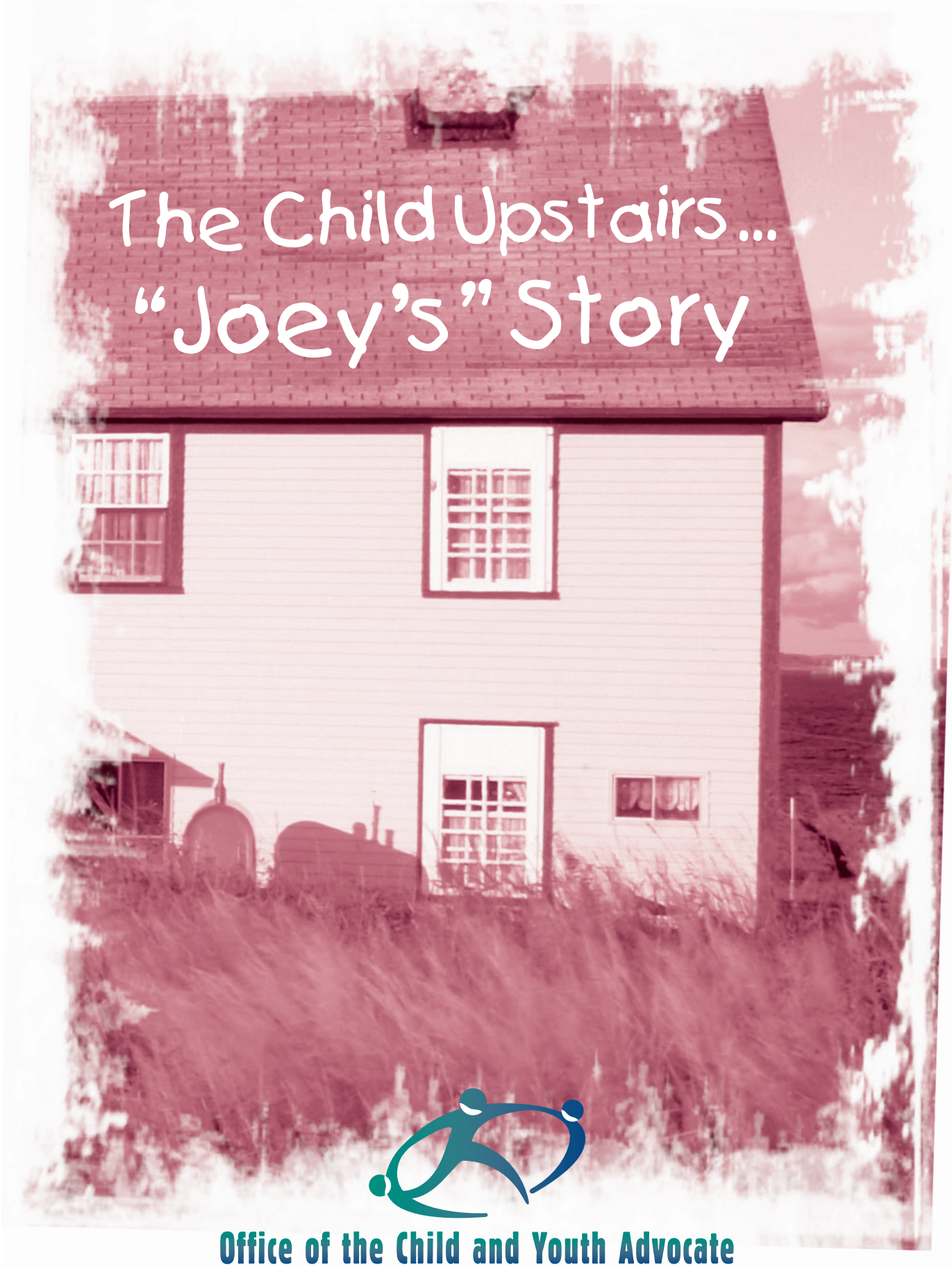
The Child Upstairs...
"Joey's" Story



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

The Child Upstairs…
"Joey's" Story.

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Disclaimer

Prior to being appointed Child and Youth Advocate, I held the position of Director of Children's and Women's Health at Eastern Health. In that capacity, when the investigation was called by the Advocate in 2006 into "Joey's" case, I reviewed his medical records and assisted in providing them to the Office of the Child and Youth Advocate. The care provided to "Joey" by those who reported to me at Eastern Health was never the subject of the investigation.

Carol A. Chafe
Child and Youth Advocate

"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace."

- Kofi Annan

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Confidentiality Caveat

Section 13 of the *Child and Youth Advocate Act* states:

(1) The advocate and every person employed under him or her shall keep confidential all matters that come to their knowledge in the exercise of their duties or functions under this *Act*.

(2) Notwithstanding subsection (1), the advocate may disclose in a report made by him or her under this *Act* those matters which he or she considers it necessary to disclose in order to establish grounds for his or her conclusions and recommendations.

(3) A report the advocate makes under this *Act* shall not disclose the name of or identifying information about a child or youth or a parent or guardian of the child or youth except and in conformity with the requirement of subsection 29(2).

Subsection 29(2) states: The advocate shall not include the name of a child or youth in a report he or she makes under subsection (1) unless he or she has first obtained the consent of the child or youth and his or her parent or guardian.

Foreword

Since my appointment on September 27, 2010 as Child and Youth Advocate for Newfoundland and Labrador, I have become increasingly aware of the various harmful and potentially harmful situations that too many of our children and youth endure on a daily basis. It goes beyond comprehension how those we most expect to be loved and cherished as the vulnerable persons they are, are so often let down by those they are the most dependant on.

Fortunately, there are many government services and departments dedicated to addressing these unacceptable situations for our children and youth. There are many professionals in various areas of service who ensure prevention and protection so that our children can become educated, healthy and productive adults. Unfortunately, as with any aspect of humans and systems, there are always the imperfections that can lead to errors, mistakes and negative outcomes.

Along with the three outstanding files for investigation that have not been completed by this office since 2005, there are current cases and files that we are actively reviewing and advocating for on a daily basis. Unfortunately, it is evident to all of us in the Office of the Child and Youth Advocate that there are consistent themes identified when we review various cases. These themes cross various services and professions but ultimately can be identified as deficiencies in the use of fundamental principles. Principles of assessment, communication, consultation, documentation, adherence to policy and collaboration that should always happen but, as evidenced, do not.

Unless and until these fundamental principles are adhered to, the children and youth of this province will continue to be at risk. That is why every child's story must be told and every effort must be made to continue to improve. There must always be best practices to provide the best services to our children and youth.

I gave a lot of thought to the purpose and effectiveness of now completing three investigations of cases that occurred over six years ago and came to the conclusion that, while it is unfortunate that time has passed, it is always important that every child's story be told and ultimately improvements made to ensure another child does not suffer.

This is the first of the outstanding investigations which tells the story of a young boy whom we have named "Joey", for reasons of confidentiality, to ensure he is seen as the little child he is and not just another case or incident.

Carol A. Chafe
Child and Youth Advocate

Executive Summary

During the year 2006, The Office of the Child and Youth Advocate (OCYA) undertook this investigation after learning of a court sentence imposed on Joey's parents for failure to provide the necessities of life for their son. While all four of their children were subsequently apprehended, Joey, who was the youngest, was deemed to be in the most severe condition.

The events outlined in this report span a thirteen month period wherein several professionals had contact with the family on a number of occasions. By all accounts (covered herein), if enhanced record-keeping and information sharing had been cultivated, Joey's situation could have been pre-empted well before his admission to hospital.

The primary deficiencies identified in the system were:

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

The OCYA investigation gathered the pertinent facts and highlighted the necessary changes that would prevent the reoccurrence of such a case. This report provides an in-depth overview of the case. Overall, the recommendations include the development of definitive policies and protocols, systematic record-keeping, required information sharing, and enhanced collaborative approaches. Addressing these critical issues will provide the necessary safeguards needed to ensure a child's safety.

The OCYA is mandated to ensure that children and youth are protected by receiving appropriate attention to their needs. The Office also provides information to the stakeholders involved about the availability, effectiveness, responsiveness and relevance of services to children. The goal is that this report will help significantly diminish the likelihood of any similar situation in future.

Introduction

The OCYA began this review in 2006. The investigation was completed on June 9, 2011 after examining the events of a thirteen month period involving two program areas operated under the auspices of the Regional Integrated Health Authority (RIHA) organization. The circumstances surrounding the length of time the OCYA has been engaged in this investigation are complex. Despite this elongated time frame, the OCYA is responsible to provide due diligence to Joey and his siblings, to reveal the findings of this investigation, and to make recommendations to enhance services in the future.

On August 1, 2006, the Child and Youth Advocate at that time served notification to the Deputy Minister of the Department of Health and Community Services (DHCS) and to the Chief Executive Officer of the RIHA of her "intention to conduct a review into the circumstances surrounding "Joey", child of ---, given the family was receiving services from the [RIHA]". The details of this review were outlined in correspondence to the RIHA and the DHCS on August 1, 2006 (Appendix A). The review was conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act*, Statutes of Newfoundland & Labrador 2001.

The mandate of the OCYA is to ensure the rights and interests of children and youth are protected and advanced and that their views are heard and considered. In doing so, the Office may be required to review or investigate matters affecting those rights and interests. It is in keeping with this legislative duty that the OCYA reports on the examination and makes recommendations based on its findings. The goal is to prevent any reoccurrence of a similar matter.

The OCYA is legislated under Section 13(1) of the *Child and Youth Advocate Act* 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 parents as Mom and Dad, the children involved as siblings or the family, and the child (most affected) as Joey. The investigation deals in particular with the time frame of February 2003 until February 2004 wherein the two program areas were involved with the family.

It is important to state that the organization responsible for the Child Youth & Family Services (CYFS) Program, as well as the Public Health (PH) Nursing Program, has undergone significant changes over the past fifteen years. Prior to 2005, both programs came under the auspices of a regional community-based board known as Health and Community Services (HCS). The responsibility for policy and standards for the programs fell to the DHCS. Since 2005, these programs have been operating under the umbrella of the RIHA. The OCYA

investigation examines the programs and services in place during the time they were the responsibility of the legacy organization, namely HCS.

This report contains numerous and various acronyms in use throughout the system, both before and after the changes; official agency names are detailed in Appendix B.

Methodology

The OCYA called a review into the case of Joey and his family as per Section 21(1) of the *Child and Youth Advocate Act*. In order to gain a comprehensive picture of the family circumstances, information was obtained from a variety of sources.

Documents relating to the services provided to the family and case files from both program areas, CYFS and PH Nursing, were provided by the RIHA. These documents were thoroughly reviewed by the OCYA. The examination of existing policies and relevant legislation helped to determine the expected standards of service and intervention.

Direct interviews were conducted with several employees from CYFS and PH Nursing with the RIHA. Written submissions were also requested from certain employees to further explain the circumstances around communication, or any lack thereof, as well as the changing dynamics of the various agencies involved. Statements of decision makers from the RIHA and the DHCS were gathered to understand the unaddressed issues and the subsequent actions that should have been taken. Several key witnesses gave testimony about their pertinent involvement in the case; those transcripts were also reviewed.

Refer to the bibliography for a complete list of the publications and documents that were requested and submitted for this review.

Mandates of Pertinent Service Providers

Child, Youth and Family Services

Under the *Child, Youth and Family Services Act* (SNL1998), the Protective Intervention Program provides social workers with the legal authority to intervene on behalf of children under the age of sixteen (16) years when child protection matters come to their attention. A referral can be made to CYFS by any individual or professional who has concerns that a child may be maltreated or may be at risk of being maltreated by a parent. Once a referral is received, it is dealt with based on the specific and applicable subsection of the *Act*. If warranted, an assessment or an investigation is started and the risk management process is used. The action taken by a social worker depends on the outcome of the risk assessment. If it is determined that there are no child protection concerns, the case is closed. A family can voluntarily request assistance or be provided with supports or referrals for other services. If there is risk, the responses range from ongoing service to a family or child to the removal of a child from the parents' care depending on the severity of the concerns and if risk to the child is imminent.

Referrals:

When a referral is received by CYFS, a social worker must assess the referral information at the intake level to determine whether or not the referral will receive further investigation. Section 14 of the *Child, Youth and Family Services Act* provides the definition of a child in need of protective intervention.

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. (1998 cC-12.1 s 14)

The provision of child protection services under the CYFS program in Newfoundland and Labrador has undergone significant changes over the past fifteen years. Prior to April 1998, the responsibility for the administration of these services fell to the Provincial Government Department of Human Resources Labour and Employment (HRLE) and its predecessor, the Department of Social Services (DSS). On April 1, 1998, the responsibility for the administration, management and service delivery of child protection services in the Province of Newfoundland and Labrador was devolved from the Province to a number of community-based regional Health Boards. This change coincided with the development and implementation of the CYFS *Act* (SNL 1998), an *Act* that was not proclaimed until 2000. The new policy, CYFS *Act* Standards and Policy 1999 (in draft from 1999 until 2007), that accompanied this legislation governed the changes from the previous DSS *Child Welfare Act* (SNL 1972). All other policy direction was guided by the DSS 1993 Child Welfare Policy and Procedures Manual (see page 1 of CYFS Standards and Policy Manual 1999 - draft).

These changes in legislation, policy and administration created the reality that child protection services was governed by two policy documents during the period December 1998 - March 2007, a time frame that includes the thirteen (13) month period of this examination. From interviews conducted with management staff of the DHCS, the commitment from that Department and HCS was that the existing DSS 1993 Child Welfare Policy Manual would be updated. It was to be consistent with the new legislation, acknowledge the new service delivery system through the community-based Health Boards, and to incorporate current best practices knowledge.

Added to this commitment was the provincial focus on the need for improved risk management in child protection services. In 2003, the Risk Management System (RMS) was revised; it provided "a standardized framework that would increase consistency and objectivity in the decision-making process" (RMS - CYFS 2003, p.5). Specifically, the direction in risk management, particularly in protective intervention cases, is "to assess risk to children through

the development of respectful relationships with children and families" (HCS Memorandum August 17, 2005). While the RMS was developed in 2003 and disseminated to the regions, it was not fully implemented until April 1, 2005. All social workers in the regions had to receive training before they could use the RMS. Until the social worker received training in RMS, only the Risk Assessment Tool was available for use by social work staff who were trained to use that Tool.

During the period 2003 -2004, the DSS 1993 Child Welfare Policy and Procedures Manual specifically stated: "The overall mission of the Child Welfare System is to protect children, to meet the basic and developmental needs of children and to support parents in their parenting role. The philosophical framework of the CYFS *Act* represents the manner in which services should be delivered to children and youth and families" (01-01-01).

In 2005, further restructuring of the community-based Health Boards resulted in CYFS coming under four regional integrated health authorities, namely: Eastern; Central; Western, and Labrador/Grenfell Health Authorities. Following implementation of the Health Authorities, DHCS still did not have a direct reporting line from these agencies but the Department did develop, monitor and maintain responsibility for the policies and standards of practice within the CYFS programs.

The CYFS *Act* and all programs and policies related to this *Act* have as their primary theme, "the protection of the child" and the promotion of the "best interests of the child". Section 9 of the CYFS *Act* identifies the best interest principles, the foundation on which the 1998 legislation is built.

Public Health Nursing

According to the PH Nursing Program Policies and Guidelines, the Healthy Beginnings Program is a voluntary program that is available to families at any time until their child enters school. Services range from postnatal followup to immunizations, breast-feeding support, and preschool assessments. To access services for a newborn and for postnatal followup, the process commences at the hospital and continues to the community level. Referrals may also be received from parents and other professionals.

Referrals:

Step 1
A Live Birth Notification Form is reviewed by a Community Liaison Nurse at the hospital upon birth and this Form is sent to the PH nurse to be used for postnatal followup. Prior to client discharge, the Community Liaison Nurse completes the

Priority Assessment sheet and scores the family as minimal to high priority for PH Nursing to follow up and continue the assessment process.

Step 2
The family is referred to PH Nursing after client discharge and contact is initiated based on the priority assessment score. The PH nurse also attempts to determine the level of service as well as any other postnatal needs and the willingness of the family to participate.

Step 3
If the family accepts postnatal service, a file is opened and the family and the child are followed under the Short Term Healthy Beginnings Program. Regardless of the priority assessment score, if a family refuses contact, the file is closed and the PH nurse makes no further contact.

Step 4
When contact with a family is successful and PH Nursing deems more long term support is needed, a Long Term Healthy Beginnings file is opened. The file can close when the family withdraws from service or the PH Nursing supports are no longer required or, as is normally the case, when the child enters kindergarten.

In 1998, community-based nursing and continuing care programs came together with social work programs from the provincial HRLE. These programs and services became the responsibility of community health boards throughout various regions in Newfoundland and Labrador. Included in this amalgamation was the delivery of PH Nursing services. As explained by management within the RIHA Board, the PH Nursing Program offers services designed to protect and promote the health of individuals and communities. These services include, but are not limited to, education and support for pregnancies, birth and early parenting, and the Healthy Beginnings Program. The main focus is to work with individuals and families to achieve an optimal level of well-being. The programs support healthy lifestyles and create supportive environments.

Similar to the philosophy of CYFS, the Healthy Beginnings Program is grounded by its own philosophical underpinnings. The foundation is anchored by the recognition that health is determined by complex interactions between individual characteristics, social and economic factors, and physical environment (Healthy Beginnings: Supporting Newborns, Young Children and Their Families Program Plan, 1998, p.1). The age when potential risk from these determinants is identified will influence the health outcomes of children. The early identification of risk factors and subsequent interventions is supported as a key component for enhancing healthy growth and development of children.

It is important to specify that unlike CYFS (Child Protection Services), the Healthy Beginnings Program is neither mandated nor legislated; involvement in the program is strictly voluntary.

Background of The Family

This family resided in a rural community in Newfoundland and Labrador. The youngest member of the family was Joey, the primary subject in this investigation.

This family first came to the attention of HCS, in February 2003, when a referral was received by CYFS. The referral was screened out and no action was taken – the reason cited: "…information does not warrant CYFS intervention; unable to contact; no phone listing". Over the next year, three additional referrals (October 2003, January 2004, and February 2004) were made to CYFS and these referrals were assigned for investigation.

In 2003, when Joey was born, a referral was sent to the PH Nursing Healthy Beginnings Program. Attempts were made to contact the family by telephone however the number Mom had provided belonged to the grandparents. Twice the PH nurse left a message with the grandmother but no return contact by Mom was forthcoming. The grandmother also indicated she was not sure of their address. PH Nursing forwarded a letter to the grandparents' address that was returned unopened, and the file was closed. When CYFS received their second referral about the family in October 2003, one of the actions undertaken was to send another referral to PH Nursing during that same month asking that they follow up with the family.

This case occurred over a thirteen (13) month period and resulted in the removal of all four children from their parents' care. (To view critical intervention calendar dates, see Appendix C.) Joey was hospitalized for a lengthy period of time with failure to thrive secondary to malnutrition. All the children were placed in the care of the Director of CYFS of HCS.

Facts Provided

Joey was born in 2003 in the Province of Newfoundland and Labrador. Hospital records indicate a birth weight of 3430 grams (7.5 pounds), which is considered to be within the normal range. Prior to Joey's discharge from hospital, an assessment was completed by the PH nurse and a referral to the Healthy Beginnings Program (short term) was completed. These assessments are routine and part of the hospital nursing discharge process. The Live Birth Notification form was reviewed by the PH nurse to determine Joey's priority score. Based on factors such as child development and family interaction, an overall priority score is attributed which falls within four categories:

9 or over – high priority
5 to 8 – moderate priority
3 to 4 – low priority
0 to 2 – minimal priority (Live Birth Notification, 2002)

This rating assists in determining the level of support required from the Healthy Beginnings Program and the involvement of the PH nurse in determining the need for short term followup. In this family, a Priority Assessment Score of six (6) was assigned to Joey. This moderate priority score was based on documentation that cited social reasons. Upon discharge, a referral was forwarded to the PH Nursing Program to be actioned by the community PH nurse where the family resided. The Live Birth Notification indicates this assessment was completed within a few days of his birth. Joey's weight on the day of discharge was 3860 grams (8.5 pounds).

In a submission to the OCYA, PH Nursing notes reveal a number of attempts were made to contact this family for followup over the next several weeks. These attempts included four telephone calls to the number provided on the Live Birth Notification. It was later learned the telephone number that had been recorded belonged to the grandparents. Information was later received that there was no direct phone number for the family. A voice message was left on the grandparents' line asking Mom to contact the PH nurse; she did not return the call. The final attempt at reaching the family was made through a letter to the grandparents' address requesting that contact be made. The PH nursing file indicates this letter was returned unopened. As per Section 4.4 of the PH Nursing Healthy Beginnings Program Plan (1998), the family was discharged from the Program.

The first time this family came to the attention of CYFS was on February 14, 2003. Information was received by CYFS alleging the family was residing in a home with no beds for the three children, little food available, unclean conditions and poor hygiene with respect to the children. The referral source also said the children were wearing dirty clothing while the parents were using

money to purchase drugs. The mother was identified as being six months pregnant (with Joey). CYFS assessed there was little identifying information and questionable motivation by the referral source; therefore, consensus was reached that: "the information does not warrant CYFS intervention" (Child Protection Report, February 14, 2003). It was suggested at the time that the informant get more specific information and call back.

The Child Protection Report dated February 14, 2003 was screened out on February 17, 2003. A notation dated January 23, 2005 indicated: "this referral was found a couple of months ago by an Intake worker" and that "the referral is to be placed in the file". A note on that file indicated the referral of February 14, 2003 was not available for review until January 2005.

A second referral was received by CYFS regarding the family on October 7, 2003. The Child Protection Report indicated the referral source was concerned about the oldest child in this family who had presented at school having had nothing to eat that day. Referral information further indicated the parents had not gotten up to get this child ready for school. Apparently, a similar incident had happened the week before; Mom's explanation was that there had been a scheduling mix-up, on her part, regarding the start time of the kindergarten class. The child had also commented on an incident whereby she picked up her baby brother and brought him downstairs because her mother was not feeling well.

This referral was viewed as genuine and the information was assigned for assessment under Section 14(k)(i) of the CYFS *Act*. The information was assigned and an investigation initiated within 24 hours as per the Priority Response Rating: "dangerous but not life threatening", of the 2003 CYFS RMS. The assessment began with an interview of Joey's sibling on October 8, 2003. From her assessment, the social worker concluded that mom did not provide breakfast on the morning in question because she had forgotten but she usually gets up with the children. Mom also cleans the house and cooks meals. The other children sometimes care for the baby brother and play with him. There were no other concerns documented from this interview.

A home visit was completed immediately after the interview. At that time, the father was present with three children. The Client Referral Management System (CRMS) notes dated October 8, 2003 outline the discussion. These notes also refer to three children being present in the home at the time the visit took place. A young female child was watching television while another young male child was upstairs sleeping. Joey was sleeping in a playpen in a room just off the living room. The specifics of the family dynamic were clarified during this home visit. Dad explained that he is the biological father of the two younger male children and his girlfriend's two older female children belonged to another man. The concerns were discussed with Dad because Mom had not returned from her visit to his parents' home nearby for the purpose of using the phone. The issues

discussed included: the oldest child not having had breakfast; Mom not getting up with the child; the oldest child's responsibility for her younger siblings, and adequate and appropriate supervision of the children. The social worker's file documentation indicates that Dad verified they had indeed slept in the previous morning but this was not a regular occurrence. Fatigue, as reported by Mom, had been a longstanding issue for her due to the presence of a chronic anemic condition. This fact, coupled with having the primary responsibility for four children under the age of six, made child care quite taxing. In addition, Mom was in receipt of Income Support and was trying to maintain the family on a limited amount of money. They were finding the food supply getting quite low at the end of a two week period; however, they were utilizing the food bank system to help bridge the gap between cheques. The social worker conducted a visual check of the food supply and there was some food available for the family. During the visit, Joey's older brother woke from a nap and was given juice.

In another file note, it was stated there was a subsequent telephone conversation with Mom and she recounted the same information obtained during the home visit. This included a definitive declaration by Mom that the children are never left alone. Some concern was raised by Mom regarding the truthfulness of one of the children. Documentation indicates they had experienced this child being dishonest and both parents believed this was a result of a recent visit with her birth father These visits were sporadic but on this occasion, the child's behavior had been deteriorating since her return.

Several types of supports and services were discussed pertaining to the eldest child's needs and behaviors and to the children in general. According to the CYFS file, it was agreed that the following actions were required to assist the family situation:

- a referral to PH Nursing to update all of the children's immunizations as well as to obtain counseling on nutrition for young children;
- a referral to the Hospital to assess behavioral difficulties being experienced with the eldest child, and
- contact with the school to support an Individual Services Support Plan (ISSP) process for the eldest child.

The parents also committed to the purchase of a safety gate to ensure the children had no unsupervised access to either floor in the home. While the situation did require some intervention, it was assessed the parents were cooperative and the children were not at risk.

A referral was made by the CYFS social worker to PH Nursing on October 15, 2003. Contact was made with Mom by PH Nursing and an appointment was set to administer Joey's first immunization, which was significantly delayed, and to begin nutritional counseling. During this appointment, an assessment of Joey was completed. A PH nurse, who was providing relief at the Clinic, completed the assessment and an examination of the documentation indicates this relief nurse was unaware of the CYFS referral. The PH Nursing Progress Note and

the Child Health Clinic Flow Sheet both indicated Joey's weight, head circumference, length and his weight/height ratio. The weight/height ratio placed him below the 5th percentile for his gender and age, meaning that for a male child his age, Joey was underweight relative to his height. The Flow Sheet indicated Joey weighed 5650 grams (12.4 pounds), a total weight gain of four pounds since his discharge from hospital. The nurse did question how much the child was consuming and was told by Mom that Joey was being fed forty (40) ounces of baby formula daily, supplemented with baby food and regular food. The nursing notes reflect questions being asked about family characteristics to explain the child's low weight/height ratio. Information was provided to Mom regarding adequate feeding amounts and the importance of proper nutrition. Joey was immunized and Mom was asked to wait to ensure there was no adverse reaction.

During Mom's wait, the regularly assigned PH nurse returned to the Clinic; she reported further discussing with Mom nutrition, feeding and family history. Mom appeared very interested in doing what was best for the family and asked questions about specific foods (HCS Progress Note). In her written submission to the OCYA, the assigned nurse noted that she reviewed the feeding schedule and its contents with Mom and advised her to increase the feeding amount and to have Joey re-weighed in seven (7) days either at the Clinic or by a physician. This was agreed to by Mom even though transportation was problematic. Based on her recollection of the visit, it appeared to the assigned PH nurse that Mom was genuine, and being experienced with three older children at home, it was the PH nurse's belief that Mom would act responsibly regarding the children's care. The assigned PH nurse also documented from recollection that during the clinic visit, "Joey was awake and bright and alert with sparkling eyes" (PH Nursing written narrative, submitted June 4, 2006, p.5). The assigned PH nurse also stated in the same narrative there was no Long Term Healthy Beginnings file on this family because they had been previously discharged from the program.

Although there is no documentation in the PH Nursing notes, the written submissions from both nurses about their conversation that day suggest confusion and miscommunication. The relief nurse stated she had told the assigned nurse that Joey's weight/height ratio was below the 5th percentile; however, the assigned nurse indicated she did not hear that comment. Additionally, the assigned nurse understood that the relief nurse who conducted the clinic visit would be responsible for following up with any referrals arising from Joey's assessment. Alternatively, the relief nurse thought the assigned nurse would conduct the followup.

Three (3) weeks later, Mom attended a Clinic with an older female sibling of Joey's for her preschool health check. During this time, Joey was not present but the PH nurse made a general inquiry about him. According to the nursing notes dated for the same day, Mom explained that Joey was "a big baby now and he had gained a lot of weight". On this date, the PH nurse rescored Joey's

original Priority Assessment Score (Live Birth Notification, 2002) increasing the original rating of six (6) to nine (9) - which is high priority. The Priority Assessment contained in the PH Nursing file indicates the following factors were considered by the PH nurse when the priority rating was changed:

2 - father of infant not in residence (Mom reported) but other support available;
3 - receiving social assistance or experiencing financial difficulties;
4 - other category: stressful relationship with child's father; difficulty caring for four children under the age of six.

It appears from an examination of the Priority Assessment that the increase in the rating was a result of: a) the "other category" being ranked higher than had been ranked upon Joey's hospital discharge; and b) the inclusion of the information regarding the father that was not present in the initial assessment. The PH Nursing notes document that this family would be followed in the Long Term Healthy Beginnings Program at the Clinic.

On November 14, 2003, CYFS contacted Mom regarding services that had been discussed and recommendations that had been made by the social worker after the October 8, 2003 home visit. The case had now been transferred to a different social worker as a result of staff changes within the CYFS Program. A meeting with Mom and Dad was scheduled for November 25, 2003. Mom arrived at the meeting alone. Information provided by Mom indicated that she was following through on the recommendations, and contact with the school revealed no other concerns outside the ISSP for the oldest child.

This referral information and assessment primarily focused on the eldest child and a determination was made by the social worker that the children were not deemed to be in need of protective intervention. A closure summary was written and submitted to the program supervisor who reviewed the file. The case closure policy followed at that time was located in DSS 1993 Child Welfare Policy and Procedures Manual 02-08-03. The program supervisor approved the closure of this file on December 9, 2003. File documentation, including the case closure summary, indicate that the referring information and subsequent assessment did not reveal serious child maltreatment, deliberate neglect or serious supervision violations.

On January 13, 2004, a third referral was received by CYFS through a named source concerning the circumstances of this family home. The informant expressed concerns about considerable drug use in the home, which was in a deplorable condition. These conditions had been witnessed by the informant. The house was described as dirty and the presence of a strong odor was also noted. Again, the concern regarding the children and inadequate supervision was alleged. It was also alleged that an older youth had taken up residence in the home and was using drugs. Admittedly, the informant's information was weeks old; however, given the recent involvement with CYFS, the decision was

made to assign the matter to the previous social worker for assessment. The referral was assigned under Section 14(a) of the CYFS *Act*.

Joey's sibling (identified subject of the second referral) was interviewed at the school by the social worker. It was concluded that the parents did smoke but in a separate room in the home, referred to as the "smoke room". This room had not been viewed by the social worker during the previous home visit. It was also established that while the parents were in the smoke room, it was this child's responsibility to look after the younger children. This indicated the lack of appropriate supervision and the children may have been left alone for extended periods of time.

The home visit revealed that an odor was present, the home was unkempt with floors that required cleaning, and there were dirty dishes on the kitchen counter. The situation was not deemed to be any more serious than during the previous home visit of October 8, 2003, approximately three (3) months earlier. Documentation indicates three of the four children were present during the home visit; however Joey was upstairs sleeping and was not seen by the social worker.

During the interview, information was obtained that alleged incidents of physical discipline of the two older children by the father. The issue of physical discipline was examined during this time. Documentation of the interview acknowledges the child identified Dad as the person using physical discipline with the children; however, there was no indication that the identity of "Dad" had been verified given the presence of a natural father and a stepfather to the two female children. The matter was discussed with Mom and Dad and both denied using physical discipline with the older children. The rationale used by Dad to explain him having no disciplinary role with the two older girls was they were not his biological children.

Again the issue of the birth father was pointed out and the parents reiterated their concern about the oldest child projecting behavior onto her step-father that she had witnessed while with her birth father. Information regarding an older youth residing in the home was confirmed and it was determined he was a relative of the family and the situation was not a permanent arrangement. This young man also had his girlfriend living there with him.

The allegation of illicit drug use was raised as well. While Mom denied any drug use, Dad admitted to being a recreational user of marijuana. He insisted he did not use drugs while the children were present. The legalities of drug use were discussed but no commitment was obtained for the cessation of that activity. Their willingness and transparency regarding this and other issues was documented as a positive indication of their desire to collaborate with CYFS. Direction provided in the DSS 1993 Child Welfare Policy and Procedures Manual 02-04-08: "A child is less at risk if there is a willingness on the part of the parent to collaborate with the social worker". The CRMS notes indicate this openness

was taken into consideration in the overall determination of immediate risk to the children. Several services were recommended and agreed to, and followup was required before any disposition could be made regarding the file. The social worker did indicate, as referenced in the file notes dated January 15, 2004, that the disposition of the case would not be decided until further inquiries were made and a consultation with the supervisor had occurred.

Further contact was made with Mom, by the CYFS social worker, to inquire if she had been successful in getting a referral from her family doctor to the Hospital. This was designed to deal with some of the already identified behaviors of her eldest daughter, which were described by Mom as worsening. It was communicated to Mom that the program manager was reviewing the case to determine if her CYFS file would be closed or transferred to Long Term Protection.

The appointment scheduled with PH Nursing for Joey's second immunization was not kept by the family. A number of telephone calls were reported to have been made by PH Nursing but the nurse was unsuccessful in reaching the parents. There was no further contact with the family by PH Nursing.

On February 4, 2004, the fourth referral was received by CYFS from an anonymous source. This source explained there was heightened concern for the children in the family; however, this time the gravest concern was for the youngest child, Joey. The informant alleged Joey was being sustained on a diet of milk alone and that it appeared he was underweight and lagging in development (i.e. unable to lift his head or stand). It was stated all the children were hungry, they wore the same clothing for days and the house was very dirty. In addition, they were exposed to a lot of smoking. The informant had recently visited the home and was providing firsthand knowledge of Joey's condition and the environment in which the children lived.

This referral information, on an already active case, required immediate attention because of: a) the specificity of the information regarding the youngest child; b) the age and vulnerability of Joey and his siblings, and c) the realization that there was a lack of information regarding Joey from previous visits to the home. This referral was categorized under Section 14(a) of the CYFS *Act*. Although the referral had been received on February 4, 2004, it was not actioned until the next day. The CRMS notes revealed the social worker consulted with her program manager regarding her workload on February 4, 2004, and the program manager advised that the referral on the family could be pursued the next day.

As in previous referrals, the first point of contact with the family was interviewing one of the children who attended school in the community. The social worker reported the physical appearance of the child was markedly

different from prior presentations. The child's hair was unkempt and there was a distinct odor from her clothes and hair. The CRMS notes dated February 5, 2004 revealed that the social worker concluded that the child had eaten peas for breakfast but could not establish what had been eaten the previous day by any of the other children. The previous claim that the father uses physical discipline was reiterated. Additionally, the social worker spoke with the guidance counselor and the child's teacher who provided more detailed information regarding this child not previously reported during past discussions with school personnel.

An immediate visit to the home was completed after supervisory direction was sought. The instructions were to observe Joey, along with the other children, given the physical presentation of the eldest sibling. Upon arrival at the home, there was an older youth present (the relative previously mentioned) who was providing care to the children while Mom was absent. The request was made to locate Mom and she was asked to return. The home required cleaning and from the vantage point of the front door, it appeared the kitchen was dirty. When Mom returned to the home, she acknowledged the difficulty of having the responsibility of caring for four children under the age of six (6) years. She also reiterated the impact of being anemic on her lack of energy. There was an acknowledgment regarding the lack of cleanliness in the home and at times, there was little food in the home but she was adamant she was there for her children. She explained how she had been to see the PH nurse in October 2003.

Documentation in the CRMS notes reference the social worker requesting that Joey, who was apparently sleeping upstairs, be produced for observation and assessment. They both proceeded to the second floor. On the way, the social worker made several other observations. There were garbage bags over the windows making the house very dark. The parents' room had a mattress on the floor with no sheets, while bags of items and loose clothing were scattered all over the floor. In addition, there were empty beer bottles and cigarettes on the floor next to the mattress.

CRMS documentation indicates other physical details were noted. The second floor was very warm and the door to the children's room was closed. When the door was opened, the heat was pronounced and the smell of urine was quite prominent. There were mattresses on the floor with no sheets, while blankets, clothing and toys were strewn about. In the room identified as belonging to Joey, there was a crib and a playpen. The windows were covered in garbage bags. Joey, who was approximately nine (9) months old, was found in the playpen. He was lying on his back and an empty bottle was next to him in the playpen. Joey appeared to be very skinny and "undernourished". He was in clothing that appeared to have been on for more than a day as indicated by the stains on his clothes and the smell emanating from his hair, body and clothing. Joey's skin was gray. He could not support his own head and could not stand. Joey appeared "wobbly" and his eyes did not seem to be clear. Joey did not cry

but was making noises. The decision was made to take Joey to the hospital without delay.

Mom acknowledged her concern about the baby losing weight; however, it was the first time she discussed this despite having had several conversations with the social worker. She implied she was following her doctor's orders regarding Joey and explained that he was drinking Similac and eating baby food. She also added that she had received instructions from the PH nurse about feeding. The two older children in the home were in much better condition although it was suspected they were hungry.

Joey was conveyed to the Hospital and it was evident that a more thorough assessment of the other three children was required, given the physical state of Joey. This led to a second consult with the program manager. An assessment was completed by two additional CYFS social workers, not previously assigned to this case, who went to the home to assist in the process. Two workers were required, given the number of children in the home, and the immediacy of the situation relating to Joey. The assistance of the police was sought and they provided support to the social workers in the home.

A further assessment of the children's physical environment was completed a short time after Joey was brought to the hospital. CRMS documentation indicates the following details were noted during this assessment. The children's rooms all had a smell of urine in them and were devoid of natural light due to the placement of dark garbage bags over the windows. Clothing and garbage was strewn throughout the second floor rooms. There was a bottle left in the crib that contained a watery milky substance resembling a powdered milk mixture. A second bottle found in the room had the top of the nipple bitten off. There was no meat in the freezer or refrigerator. There were some cans in the cupboard; however, without labels, it was difficult to identify the contents. The refrigerator was soiled. The "smoke room" was viewed during this time. The social workers' documents indicate that given the odor, marijuana was likely being smoked in this room. In addition, empty liquor bottles were present. The other children present in the home were brought food by the social workers as documentation reflected the children were hungry.

A third consult occurred with the program manager by one of the social workers involved. During this consult, it was learned by the social worker that Dad had a child from a previous relationship who had been abused and neglected by Dad and his previous partner. That child had been removed from his care. The history of Dad's previous child protection involvement was only discovered following Joey's admission to hospital.

The decision was made by CYFS to remove all four children from the care of the parents and place them under the temporary guardianship of the Director in the Region for CYFS. Joey was admitted to hospital after an initial

examination that discovered the need for immediate medical treatment. Despite the parents' assertions that Joey was being fed formula and baby food, he was now presenting in an emaciated condition and 1.84 kilograms (four pounds) heavier than when he was discharged after his birth. There was no organic cause for Joey to be so significantly underweight and malnourished; it was determined that Joey's parents had neglected to feed him. The remaining three children were placed in a foster home. Joey's twenty-three (23) month old sibling was also malnourished; however, his condition was more favorable and could be managed by the foster parent with direction from the pediatrician. The information held by the PH Nursing Program was disclosed to CYFS following the discovery of Joey's perilous condition and his subsequent admission to hospital. At no time did Joey's parents seek medical attention for him regarding their reported concern about his weight loss. Joey's history of feeding as reported by Mom was not consistent with his medical condition.

Joey remained in hospital for over a month, where it was determined and documented in Joey's medical file that the diagnosis of failure to thrive secondary to malnutrition was not a result of organic causes. In direct testimony by the physician, it was stated the situation had been "ongoing for sometime to cause this young child to be in the physical condition he was found in". Upon admission, Joey was almost 10 months and weighed 5750 grams (12.6 pounds) which was only a total weight gain of 1890 grams (4.1 pounds) from his discharge weight after birth of 3860 grams (8.5 pounds). The physician predicted imminent death for Joey if there had been no intervention into this matter by child welfare officials (Discharge Summary, p.5).

Joey's diagnosis of failure to thrive secondary to malnutrition was supplemented upon his discharge from hospital with the confirmation of global developmental delay due to severe malnutrition and social deprivation. This delay has the potential for "long-term, permanent neurological and developmental problems". It was also acknowledged by the attending pediatrician in her testimony that Joey would have "certainly succumbed to this maltreatment if it had not been for the intervention of CYFS officials".

The testimony of the physician included: "Upon admission to the hospital … had no subcutaneous fat, very little muscle…and one could easily feel his bones underneath his skin. He had significant head lag, and was very weak, and appeared frail….with decreased tone / strength in the central part of his body…. was not able to roll over, could not sit and had … a distended belly" (Transcript, 2006). As well, testimony provided by the physician included information regarding four to five (4-5) bruises on Joey's forehead and a bruise under the left eye and on the upper eyelid. "It appeared that Joey's skin was beginning to crack" (Transcript, 2006).

In 2004, Joey's parents were indicted and charged with failing to provide the necessities of life. They were sentenced to one year imprisonment and two years probation.

Findings and Analysis

In February 2004, Joey and his siblings were removed from their parents' care due to serious concerns of neglect and child maltreatment. Joey's siblings were immediately placed in temporary foster care while he was admitted to the Hospital for over a month with failure to thrive secondary to malnutrition. Essentially, Joey was not fed by his parents – a fact which ultimately would have led to his death.

The question to be asked is: *"Should the fact that the family was receiving services from two program areas of HCS, namely the CYFS Program and the Healthy Beginnings PH Nursing Program, have prevented this from happening to Joey"?*

What needs to be recognized is that Joey's parents, whom he was completely dependant upon, were ultimately responsible for neglecting him. Nonetheless, professionals from PH Nursing and CYFS were involved with this family for several months before Joey was hospitalized for failure to thrive and malnutrition. In fact, the attending doctor indicated that Joey's condition should have been evident to anyone who saw him. This was not a condition that occurred over a few days; it had gradually emerged over several months. Additionally, there was no medical reason for Joey's low weight.

Resulting from the examination of the documentation provided and interviews conducted, several opportunities were identified where both service providers could have become aware of the family circumstances and Joey's condition much earlier.

1. The case file revealed that a Child Protection Report showing the first referral to CYFS regarding the family was received three months before Joey's birth. It was alleged the home was dirty, there was little food in the home, and the parents spent their money on drugs. Three days later the file was screened and closed; it was indicated on the Intake Report "the information does not warrant a CYFS investigation". It was later determined by the Director in the Region, based on an internal review of the case, that the referral was screened out in error and should have been actioned. The referral documentation relating to the family was also filed in error in the offices of CYFS. An attached note on the Intake Report revealed the referral was found on January 23, 2005 - after the children were removed.

The screening process used and the information management system in place had many deficiencies. The CRMS was in the initial stages of implementation at this time and was facing many system challenges relating to its ability to cross reference historical information. Manual checks of historical,

closed or screened out referrals were the normal practice; however, manual checks were not always valid.

2. The family file revealed that a second Child Protection Report was received on October 7, 2003. The Departmental Records Check under CRMS did not reveal previous involvement from CYFS or PH Nursing. The CYFS social worker assigned did not have knowledge of the first referral that alleged concerns about these children and was acting as though this was the first referral received on the family. As indicated in the DSS 1993 Child Welfare Risk Management Policy 02-04-05: "repeated, unsubstantiated reports may also suggest that maltreatment is present but that it may not have been clearly discernable during previous investigations". This statement highlights the limitations of the new CRMS at the time of this second referral, and it was not documented in the file whether a manual records check was conducted. The referral was screened in for follow up and the CYFS social worker involved did address the concerns with the parents; referrals were made for further support of the eldest child and the family. A referral was made to PH Nursing as well as to the Hospital for counseling. Based on the nature of the referral, which related to the eldest child, the issues were assessed. The CYFS social worker confirmed the existence of food in the home, a partial observation of the home occurred and two other siblings were seen and observed while Joey was not. No abuse or neglect was identified and the program principle of the least intrusive process was taken (DSS 1993 Child Welfare Policy 01-01-01 and 02-09-03).

There are three Risk Management steps not covered under this assessment that would have revealed more about the family: 1) the Risk Assessment Instrument was not used to assess risk for all children; 2) all children in the home were not interviewed, and 3) the condition of the children's environment was not totally examined. Policy relating to Investigations/Information Gathering indicates that where "abuse or neglect is suspected, the investigation shall include: the completion of the Initial Safety Assessment; in-person interview with siblings, and a home visit to see where and how the child lives" (DSS 1993 Child Welfare Policy 20-03-03).

The CYFS social worker assigned was a new graduate and relied on the program manager for direction. During her interview under subpoena, she disclosed she was not trained in the RMS and did not use the Risk Assessment Instrument during the assessment of this case. Additionally, she indicated she did not observe the remainder of the home, and upon consult with the program manager, she was not directed to see all of the children in the home. Also, Mom had reported moving to Newfoundland from another province. The client file and the CRMS notes do not indicate a consult had occurred with the child protection agency in the other province.

3. On November 12, 2003, a new CYFS social worker was assigned to the family. Two days later, the social worker contacted Mom to arrange an office appointment for later in the month. After a favorable meeting with Mom on November 25, 2003, it was determined the file of October 7, 2003 could be closed. There had also been contact made by the social worker with the eldest child's school. Both parents had attended an ISSP meeting at the school and no concerns were being expressed at the moment. As per directive 02-08-03 of the DSS 1993 Child Welfare Policy, prior to closure, "other agencies and professionals involved in the case shall be informed of the decision to terminate service." The CRMS notes in the file did not reveal that the current social worker had consulted with the PH nurse to determine the outcome of the CYFS referral to the PH nurse in October 2003, and to now advise PH Nursing of the file closure. Additionally, DSS 1993 Child Welfare Policy 02-08-05, related to case supervision, indicates that when a file is transferred or when a file is considered for closure, the supervisor shall review each case and record keeping policy. DSS 1993 Child Welfare Policy 02-08-06 also indicates that "all case recording respecting child abuse/neglect investigations shall be signed and dated by the social worker and be read, signed and dated by the supervisor". The program manager approved the case for closure, although the CRMS notes did not reveal an assessment of the case by the program manager prior to closure. The file was closed on December 9, 2003.

Such an assessment would have revealed that Joey had not been observed, that a thorough examination of the home environment had not occurred, and that the PH nurse had not been consulted upon closure. It is reasonable to conclude that an in-depth supervisory consult would have resulted in the identification of policy deficiencies or contraventions, along with the requirement for another home visit, as well as follow up with the PH nurse.

4. On January 13, 2004, a third referral was received regarding the family. The referral referenced concerns regarding the parents' drug use in the home, the unkempt condition of the home, and inadequate supervision of the children. The CYFS social worker assigned did interview the eldest child and assessed the concerns with the parents. Joey's siblings were seen face-to-face during a home visit and a partial observation of the home occurred. Joey was not seen nor was there an observation of the whole home environment. The CYFS social worker assessed the parents as willing to cooperate and referred the family to services. A review of the circumstances with the program manager occurred for further disposition of the case.

Similar to the October 7, 2003 referral regarding the family, policy relating to Risk Management was not followed. The CYFS social worker did not use the Risk Assessment Instrument, interview all the children in the home, or observe

the total environment. When interviewed under subpoena, the CYFS social worker confirmed she was aware of the Risk Management policy but due to an oversight, did not complete the Initial Safety Assessment form or view the whole home environment. Additionally, she indicated all of the children who could be interviewed were and there was no requirement at that time to see all of them. As a result, Joey was not seen or observed nor did the program manager require that step to occur. As of January 13, 2004, three referrals had been received by CYFS regarding the family; however, Joey had still not been seen by CYFS officials.

5. The fourth referral was received February 4, 2004, wherein the majority of the concerns presented were related to Joey. The source of the referral indicated that he was underweight and lagging in development. It was also stated the other children in the home were not properly fed, and the home was dirty. The social worker, previously assigned the third referral, spoke to the school guidance counselor and the eldest child's teacher who revealed far more concerning information about her. According to the CRMS notes, these concerns had been ongoing for several months but had not been communicated to CYFS by the school. The CYFS social worker conducted a critical and thorough assessment of the family and the home at this time.

All policy was followed and consultation with the program manager occurred at critical stages of the assessment. The decision to have Joey medically assessed immediately and the subsequent removal of all the children prevented the continuance of any neglect. The Director in the Region was advised by the program manager of Joey's condition and of his diagnosis of "failure to thrive".

The Director was provided with additional information about the family. During this discussion, the Director recalled information about Dad having a child from a previous relationship who was removed from his care due to abuse and neglect and no further contact had occurred with this child. This file was recorded and stored under the biological mother's name and as a result, previous record checks did not associate Dad with CYFS. It was apparent Dad had not revealed his past involvement with Child Protection to the two CYFS social workers involved with this family. The facts regarding Dad's previous history were immediately communicated to the CYFS social workers and the decision to remove the children became more evident. Dad's previous history could and should have revealed a high risk concern for the children resulting in a more intrusive role by CYFS when the first or second referral was received.

6. PH Nursing and The Healthy Beginnings Program became involved with this family upon Joey's discharge from hospital. Discharge documents revealed Joey to be of normal weight of 3860 grams (8.5 pounds) with no recorded medical concerns. Documentation showed that upon discharge, Joey received a moderate rating of six (6) on the Priority Assessment.

This rating was based on social factors; a young single mother with four children under six (6) years of age in receipt of Income Support. Given the social factors and potential risk of neglect for the children, a referral to CYFS should have occurred, if not upon discharge from hospital, then upon discharge from The Healthy Beginnings Program. As indicated in PH Nursing Program Policy and Guidelines, May 2000, Procedure for Processing the Postnatal Referral, nurses use their professional judgment regarding relevant information from the family's past and information from the Live Birth Notification to determine followup. Based on the professional judgment of PH Nursing, a referral to CYFS regarding the family did not occur. Guidelines regarding discharge from the Healthy Beginnings Program indicate that at least three attempts to contact the family have to be made; a family can refuse service or be unavailable to receive the service. The family was discharged from the Healthy Beginnings Program in September 2003, after several unsuccessful attempts were made to contact them. The program is not governed by legislation and families cannot be forced to participate. The specific PH Nursing guidelines regarding file closure were followed.

7. The CYFS social worker investigating the referral of October 7, 2003 contacted the long term PH nurse to arrange an appointment to see Joey for his Health Check; to administer his first immunizations and to provide nutrition counseling to Mom. The referral from CYFS to PH Nursing regarding Joey was not recorded in the progress notes or in the CRMS notes. Joey was brought to the clinic by his mother in October 2003 and seen by a PH nurse who was providing relief at the Clinic. The relief PH nurse completed a Health Clinic Flow Sheet and recorded Joey's low weight and size, below the 5th percentile for his age, and she discussed nutrition with Mom. The long term PH nurse returned to the office and subsequently met with Mom to again discuss nutrition and reviewed a feeding schedule for Joey. The PH nurse did not question Mom in depth about the reported amount of food she was feeding Joey compared to his apparent size and weight. Mom was advised to increase Joey's feeding and return to have him weighed in seven days.

There appeared to be concern for Joey's weight but the absence of nursing documentation and miscommunication about who would take what action (as outlined in the PH Nursing written submissions) makes it difficult to determine what, if any, consultation occurred between the nurses in the clinic. Furthermore, a consult should have occurred with the CYFS social worker to discuss the results of the clinic visit with Mom and Joey. His low weight was not reported to the CYFS social worker or to the family doctor; nor was there documentation confirming that Joey was weighed seven days later or that Mom followed up at another location about this issue. Joey's condition, as later reported by both nurses in their submissions, was not viewed as a concern; subsequently, PH Nursing took no further action. It is reasonable to conclude that a PH Nursing

consult would have resulted in a more invasive course of action by CYFS if they were aware of Mom's non-compliance and of Joey's low weight. Based on the notes of the attending doctor when Joey was admitted to hospital, signs of malnutrition would have been evident during this October contact.

8. The next meeting with PH Nursing and the family occurred 3 weeks later when Mom presented at the Health Clinic with an older female sibling for a preschool health check. Although Joey was not present, the PH nurse changed his Priority Assessment Score from a moderate six (6) to a high priority nine (9). There is little documentation explaining the increase in the Priority Assessment Score or that the higher ranking was communicated to the CYFS social worker. Policy allows a PH nurse to change the priority ranking without seeing a child. Documentation does not exist to indicate that Mom was questioned by the PH nurse on this date regarding Joey's weight or if Mom had gotten him re-weighed seven (7) days after the last clinic visit (as was recommended); however, the nurse noted Mom's assertion that Joey had gained weight and was now a big baby. The family was now on a Long Term Healthy Beginnings caseload.

According to the Program Manual (p.3), the PH nurse must write a letter of notification to the family physician and/or social worker once a child has been identified for long term followup. No letter of notification was sent.

9. Mom did not attend the scheduled two (2) month follow-up appointment for Joey with the PH nurse. The PH nurse recorded in the CRMS notes that Mom had not kept or rescheduled this appointment. Further, it was verified by the PH nurse in the statement provided for this investigation that the missed appointment was not communicated to the CYFS social worker. A history of non-compliance with Mom in relation to followup for Joey and her other children was already known to the health clinic staff.

All of these contacts with the family revealed deficiencies within the system, namely: a) lack of adherence to policy; b) policy gaps; c) lack of communication and collaborative practices; d) insufficient information management and documentation. Additional issues exacerbated these factors.

During May 2000, the computerized CRMS replaced the paper driven Child Welfare Registration System throughout the Province. The CRMS program was designed to track data, retrieve data, receive referrals and document information for all the Boards, the DHCS, and CYFS. The issues identified in this investigation concerning CRMS are reflective of a system operating with deficiencies and limitations, namely: the storage of client files; the manner in which files are recorded on the system; cross referencing abilities, and search processes within the service areas. These flaws, within the system as a whole,

severely affected the ability to access historical and current documentation about Joey and his family.

An effective information management system would have revealed the first referral to CYFS and Dad's previous involvement with CYFS. As confirmed by the informants, the CRMS was still in the early stages and the screening process was an issue not fully resolved. A great deal of historical documentation had not been inputted into CRMS and the region was dealing concurrently with a computerized system and a paper system. The proper storage of documentation and detailed background checks within CYFS, and between other agencies, may have produced more information on the family history.

Gaps in policy and guidelines were identified in both the program areas of CYFS and PH Nursing. When Joey was assessed as falling below the 5th percentile in weight/height ratio for a child his age, the PH Nursing guidelines did not outline subsequent steps for the nurse to follow. When Joey's priority score was changed from moderate to high risk, guidelines permitted this change without seeing a child. Further, these guidelines did not indicate additional steps to be considered by a nurse when the ranking changed. CYFS Policy required that an in-person interview with a child(ren) shall be included in the information gathering stage of an investigation. This policy did not extend to accommodate observing or seeing all children in the home, particularly young children who do not have the capacity to speak for themselves. Typically, where policy does not exist, clinical judgment often prevails. Clinical judgment is necessary within the disciplines of nursing and social work to permit the critical analysis of cases where other action may be deemed necessary. One would have expected followup with Joey based on clinical judgment, particularly given that the philosophy of both service areas focuses on the prevention of child maltreatment.

During the investigation, it was noted that many of the program policies and guidelines were followed by CYFS and by PH Nursing. Conversely, it was apparent that there were some instances where CYFS and PH Nursing staff should have followed policy but did not. During the information gathering stage of the second and third referrals, both social workers did not complete a risk assessment or see the whole environment. Upon case consultation with the program manager, these missed steps were not identified at that level. Further, upon case closure of the second referral, consultation did not occur with the PH nurse who had a significant role in the disposition of Joey's case. Again, when reviewing Joey's file for closure, this step was also missed by the social worker and the program manager. In addition, the PH nurse did not follow up with CYFS regarding the referral made in October 2003.

Another dynamic factor is that the CYFS *Act* does not reference neglect under section 14 as an indicator of child maltreatment. The DSS 1993 Child Welfare Policies and Procedures Manual does contain a section on neglect; however, this manual applies to the previous *Act* (DSS *Child Welfare Act*, SNL

1972), which has not been in effect since 1998. Further, informants acknowledged that a great deal of front line child protection social work is conducted by new graduates who lack experience and have little training or skill development in the area of child protection and maltreatment.

Communication and collaborative practices are fundamental to any working relationship. The investigation revealed this essential process was almost non-existent between PH Nursing and CYFS. Although there was some evidence of communication with the eldest child's school, CYFS did not extend their collaboration beyond that. PH Nursing held very significant pieces of information regarding Joey that should have been shared long before he was physically seen by CYFS and subsequently admitted to hospital for failure to thrive. As the history of contact with the family was not properly documented or shared, the children continued to be at risk. Both program areas work with a vulnerable population and the ability to communicate and collaborate when child maltreatment occurs is critical.

There does not appear to be an internal process in place regarding the review of sentinel events or critical incidents for CYFS or PH Nursing. Management officials within CYFS and PH Nursing, who were responsible to oversee these program areas, were charged with the task of reporting to the Minister of DHCS on the incident and were also responsible to critically review all of the contacts with the family. While this process has been implemented since the establishment of the Regional Health Boards, transparency and accountability mechanisms have evolved to include other levels of review through quality assurance processes. The informants from both areas of management revealed during their submissions to this investigation that a formalized, separate quality assurance report was not completed at that time because a process of this type did not exist. Such a report would have allowed a further independent analysis of Joey's circumstances. It is prudent to have a separate group of individuals critically examine all sentinel or critical events which may occur in any program area.

It is important to point out that two service providers held information that should have been shared much sooner with CYFS. The teaching staff of the eldest sibling's school and the PH Nursing staff should have realized their legal requirement to report concerns of child maltreatment to CYFS when they became aware of the issues.

It became evident from the analysis of the documentation and interviews conducted with staff and management of CYFS and PH Nursing that there were other dynamics requiring attention. The CYFS Program was operating under new legislation enacted during 1998 which did not have a completed policy manual to support the new *Act.* Social workers were alternating their practice between two policy manuals. This created a great deal of ambiguity, diversity

and inconsistency in the application of the policy. In addition, there were differences of opinion regarding interpretation of the policy at all levels of service.

The organizational culture at the time was new and constantly changing. When CYFS joined the regional Health Boards during 1998, service providers who never worked together before were required to do so. They were challenged to find ways to better communicate on matters of importance such as the development of multi-disciplinary teams. This process took some time. Additionally, the Board structure changed by amalgamating in 2005 and the programs were again in a state of flux.

The CRMS program had a 'go-forward' implementation date of May 8, 2000, and any paper documentation preceding that date was not fully implemented into CRMS. The ability to conduct an in-depth All Program Search and to cross reference previous involvement by CYFS was conducted manually. Manual checks were still a requirement and will be in future until the historical documentation is inputted into CRMS.

The lack of clinical supervision in the assessment and decision making process was evident. In reality, what was occurring was more of a case management process as opposed to clinical supervision. The demands of high workloads, social workers performing administrative duties, inexperienced staff with little training or skill development in the assessment of child maltreatment and neglect, made it almost impossible for managers to provide favorable support to the front line social workers.

Examination of the factual circumstances related to Joey and his siblings revealed several key findings which point to the many challenges facing both the CYFS and PH Nursing programs within the larger system. The culmination of these factors predestined Joey and his siblings to remain in an environment where neglect and maltreatment were commonplace. These findings were corroborated by the individuals from CYFS, PH Nursing and HCS who were involved in this investigation. In summary, the key findings are:

- Lack of adherence to policy and Risk Management protocols.
- Insufficient professional collaborative practice and communication.
- Lack of reporting of child maltreatment.
- A fluctuating Records Management System and CRMS limitations.
- One piece of legislation (CYFS *Act*) and two policy manuals.
- Lack of clinical supervision.
- Insufficient documentation and clinical recording.
- Lack of skills-based training and professional development.
- Recruitment and retention of professional staff.
- Lack of a quality assurance process.
- The voluntary nature of Public Health Programs.

- The culture within CYFS (constant change and uncertainty).

This investigation process provided insight and perspective on how the family was receiving services through two separate programs, namely CYFS and PH Nursing under the auspices of HCS, while Joey remained unseen. The findings and analysis reveal that the service providers should have been aware of Joey's circumstances earlier; the investigation revealed both missed opportunities and flaws within the system.

The primary deficiencies identified in the system are:

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

These all contributed to the prolongation of Joey's circumstances. It has been clear throughout this investigation that if these systems worked in an optimal manner, Joey would have been seen and observed earlier and consequently would have been treated much sooner. In addition, Joey and his siblings would have been removed earlier from the parents who were neglecting them.

Recommendations

The mission of the Office of the Child and Youth Advocate is to ensure that the rights and interests of children and youth are protected and advanced. To help achieve that mission, the OCYA investigates cases such as this and ultimately makes recommendations. After completing a Review or Investigation under the *Child and Youth Advocate Act*, SNL, 2001, Chapter C -12.01, the Advocate may, under section 15(1)(g) of the *Act,* "make recommendations to government, an agency of government or communities about legislation, policies and practices respecting services to or the rights of children and youth".

Therefore, based on the findings of this investigation, the Office of the Child and Youth Advocate makes the following recommendations to the Regional Integrated Health Authority regarding Public Health Nursing and Child, Youth and Family Services. The recommendations are also being made to the Department of Health and Community Services and to the Department of Child, Youth and Family Services (as the ultimate responsibility for CYFS [provincially] was transferred to the newly created Department of CYFS during April 2009 with formal transfer to take place during the fall of 2011).

The Office of the Child and Youth Advocate will monitor the progress of all existing initiatives and the recommendations of this investigation with the Regional Integrated Health Authority and the Department of Child, Youth and Family Services until they are implemented.

Recommendation No. 1
All historical documentation held by CYFS must be inputted to the CRMS. The 'All Program Search' and cross referencing functions must operate at optimal levels.

Recommendation No. 2
Policy must be developed by CYFS to direct that all children in a family be critically observed during a referral and during every home visit.

Recommendation No. 3
CYFS must ensure proper completion of the Child Protection Report. The Report must be completed at the point of Intake to include all relevant referral information. The appropriate sections/subsections of the *Act* must be reflected in the Child Protection Reports.

Recommendation No. 4
Staff education must be developed and implemented to ensure that:
(a) all new hires receive orientation in the area of child maltreatment including: intake, assessment, risk management, and communication;
(b) continuing education occurs in the areas of skill development, clinical documentation and child maltreatment for all social work staff, and
(c) all regional managers receive clinical supervision training.

Recommendation No. 5
Policies and guidelines must be developed by PH Nursing to require that:
(a) all nurses refer families to the appropriate professionals when a child's weight falls below the medically acceptable percentile;
(b) all new hires in nursing receive training in child maltreatment and clinical documentation, and
(c) continuing education in child maltreatment and clinical documentation be provided for all PH nurses.

Recommendation No. 6
(a) Collaborative practice initiatives must be developed and advanced between the disciplines of social work and nursing.
(b) Policy and guidelines must reflect ongoing collaborative practice.

Recommendation No. 7
Establish a quality assurance process to address critical incidents and sentinel events that occur within CYFS and PH Nursing programs.

Recommendation No. 8
(a) Protocol must be developed with the Department of Education regarding the legislated duty to report in cases of suspected child maltreatment, and
(b) All appropriate service providers with the Department of Education and PH Nursing must receive training on child maltreatment and their legislated duty to report.

Recommendation No. 9
Protocol must be developed with CYFS and the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.

A summary of these recommendations (Appendix D) is attached.

Conclusion

It is evident from this investigation that there were numerous missed opportunities whereby CYFS and PH Nursing could have intervened and lessened the time Joey and his siblings were neglected. There were also many opportunities available to Mom and Dad to accept the assistance of the professionals and to initiate contact of their own accord. They did not seek assistance and in fact, they masked the neglect Joey was suffering.

While the CYFS and PH Nursing responses were in keeping with many of the policies, standards and guidelines in place at the time, there was also evidence of non-adherence to policies. Sharing information and clinical judgments would have revealed a far more accurate picture of Joey and his family and resulted in the earlier detection of neglect and maltreatment. Coupled with this non-sharing and lack of documentation was a set of circumstances that revealed flaws within the system which were linked to constant organizational change and systemic problems.

If the systems had been working in an optimal manner, it is reasonable to believe that Joey's circumstances would have been immediately apparent to those who were involved. Once Joey was finally seen and assessed, all the necessary steps were implemented to ensure Joey and his siblings were safe and cared for.

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Appendices

Appendix A Letters commencing investigation

Appendix B List of acronyms used in this report

Appendix C Calendar of timelines referenced

Appendix D Summary of Recommendations

APPENDIX A

Letters commencing investigation

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

August 1, 2006

DELIVERED BY COURIER
STRICTLY PRIVATE AND CONFIDENTIAL

Mr. John Abbott
Deputy Minister
Department of Health and Community Services
Confederation Building, P.O. Box 8700
St. John's, NL A1B 4J6

Dear Mr. Abbott:

Re: Notice of Review Pursuant to the *Child and Youth Advocate Act*
born 2003
Newfoundland and Labrador

I write at this time to advise you of my intention to conduct a Review into the circumstances surrounding , child of given the family was receiving services from the Regional Integrated Health Authority. This Review will be conducted in accordance with the provisions of Section 15(1)(a) of the *Child and Youth Advocate Act* (the "Act"), which states:

> 15(1) In carrying out the duties of his or her office, the advocate may
>
> (a) receive and review 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.

In accordance with Section 20 of the Act, I am now informing you of my intentions.

> 20 Before reviewing or investigating a complaint, or before conducting a review or an investigation of a department's or agency's services,

Suite 604, TD Place, 140 Water Street, St. John's, NL A1C 6H6
Tel: 709-753-3888 • Toll Free: 1-877-753-3888 • TTY: 709-753-4366 • Fax: 709-753-3988
Email: office@ChildAndYouthAdvocate.nl.ca • Web Site: www.ChildAndYouthAdvocate.nl.ca

the advocate shall inform the deputy minister or the administrative head of the department or agency of the government affected of his or her intention to conduct the review or investigation.

To further advance the ability of the Office of the Child and Youth Advocate to carry out this Review, Section 21 of the Act provides that:

21(1) The advocate has the right to information respecting children and youth that is

(a) in the custody or control of a department or agency of the government; and
(b) necessary to enable the advocate to perform his or her duties or exercise his or her powers under the Act,

21(2) A person who has custody or control of information to which the advocate is entitled under subsection (1) shall disclose the information to the advocate.

I request that your Department provide to this Office all information and documentation with respect to , and the , family that is in the custody and control of your Department, including any reports that have been compiled as a result of any internal review that was undertaken by your Department regarding this matter. Also, copies of relevant policy or protocols governing the delivery of services in existence at that time and any subsequent changes to such policies/protocols are specifically requested. A similar request has been made to , Chief Executive Officer, Regional Integrated health Authority. We will advise you of further requirements as they develop.

Thank you in advance for your cooperation in this matter.

Sincerely,

Darlene Neville

Darlene Neville
Child and Youth Advocate

/sp

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

August 1, 2006

DELIVERED BY COURIER
STRICTLY PRIVATE AND CONFIDENTIAL

Chief Executive Officer
Regional Integrated Health Authority

, NL

Dear Mr.

Re: Notice of Review Pursuant to the *Child and Youth Advocate Act*
, born , 2003
, Newfoundland and Labrador

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21(2) A person who has custody or control of information to which the advocate is entitled under subsection (1) shall disclose the information to the advocate.

I request that the Regional Integrated Health Authority provide to this Office all information and documentation with respect to this family and, in particular, , that is in the custody and control of the Regional Health Authority, including any reports that have been compiled or protocol changes made as a result of any internal review undertaken by your organization regarding this matter, and including, but not limited to, all documentation compiled by the medical, nursing and social work staff who delivered services to /. A similar request has been made to Mr. John Abbott, Deputy Minister, Department of Health and Community Services. We will advise you of further requirements as they develop.

We realize that this information will have to be photocopied. We are interested in receiving copies of any internal reports and protocol changes made as a result of this case on a priority basis. We request the remaining information be provided within six weeks of the date of this letter, on or before September 15, 2006.

Thank you in advance for your cooperation in this matter.

Sincerely,

Darlene Neville

Darlene Neville
Child and Youth Advocate

APPENDIX B

Acronyms used in this report

Appendix B

Acronyms used in this report:

Acronym	Official Title
CRMS	Client Referral Management System
CYFS	Child, Youth and Family Services
DHCS	Department of Health and Community Services
DSS	Department of Social Services
HCS	Health and Community Services
HRLE	Department of Human Resources Labour and Employment
ISSP	Individual Services Support Plan
OCYA	Office of the Child and Youth Advocate
PH	Public Health
RIHA	Regional Integrated Health Authority
RMS	Risk Management System

APPENDIX C

Calendar of timelines referenced

APPENDIX C

February 2003						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

CYFS 1st referral – screened out
CYFS File Closed – 3 days later

April 2003						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

PHN attempt contact
PHN attempt contact

May 2003						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

PHN left **msg** (grandparents' phone #)
PHN sent letter *(grandparents' address)

Letter returned unopened 15 days later

October 2003						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

CYFS 2nd referral – eldest child
CYFS Home visit / interviews
CYFS Referral to **PHN**
CYFS spoke to guidance counselor
CYFS Phone conversation with Mom
PHN Clinic visit with Joey & Mom
(Child Under 5th percentile)

November 2003						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

CYFS- Case transferred to new **SW**
PHN- Clinic assessment for **2nd** child (Joey not present but his priority assessment score changed to high risk rating)
CYFS- Left message with Mom for meeting
CYFS- New **SW** had meeting with Mom

December 2003						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

CYFS- File (2nd referral October, 2003) Closed

January 2004						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

PHN- Mom missed **appt.**
CYFS- **3rd** referral
- Consult with program manager

CYFS- Home visit / interviews
- Child interviewed at school

CYFS- Phone conversation with Mom re ongoing intervention needs

February 2004						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

CYFS - **4th** referral (file from 3rd still open)
CYFS - Home visit / assessment
- Interview guidance counselor, teacher and child
- All children removed from home
- Joey admitted to hospital

APPENDIX D

Summary of Recommendations

Appendix D

Summary of Recommendations

Recommendation No. 1
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Office of the Child and Youth Advocate

PROVINCE OF NEWFOUNDLAND AND LABRADOR