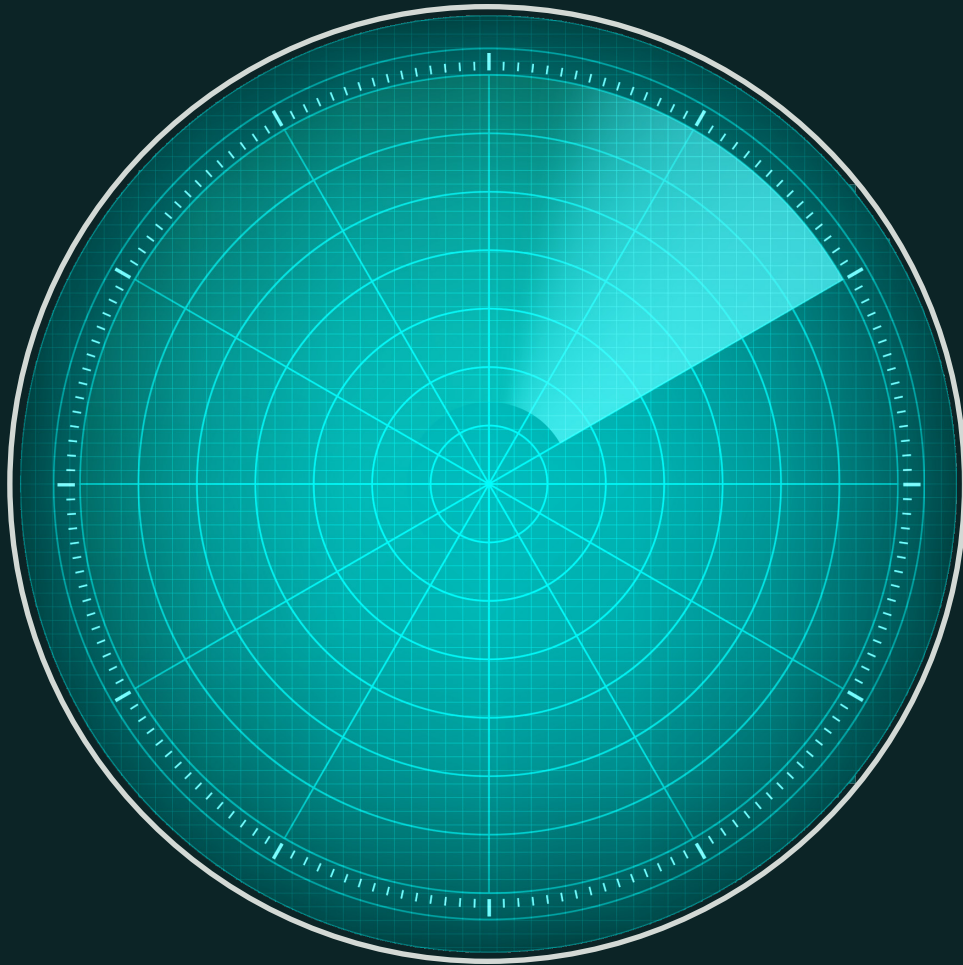


Off the Radar



Office of the Child and Youth Advocate
Newfoundland and Labrador

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Message from the Child and Youth Advocate

Children and youth have a right to live with their family. When it is unsafe or they are unable to do so, it is incumbent on child welfare agencies and respective government departments to secure alternate living arrangements that meet their needs, rights, safety, and well-being.

When young people are placed in alternative living arrangements they have the right to special care, protection, and regular monitoring, as well as the right to decisions being made in their best interests. These are universal human rights of young people as found in the **United Nations Convention on the Rights of Children**, a convention that has been in existence since 1989 and ratified by Canada since 1991.



These rights are even more vital when children are moved between provinces by government systems. Communication, transparency, monitoring, and accountability are critical when vulnerable children are being moved, not only out of their family home, but out of their home province. In such cases, it is incumbent on provinces to work in unison to ensure the best interests of children.

This investigation was called after the Child and Youth Advocate received information regarding the maltreatment of two young children. These children were in the care and custody of another province but had been placed in a home in Newfoundland and Labrador where they resided for nearly two years.

During this time, there was no vigilance and neither the children, nor their care, was consistently monitored. Sadly, there was a lack of communication, shared responsibility, oversight, and accountability; all of which could have mitigated the risks for these young, vulnerable children.

The recommendations in this report call for stronger provisions, monitoring, and expectations between provinces. The safety, well-being, and rights of children depend on systems getting it right and “not letting children fall off the radar”.

Sincerely,

Wilma MacInnis, MSW, RSW
Child and Youth Advocate

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Introduction

The Office of the Child and Youth Advocate

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

United Nations Convention on the Rights of the Child

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

Investigative Process

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

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

The investigative process may include sworn interviews, review of documents and reports, file reviews, policy analysis, legislative considerations, consultation with experts, examination of critical issues, research, and other factors that may arise for consideration.

About This Investigation

This investigation was called after the Child and Youth Advocate received information regarding the maltreatment of two young children. These children were in the care and custody of another province but had been placed in a home in Newfoundland and Labrador where they resided for nearly two years. This investigation involved sworn interviews, a comprehensive review of case file documents, and an examination of relevant policy and legislation.

Documents Reviewed

From the former Department of Children, Seniors and Social Development (now the Department of Social Supports and Well-Being):

Inquiries File

Provincial Office Adoptions File

Interprovincial Adoption Application – Case Notes, Documentation, and Regional E-mails

Interprovincial Foster Home Service – Documentation

Other Children and Youth Care and Protection (CYCP) – Jurisdictional Request – Case Notes and Documentation

Interprovincial Protocol – E-mails

Protection Intervention Program Documentation

From NL Health Services:

Client and Referral Management System (CRMS) Documentation

Meditech Records

Case Summary

This was a complex case involving two provinces and their respective jurisdictions. This report, including its findings and recommendations, speak only to the services provided by Newfoundland and Labrador, abbreviated herein as 'NL'. There remain many unanswered questions which only the originating province, abbreviated herein as 'OP,' will be able to answer. These answers should be sought by the respective oversight body.

This case involved two children who were in the care of another province's child welfare agency since birth. In 2018, the OP requested that NL's Department of Children, Seniors and Social Development (CSSD), now named the Department of Social Supports and Well-Being (SSWB), complete an assessment of two persons identified as potential adoptive applicants.

The original adoption application was for one child but was amended in April 2019 to include an older sibling. A further amendment was made by the OP in December 2019 where the older sibling was removed from the application and a younger sibling was added. While the adoption assessment was ongoing, the prospective caregivers questioned their commitment

to the children on at least four documented occasions: November 2018, February 2020, May 2020, and September 2020. On the February 2020 occasion, they withdrew from the adoption assessment, only to then request that the process continue. One of the caregivers wanted to explore adoption as a single parent, which was not possible since both adults were married and living together. Additionally, several delays were experienced during the adoption assessment process. The OP had not received permanent custody of the children and were engaged in the court process. The approval was further delayed by the COVID-19 pandemic in 2020 and then again due to changes in social work staff from both provinces. This caused further hesitation by the caregivers as they expressed wanting to adopt the children earlier and the children were now getting older. They were also reluctant to meet and work with CSSD staff and preferred communicating with social workers from the OP.

In September 2020, NL approved the adoption and requested final signatures from the caregivers. Despite this approval, the caregivers ultimately decided to withdraw from the process again, this time providing both provinces with notice of “full and final termination of the adoption process”. Many attempts by CSSD to reach the caregivers to discuss their reasoning were unsuccessful and a decision was made by NL to respect their wishes. An in-person discussion was not conducted due to COVID-19 restrictions. A recommendation to close the file was made by the region and submitted to the Provincial Office, which then advised the caregivers by mail.

In January 2021, approximately three months after the adoption process was terminated, CSSD’s Provincial Office received an Interprovincial Request for Services from the OP regarding the same children. This request outlined that the children were going to be placed in NL to live with their caregivers and that assistance would be required from NL social workers to assess and supervise the placement. These caregivers were the same people who had just terminated the adoption process. The request acknowledged the cancelled adoption plan but noted that the caregivers were now open to fostering the children instead. CSSD were asked through this Interprovincial Request for Services to update the previously obtained information, including the home study, to reflect the new foster care arrangement. Social workers from the OP came to NL with the children on January 16, 2021, and returned to their province six days later, leaving the children with the caregivers.

From January to April 2021, there exists correspondence between CSSD and the OP regarding the plan for the children. Much of this correspondence is in e-mail format, and some telephone meetings are mentioned; however, the file review did not find any documented evidence of these meetings.

Initially, there was a plan for CSSD to complete a Significant Other Foster Home Assessment of the caregivers chosen by the OP, as indicated in the Jurisdictional Request. This would be standard procedure so NL could ensure the caregivers met this province’s requirements and not just those of the OP. However, NL advised the OP that they were unable to assist them due to the lack of an Interprovincial Placement Agreement (IPPA) and the 14-day COVID-19 isolation period that was in effect at that time. The Interprovincial Coordinator for NL also reached out to a senior program analyst for the OP on January 18, 2021, to express confusion

over the process being used. Despite this, the children had already been placed in the home. There is evidence demonstrating that an Interprovincial Foster Home Service file was opened in CSSD's Integrated Service Management (ISM) system on February 2, 2021, and a NL social worker was assigned to complete an assessment of the caregivers. However, this assessment did not go ahead, the social worker never met with the children and believed that assistance from NL would no longer be required. During investigative interviews, the social worker assigned could not recall opening the file and concluded it could have been opened in error. The file closed on March 1, 2021, nearly a month later.

Investigative interviews revealed that CSSD employees had differing perspectives on why the children were here and for how long. Despite drafted interprovincial documentation suggesting the children were being placed here, some staff who were interviewed believed the children were staying in NL for an extended visit and that they would be returning to the OP. Others believed that the OP was planning to transfer custody to the caregivers. E-mail correspondence from April 2021 confirms the OP no longer wanted CSSD to complete the foster home assessment and were going to proceed using their own workers. In this e-mail the OP thanked CSSD for a recent home visit by a NL social worker that occurred in April 2021. Other than this e-mail and confirmation during investigative interviews, there is no documentation of this visit, or any visits to the home by CSSD staff during that time. In the same e-mail correspondence, the OP advises NL that they will likely require CSSD's assistance again for additional home visits going forward. This investigation found that CSSD agreed to this but there were no further requests and no action was taken by CSSD to provide oversight nor to check in with these children or caregivers.

In fact, after April 2021 there is no further documented contact between the OP and CSSD. There is also no documented evidence of any CSSD involvement or contact with the children for the next 22 months. However, the health records indicate that more than one year later, the children received immunizations through NL Health Services. Documentation revealed that the nurse administering the immunizations had questions around the status of the children as it related to consent and contacted the Department of CSSD to inquire about same. No evidence was found in CSSD documentation to verify this contact, and the social workers interviewed could not recall this occurring. No evidence was found that CSSD made any inquiries regarding why the children remained in NL well beyond what would be reasonably considered an "extended visit".

NL became reengaged in February 2023 when the Interprovincial Coordinator at CSSD's Provincial Office received an Interprovincial Request for Services from social workers with the OP. They advised they were on their way to NL to visit two children placed in this province, but their flight had been significantly delayed by inclement weather. They had concerns and identified that the caregivers no longer wanted to care for the children and the placement was breaking down. Upon receiving this information, the realization was made by CSSD that these were the same children who came to the province in January 2021. There was no IPPA in place and the OP had been acting independently. There had been no planning, monitoring, or oversight of the children's placement by NL social workers during their extended stay in the province or the two years the children had remained in the province.

On March 2, 2023, at the request of the OP, CSSD sent two NL social workers to the home where the children had been living for nearly two years. They spoke to the caregivers and the children while social workers from the OP were present on speaker phone. During that time, several safety concerns were identified related to supervision. The workers left and consulted with management as well as staff from the OP. There was no documented discussion regarding the fact that the children had been residing in the province for nearly two years. A clinical decision was made that the concerns identified did not meet the threshold for a safety plan or any additional intervention. The social workers from the OP advised they would arrive in NL in the next two days. Upon arrival, these workers took the children to receive medical examinations. During this time, the children disclosed physical abuse to the social workers from the OP. They were immediately removed from their caregivers and a police referral was made.

After a police investigation, charges were laid related to maltreatment of the children. The children were placed temporarily with other NL caregivers and CSSD staff began assessing them as a possible Significant Other Foster Home placement. Due to the needs of the children this arrangement was not pursued, and the children ended up returning to the OP with their social workers.

Findings and Recommendations

Child Rights Framework

As noted in the introduction, all work of the Office of the Child and Youth Advocate is rooted in the 1989 **United Nations Convention on the Rights of the Child** (UNCRC) which is comprised of 54 articles. The following findings and recommendations will be guided by the Convention.

The findings in this case are that several of the children's rights were contravened. These rights include: the right to protection from violence, abuse, and neglect (Article 19), protection by the state while unable to live with family (Article 20), and the right to have treatment and placement reviewed while in care (Article 25).

It is well documented that children in care are considered society's most vulnerable and are at significant risk for poor developmental and social outcomes (Vig et al., 2005; Sariaslan et al., 2022). By being in care, the children in this case were already at increased vulnerability and deserved to be protected from all forms of harm. While the intent of this report is not to assign blame or discuss criminal actions, it should be noted that there was evidence of neglect and maltreatment concerns while the children lived with their caregivers in contravention of their rights.

In addition to the existing rights contraventions and vulnerabilities, significant gaps were identified in the following areas:

1. The Implementation of the Provincial/Territorial Protocol and Completion of an Interprovincial Agreement (IPPA)
2. Supervision and Monitoring
3. Documentation Practices
4. Communication Between Service Providers

The Provincial/Territorial Protocol and the Interprovincial Placement Agreement

To better understand what occurred in this case, an understanding of the Protocol which governs the movement of children and families between provinces is required. One way to help ensure that children in care who move from one province to another are protected is through the Provincial and Territorial Protocol.

Formally known as the Provincial/Territorial Protocol on Children, Youth and Families Moving between Provinces and Territories, the PT Protocol was adopted in 2016 by nine provinces and three territories and adopted by all provinces and territories by 2019. The Protocol outlines the roles and responsibilities of agencies and organizations who work with children and families moving between jurisdictions. The PT Protocol covers child protection, children and youth in care, children and youth in out of care placements, and adoption services. Both the OP and NL are Protocol signatories and therefore agree that its implementation is mandatory. The PT Protocol provides clear guidance around how it should be used including forms that signatories can use when requesting services from another jurisdiction.

The PT Protocol is appended to CSSD's Protection and In Care Policy and Procedure Manual and Policy 4.8 is specific to the Protocol. There is evidence to suggest that NL made multiple attempts to use the PT Protocol. This is evidenced through partially completed forms such as the Interprovincial Placement Agreement (IPPA) form. The IPPA is used when children are being placed by another region or another province to outline critical information. The sending and receiving regions must negotiate and come to an agreement that meets both provinces' legislative requirements and standards of care. In this case, the expectation under the PT Protocol would be that an IPPA be completed outlining each province's responsibilities.

“Where a request is received from another PT to transfer a child or youth to this province, the social worker shall follow the PT Protocol and adhere to the responsibilities outlined for a receiving PT, including the negotiation of an IPPA. A manager shall sign the IPPA as the Local and Central Signing Authority for the receiving PT. A copy of the IPPA shall be placed on the child or youth’s file and another copy shall be forwarded to the Interprovincial Coordinator. The social worker shall ensure a file is set up (electronic and paper copy) when a child or youth transfers from another PT.” (Policy 4.8, Procedure 9, Children Seniors and Social Development Protection and In Care Policy and Procedure Manual, 2025).

In this case the IPPA was not negotiated before the children’s arrival and was never finalized. There is also no evidence of files having ever been created in ISM for these children. Additionally, the responsibilities of the IPPA would include the completion of supervision and monitoring, referred to in policy as courtesy supervision or courtesy work, on behalf of the originating region such as visiting the children at regular intervals.

While the term “courtesy” appears in both the Department’s Protection and In Care Policy and Procedure Manual and the PT Protocol, its use in these contexts is problematic. It implies that the activities being completed are not mandatory and are being provided in good faith. However, the supervision of these children was not only critical to the success of the placement but was their right as rights holders. The Department of CSSD, and NL as the receiving province, had an obligation to these children once they knew they were in this province. The omissions and failure to follow established policies resulted in the violation of the rights of two vulnerable children.

During investigative interviews there were some differing opinions presented regarding who was responsible to ensure the IPPA was completed. While the process of moving children between jurisdictions usually starts with a request from another province to CSSD’s Provincial Office, the request is fulfilled by the respective region. Investigative interviews clarified that the Provincial Office answers questions about the PT Protocol, passes on information to relevant parties, participates in consultation, and completes coordination. All clinical decisions and required activities are the responsibility of regional staff.

There is evidence to demonstrate that CSSD’s Provincial Office attempted to explain to the OP’s counterpart office how the PT Protocol and IPPA should be used and the OP expressed unfamiliarity with the process. While it is clear in the Protocol that it is the responsibility of the OP to initiate and complete this documentation before moving the children, NL as the receiving province did not seek information to confirm their agreement and did not sign any paperwork. Whether NL did or did not agree with the OP’s terms, investigative evidence confirms they knew the children were in NL with no agreement finalized.

Investigative interviews further revealed that it is not uncommon for children to be placed in the province while negotiations are ongoing and issues are being resolved, concluded usually over the course of a few weeks. The Interprovincial Coordinator in this case recalled forwarding a draft IPPA to the region and stated the responsibility then rested with the zone manager.

Once the realization occurred that the children were in this province for an extended time period, there should have been efforts made by CSSD staff to finalize the details of the agreement or request that workers from the OP take the children back to the OP. Both regional and provincial staff should have ensured that there was a plan for these children with paperwork completed, and the oversight process implemented.

The expectation when there are disagreements or unresolved items between provinces or territories is to follow the Dispute Resolution process as outlined in the PT Protocol under Section 6. The Protocol notes that most issues arising between provinces or territories can be resolved at the local level, which is between caseworkers or supervisors and managers. However, if resolution or consensus is not possible, the next avenue is to engage both Interprovincial Coordinators from the respective provinces or territories to find a mutually satisfactory resolution within 14 calendar days of receiving the matter (PT Protocol Section 6.2: Involvement of Interprovincial Coordinators). If solutions are still not achieved, the Protocol outlines a final step in dispute resolution process where the matters are escalated further.

“In the event that the dispute or issue cannot be resolved between the interprovincial coordinators for each PT as described in 6.2, the matter shall be referred to the PT Director of Child Welfare in each PT. A mutually satisfactory resolution of the matter will be determined and communicated within 14 calendar days of the PT Directors receiving the matter or longer time period agreed to by both PT Directors” (Section 6.3 Involvement of Provincial and Territorial Directors of Child Welfare, Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories, 2023, as appended in the Department of Children’s Seniors and Social Development Protection and In Care Policy and Procedure Manual, 2025).

There is no documented evidence to suggest that the OP and NL were able to come to any consensus regarding the completion of the IPPA at the local (regional) level. Some efforts were made by CSSD’s Interprovincial Coordinator to seek clarification from the OP, but this does not appear to have moved forward. There is also no evidence to indicate that any dispute resolution occurred at the highest Provincial Director level. Adherence to the Protocol would have enabled both provinces to finalize the pieces that were not yet agreed upon within clearly defined deadlines.

Supervision and Monitoring

The OP was clear in January 2021 that their plan was to place the children in NL with their caregivers. The OP informed NL of this plan approximately two weeks before bringing the children to the province. This is not considered an appropriate amount of time given the significant negotiation and documentation required for the PT Protocol before placement. Section 8.2.2.1 of the PT Protocol states:

“When planning for a child or youth to reside with a relative or significant person in a receiving PT, the originating PT shall consult with the receiving PT and shall provide the receiving PT with 60 days prior written notice of the plan or such shorter period of time as negotiated between the originating and receiving PTs...” (Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories, 2023, as appended in the Department of Children’s Seniors and Social Development Protection and In Care Policy and Procedure Manual, 2025).

In this case the OP failed to meet the required notice outlined in the Protocol, and CSSD had just days, rather than months, to act when notified that the children were coming to the province. It was also during the COVID-19 pandemic when a 14-day isolation protocol was put in place by the Department of Health and Community Services for travelers to NL. Once CSSD was made aware that the children were in the province, there were interprovincial discussions around the placement of the children and its duration. The OP articulated in draft Interprovincial Placement Agreements and in correspondence about the children that they were being placed here. However, several concerns were identified at this time including the previously cancelled adoption application and indications the male relative did not want to care for the children. Investigative interviews confirmed that the female relative wanted to foster as a single parent despite being married and refused multiple times to be involved with CSSD.

During investigative interviews conducted with both the Provincial Office and the region it was suggested that the children may have been in the province for an extended visit and not placed. However, as the months passed, it likely became clear to workers that the children were staying much longer than a visit. This is acknowledged through communication between the OP and NL between January and April of 2021. Two days after the children arrived in NL, CSSD asked the OP for an alternative family member to be identified in the event of a placement breakdown. Given that there were concerns about the family members, it is reasonable that CSSD would ask for an alternative arrangement. NL did not receive the alternative contact information from the OP and did not follow-up to obtain this information.

The OCYA investigation confirmed that NL did complete at least one home visit to check on the children in April of 2021. This social worker identified similar concerns as previously noted, such as the caregivers' lack of commitment and a fixation on financial compensation. The details of this visit with the family, as well as concerns about the arrangement were then relayed to the OP, as well as told to regional management at CSSD. There are no case notes documenting the details of this home visit. No further visits were completed, no IPPA was ever finalized, and the placement was never approved by NL.

The OP chose the caregivers and assessed them as an ideal placement for the children. For this arrangement to be appropriately implemented, NL would also have to assess this family to ensure they met the requirements of a Significant Other Foster Home placement under NL's standards. This would have involved a home assessment and safety checks amongst other criteria. While many of these elements were completed during the caregivers' earlier adoption application, they had to be revised in 2021 as the requirements for in-care and adoption are different.

After April 2021, these children were left without any NL supervision or oversight. Workers from the OP may have visited the children over the next 22 months, but the standards would not have been the same, and whether they would be licensed to provide ongoing social work services in this province is also questionable. NL child protection social workers should have been the ones to monitor the placement and therefore the children's right to safety and to have their placement reviewed regularly was not upheld. As a result of the lack of oversight, the questionable care of the children provided by their caregivers was not discovered until nearly two years later. This lack of oversight had a detrimental impact on the well-being of these children.

We acknowledge that without a signed IPPA that there was no obligation for CSSD to independently seek to monitor the children. We also acknowledge that the OP no longer wanted an assessment completed by NL and advised they were going to complete this themselves. Despite these acknowledgments, NL still completed a home visit on the OP's behalf and stated they were available to do more. There was some discussion that the OP may have been seeking to transfer custody of the children to the caregivers, and CSSD asked to be informed if this happened. It would be reasonable to expect that at some point NL would have asked whether the children would continue to live here, yet they did not follow up on their status, location, or well-being.

A potential opportunity to make inquiries regarding the children presented itself in fall of 2022 when the caregivers took the children to a public health office for immunizations. The community health nurse who saw the children was uncertain whether the relative was able to consent on the children's behalf and noted that the children did not have NL health cards. The local CSSD office was contacted to inquire about the children's custody status and how to proceed. According to health documentation, the CSSD worker reported there were no open files related to the children. There is no CSSD documentation regarding their actions nor was there any recollection during investigative interviews of this event. This event ought to have alerted CSSD officials that the children were still in NL.

Documentation Practices

This investigation revealed poor documentation practices at the regional and provincial levels of CSSD, and warranted a closer examination of the types of documentation that are required at the provincial level. The documentation provided for examination was sparse. E-mail communication was the only available record of correspondence from the Provincial Office to the regional office, as well as between the provincial offices of NL and the OP. Often telephone or virtual meetings were scheduled via e-mail to discuss the plan for the children but there was no record of the meetings having occurred. Investigative interviews revealed limited recollection of these meetings, but it was confirmed that when they did occur, there would be no documentation of any decision making or next steps. There were also no notes by any Clinical Program Supervisors or Zone Managers, and it was often assumed the frontline worker would document a meeting or call if they were present. Higher level meetings without a frontline worker present, such as between Provincial Office and the Zone Manager were not documented at all.

The Provincial Office is responsible for receiving and assigning interprovincial requests from other jurisdictions. The Interprovincial Coordinator is the first point of contact in this process and is responsible for liaising between NL and the other province making the request. According to the information received through investigative interviews, the OCYA understands that the coordinator receives and interprets the IPPA and may often need to collect information, seek clarification and engage in discussions with other jurisdictions as required under the PT Protocol.

The Advocate was informed that employees at Provincial Office do not take any case notes while working on a particular file and there are no formalized policies related to documentation practices. While the employees are policy and program development specialists, many of whom are trained social workers, they do not document case notes as their decisions and activities are related to policy and not considered clinical in nature. They do however have access to the ISM system to access client information as needed, and some can open and close files. They have many conversations which would be considered high level in nature. Investigative interviews revealed that some employees kept handwritten notes or transitory notes during phone calls, but these were never transferred into case notes or uploaded into ISM. It was expected that the region would be the one documenting. However, given the critical nature of the involvement of Provincial Office staff, it is reasonable to expect that documentation at that level must occur and be tailored as it relates to policy adherence.

At the regional level, there was also a failure to document meetings that occurred virtually and by phone. There were also several consultations between frontline workers and management that were undocumented. A social worker had face-to-face contact with the children in NL in April of 2021. We confirmed this visit occurred and that a report was provided to the OP via e-mail. We found no evidence that the work completed by NL for the OP was ever documented in the ISM system. Review of investigative files indicated that no CSSD files existed in ISM under the children's names. There was an Interprovincial Foster Home Services file opened in February 2021, but it was closed again a month later. There were no case notes attached to this file.

A final area of concern occurred when NL actioned the Interprovincial Request for Service in the spring of 2023. Many of the case notes submitted by the social worker were put in ISM in January of 2024, nearly eleven months after the client contact occurred. This coincided with the initiation of the OCYA investigation. When asked about the missing notes during investigative interviews, it was explained that notes of work completed on the OP's behalf would be captured in the OP's file rather than CSSD's. This is problematic as the information received when CSSD workers did visit the home would have constituted a referral under the Structured Decision Making (SDM) model. This information was concerning children in NL jurisdiction and CSSD had a mandate to assess rather than rely upon the OP.

It should be noted that in November 2025, the Department of Social Supports and Well-Being announced multiple improvements to Interprovincial Coordination Services to "strengthen information sharing and documentation practices of interprovincial requests and alerts". One such improvement was updating the Interprovincial Coordinator role to include the ability to add administrative case notes in ISM where regional staff can then view them. The regional staff remain responsible for adding case notes regarding case management, clinical decision making, and direct involvement. Additional improvements included changes to how child protection alerts from other jurisdictions are recorded, new dropdown options in ISM, and the creation of a designated email address for Interprovincial Requests for Service and Placement Agreements. These enhancements are a positive step, and we commend the Department for implementing changes which will improve service delivery to children and youth moving between jurisdictions.

Communication Between Department Staff

As previously noted, the original plan for the caregivers to adopt the children was unsuccessful. When the adoption was called off by the caregivers, CSSD's Provincial Office requested a file closure recommendation from the regional staff and proceeded to send the caregivers a file closure letter. This letter was dated January 25, 2021.

On January 16, over a week prior, the OP's planned placement was initiated. Social workers from the OP were already in NL with the children and CSSD's Provincial Office, responsible for the in-care program, were receiving and actioning the Interprovincial Request for Services. Both were occurring at the same time about the same children. Given that the adoption file was closing, and the children were now being placed with the same caregivers, information ought to have been known about the caregivers' questionable commitment to these children. Both the adoption and in-care programs were under the direction of the same person at the time (this has since changed and there are now two directors who oversee each program area). The information could have been shared with the staff tasked with completing the Interprovincial Request. At the very least, had there been documentation in ISM, it would have been accessible by the In Care Coordinator.

As noted previously, communication regarding the children ceased after spring 2021. The last contact from Provincial Office was a letter dated May 10, 2021, addressed to the caregivers advising their adoption file continued to remain closed and for them to reach out if they wanted to discuss this further. There was no mention in this letter of the children continuing to reside with them in any capacity.

The final communication from the region was on April 15, 2021, less than a week after the home visit. It was a communication from the Zone Manager to the Clinical Program Supervisor asking to be updated if the OP pursues a transfer of custody. By this point, it would have been reasonable to expect NL to seek confirmation, regardless of the OP's plan. Such confirmation could have established that the children's stay was more than an extended visit, necessitating them to operationalize their oversight responsibility, including monthly visits as required by provincial standards at the time. However, the OCYA found no evidence of follow-up with the OP to confirm that, in the absence of an agreement, they would be responsible for the children, including case management and surveillance.

Recommendations

The following are recommendations for the Department of Social Supports and Well-Being:

Recommendation 1:

The Department of Social Supports and Well-Being examine the current policy and practice to ensure Interprovincial Placement Agreements are completed for children who are placed in Newfoundland and Labrador from other originating provinces and territories prior to placement. The Provincial Office should be responsible for the tracking and monitoring of all IPPA requests, including follow up with the region to ensure these are registered, finalized, and returned.

Recommendation 2:

The Department of Social Supports and Well-Being abandon the use of the word “courtesy” in policy and practice as it relates to the supervision and monitoring of placements for out of zone and out of province placements. Any current use in policy should be reviewed and replaced with more appropriate language to describe the critical expectations of social work practice and legislative responsibility.

Recommendation 3:

The Department of Social Supports and Well-Being audit communications between Provincial Office and the regional offices regarding interprovincial files and requests. Consideration should be given to the completion of Interprovincial Placement Agreements, updates regarding interprovincial files, and statistical information on the number of children placed by other provinces. Consideration should also be given to the implementation of criteria around how the Provincial Office and the regions exchange information related to these requests.

Recommendation 4:

The Department of Social Supports and Well-Being review the role of the Interprovincial Coordinator particularly regarding the high level of ongoing consultation and decision making required for interprovincial files. Consideration should be given to redefining the position to include shared clinical decision making with the region. The position should also focus exclusively on duties related to interprovincial coordination.

Conclusion

All children have a right to be safe and protected. This case highlights the failure of two provinces to protect two young, vulnerable children in care. For 22 months these children went unseen by the Department of CSSD during which allegations of maltreatment were reported.

It is clear from this investigation that workers from the OP did not have a comprehensive understanding of the PT Protocol and how it should be implemented. NL attempted to educate the OP about the appropriate steps to take but failed in their duty to follow up on the children when the plan was unclear. Despite any verbal agreement there may have been between the two provinces, without a formal finalized Interprovincial Placement Agreement these children remained placed in NL without any oversight and corresponding accountabilities, from social workers employed by this province.

This case stresses the fundamental right and importance of monitoring children in care who are in NL from other provinces and the consequences when that monitoring does not occur. As duty bearers, the province had a duty to ensure these children were safe and cared for while residing in the province. Where there may have been concerns or a lack of clarity surrounding the situation, both provinces could have sought clarity around what was expected. This highlights the need for stringent adherence to the Protocol by all signatories.

Further, this case emphasizes the need for more comprehensive documentation and communication at and between the regional and provincial levels. We acknowledge the improvements the Department has since put in place to strengthen information sharing and documentation practices related to interprovincial requests and expect these efforts will continue and a situation such as this does not reoccur. Children's safety, rights, and well-being depend on it.

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