Blanket of Insecurity

December 2021

Office of the Child and Youth Advocate
Newfoundland and Labrador

Published by:

The Office of the Child and Youth Advocate
Newfoundland and Labrador
193 LeMarchant Road
St. John's, NL A1C 2H5

Printed by:

The Queen's Printer
Government of Newfoundland and Labrador

Message from the Child and Youth Advocate

I would love to see every child born into a life of hope, possibility, stability, and at the centre of the family who can wrap a cloak of love around this new little person. Good homes do not require riches. Good homes do not require perfection.

When a child is born into a precarious and unstable life, every effort must be made to ensure their world becomes safe, protective and nurturing. This cannot happen with the number of moves and placements this young child experienced from infancy. It runs counter to everything we know about building attachment and trust in a small child's world.

When children are removed or placed in an alternate care arrangement, their circumstances must improve. Their lives must be better. Their rights must be protected. This investigation does not provide a glowing grade of either.

Sadly, this child's experiences are not unique in that many children and youth experience multiple moves throughout their involvement with protection services. They have no sense of control or predictability, and their world can feel chaotic. When this occurs on the heels of unsafe and inappropriate care at home as a starter in life, there are big mountains for these children and youth to climb. It is not impossible to survive and thrive, but it is quite a trek.

I have made every effort to ensure this report does not identify this child and family. I ask that all readers respect the child's privacy.

Jacqueline Lake Kavanagh
Child and Youth Advocate

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Introduction

The Office of the Child and Youth Advocate

Newfoundland and Labrador's Child and Youth Advocate is an independent Statutory Officer of the House of Assembly. She derives authority from the **Child and Youth Advocate Act**. The role of the Advocate is to protect and represent the rights, interests, and viewpoints of children and youth in Newfoundland and Labrador. This is accomplished through individual advocacy, investigations and reviews, systemic advocacy, and children's rights education.

United Nations Convention on the Rights of the Child

The Office of the Child and Youth Advocate operates from a children's rights framework. Children's universal human rights are articulated in the **United Nations Convention on the Rights of the Child**. Canada ratified this Convention in 1991 with written endorsement and support from all provinces and territories. The Convention is the most universally accepted human rights framework in the world today. It speaks to the social, cultural, economic, civil, and political rights of children. Children's rights are real and meaningful. When these rights are protected and respected, they help children live better lives and have improved opportunities.

Investigative Process

Section 15(1)(a) of the **Child and Youth Advocate Act** provides the Advocate with authority to receive, review, and investigate a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the Advocate. The Advocate may release a public report upon completion of an investigation. The purpose of the report is to present findings regarding the services provided to young people and to make recommendations that will help prevent similar incidents from occurring in the future.

The investigative report does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the **Criminal Code** of Canada. It is intended to identify and advocate for systemic improvements and meaningful changes that will result in better responses, and enhance the overall safety and well-being of young people who are receiving designated services. It is not about finding fault with specific individuals.

The investigative process may include interviews under oath, review of reports and documents, file reviews, policy analysis, legislative considerations, consultation with experts, examination of critical issues, research, and other factors and evidence that may arise in the course of an investigation.

Case Summary

This child was born eight weeks premature with medical complications. Child protection authorities received its first of at least 14 referrals days after his birth. These referrals involved abuse and neglect. There were other concerns noted from various sources throughout the file. He was born into a family where there was family violence, drug abuse, mental health issues, and criminal activity. Some of these issues carried over and were present in the alternate care arrangements where he was placed. He experienced significant instability in his living and care arrangements with multiple moves in his first year alone. His parents' relationship was unstable and violent, with his mother seeking help from a crisis shelter before he turned two months old. After the relationship failed, the mother became involved with a man who had been previously charged with sexual offences against a young boy. The child lived in multiple care placements and arrangements. There was a lack of permanency planning. He missed many important medical appointments and was not properly administered his prescribed medications. He had unexplained injuries and there was suspected abuse. He exhibited sexualized behaviours. He had a high absenteeism rate from daycare, Kinderstart sessions, as well as from school. These myriad of concerns were persistent in the child's life, and were not necessarily about a unique point in time.

In this child's first year, there were several referrals involving violence between the parents. There were also concerns related to his supervision. Shortly after he turned one year old, the arrangement was that family members had the responsibility of supervising his time with his parents. When this proved to be ineffective, a warrant was obtained and he was removed and placed in a staffed home. The parents appeared to make progress and a supervision order was put in place.

CSSD returned him under a supervision order after six months in care. The parents ended their relationship soon after reunification. He remained with his mother. Concerns regarding supervision, exposure to dangerous individuals and drug use continued. In fact, there were ongoing concerns about the mother's drug abuse and on multiple occasions she failed drug screens with results showing she tested positive for cocaine, opiates, oxycodone and marijuana.

This child was placed with extended family under a safety plan for four months, after which time a kinship arrangement was approved. Social workers visited the child regularly at school and at the family members' home.

Concerns surfaced about his medication. A blood test and urinalysis confirmed the absence of prescribed medication. The kinship was terminated due to medication mismanagement. Specifically, there were incidents of missing prescription pills, and this was verified by a pharmacist on one occasion. CSSD had a strong suspicion that his medication was being sold or misused. The kinship providers were added to the existing protection file. Despite their assurances there would be no issues with the child's prescription going forward, the concerns continued.

CSSD began working with the mother toward reunification. Visits between the mother and child were supervised by an agency and reportedly went well. Unfortunately, concerns related to medication mismanagement for the child were also identified during visits with his mother. A risk assessment showed the child would be considered high risk if returned home. Despite the risk rating, it was decided at a legal case conference shortly thereafter that the child would return to the mother's care under a Supervision Order.

Due to concerns related to drug use, exposure to dangerous individuals and improper supervision, CSSD implemented an out-of-home safety plan with a family member shortly after the child returned home. When they found evidence of potential physical abuse, a court warrant was obtained and he was again removed from his mother. During the standard placement medical, the doctor questioned why the child had been diagnosed and prescribed medications for ADHD without appropriately being followed by a pediatrician. CSSD also learned that the child had missed important appointments in neurology, cardiology and the lifestyle clinic during his time in care.

CSSD applied for temporary custody and protection concerns continued during the months before court. The mother also regularly missed important appointments and visits with him. The visits that did take place did not go well. The application for temporary care was amended and CSSD applied for continuous custody. At a legal case conference to discuss the application for continuous custody, the mother indicated she did not want her child out of her home permanently. She agreed to work with CSSD. She attended all visits and the quality of these visits improved. She also completed recommended programs and began counselling. Six months later, the child returned home.

Findings

a. Kinship Placements

CSSD sought alternative placements and care arrangements for this child because his home environment was deemed unsafe. However, there were serious concerns noted in the file about the safety of the family home where he was placed. When concerns arose regarding medication mismanagement, the kinship agreement was terminated, yet he remained in the home for months. With this placement deemed high risk and his mother's house deemed high risk, he was eventually removed. A thorough initial kinship assessment and effective ongoing monitoring would have identified significant and important information about the extended family, some of which had been previously presented to both social workers and police.

b. Stability/Permanency

Stability and permanency are significant factors in determining a child's best interest. The ultimate goal of permanency planning is to ensure a secure environment with lifelong bonds that will support the child into adulthood. Unfortunately, the child did not have a stable home environment. In his first year, he lived with his parents and paternal grandmother, required emergency shelter when his mother sought help for family violence, resided with his mother and maternal grandmother, and had placements in a staffed home, a foster home, and a caregiver's home. He spent more than two years with extended family members. He spent years outside his parents' home without a temporary or continuous custody order.

c. Education/ Absenteeism

His absenteeism from daycare (58 of 131 days) was a precursor to his excessive unexcused absences from school. Unfortunately, his case is clearly illustrative of the message in the Child and Youth Advocate's report "Chronic Absenteeism: When Children Disappear" which spoke to the frequent complex underpinnings of school absenteeism and the need for holistic multi-disciplinary responses. The report identified absenteeism as a potential indicator of significant concerns about neglect, abuse and serious issues at home, which are beyond the ability and mandate of schools to address and require protective intervention. This case provides such an example.

In attempts to engage CSSD, the school guidance counsellor rightly reached out to CSSD in 2015 to advise of excessive absenteeism, low maturity, and poor emotional regulation. Late in 2015, the school reported to the social worker that he missed 82 days of Kindergarten. In 2016, his teacher contacted CSSD to inform that he had missed 37 unexcused days between January and May and exhibited atypical behaviour. In 2016, his teacher contacted CSSD about her concerns regarding his behaviours, language delays and poor academics. This information, in the context of his known life experiences and protection needs, should have been a glaring message that major collaborative intervention was required for this little boy.

Due to frequent moves/placements, he changed schools several times. This created further disruption and instability in his life. It further demonstrates the importance of permanency and child-centered planning which necessarily involves muti-agency collaboration.

Recommendations

Recommendation #1:

The Department of Children, Seniors and Social Development verify the history of extended family when determining suitability of placing a child with extended family and ensure this is documented.

Recommendation #2:

The Department of Children, Seniors and Social Development review and clarify its commitment beyond financial support when out of home safety plans and kinship placements are engaged on behalf of a child.

Recommendation #3:

The Department of Children, Seniors and Social Development clearly identify immediate steps to mitigate risk to a child when a kinship agreement is terminated because it is no longer considered safe or appropriate for the child.

Recommendation #4:

The Department of Children, Seniors and Social Development conduct an audit of all long-term out-of-home placements, including kinship placements, to identify and address factors impacting permanency for these children.

Recommendation #5:

The Department of Children, Seniors and Social Development give greater consideration to reports and communications from teachers and school authorities when protection concerns exist for the child.

Final Thoughts

This report examined the responses provided to a child with complex needs which included safety and protection, health and education. Frequent moves and multiple caregiver arrangements in this young child's life were clearly problematic, however placement with caregivers who did not have the child's best interests at heart provided further threats to his well being. He did not experience a sense of security. In fact, insecurity and uncertainty was his foundation in life.

When this child's situation in life and the responses and services he received are assessed against the United Nations Convention on the Rights of the Child, there are clear deficiencies in upholding his rights. A child's best interests must guide decision making and responses. Every child has a right to be protected from physical and mental harm. Every child has a right to live with and be raised by parents unless it is not safe. Any alternate care arrangement must be safe must be reviewed regularly to ensure it is best for the child. Every child has a right to a safe home. Every child is entitled to quality health care and education. Every child has a right to be protected from drugs and the drug trade. Gaps existed in protecting this child's rights.

Public services are not static and they change over time. While efforts are being made to improve responses to children in need of protection, issues raised in this report continue for far too many children and youth. While this report focused on one child, it is about more than one child. Systemic change is required.

Appendix 1: References and Resources

Children, Youth and Families Act, SNL 2018 CHAPTER C-12.3

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Rumberger, Russell. W. (2017). *Student Mobility: Causes, Consequences, and Solutions*. University of California. Retrieved from https://nepc.colorado.edu/publication/student-mobility

Appendix II: Investigative Documents and Interviews

Documents Reviewed

Department of Children, Seniors and Social Development

- Protective Intervention File
- In Care File
- Kinship File

Department of Health and Community Services

- Regional Health Authority Files
- Hospital records

Department of Education

- School District File

Investigative Interviews

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