of the clinic. In addition, the nurse-in-charge *"arranges staff meetings on a regular basis for all members of the health care team for better co-operation and for discussion of common problems and solutions"* (Regional Nurse II Position Description, LGRHA, 2002 & 2007).

In an interview with the Advocate, a nurse was asked whether or not the nurses at the clinic would have brought forward concerns to the nurse-in-charge regarding the children's repetitive skin infections and questionable hygiene. This nurse indicated that while discussions of this nature could occur between the nurse-in-charge

and the nursing staff, they did not necessarily happen. She stated that the nurses employed at the clinic were capable of assessing and treating patients without necessarily consulting with the nurse-in-charge: *"These are regional nurses and we're all responsible for our own practice"* (Transcript of ACY Interview, 2014, p. 105). She did report that at times, the nurse-in-charge would engage in conversations with the other nurses to discuss concerns regarding patients; however, *"It just does not present in these charts as being done"* (Transcript of ACY Interview, 2014, p. 111).

As a result of the lack of communication occurring between nursing staff and the nurse-in-charge, it appears that there was no supervisory oversight with respect to this family and their serious and persistent health problems. According to a leading nurse researcher, Nancy Blake, an effective charge nurse *"needs to incorporate leadership and communication skills with conflict resolution, time management and organizational techniques, delegation, mentorship, education, and role modeling"* (Blake & Young, n.d). In addition, charge nurses *"are aware of the big picture"* (Blake & Young, n.d.).

The Advocate determined during interviews with staff that the nurse-in-charge should be aware of what is occurring in the clinic; however, there was no one person *"seeing the bigger picture"* (Transcript of ACY Interview, 2014, p. 107). When asked whether or not the nurse-in-charge had the added responsibility to be aware of the issues presenting at the clinic, the response was yes; however, that duty was not always manageable for the nurse-in-charge given the number of other duties she was responsible for: *"I guess it translates to time"* (Transcript of ACY Interview, 2014, p. 163).

When the Advocate identified during an interview the total number of visits the children had at the clinic and the number of antibiotic prescriptions they had received, it was obvious that the nurses interviewed had not been aware of the frequency of either. When asked why they would not have been aware, one nurse replied:

> *I guess it's because there are so many other things going on in that clinic. Like this – and I mean that's not an excuse, that's an explanation… There is just, it's just so busy in this clinic. There is constant mental health issues. There is constant sick people. There's – it's just constant... And you're going as fast as you can* (Transcript of ACY Interview, 2014, p. 149).

Had regular communication and case consultations been occurring among the nurse-in-charge and the nursing staff, the children's health problems would have been more comprehensively understood by the staff at the clinic. Each nurse who saw one of the children would have been aware of previous conditions, the number of visits and the number of antibiotic medications the children were receiving to

treat the many health problems they presented with. The nurse-in-charge must be the leader in the clinic ensuring communication and case consultations are occurring with staff on a regular basis.

RECOMMENDATION 6

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.

DOCUMENTATION DEFICIENCES

Department of Child, Youth and Family Services

Deficiencies in documentation were apparent throughout the family's CYFS file during the period of this investigation. Deficiencies included lack of documentation and non-adherence to documentation standards and policies. The most prevalent deficiency was timely entry of case notes or CRMS notes.

DCYFS standards required social workers to document all service notes in CRMS *(CYFS Best Practice Guidelines for Using CRMS, 2002)*. While CRMS training began in this community in October 2004; the program was not fully implemented until December 2005. Regardless of the method of recording, social workers were expected to maintain records of their contact with clients. The *Standards for Social Work Recording* as set forth by the Newfoundland and Labrador Association of Social Workers (NLASW, 2005) states:

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

Additionally, the *CYFS Best Practice Guidelines for Using CRMS (2002)*, which was in effect during the time frame of this investigation, outlined the standard for completion time of notes pertaining to the social worker's contact with the family:

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

At times throughout the period of this investigation, notes pertaining to contact with this family were recorded days, weeks, and months after the contact occurred. CRMS notes pertaining to the second CPR of 2008 were added ten (10) months after the occurrence. The missing documentation appears to have come to light when a program manager inquired as to the whereabouts in order to sign off on the referral. At that time, a social worker assistant entered a CRMS note that outlined the details of a home visit that was completed with a social worker in response to the CPR; however, the social worker did not document anything in CRMS. In an interview with the Advocate, the social worker stated that she did not document her involvement with the family in that instant due to her involvement with other cases that were more urgent at the time. Though the concerns being expressed about this family were serious, the social worker relayed that there were other families in more precarious situations: *"… although it doesn't look very good in the file, [Mom] did have, compared to other families and things we're dealing with, she had more support"* (Transcript of ACY Interview, 2014, p. 259). This social worker reported that in terms of documentation: *"it physically was not possible to document all the contact I had"* (Transcript of ACY Interview, 2014, p. 64). To further elaborate the struggles faced by social workers in this community with not being able to meet documentation standards, this social worker explained in her interview with the Advocate, that the priority was to take action on the referral: *"… it was our practice to have the referral and go and work on that and worry about the documentation later"* (Transcript of ACY Interview, 2014, p. 119). In most cases though, there was no time later to document what action had been taken on a referral.

While there were times the social worker was unable to document anything pertaining to her involvement with the family, other times multiple contacts were captured in the one note. In 2003, the social worker documented in one case note the interactions she had with Mom over that entire month. The note described two (2) conversations with Mom, a home visit with the family and a conversation with clinic staff. When the Advocate asked about this case note in an interview, the social worker stated: *"Yes, that certainly isn't best practice or the standards that I would have wanted to have had at that time, but, again, it was a reality of the situation in [community]…"* (Transcript of ACY Interview, 2014, p. 111). This social worker went on

to provide an analogy in an attempt to explain the challenges faced by her as the only social worker in that community at that time:

> *Like, we have laws against using cellphones while driving for very obvious reasons. Lots of research [has] shown that people's judgment is impacted, you know, if they're distracted or if they're focusing on too many things. And yet, at this point in time, and throughout the life of the file, probably, any social worker who was involved was put in a very difficult situation where you were basically given a car, let's say through caseload, and told there are five cellphones in the car that you're required to answer and to carry on lucid conversations with and plan. You may also have to listen to updates on the radio for other things that might be happening. You may have a client having a psychotic episode in the backseat that you're rushing madly while answering the cellphones and driving to get to the emergency hospital, and you have a flat tire. And somewhere along the way you, you know, there is a traffic cop directing you to go off in a totally other direction. And then you may be asked to get out of your car and go and drive someone else's car for a week or so. And that's why these types of situations happen. Whenever you get the opportunity to sit down with a pen and paper you're like what happened in the last month… And that's why they end up in one note* (Transcript of ACY Interview, 2014, pp. 112-113).

Though the file remained open for the duration of the investigative period, there were times when no contact was documented with this family for years. Most significantly, there was a two (2) year gap in notes from 2003 to 2005 and again, a two (2) year and three (3) month gap from 2005 to 2008. When a social worker was asked in an interview with the Advocate, she indicated that she may not have had any contact with the family in a professional capacity during that time, hence the lack of documentation. Given the size of the community, she did indicate that she would have had casual contact with the family during the time frames noted:

> *I mean one of the wonderful things about working in [community] is that even though it may not be recorded in here I may have seen these children weekly just out in the community with their grandmother or at the grocery store… it was very common to see them and see how people were doing* (Transcript of ACY Interview, 2014, p. 94).

Another issue identified with CYFS documentation throughout the period of this investigation was lack of detail. Often times, notes entered into CRMS were brief with very little information or context. Another social worker took over this family's file in 2009 until 2010. Four (4) months after initial contact with the family, this social worker noted in CRMS that her supervisor had asked her to *"assess situation at*

the [family] home". There were no other details provided explaining what prompted this direction. Similarly, in 2010, two (2) months after her last contact with this family, this social worker documented in CRMS: *"Supervisor [--] said to close the intake"*. It is unclear from the documentation what *"intake"* this social worker was referring to or why it was being closed. The Advocate attempted to reach this social worker for an interview to discuss her management of this family's CYFS file; however, it was learned that she has left the Province and was unable to be located by the Advocate.

In addition to the difficulties in meeting documentation standards regarding case and CRMS notes, there were times when other documentation standards were contravened. The *Risk Management System (RMS, 2003),* which was in effect during the time frame of this investigation, states: *"All referrals on new, reopen and active cases shall be recorded on the Child Protection Report form 14-704, and as soon as possible and no later than 24 hours."* Despite this policy directive, many times throughout the period of this investigation, child protection concerns were presented to social workers that were not recorded in a CPR. From 2002 to 2005, there were three (3) times when concerning information was received by the social worker but not documented in a CPR. When asked by the Advocate in an interview, this social worker could not provide an explanation; however, she did indicate that a CPR should have been completed in all three (3) cases (Transcript of ACY Interview, 2014). Similarly, in 2010, very serious concerns were brought to the attention of another social worker by a nurse at the community clinic. Ryan and Sally had not been brought in for their appointments, they were believed to be sick, and they were currently in a home without appropriate supervision where adults were thought to be drinking. The police attended the family's home that night and also made a referral to CYFS as *"there was no person in the residence that was in a sober condition and able to care for the children."* Despite these referrals, a CPR was not present in the file pertaining to the events of that night.

Upon the determination that a CPR will be accepted for investigation, a social worker must determine whether or not the child is now safe. Risk Decision #3 of the *RMS* (2003) states: *"The social worker shall complete the Safety Assessment form 14-628 as soon as possible, and within 24 hours of the child being seen."* One day after receiving the first CPR of 2008, the social worker completed a handwritten Safety Assessment; however, this form was not added to CRMS until over one year and nine (9) months later. In completing this Safety Assessment, the social worker found the children to be *"unsafe"* yet there was nothing documented as the Safety Response on this form. *RMS* (2003) states: *"In cases where the child's situation is assessed as "unsafe," document under "Safety Response" the interventions which have taken place or which will be taken immediately to protect the child from immediate*

and serious harm." When the Advocate asked about this in an interview, the social worker stated:

> *That is unusual that I have a blank one here, but, again… in the context of everything else that was going on at that time, and all the other assessments being done, that this one just didn't get completed fully* (Transcript of ACY Interview, 2014, pp. 240 – 241).

In addition to noting a Safety Response when a child is deemed *"unsafe", RMS* (2003) requires the completion of another form: *"When the social worker assesses the child's situation as unsafe, a Safety Plan Form #14-855 shall be developed immediately."* It appears from CRMS notes that the social worker encountered many delays when trying to meet with Mom to discuss the concerns that arose out of this CPR and as a result, the Safety Plan was not completed until two (2) weeks after the children had been deemed *"unsafe"*. When completing the Safety Plan, a social worker must identify safety factors, describe specific outcomes which will indicate the safety factor has been reduced, identify the steps to be taken to achieve these outcomes and indicate the expected time frame for completion of each step. The Safety Plan for the first CPR in 2008 listed steps to be taken by Mom; however, the start date for these steps pre-date the generation of a CPR by CYFS and any action taken on this referral by the social worker. When the Advocate asked about this in an interview, the social worker could not provide an explanation. She did indicate that Mom may have reported that she had already commenced the activities listed therefore the start dates reflected same (Transcript of ACY Interview, 2014).

The social worker indicated in her interview with the Advocate that she made her supervisors aware of her concerns about not being able to meet documentation standards. Additional time was requested for completion of such tasks but requests were *"consistently denied"* (p. 92):

> *Because then, as now, we are not provided any overtime to record case notes. And if -- I found that if we had a file where there were very, very serious - not that this is not also very serious but – more pressing, more immediate concerns for children's safety, those were the files that were given more attention, especially if they were headed to court. You know, there was lots of pressure, for very good reason. To keep the case records up to date. And that's where your time would have been spent. And any requests I ever made for overtime to do case notes was denied because they were considered administrative task, which I argued against quite often* (Transcript of ACY Interview, 2014, p. 91).

Instead of approving the much needed overtime to complete documentation pertaining to a file, the social worker indicated that other ineffective solutions were often suggested by management: *"… just go in your office and hang a Do Not Disturb sign and get it done"* (Transcript of ACY Interview, 2014, p. 92). The social worker

told the Advocate that she often argued that case notes pertaining to a file were an important part of clinical practice, not an administrative task as it was considered by management: *"You have to have them. You know, whether you're going to court or not, another social worker – like if I don't go back to [community] for whatever reason, someone needs to have a record to refer to"* (Transcript of ACY Interview, 2014, p. 93). In a conversation with one of her zone managers, the social worker queried if there was an unspoken expectation that the social workers in the community work unpaid overtime. She said she asked this question because she and other staff were constantly being told that they were not meeting the standards of practice. She reported that her zone manager told her that there was no such expectation; however, the social worker still felt this was untrue: *"… I think even though he says there isn't, I think there is an expectation that we work unpaid overtime"* (Transcript of ACY Interview, 2014, p. 142).

The inability to meet documentation standards did not just impact the file a social worker was working on; it also had an impact on workplace dynamics. A social worker told the Advocate in an interview that the challenges in meeting unattainable standards has resulted in the loss of good social workers from that CYFS office. One social worker described as *"very competent"* only stayed in the community for one year:

> *… she was so concerned about her documentation not being up to date, not meeting that standard that she was working overtime all the time. She was taking her Risk Assessments home at night. She was in there every day on Saturday and Sunday. She was so stressed out, she just had to leave. She left* (Transcript of ACY Interview, 2014, p. 138).

When the Advocate asked whether or not the struggles with documentation present in this family's file were still a struggle today in that CYFS office, the social worker indicated that they were: *"It's a constant struggle… still ongoing and always was ongoing. The absolute challenge of keeping documentation up to date"* (Transcript of ACY Interview, 2014, p. 114). Caseload demands and inadequate staffing are still significant factors affecting the ability of social workers in that CYFS office to meet documentation requirements and standards.

In the investigative report *"Sixteen"*, released in 2013, the ACY recommended that:

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

While this recommendation has been identified as implemented in *The Advocate's Report on the Status of Recommendations 2014* based on the response provided by

the DCYFS, it is evident from the information gathered during this investigation that the social workers in this community are still experiencing difficulties in being able to meet policy standards.

RECOMMENDATION 7

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).*

LACK OF COMPREHENSIVE ASSESSMENT, INTERVENTION AND FOLLOWUP

Department of Child, Youth and Family Services

Evident in the family's CYFS file throughout the period of this investigation was the struggle the social workers had in responding to child protection concerns and providing appropriate interventions where necessary. There were times when the response to a child protection concern was delayed, assessment of the children's safety was not as comprehensive as it should have been and planned followup did not occur. Factors contributing to these issues included unmanageable caseloads and inadequate staffing.

Risk Decision #1 of the *RMS* (2003), which was in effect during the time frame of this investigation, states:

> *All referrals on new, reopen and active cases shall be recorded on the Child Protection Report form 14-704 and as soon as possible and no later than 24 hours. The Initial Intake Report form 14-696 shall also be completed for all referrals, and as soon as possible and no later than 24 hours.*

Furthermore, Risk Decision #2 of the *RMS* (2003) states:

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

A Consultation Request was sent to CYFS in 2005, addressed to a different social worker than the one assigned to the family's file at that time. The request was sent by a doctor who was requesting that *"Social Work"* see this family due to Kevin's repeated bouts of serious skin infections despite Mom being provided with information about the necessity of cleanliness and hygiene. Kevin had most recently presented at the community clinic with a large *"plaque like area"* on his body and was receiving *"potent antibiotics"*. The request was stamped as received by CYFS the following day, yet action to address the concerns expressed by the doctor did not occur until nearly two (2) weeks later. The information was not recorded in a CPR; therefore, there was no response priority identified. When asked in an interview with the Advocate about the delay in responding to the concerns expressed in this request, the social worker could not provide an explanation and she wondered whether or not she was out of town at the time of this request as it was not addressed to her. She stated she would usually make every attempt to get out and address concerns such as this one right away (Transcript of ACY Interview, 2014).

Similarly in 2008, after responding to reported concerns, the police made a referral to CYFS that noted the children were present in the home while excessive drinking was occurring. The incident occurred on a Friday night and the police faxed their referral to CYFS a few hours later, early on a Saturday morning. A CPR was not completed by CYFS until Tuesday and the children were seen on that day. When the social worker was asked in an interview with the Advocate about the delay, she was unable to explain why followup had not occurred on Monday (Transcript of ACY Interview, 2014).

On a Saturday night in 2010, a social worker was contacted by the community clinic and it was reported that the children had not been brought in for their appointments that day. It was thought that they were at home without proper supervision due to their caretakers being intoxicated. This information was not recorded as a CPR and the program manager, with whom the social worker consulted, directed there be no immediate action taken in response to these concerns. The police attended the family's home that night after receiving calls from the community clinic and Mom. The police faxed a referral to CYFS a few hours later, early Sunday morning, stating that while the children appeared to be in good health, *"there was no*

person in the residence that was in a sober condition and able to care for the children." The social worker noted in CRMS that she received the referral from the police on Sunday, yet she did not record the information as a CPR. More concerning was that followup to concerns expressed for the children's safety and wellbeing by two (2) different referral sources did not occur until the following Friday; six (6) days after the original incident. The Advocate attempted to reach this social worker for an interview; however, it was learned that she has left the Province and was unable to be located.

In addition to the delays in responding to child protection concerns regarding this family, it appears ongoing monitoring and followup was not occurring. Throughout the review of this family's CYFS file, gaps in documentation and presumably contact with the family, were often noted following serious concerns and referrals. A social worker indicated in an interview with the Advocate that *"there would be long lengthy periods of no contact but that doesn't mean there wasn't concern…"* (Transcript of ACY Interview, 2014, p. 94). Though followup would be included as part of the ongoing plan to monitor this family, the reality did not match the intention. This social worker also indicated that while she was aware of the standards of practice and what she should be doing to meet those standards, action on this file was often referral driven: *"But the reality was, is that we were only going and probably seeing this family when referrals came in, and that there was very little ongoing follow-up or case planning happening"* (Transcript of ACY Interview, 2014, p. 72). When asked whether or not she voiced these concerns to her managers, the social worker indicated she had but it did not seem to have the impact she had hoped for: *"… honestly, often I just felt like I was sending out messages, you know, in a bottle that people weren't receiving"* (Transcript of ACY Interview, 2014, p. 32).

Due to the inability to provide ongoing followup, the social worker reported that CYFS would often rely on other agencies such as the community clinic and the police to provide information or report concerns about the family (Transcript of ACY Interview, 2014). After her home visit with the family in 2005 to address the concerns expressed by a doctor in a Consultation Request, the social worker documented in her case notes that she and the CSW would conduct a follow-up visit with the family in a few weeks. The next note on this family's file was dated 2008. When asked in an interview with the Advocate whether or not the planned followup occurred, the social worker stated: *"No, I'd say that case shuffled to the bottom, unfortunately, of our pile until the next referral"* (Transcript of ACY Interview, 2014, p. 153). When asked how Kevin's health and wellbeing were being ensured if no followup was occurring, the social worker indicated that they would have relied on the community clinic to report further incidents of poor hygiene and infection. The Advocate further inquired as to whether or not the social worker was confident that the other professionals would contact her or identify issues occurring with the

children. This social worker indicated that there was not much of a choice: *"Sadly, that is what we often relied on when we didn't have time to do proper follow-up with the family in case planning"* (Transcript of ACY Interview, 2014, p. 154).

Upon receipt of a referral from the police in 2008, the social worker did complete a home visit with the family where she saw the children and spoke with Nan and Pop. Mom was asleep at the time of this visit so the social worker did not get to speak with her regarding the concerns expressed by the police. A Safety Assessment was completed the next day and the children were deemed *"unsafe"*. Risk Decision #3 of the *RMS* (2003) states: *"When the social worker assesses the child's situation as unsafe, a Safety Plan Form #14-855 shall be developed immediately."* Many unsuccessful attempts were made by the social worker and the CSW to connect with Mom in the days following the completion of the Safety Assessment. Twice when the social worker visited the home, Mom and the children were on their way to the community clinic. This social worker tried calling Mom to set a time to meet but was told by Nan on two (2) occasions that Mom was asleep. Two (2) weeks after the incident that prompted the police referral, the social worker finally met with Mom and completed a Safety Plan. When the Advocate asked in an interview if it was typical practice to allow delays such as this to occur when following up on a referral, the social worker stated:

> *That certainly was an approach that I took with [Mom] because I was trying to foster some cooperativeness, I guess, with her because she could be so hostile and I felt like taking a slower gentle approach with her was good because that had worked for us in the past…* (Transcript of ACY Interview, 2014, p. 226).

The social worker went on to explain that at the time of this referral, she was the only social worker in the community and she had many other demands requiring her attention. She indicated she was investigating two (2) child abuse cases, one sexual assault case, she had three (3) children in care who were in crisis, she was working on a social history for an adoption, vetting a file for disclosure, working with a client who had been placed in an out-of-province placement, and there were referrals on four (4) other families alleging serious concerns of neglect and substance abuse (Transcript of ACY Interview, 2014). As a result of all these demands, delays in following up with Mom regarding the referral were accepted: *"That was just a normal course of how things were running along there"* (Transcript of ACY Interview, 2014, p. 229).

The Safety Plan that was finally completed as a result of the first CPR received in 2008 noted that Mom had support from her family, specifically Nan; she was attending counselling; and the children had *"sober minders"* on the night in question. In an interview with the Advocate, the social worker was asked why Nan would have been considered a protective factor given the police referral indicated all members

of the household were known to be abusing alcohol. The social worker explained that while Nan did contribute to some of the risk factors for the children, she was supportive to Mom in many ways (Transcript of ACY Interview, 2014). This social worker said that in this instance, she was trying to determine what kind of support system Mom had and for the most part, Nan was considered a support. When asked whether or not she would have confirmed Mom's reports of having had *"sober minders"* on the night in question, the social worker responded: *"… I would only have stated that if I had been advised by either [Mom] or her parents that the children had a babysitter. And then… I would have gone and confirmed that with the babysitter"* (Transcript of ACY Interview, 2014, p. 249). Similarly, the social worker said that while not documented, she would have followed up to confirm Mom was indeed attending counselling.

The Safety Plan listed steps to be taken by Mom, which included attending counselling and abstaining from alcohol consumption. The next documented contact the social worker had with the family following the completion of the Safety Plan was five (5) months later, after the receipt of another referral. When the Advocate asked in an interview whether or not the Safety Plan was reviewed with Mom to ensure she was completing the steps to be taken, the social worker said there was no indication from her CRMS notes that any followup occurred. She stated that *"would have been the norm in 2008"* (p. 251) due to the other files she was working on at that time (Transcript of ACY Interview, 2014).

A referral received five (5) months later alleged that Mom had been drinking heavily for a few days; the referral source was unsure whether Mom had any babysitters for the children. A Safety Assessment was completed by the social worker and the children were deemed *"safe"*. The social worker noted that Mom was sober and at home with the children when a home visit with the family was completed and previous concerns regarding Mom's drinking were noted as being monitored by CYFS. In an interview, the Advocate asked if any consideration was given to the conditions of the Safety Plan that had been completed five (5) months prior when the safety of the children was being assessed this time. The social worker stated: *"No, because we probably did not review this file"* (Transcript of ACY Interview, 2014, p. 266).

Despite being outlined in the *RMS (2003)*, it appears that at times steps were skipped in the *RMS* process. As previously mentioned, a social worker was contacted in 2010 by the community clinic and concerns were reported about the children's safety and wellbeing. The information was not recorded as a CPR and the program manager, with whom the social worker consulted, directed there be no immediate action taken to address these concerns. Even after receiving a referral from the police, a CPR was not generated by CYFS. This social worker visited the home nearly a week later but it was not documented in CRMS whether she saw or spoke with the

children. In addition, it does not appear from file documentation that a Safety Assessment was completed; however, a Safety Plan was. According to the *RMS (2003)*, a Safety Plan is completed upon the determination that a child is *"unsafe"*, i.e. after the completion of a Safety Assessment. It appears that in this instant, three (3) critical steps were missed in the *RMS* process; first, the completion of a CPR and Initial Intake Report that would have indicated response priority; second, face-to-face contact and interview of the children where developmentally appropriate; and finally, the completion of a Safety Assessment within 24 hours of the children being seen.

The Safety Plan that was completed in response to the 2010 incident noted that the children did not have any sober caretakers on the night in question. Mom had been warned about this previously by a social worker who had advised that there was not to be any alcohol use when the children were home. Given this social worker was aware that Mom had disregarded previous warnings, it is unclear why she then noted on the 2010 Safety Plan that: *"[Mom] willing to provide a sober caretaker to protect children."* It was obvious from this most recent incident that Mom was not ensuring the children had sober caretakers despite previous warnings. This social worker listed steps to be taken by Mom as part of the Safety Plan, which included Mom protecting the children by bringing them to a *"sober home"* and ensuring there was no smoking occurring in the home while people were drinking. The expected completion date for each step was three (3) months later. Despite this, there are no CRMS notes indicating any followup occurred on that date.

The *RMS* process includes two (2) important steps that were not evident as completed by CYFS throughout the period of this investigation; the completion of a Risk Assessment Instrument and a Family Centered Action Plan. Risk Decision #6 of the *RMS (2003)* states:

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

Furthermore, Risk Decision #7 of the *RMS (2003)* states:

> *The social worker shall complete, with the family, a Family Centered Action Plan (form 14-858). This shall include a face to face interview and contact, where developmentally appropriate with any child de-*

> *fined to be in need of protective invention and the case remains open. The Family Centered Action Plan (Form 14-858) shall be completed within 60 days of receipt of the Child Protection Report.*

According to the *RMS (2003)*, the social worker must review and revise the Family Centered Action Plan with the family six (6) months after the initial plan is developed, for high risk and moderately high risk ratings and every six (6) months thereafter. For medium and moderately low risk ratings, the Family Centered Action Plan must be reviewed and revised within nine (9) months of the initial plan being developed and every nine (9) months after. In both instances, a supervisory signature is required. In addition, the social worker *"must review/revise the Family Centered Action Plan whenever the Risk Assessment Instrument is completed/reviewed or when other assessments are completed"* (Risk Decision #8, *RMS*, 2003).

Though the *RMS* was developed in 2003 and disseminated to the regions, implementation of the system occurred at a later date. A social worker stated in an interview with the Advocate: *"… we were given access to do Safety Assessments, Safety Plans and then there was quite a gap before we got the training in the risk tool itself"* (Transcript of ACY Interview, 2014, p. 276). According to the DCYFS, full implementation of the *RMS* occurred on January 1, 2008. When asked in an interview with the Advocate, if a Risk Assessment Instrument was ever completed for this file, the social worker stated: *"… I would not have done it while I was involved in that file, no"* (Transcript of ACY Interview, 2014, p. 277). Similarly, when asked if a Family Centered Action Plan had ever been completed, this social worker told the Advocate: *"No. And, again, that would have came even later than our risk assessment used at the [community] office"* (Transcript of ACY Interview, 2014, pp. 277 – 278). It appears from file documentation that a Risk Assessment Instrument and Family Centered Action Plan were also not completed by the social worker who had responsibility for this file from 2009 to 2010.

The delays in responding to child protection referrals paired with the lack of comprehensive assessment, intervention and followup, left Kevin, Ryan and Sally unprotected. While at times, the family was advised that social workers would be conducting unannounced home visits to assess the situation in the home, these visits did not occur. Moreover, followup of any kind was not occurring. Many of the concerns expressed to CYFS about the family involved the use and abuse of alcohol by the children's caretakers, which left the children without appropriate supervision. In visits the social workers had with Mom, she would claim she was going to quit drinking or at least ensure the children had sober caretakers when drinking was occurring in the home. Despite these claims, reports were continually being made to CYFS that Mom was not fulfilling either commitment. Given the social workers were not able to follow up immediately on many of the referrals or able to conduct unannounced home visits, they relied heavily on Mom's word that drinking was not

occurring around the children. If immediate response to referrals, proper assessments and interventions as well as sporadic unscheduled visits and regular followup had been occurring, the social workers would have seen firsthand what was truly going on in that home.

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

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

In many ways, due to the lack of comprehensive assessment, intervention and followup, the children's right to protection from harm was not upheld.

In the investigative reports *"Out of Focus"* and *"Sixteen"*, released in 2012 and 2013 respectively, the ACY recommended that the DCYFS ensure compliance and consistency in the application of the *Risk Management System* as well as ensure that social workers complete comprehensive assessments in accordance with the *Risk Management Decision-Making Model Manual* (2013). While these recommendations have been identified as implemented in *The Advocate's Report on the Status of Recommendations 2014* based on the response provided by the DCYFS, it is evident from the information gathered during this investigation that the social workers in this community are still currently experiencing difficulties in being able to complete comprehensive assessments, intervention and followup.

RECOMMENDATION 8

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).*

LACK OF COLLABORATION, COMMUNICATION AND INFORMATION SHARING

Department of Child, Youth and Family Services
Department of Health and Community Services
Labrador-Grenfell Regional Health Authority
Department of Justice
Royal Canadian Mounted Police

A consistent theme throughout the investigative process was the lack of collaboration, communication and information sharing among the professionals involved with this family. CYFS, the community clinic and the police all had pertinent information about the family including serious concerns about the safety and wellbeing of Kevin, Ryan and Sally, yet each organization appeared to operate independently of one another. The police were aware of alcohol use and abuse as well as outbursts of physical violence occurring in the home by the adult residents; both issues left the children at risk. Staff at the community clinic had more documented contact with Kevin, Ryan and Sally than anyone else involved. They were aware of many things that were of concern for the children such as the numerous visits where the children presented with serious and repetitive infections, the times the children were brought to the clinic by caregivers who admittedly or presumably had been consuming alcohol and the many times the children were not brought in for scheduled follow-up appointments. Additionally, clinic staff suspected that Mom and Nan were not adhering to the children's prescribed treatment plans, which included compliance with prescribed medication orders as well as instructions regarding good hygiene practices and the avoidance of second-hand smoke. CYFS was aware of many of the same issues, but not to the same extent as that of the other two (2) organizations. While there were times when discussions would occur between these professionals, sharing of information was not occurring consistently. Had these organizations been working collaboratively, they would have had a more complete picture of what was going on for Kevin, Ryan and Sally at that time.

When asked in an interview with the Advocate about the relationship between the community clinic and CYFS, a nurse stated: *"Even though we were supposed to be working together, I often felt like we were two separate entities"* (Transcript of ACY Interview, 2014, p. 13). She elaborated to say that often when staff from the

community clinic would ask questions about what would happen after information about a child or family was relayed to CYFS, they would not get any feedback. While the nurse stated she understood that confidentiality was a concern, she felt that staff at the community clinic and staff with CYFS were all working for the family; therefore, discussions should be happening between the two (2) organizations. While she respects the job the social workers are doing, she would like to see more communication:

> *… the CYFS social workers are really, really good. They do come down and they do ask to see charts and they do sometimes talk to us about families, but it's the… feedback loop that seems to suffer. And I know that as a rule they are not obliged to give feedback, but I'm in that circle of care and I feel I should have the feedback* (Transcript of ACY Interview, 2014, p. 16).

She went on to say that they are both working for the same cause but if they are working in their own silos, then important and beneficial information can get lost. The nurse did state that communication has improved in recent years, which was a welcomed adjustment: *"It's encouraging for us nurses, because when I make a call to CYFS about something, or I talk to a social worker about something and I don't get any feedback, how do I know where to go next?"* (Transcript of ACY Interview, 2014, p. 22).

A social worker also commented on the relationship between CYFS and the community clinic in her interview with the Advocate: *"… we had a very good relationship with the clinic staff and they certainly would have notified us if they had… concerns"* (Transcript of ACY Interview, 2014, p. 103). This social worker stated that the staff at the community clinic were very diligent in relaying their concerns to CYFS. In fact, this social worker reported that CYFS often relied on reports from the community clinic when they did not have time to do proper followup with the family. When asked whether or not CYFS would contact a referral source, such as a staff member from the community clinic, to advise of what action had been taken, the social worker indicated that it was dependent on the level of involvement of that referral source: *"… if they were someone that was going to be continuing to provide service then, yes, we would have phone calls and discussions with them"* (Transcript of ACY Interview, 2014, p. 183). This social worker went on to say that while they would freely share information, it was not practice to report back on any action taken: *"… it wasn't our practice to call them back and inform them of what we had or hadn't done"* (Transcript of ACY Interview, 2014, p. 186). When asked the reason for this, she stated it was a time issue: *"… I would not have the luxury of sitting in my office thinking, oh, I should call [nurse] and tell her that. You just don't get the opportunity to do that"* (Transcript of ACY Interview, 2014, p. 188). Despite these barriers to communication and collaboration, the social worker did point out that the small

size of the community where they worked did allow for more knowledge among the professionals of what was going on at each of these other organizations:

> *We are aware of what's going on because we all know each other. It's not like St. John's where you might, you know, get a referral from a nurse and you have no idea who that person is or where they are and you may never ever see them in your entire lifetime…* (Transcript of ACY Interview, 2014, p. 186).

When asked about information sharing and collaboration with the police in the community, a social worker in an interview with the Advocate stated that it varied from case to case: *"… we have some cases going on in [community] right now… there is lots of collaboration between us, the [police] and the clinic"* (Transcript of ACY Interview, 2014, pp. 159 – 160). Unfortunately, this is not always possible for each case. The social worker noted staff turnover and time restraints as factors contributing to communication and collaboration deficiencies:

> *… you know, you are always having to build a new relationship with whoever is there and the sergeant… we've always been trying to do that work. It just doesn't always go the way we wanted to because… you don't always have the time to make it happen* (Transcript of ACY Interview, 2014, pp. 158 – 160).

The information each of these organizations had about this family illustrated many concerns on their own, but had they been compiled, it would have formed a more complete perspective and would have shown just how dire the children's living situation truly was. When asked her views on collaboration, a social worker stated: *"I think collaboration is key…"* (Transcript of ACY Interview, 2014, p. 194). She went on to say that all the information that was known about this family and the concerns other organizations had for the children should have been brought together in some meaningful way.

Through interviews with community clinic staff and CYFS staff, the Advocate learned that years ago there had been a committee in the community comprised of different professionals that would meet on a regular basis to discuss cases that may involve multiple service providers (Transcript of ACY Interview, 2014). Committee members included nursing staff from the community clinic and Public Health, CYFS staff, police officers, and school representatives. In addition, local elders were invited to attend. During these meetings, committee members in attendance would share information pertaining to cases of common concern. This process was viewed as quite valuable and beneficial to all involved. Community clinic staff and CYFS staff who were interviewed by the Advocate could not explain why the committee was disbanded; however, they speculated it was a result of confidentiality concerns. In an interview, a nurse stated that another process was initiated a few years

later called the Individual Support Services Plan (ISSP); however, she indicated that it was a more cumbersome approach than the committee had been (Transcript of ACY Interview, 2014).

In the investigative reports *"Turning a Blind Eye"* and *"Out of Focus"*, released in 2012, the ACY recommended that the DCYFS and DHCS ensure provincially that collaborative practice initiatives are developed and advanced between disciplines of social work, health, justice and education, and that policy and guidelines reflect collaborative practice. While these recommendations have been identified as implemented in *The Advocate's Report on the Status of Recommendations 2014* based on the response provided by the applicable departments, it is evident from the information gathered during this investigation that the service providers in this community are still experiencing difficulties in collaboration, communication and information sharing.

RECOMMENDATION 9

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.

CHALLENGES TO SERVICE PROVISION

Kevin, Ryan and Sally resided in a remote and isolated community in Labrador. This community, like many other communities throughout the Province, face many challenges including mental health issues and addictions. The isolation of the community paired with these issues create unique challenges to service provision. Many of the challenges faced by the service providers who were involved with this family, mainly the community clinic and CYFS, contributed to the deficiencies in service provision identified throughout this investigation. In the case of CYFS, there were also human resources issues identified within the agency that impacted the ability to provide appropriate and effective services to these children.

Department of Health and Community Services
Labrador-Grenfell Regional Health Authority

The community clinic is the only health centre located in this community. It is staffed by nurses; a doctor visits once a month and is available for consult via telephone or videoconference. In an interview with the Advocate, a nurse stated that on average the community clinic sees between thirty (30) and forty (40) patients a day. In addition to those regular appointments, the clinic could potentially see another twenty (20) or more people as *"walk-ins"* (p. 152) or emergencies (Transcript of ACY Interview, 2014). The frequency of walk-in and emergency visits, according to the nurse: *"depends on the time of the season"* (Transcript of ACY Interview, 2014, p. 154). With such a high number of patients coming to the clinic on a daily basis, staffing is a major concern. In an interview with the Advocate, a nurse stated: *"…for two years [we] had two vacancies that we were just filling with casuals."* (Transcript of ACY Interview, 2014).

Compounding, and possibly contributing to, the high number of patients seen in the clinic daily and the persistent staffing issues, is the context in which the clinic operates. In interviews with the Advocate, nurses indicated that the environment in which they work is extremely stressful. In 2010, around the time Ryan and Sally died, there were several other deaths in the community in a five (5) to six (6) week period of time (Transcript of ACY Interview, 2014). One nurse stated: *"We don't live and work in ordinary circumstances"* (Transcript of ACY Interview, 2014, p. 47).

The root cause of many of the concerns noted by the nurses appears to be challenges such as mental health issues and addictions. In interviews with the Advocate, nurses discussed these complex issues and the struggle of the residents to cope with them in light of the community's limited resources. One nurse relayed that some of the residents have left the community for treatment; however, it is not always effective and there is a high incidence of relapse upon their return.

For the nurses at the community clinic, there is a sense of frustration and awareness that they can only help so much. One nurse stated:

> *And we're the ones, the nurses are the ones who are trying to provide band-aid treatments for everyone, and really we're… that's all we're doing. We're not fixing. We're not making the problems go away and we're not getting better lives for the children… And there's a lot of it going on up there. There's still lots of children at risk, lots of babies at risk* (Transcript of ACY Interview, 2014, p. 166).

Department of Child, Youth and Family Services

The challenges faced by CYFS in the provision of services were a product of both the community environment and issues within the organization. In an interview with the Advocate, a social worker provided insight to the challenges she has faced in trying to provide child protection services to the children and youth of this community.

For several years, there was only one social worker employed at the CYFS office in this community (Transcript of ACY Interview, 2014). As such, this social worker was responsible for multiple program areas; those under the Child Welfare program but also those under Youth Corrections and Family and Rehabilitative Services. In addition, for approximately six (6) years, there was no on-site clinical supervisor in this CYFS office. Subsequently, supervision and consultation could be a struggle (Transcript of ACY Interview, 2014). Often the clinical supervisor could not be reached for consult via telephone, so conversations would occur via e-mail. In an interview with the Advocate, a social worker indicated that the off-site clinical supervisor would make *"sporadic visits"* (p. 164) to the community (Transcript of ACY Interview, 2014).

The CYFS office in this community also employed community service workers (CSWs). A social worker explained in her interview with the Advocate that CSWs were local people hired by CYFS to aid in the delivery of services. This social worker went on to say that despite the presence of CSWs, she was still ultimately responsible for the files held by CYFS: *"All the files in [community] would have been assigned to me"* (Transcript of ACY Interview, 2014, p. 11). She would provide the CSWs with direction for work they completed on files; however, if the client and/or situation required it, she would become more involved. When the Advocate asked what training the CSWs had received, the social worker stated that they were not formally trained: *"- community service workers were expected to provide frontline social work and they were not qualified to do it"* (Transcript of ACY Interview, 2014, p. 76). This social worker elaborated by stating that the people filling these positions were great people to work with but they did not have the same *"professional assessment abilities"* (p. 76) that fully trained social workers did. When asked about the current CSW practice in the community, the social worker stated that the role of a CSW now is more supportive: *"… will do some very basic follow up with the client"* (Transcript of ACY Interview, 2014, p. 84).

In addition to directing the CSWs, the social worker indicated that when new social workers are hired, she spends quite a bit of time with them as they are typically new graduates and *"they require a lot of support"* (Transcript of ACY Interview, 2014, p. 38). While the addition of new social workers to this CYFS office is wel-

comed, the absence of an on-site clinical supervisor means that the social worker is relied upon by new workers to provide guidance and direction on files: *"I'm still spending 50 to 70 percent of my day with the other two social workers on Child Protection"* (Transcript of ACY Interview, 2014, p. 115). The social worker told the Advocate in an interview that they currently have an on-site clinical supervisor; however, at the time of the interview, this position was only being temporarily filled for three (3) months (Transcript of ACY Interview, 2014).

Being the sole provider of child protection services for a significant period of time in a community with such high needs meant there were a lot of expectations on this social worker. In addition to her many responsibilities in this community, she told the Advocate in an interview that she would often be called away for training or asked to provide services in other communities in Labrador: *"I may have been called away to investigate foster homes in [community], [community], [community], go and support a child in care in [community] following a suicide in his family"* (Transcript of ACY Interview, 2014, p. 19). The Advocate asked this social worker if she ever expressed her concerns to her supervisors and the social worker indicated that she had on multiple occasions; however, she did not get the response she had hoped for. In one instance:

> *… I had a supervisor say to me, you know, [other community] office is in such a mess. But I'm not worried about [this community] because [social worker] is there. And I'm like, well, you should be worried because I can't do this* (Transcript of ACY Interview, 2014, p. 37).

When asked by the Advocate about her caseload, the social worker indicated that while she is aware that the proposed standard ratio is one social worker for twenty (20) case files; she indicated that is not the reality in this community. This social worker told the Advocate in her interview of April 2014 that she currently has, on average, forty (40) to forty-two (42) case files but that number fluctuates with the number of staff present in the office (Transcript of ACY Interview, 2014). In 2006, this social worker reported that she had 42 cases but that number grew to 71 cases in 2008. While all her cases were important, the social worker indicated that this family was not the most severe:

> *… I can't help but compare it to other files, that there did seem to be more of a support network and… more eyes on [Kevin] because of his medical issues… there were other young children in the community who were quite healthy but were being severely neglected, that we were dealing with* (Transcript of ACY Interview, 2014, p. 79).

As the only social worker in the community for certain periods of time, when the social worker was away, service provision was often at a standstill. The remoteness of this community meant that travel, and subsequently time off from work, was sometimes required:

> *… people don't realize when you live and work in [community], if you have to go to a doctor appointment or if you have to see a dentist or get your eyes checked or whatever, that's at least three days away from work, because you have to spend the day [travelling] to… wherever you're headed, and have your appointment and then [travel] back. And certainly, I have experienced lots of weather delays* (Transcript of ACY Interview, 2014, pp. 18 – 19).

This social worker told the Advocate in an interview that at one time, she was on leave from work for several months. Despite this, the family's file remained assigned to her on CRMS as there was no other social worker in the community during that time frame (Transcript of ACY Interview, 2014). Subsequently, there was no activity on this file or documented contact with the family until a new social worker was hired and took over the file.

With regards to staffing, a social worker told the Advocate in an interview that this CYFS office has the funding for five (5) social worker positions; however, at the time of this interview only three (3) of these positions were filled (Transcript of ACY Interview, 2014). The location and the high needs of the residents in this community make recruitment for these positions difficult. In addition to that, the social worker stated that at times, the new hires have been misled in terms of what to expect upon beginning the new job. She reported that new hires have been told before they arrive in the community that they will receive benefits as part of accepting a position in a remote and isolated community. These benefits might include access to a motorized snow vehicle for personal use, a fully furnished home with amenities such as dishes, utensils and satellite television (Transcript of ACY Interview, 2014). She continued to say that upon arrival, the new hires do not always get what they were expecting or had been offered:

> *… after arriving… you're not allowed to use [motorized snow vehicle] for personal use… they might have two plates and a spoon… And the place is not clean when they move in. Quite filthy in some cases. Needing to be renovated…*" (Transcript of ACY Interview, 2014, pp. 135 – 136).

The resulting dissatisfaction along with excessive caseloads and workplace stress has led to many new hires leaving within a relatively short period of time.

A social worker told the Advocate in an interview that the creation of the new DCYFS has not resulted in improvements: *"… it seems to be even worse now that we've left Grenfell and we're with the department…"* (Transcript of ACY Interview, 2014, pp. 35 – 36). She indicated that there seems to be a disconnect between the staff who are trying to provide programs and services and the staff who are responsible for human resources. This social worker told the Advocate that she participated in a teleconference earlier this year with staff from the DCYFS and she relayed her concerns about staffing within this CYFS office. Despite this opportunity, the social worker is uncertain the issue will be addressed: *"… it's been on the radar for the last 20 years because people have been talking about it but… it's just not getting any easier"* (Transcript of ACY Interview, 2014, p. 41).

In addition to issues around staffing social worker positions, a social worker told the Advocate in an interview that this CYFS office was also without a secretary for *"a year or more"* (Transcript of ACY Interview, 2014, p. 36). The absence of an administrative support person meant that extra responsibilities fell to the workers who were present in the office. The social worker said that this affected productivity:

> *… they don't realize how disruptive that is because… when it was myself and either one social worker or a second social worker, we were told… you have to take turns answering the phone and… greeting people at the door, faxing, filing, whatever… it's a busy office* (Transcript of ACY Interview, 2014, pp. 36 – 37).

An additional challenge faced by this CYFS office is the provision of an on-call service to the residents of this community and others. In an interview with the Advocate, a social worker indicated that a formal on-call system started late in 2010 (Transcript of ACY Interview, 2014). Prior to this, an after-hours response was not always guaranteed. The current system covers several communities in Labrador and is operated on a rotational basis by the social workers in three (3) of these communities. The social worker explained that there are no social workers present in the other communities. The absence of a social worker poses a major challenge when an on-call response is requested: *"…you could be in [community] and receive a call about a serious incident in [community], where there is no social worker… then you're struggling trying to find other resources in the community that can go out and respond..."* (Transcript of ACY Interview, 2014, p. 217). This social worker indicated that often the only point of contact in those communities would be the police.

To further illustrate what it is like to work in a community with so many high needs families without the proper resources to provide required services, the social worker provided this analogy:

> *… imagine you're a constable and you're told, okay, you're going to work traffic duty on this very busy highway, and this is your territory. You've got this little off-ramp right here that can hold five cars. So your*

> *job is to stand there and flag any car going by that has issues; whether it's traffic violations or whatever… so you get there and you go, wow, yeah, this is a busy road. I'm pulling cars over. You can only put five, depending on the size of the vehicle there. Every single car you pull over triggers all of this paperwork and work assessments that you have to do for each one. While you're doing that your radio is on, constantly going off. And you could be called and say, oh, we need the stats on how many cars you pulled over yesterday. Also, we need the stats on how many cars you might have pulled over five months ago… and we need them ASAP because we get calls like that from the province all the time… then you may see a car coming that has smoke coming out of the engine. You know it's going to crash and cause a catastrophe, so what you do is you say, okay, we got to make space for this one, so I'm going to tell these three cars up front to leave. I am going to tell them to go to the depot three miles down the road. Someone is going to meet you there and walk you through the process of what you need to do to solve your issues. By the way, that person will be me. I just can't tell you when I'm going to get there. It could be tomorrow, it could be three months from now, it might not be ever. And so then you're pulling over this other one and you're dealing with that. So you never get to the other stuff. And that's what it's like* (Transcript of ACY Interview, 2014, pp. 50 – 51).

In 2006, 2008 and again in 2011, a social worker wrote letters expressing concerns regarding the challenges this CYFS office was having. In 2006, she wrote to the Chief Operating Officer of the LGRHA and sent copies to her program manager, the regional director of CYFS, the Chief Executive Officer (CEO) of the LGRHA and the Minister of the Department of Health and Community Services (DHCS). This letter was written in response to a *"memorandum from the [Minister of DHCS] and the CEOs of the Regional Health Boards inviting commentary from child protection workers… to share… views on how we are doing and where we can improve"*. In this letter, the social worker posed the question: *"Are children in [community] being adequately protected by Child, Youth and Family Services?"* She answered her own question, simply, *"no"*. She proceeded to explain her response, which included an overview of the community and the challenges facing the residents. She talked about the high rates of suicide and the cycles of generational abuse and neglect among many of the families, which are further complicated by poor coping skills and addictions. The social worker provided a summary of the caseload of that community's CYFS office and the staffing crisis they faced. She stated: *"I have worked here for [many] years and have never felt as uncertain in my capability to fulfill my role as a child protection worker as I do at present."* When asked in an interview with the Advocate

what response she received from this letter, the social worker reported that the only response was a telephone call from the regional director of CYFS. The social worker said that the regional director had indicated she *"could expect some feedback as to what improvements could be made in the future"* (Transcript of ACY Interview, 2014, p. 289). The social worker did not hear anything further.

In 2008, the social worker wrote another letter, which was addressed to her clinical supervisor and a copy was sent to her administrative supervisor. In her letter, she referenced her previous letter of 2006 and identified many of the same concerns. She again stated that she did not feel the children in this community were being adequately protected by CYFS. She provided a summary of the current caseload and the challenges faced by her as the only frontline social worker in the community. The purpose of this letter was to inform her clinical supervisor that she was unable to meet the demands of her position or fulfill the requirements of the child protection mandate *"due to the volume of work."* She indicated that case planning and documentation were suffering. Overall, the situation in that office had deteriorated since her letter of 2006. When the Advocate asked in an interview what response she received to this letter, the social worker reported that her clinical supervisor acknowledged via telephone that he received the letter but she did not receive anything from him in writing. She said she was assured that the provincial office was aware of the problems and they were working on recruitment and retention strategies (Transcript of ACY Interview, 2014). The social worker did not receive anything further.

In 2011, the social worker wrote a third letter in collaboration with her colleagues. This letter was addressed to her clinical supervisor and administrative supervisor and a copy was sent to the regional manager. Similar to the previous two (2) letters, this one also addressed the social workers' inability to adequately serve the residents of that community and to meet the expectations of the CYFS policies for best practice. Challenges were expressed throughout this letter highlighting the workers' inability to meet documentation standards and the subsequent lack of *"managerial understanding or support"* in meeting those goals. Staffing concerns were also mentioned; specifically, the lack of clerical support and the effect that had on office functioning. Finally, they wrote:

> *Morale and job satisfaction is at a low and stress levels are at an all-time high in this office. As professionals, we feel ethically and morally responsible regarding the quality of our work. The liabilities inherent in our child protection practice with clients weighs heavily on us as we are expected to address an overly-demanding volume of work at an impossible pace.*

When asked by the Advocate in an interview if a response to this letter was received, the social worker reported that there was no formal feedback received from any of the recipients (Transcript of ACY Interview, 2014). When the Advocate asked if she has seen any improvement since the 2011 letter, the social worker stated she had not in terms of the operations of the office. Additional social workers were hired but the office was without a secretary for about one year. As a result, the social workers were asked to *"take turns manning the front office and the phones"* (Transcript of ACY Interview, 2014, p. 301). The social worker also stated that the morale in the office was bad over the past year. The addition of the new on-site supervisor in the spring of 2014 was the biggest improvement; however, at the time of the interview, this position was only being temporarily filled for three (3) months. The social worker indicated in her interview that her wish is that any future supervisor coming to that office and the DCYFS would listen to the concerns expressed by her and other workers over the years and subsequently make the necessary changes: *"It just seems that we're so far away and isolated, that unless there's a terrible tragedy, no one pays any attention to us"* (Transcript of ACY Interview, 2014, p. 319).

The Advocate contacted the Deputy Minister of the Department of Child, Youth and Family Services in January 2015 to inquire about the supervisor position at the CYFS office in this community and was advised that the position is still being filled on a temporary basis. The person who is currently in the position is only in the community (i.e., on-site) two (2) weeks per month. The Deputy Minister indicated that the position has been, and will continue to be, advertised until it is filled on a permanent basis. Additionally, the Deputy Minister advised the Advocate in correspondence of February 2015 that the fourth social worker position was filled in the CYFS office in this community in April 2014 and recruitment is ongoing to fill the fifth position.

In February 2015, the Advocate contacted the Deputy Minister of the Department of Child, Youth and Family Services to confirm whether or not there was any further response or action taken as a result of the three (3) letters written by the social worker other than the two (2) telephone calls the social worker reported she received. The Deputy Minister responded in a letter that: *"Follow up was completed with the social worker in response to the letters of 2006 and 2008. In response to the letter of 2011, the direct follow up completed with the social worker is unknown."* Also in this letter, the Deputy Minister provided details of key initiatives that have been put in place to address ongoing concerns in the Labrador region.

Every child deserves appropriate and effective service delivery regardless of place of residence. However, when service provision is compromised as a result of contextual factors, either occurring in the community or within the organization itself,

those factors cannot be ignored. Those factors also cannot be used to excuse ineffective and inappropriate service delivery. Government departments and agencies cannot be complacent in their provision of services to isolated, rural and remote communities. Government departments and agencies cannot accept lower standards for the children and youth residing in these communities. Assessments of the needs of these communities have to be completed and government departments and agencies have to determine how they can meet the needs identified to ensure that every child and youth in Newfoundland and Labrador is receiving an acceptable standard of service provision regardless of where they live.

RECOMMENDATION 10

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.

Conclusion

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 needs of Kevin, Ryan and Sally and whether their right to services was upheld. It was evident throughout the course of this investigation that the needs of these children were not met, their rights were not respected and their right to services was not upheld. Despite the involvement of professionals from the DCYFS, DHCS, the LGRHA and the Department of Justice; the best interests of Kevin, Ryan and Sally were not at the forefront of service provision.

Kevin, Ryan and Sally lived in a small community and were quite visible to the service providers located there. The police and the staff at the community clinic were aware of the struggles the children in this family faced on an almost daily basis. Despite this, many serious concerns regarding the children's safety and wellbeing were not reported to CYFS. While the service providers admittedly were quite familiar with one another given the size of the community; collaboration and communication among these professionals was severely lacking.

In addition to the service providers operating independently of one another, each health and child protection intervention for this family was treated in isolation of previous interventions. Past diagnoses and treatments plans were not reviewed by clinic staff prior to new ones being made or prescribed. At times, important notes on the children's health files concerning allergies were overlooked creating a potentially dangerous situation upon prescription of certain medications. Previous Safety Assessments and Safety Plans were not reviewed by CYFS staff upon receipt of new referrals to ensure previous interventions had been adhered to by the children's caretakers prior to a new protection measure being put into place. In addition to this lack of comprehensive assessment, CYFS documentation was often incomplete and response to child protection concerns was delayed. Followup with this family was referral-driven and case planning was nonexistent.

Service provision in this community by the clinic and CYFS was severely impacted by issues occurring in the community and, in the case of CYFS, issues occurring within the agency. These issues need to be addressed. They can no longer be used as justification for acceptance of a lower standard of service provision for children and youth living in remote and isolated communities. Every child and youth in Newfoundland and Labrador has a right to receive services provided by the provincial government and this right to services must be upheld regardless of where in the Province they live.

The mandate of the ACY is to ensure that the rights and interests of children and youth are protected and advanced and that their voices are heard. It is in keeping with this legislative duty that the ACY reports on the investigation and makes recommendations based on its findings. The goal is to prevent any reoccurrence of a similar matter. After completing a Review or Investigation under the *Child and Youth Advocate Act (SNL 2001)*, the Advocate may, under section 15(1)(g), *"make recommendations to government, an agency of government or communities about legislation, policies and practices respecting services to or the rights of children or youth."* Based on the findings of this investigation and as identified in the body of this report, the Advocate for Children and Youth has made ten (10) recommendations. Pursuant to Section 24(1) of the Act, the Advocate will continue to monitor and follow up on the recommendations arising from this investigation until they are all appropriately addressed by the applicable government department or agency.

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Appendices

Appendix A

List of Acronyms used in this Report

Acronym	Official Title
AA	Alcoholics Anonymous
ACY	Advocate for Children and Youth
ARNNL	Association of Registered Nurses of Newfoundland and Labrador
CEO	Chief Executive Officer
CHA	Community Health Aide
CPR	Child Protection Report
CRMS	Client Referral Management System
CSW	Community Service Worker
CWA	Child Welfare Allowance
CYCP	Children and Youth Care and Protection
CYFS	Child, Youth and Family Services
DCYFS	Department of Child, Youth and Family Services
DHCS	Department of Health and Community Services
DHRE	Department of Human Resources and Employment
DHSD	Department of Health and Social Development, Nunatsiavut
DSS	Department of Social Services
Eastern Health	Eastern Regional Health Authority
ECG	Electrocardiogram
ENT	Ear Nose Throat Specialist
HCS	Health and Community Services
ISSP	Individual Support Services Plan
Janeway	Janeway Children's Health and Rehabilitation Centre
LGRHA	Labrador-Grenfell Regional Health Authority
MOU	Memorandum of Understanding
NLASW	Newfoundland and Labrador Association of Social Workers
PHN	Public Health Nurse
RCMP	Royal Canadian Mounted Police
RMS	Risk Management System
RNC	Royal Newfoundland Constabulary
UNCRC	United Nations Convention on the Rights of the Child

Appendix B

Mandates of Pertinent Service Providers

Department of Child, Youth and Family Services

In 1990, the *Child Welfare Act* was revised from its original version of 1972 to better address the welfare of children. The 1990 Act governed child protection services in the Province until 2000 when a new *Act* was implemented. It is evident that the provision of child protection services in Newfoundland and Labrador has undergone significant changes since that time. Up until 1997, the responsibility for child protection services was under the purview of the Department of Social Services (DSS). In 1997, the DSS was renamed the Department of Human Resources and Employment (DHRE). On April 1, 1998, the Department of Health and Community Services (DHCS) assumed responsibility for the policy direction of child protection services. The responsibility for the administration, management and service delivery of child protection services in Newfoundland and Labrador was devolved from the DHRE to a number of Health and Community Services (HCS) Boards.

This change coincided with the development and implementation of the *Child, Youth and Family Services (CYFS) Act* (SNL 1998), an *Act* that was not proclaimed until January 5, 2000. The policy that was developed under this legislation, *Child, Youth and Family Services Act Standards and Policy Manual* (in draft from 1999 until 2007), governed the changes from the previous DSS *Child Welfare Act* (SNL 1972). All other policy direction was guided by the DSS *Child Welfare Policy and Procedures Manual* (1993). The DHCS committed to ensuring this new policy manual would be consistent with the new legislation; it would acknowledge the new service delivery system through the various HCS Boards, and would incorporate current best practice knowledge.

Added to this commitment was the provincial focus on the need for improved risk management in child protection services. The DSS *Child Welfare Policy and Procedures Manual* (1993) included a risk assessment instrument. Reference No. 02-04-04 of the manual outlined the purpose of the tool: *"The risk assessment instrument attempts to standardize the questions asked by child protection social workers to assure that the decision making process is more objective, more consistent and therefore more accurate"* (1993, p.1). In 2003, *the Risk Management System* (RMS, 2003) was revised; it provided a *"standardized framework that would increase consistency and objectivity in the decision-making process"* (p.5). While the *RMS* was developed and disseminated to the regions in 2003, it was not fully implemented until April 1,

2005. The Risk Assessment tool was only available for use by social workers who had received training in *RMS*.

In 2005, further restructuring of the HCS Boards resulted in Child, Youth and Family Services coming under the four (4) Regional Health Authorities: Eastern, Central, Western and Labrador-Grenfell. Following implementation of the health authorities, the DHCS still did not have a direct reporting line from these agencies; however, the DHCS did develop, monitor and maintain responsibility for the policies and standards of practice within CYFS programs.

On March 9, 2009, the creation of the Department of Child, Youth and Family Services (DCYFS) was announced in the provincial budget. On April 9, 2009, the order was given by council in the House of Assembly to create the DCYFS. Transition legislation was assented to on May 28, 2009. This legislation put in force the minister's authority to direct each Regional Health Authority to continue to provide, carry out and administer CYFS services, responsibilities and programs until the region had successfully transitioned to the new department (Chapter 26, Statutes of Newfoundland and Labrador, 2009). From March 2011 to March 2012, the DCYFS transitioned approximately 800 CYFS staff from each of the Regional Health Authorities; beginning with the Western Region in March 2011, Central Region in July 2011, Eastern Rural in October 2011, Eastern Urban in November 2011 and concluding with Labrador in March 2012. A new CYFS organizational model was implemented within each region upon successful transition to the DCYFS. The new organizational model is meant to ensure frontline staff and managers have required tools and supports to effectively provide services to children and youth in need of protective intervention.

In 2011, new child protection legislation was proclaimed. *The Children and Youth Care and Protection (CYCP) Act (SNL 2010) replaced the CYFS Act* (SNL 1998). Section 8 of CYCP Act states the purpose of the Act: *"to promote the safety and well-being of children and youth who are in need of protective intervention."* The *CYCP Act* provides the legislative authority for the delivery of services to children, youth and families including: the Protective Intervention Program, services for children and youth in care, placement resources and the Youth Services Program. *The Protection and In Care Policy and Procedure Manual* (2011) contains policies guided by the *CYCP Act*. All interventions address children in need of protective intervention and a range of supports and services are provided to reduce risk to children and youth.

Documentation has been and continues to be an important tool for social workers working with CYFS programs. The Client Referral Management System (CRMS) is an electronic database used by social workers to record interactions with clients and other client information. Social workers enter service notes in CRMS and these notes document both the date the note was entered in CRMS and the date the inter-

action or activity referenced in the note occurred. According to the *CYFS Best Practice Guidelines for Using CRMS* (2002), all social workers were *"required to document all service notes in CRMS"* (p.5). In July 2012, the DCYFS updated documentation standards with the creation of the *CYFS Documentation Guide*.

All CYFS interventions from 2002 to 2010 for the children in this investigation provided under the Protective Intervention Program were subject to the *CYFS Act* (SNL 1998), *Risk Assessment in Child Protective Services* (1991) until 2005 when the *Risk Management System* (2003) was fully implemented in each Regional Health Authority, the DSS *Child Welfare Policy and Procedures Manual* (1993), the *CYFS Act Standards and Policy Manual* (1999), and the *CYFS Standards and Policy Manual* (2007). Services provided to this family were not subject to the *CYCP Act* (SNL 2010) or the *Protection and In Care Policy and Procedures Manual* (2011).

Protective Intervention Program

The Protective Intervention Program is designed to help ensure the safety and wellbeing of children for whom there is a risk of maltreatment, by omission or commission of a parent. Child protection legislation provides social workers with the legal authority to intervene to protect children under the age of sixteen (16). Referrals can be made by any individual or professional who is concerned that a child is or may be in need of protective intervention. Once a referral is received, the *Risk Management Decision-Making Model* (2013) is utilized to determine if a referral will be investigated in accordance with the definitions of a child in need of protection outlined in Section 10(1) of the *CYPC Act.* Once an investigation is complete, the social worker determines whether the child protection concerns are verified and if the child needs ongoing protective intervention. If no protection concerns exist, the file is closed. If protection concerns exist, the response can range from the provision of services to a child and his or her family through the development of a plan with the parent, to the removal of a child from the parents' care, depending on the nature of the concern and the degree of risk to the child.

A Child Protection Report (CPR) received under the *CYFS Act* (prior to June 30, 2011) was required to be assessed by a social worker at the intake level to determine whether or not further investigation was warranted. The *Risk Management System* (2003) guided the assessment process for referrals received. When determining whether a CPR was accepted for investigation, jurisdiction and reasonable grounds to believe a child was in need of protective intervention as defined in Section 14 of the *CYFS Act* (SNL 1998) were required to be met. Section 16 of the *CYFS Act* (SNL 1998) provided the authority to investigate. Section 14 of the *CYFS Act* (SNL 1998) defined a child in need of protective intervention as follows:

14. A child is in need of protective intervention where the child

(a) is, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent;

(b) is, or is at risk of being, sexually abused or exploited by the child's parent;

(c) is emotionally harmed by the parent's conduct;

(d) is, or is at risk of being, physically harmed by a person and the child's parent does not protect the child;

(e) is, or is at risk of being, sexually abused or exploited by a person and the child's parent does not protect the child;

(f) is being emotionally harmed by a person and the child's parent does not protect the child;

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

(h) is abandoned;

(i) has no living parent or a parent is unavailable to care for the child and has not made adequate provision for the child's care;

(j) is living in a situation where there is violence; or

(k) is actually or apparently under 12 years of age and has

(i) been left without adequate supervision,

(ii) allegedly killed or seriously injured another person or has caused serious damage to another person's property, or

(iii) on more than one occasion caused injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing, either with the parent's encouragement or because the parent does not respond adequately to the situation.

Support Positions

During the period of this investigation, the CYFS office employed Community Service Workers (CSWs) and Social Worker Assistants. At that time, the primary purpose of a CSW was to provide a wide variety of para-professional services in conjunction with social workers within Child Welfare, Community Corrections, and Family and Rehabilitative Services (Community Service Worker Position Description, CYFS, 2002-2010). Similarly, the Social Worker Assistant was responsible for assisting the social work staff with carrying out their work with children, youth and families in all program areas (Social Worker Assistant Position Description, CYFS, 2002-2010). Currently, a CSW and a Social Worker Assistant are both responsible for the provision of distinct administrative and supportive services to social workers, whose clients are receiving therapeutic interventions and services within the spectrum of CYFS. Both positions are considered professional support positions that assist social workers in the daily provision and coordination of activities necessary for effective client service delivery and case management (Community Service Worker and Social Worker Assistant Position Description Forms, 2011).

Department of Health and Community Services

The Department of Health and Community Services provides a lead role in policy, planning, program development and support to the four (4) Regional Health Authorities and other health and community service agencies. The Department monitors the Regional Health Authorities and agencies in respect to program implementation, accountability and health and community outcomes. The DHCS is involved in initiatives such as Wellness, Healthy Aging, Mental Health and Addictions, Violence Prevention, Immigration Strategy and Poverty Reduction. The Department is accountable for forty-one (41) pieces of legislation and ensures budget controls are in place and adhered to by the Regional Health Authorities and other agencies (Department of Health and Community Services, 2014).

Eastern Regional Health Authority (Eastern Health)

Eastern Health is the largest Regional Integrated Health Authority in Newfoundland and Labrador and provides a full continuum of health services. The vision of Eastern Health is to focus on both a community and individual approach to health. Eastern Health extends from St. John's to Port Blandford and includes the Avalon, Burin and Bonavista Peninsulas (Eastern Health, 2014). More than eighty (80) hos-

pitals, health care centres, long-term care facilities and community care sites can be found in this region. Eastern Health operates seven (7) acute-care facilities, including the Janeway Children's Health and Rehabilitation Centre (Janeway), six (6) community health centres, twelve (12) long-term care facilities, the Dr. H. Bliss Murphy Cancer Centre and the L.A. Miller Rehabilitation Centre (Eastern Health, 2014).

The Janeway Children's Health and Rehabilitation Centre (Janeway)

The Janeway is the only children's hospital in Newfoundland and Labrador and provides inpatient and ambulatory care to children from infancy to eighteen (18) years of age. Inpatient and outpatient child and adolescent psychiatry services are provided at the Janeway.

Labrador-Grenfell Regional Health Authority (LGRHA)

The Labrador-Grenfell Regional Health Authority (LGRHA) was formed in April 2005, with the merger of Grenfell Regional Health Services and Health Labrador Corporation. The Health Authority provides health and community services to the communities north of Bartlett's Harbour on the Northern Peninsula of Newfoundland and to all of Labrador; a total client population of approximately 37,000 people. Providing both primary and secondary health services, it operates twenty-two (22) facilities, including three (3) hospitals, three (3) community health centers, fourteen (14) community clinics stations and two (2) long-term care facilities.

In Aboriginal communities, the LGRHA is joined by the Nunatsiavut Government's Department of Health and Social Development (DHSD), two (2) Innu Band Councils, NunatuKavut (formerly the Labrador Métis Nation), Health Canada and private practitioners in delivering community health programs that meet the health needs of residents in the region (Labrador-Grenfell Health, 2014a).

Community Clinic

The Community Clinic referenced throughout this investigative report provides primary health care to the people of the community. It is staffed by Regional Nurses (I and II) as well as personal care attendants, a laboratory aide, a clerk and maintenance repair workers. The clinic has two holding beds, an incubator, a crib, basic

trauma and resuscitation equipment, as well as a defibrillator. In emergency situations, patients are transported to an appropriate medical centre (Labrador-Grenfell Health, 2014b).

In certain geographical areas of the Province where there is no access or limited access to a pharmacist, registered nurses are required to dispense prescribed medications as part of their scope of practice. As per the ARNNL *Dispensing by Registered Nurses* (1999) document and the *Labrador-Grenfell Health Community Clinic Services Policy and Procedure Manual*, nurses employed at this Community Clinic had the authority to dispense medications. In addition to dispensing, the regional nurses employed at the Community Clinic also had the authority to prescribe medications. In certain circumstances, nurses may be required to perform competencies outside the approved scope of nursing practice. Prescriptive authority is one of these non-delegated competencies. In certain practice settings, such as the Community Clinic, a nurse is able to initiate select treatments without a client-specific medical order but in accordance with the policies and procedures outlined in the *Labrador-Grenfell Health Community Clinic Services Policy and Procedure Manual.*

Department of Health and Social Development (DHSD), Nunatsiavut Government

The mission of the Department of Health and Social Development (DHSD) is to protect, promote and improve the health and wellbeing of the Labrador Inuit. This is accomplished through the provision of community-based programs and services, advocacy and collaboration. Since its formation, the DHSD has been working to create greater harmonies and efficiencies between health and social programs offered by provincial and federal governments and those offered by the Nunatsiavut Government. The DHSD renews its mandate annually based on consultation with Beneficiaries.

The DHSD has seven (7) community offices along the east coast of Labrador as well as a regional office in Happy Valley-Goose Bay. In one community, the DHSD also has a Status of Women Office that consists of a Status of Women Coordinator and a Project Coordinator and there is also a Division of Youth and Elders, which includes a Youth Administrator and an Elder Coordinator. The DHSD provides a range of programs and services to Nunatsiavut Beneficiaries including Healthy Children Initiatives, Additions Services as well as Home and Community Care.

At the regional level, the DHSD is responsible for oversight, policy development, program development and program implementation. At the community level, the DHSD community teams work closely with LGRHA to deliver health and social ser-

vices. In all communities these teams include a Public Health Nurse, Team Leader, Community Health Workers, and Child Care Workers. Mental health teams have also been created, with some communities sharing positions and/or receiving regularly scheduled services (Department of Health and Social Development, 2014).

Public Health

The focus of the public health programs of the DHSD is disease prevention and promotion of health in Nunatsiavut communities. The Public Health Nurse, with support from the other members of the community health team, offers various services at the community level including, but not limited to, immunization programs, sexual health promotion, and communicable disease awareness (Public Health, DHSD, 2014). In addition to the Public Health Nurse, a Community Health Aide supports and enhances the delivery of Public Health and Home and Community Care programs in the communities of Nunatsiavut. The Community Health Aide works closely with the Public Health Nurses as well as clients to achieve mutual goals of optimal health for the community and continuity of service (Community Health Aide Position Description, DHSD, 2008).

Department of Justice

(Renamed the Department of Justice and Public Safety on October 10, 2014.)

The Department of Justice is responsible for the administration of the Province's legal system. This includes the administration of the courts, policing, adult corrections, secure youth justice services, and victims' services. The Department of Justice provides policing services via two policing agencies: the Royal Newfoundland Constabulary (RNC) and the Royal Canadian Mounted Police (RCMP). The general public relies on the Department of Justice to protect their rights, liberties and freedoms. Civil services are provided to government through legal advice and representation in litigation. Those who are accused or convicted of criminal offences as well as victims of crimes receive services through the justice system such as police services, court services, prosecutions, legal aid, victim services and support enforcement (Department of Justice, 2014).

Royal Canadian Mounted Police

The Royal Canadian Mounted Police (RCMP) is the national policing agency of Canada; an agency of the Ministry of Public Safety Canada. It is responsible for fostering and maintaining peaceful and safe communities through a full range of policing responses. In Newfoundland and Labrador, pursuant to the Provincial Policing Services Agreement between the Province and the Federal Government, the RCMP is responsible for providing frontline policing services to approximately 60% of the Province's population in over 50 locations throughout the Province, often in rural and remote areas (Department of Justice, 2014).

Appendix C

Investigative Documents and Interviews

Investigative Documents:

Department of Child, Youth and Family Services

- Family's Protective Intervention File (2002 – 2010)

Department of Health and Community Services

- Labrador-Grenfell Regional Health Authority
  - Hospital File for "Kevin" (2002 - 2012)
  - Hospital File for "Ryan" (2006)
  - Hospital File for "Sally" (2007 - 2008)
  - Community Clinic File for "Kevin" (2002 - 2010)
  - Community Clinic File for "Ryan" (2006 - 2010)
  - Community Clinic File for "Sally" (2007 - 2010)
- Eastern Regional Health Authority
  - Janeway Children's Health and Rehabilitation Centre File for "Kevin" (2002 - 2013)
  - Hospital File for "Ryan" (2006)
  - Hospital File for "Sally" (2007)

Department of Justice

- Royal Canadian Mounted Police Records (2000 - 2010)

Nunatsiavut Government

- Public Health Nursing File for "Kevin" (2002 - 2009)
- Public Health Nursing File for "Ryan" (2006 - 2009)
- Public Health Nursing File for "Sally" (2007 - 2009)

Investigative Interviews:

Investigative interviews were completed by the Advocate with staff from:

- Department of Child, Youth and Family Services
- Labrador-Grenfell Regional Health Authority

Appendix D

Recommendations

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

Recommendation 1

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

Recommendation 2

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.

Recommendation 3

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.

Recommendation 4

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.*

Recommendation 5

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.

Recommendation 6

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 7

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

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).*

Recommendation 9

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.

Recommendation 10

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.

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