# Out of Focus

Office of the Child and Youth Advocate

PROVINCE OF NEWFOUNDLAND AND LABRADOR

# Out of Focus

## Published by:

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

## September 2012

INVESTIGATIVE TEAM

Child and Youth Advocate

Carol A. Chafe

Investigators & Reviewers

Connie Pike, BA Police Studies (Lead)
Jennifer Forristall-Prim, BSc, MASP
Karen Gray, MSW, RSW

Administrative Support

Amanda Mercer
Danielle Luby

Graphic Design

Nicole Rogers

“I believe the best service to the child is the service closest to the child, and children who are victims of neglect, abuse or abandonment must not also be victims of bureaucracies. They deserve our devoted attention; not our divided attention.”

*- Kenny Guinn*

# Table of Contents

# Acknowledgement

The Office of the Child and Youth Advocate would like to commend those people who brought forward concerns regarding the children for whom this report is written. In particular, one individual who persisted in raising concerns for "William" until they were finally heard. We encourage everyone in Newfoundland and Labrador to continue to bring forward any concerns regarding a child or youth in the hope that one day every child's voice will be heard.

# 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

It is evident to each of us in the Office of the Child and Youth Advocate that there are many children and youth in our province who endure far from ideal family situations. It is also evident that there are many dedicated professionals from various government departments and agencies who strive every day to meet the needs of these children and youth. Unfortunately they are not always successful.

This is the third outstanding investigation since 2005 of the Office of the Child and Youth Advocate, that, as the new Advocate, I committed to ensuring would be completed. While it is unfortunate that time has passed, the importance of telling each child's story remains a priority now and always; it reminds us that we can never lose sight of the vulnerability of those we serve. We must constantly strive to protect them.

For reasons of confidentiality we cannot identify these children but we have given each a name to ensure they are seen as the little children they are. This is the story of "William", "Olivia", "Steven", and "Hannah", four children who were truly victims of neglect and who, for many years, should have been the focus but were not. While many challenges and complexities exist in working in high-risk family environments, there is no rationale for not keeping the child as the focus in all assessments and decision making.

Unfortunately tragedies such as accidental fires happen and in this case, claimed the lives of five people including two children and injured one other. On behalf of the Office of the Child and Youth Advocate, I extend my condolences to their families.

The goal of any investigation is not to lay blame but to identify what went wrong and to prevent it from happening again. This investigation once again highlights themes of deficiencies in the use of fundamental principles by various services and professionals. These include principles of assessment, communication, consultation, documentation, adherence to policy, and collaboration.

While such tragedy cannot always be prevented, the safety of children can however be ensured. We as adults and professionals must make certain the children are the focus and that their best interests are always considered.

**Carol A. Chafe**
**Child and Youth Advocate**

# Executive Summary

During the year 2009, the Office of the Child and Youth Advocate (OCYA) undertook this investigation following a house fire which claimed the lives of five (5) people, including two children, William from Family A and Hannah from Family B. Both of these children were on active Child Youth and Family Services (CYFS) child protection caseloads.

The events outlined in this report span a thirteen (13) year period wherein many social workers and support workers had contact with the families on a regular basis. Except for relatively short and temporary placements that were voluntary, William remained in the care of his mother throughout this time frame. Olivia, Steven, and Hannah, the three (3) children in Family B, had been removed from their mother's care in March 2005 due to issues of neglect but were returned to her three (3) months later. Sadly, when vigilance, reviews, and analysis should have happened during the course of contact with these families, file documentation does not reflect that the necessary safeguards were in place.

The primary deficiencies identified in the system were:

1) nonadherence to policy or lack of policies;
2) lack of in-depth clinical reviews and analysis;
3) lack of documentation and communication;
4) lack of collaboration amongst the service providers, and
5) staff changeover.

The OCYA investigation gathered the pertinent facts, analyzed the data and recommended the necessary changes that would prevent the reoccurrence of such a situation. This report provides an in-depth overview of the case. Overall, the recommendations include: compliance with policy; detailed record keeping; debriefings and full case reviews with newly assigned staff; having experienced social workers assigned to high-risk cases; regular clinical reviews of cases; 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 the rights of children and youth are protected and that they receive appropriate services to meet 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 the future.

# Introduction

On August 3, 2009, the Child and Youth Advocate at that time served notice to the Deputy Ministers of the Department of Health and Community Services (DHCS), the Department of Child, Youth and Family Services (CYFS), and to the Chief Executive Officer of the Regional Integrated Health Authority (RIHA) of her "intention to conduct an Investigation of the services provided by the RIHA to the families of ---," given that they were receiving services from these government departments and agencies. Details of initiating the investigation were outlined in written correspondence to all parties on the aforementioned date (see 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 and Labrador 2001.

The investigation by the OCYA was completed on August 15, 2012 following a careful examination of the interventions with Family A over a thirteen (13) year period and with Family B over an eleven (11) year period. The circumstances surrounding the length of time the OCYA has been involved in this investigation are complex.

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 in both families as Mom and Dad; the families will be differentiated as Family A (Mom - Marion) and Family B (Mom - Sharon). The child in Family A will be known as William. There were two additional children born to the Mom in Family A but the little girl had medical issues and never resided with her parents. The other little boy in Family A briefly resided with his mother but basically lived with his dad and grandmother for the major portion of time covered in this review. The three (3) children in Family B will be known as Olivia, Steven, and Hannah. The dads in both families were rarely present.

This investigation deals in particular with the time frame of December 1995 until June 2008 wherein the Child Protection program area of the RIHA was involved with both families.

Due to the numerous changes in departmental oversight, Appendix B outlines the programs and services in place and the respective department having responsibility at various given times. This report contains numerous and various acronyms in use throughout the system, both before and after legislative changes occurred; official agency names and terminology are detailed in Appendix C.

The significant number of referrals made about each family necessitated the use of calendars for each year CYFS was involved. These calendars are included in Appendix D and Appendix E.

# Methodology

The OCYA called a review into this case as per Section 21(1) of the *Child and Youth Advocate Act*. Information was obtained from a variety of sources to accurately capture the circumstances that necessitated such a review.

Case files from CYFS were provided by the RIHA. The documents spanned a thirteen (13) year period. All written correspondence and records were thoroughly reviewed by the OCYA. In addition, the Office reviewed policies, protocols, and legislation as it corresponded with the relevant time frames within that historical span.

Interviews were held with a variety of stakeholders to answer unaddressed or ambiguous issues and to clarify decisions that were made. The changing dynamics of the organizations involved and the service strategies implemented needed further explanation to properly understand and review the documentation.

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

# Mandate of Pertinent Service Provider

## Child, Youth and Family Services

In 1990, the *Child Welfare Act* was revised from its original version of 1972 to better address the welfare of children. Section 12(1) of the 1990 *Act* outlined the Director's ability to apply for a declaration of neglect where it is believed that a child is in need of protection. It read:

*12(1) Where it is believed, on reasonable and probable grounds, that a child is in need of protection, the director or a social worker or a person authorized by the director in writing may apply to a judge for a declaration that the child is a child in need of protection.*

This 1990 *Act* governed child protection services in the province until 1998 when a new *Act* was implemented. It is clearly evident that the provision of child protection services in Newfoundland and Labrador has undergone significant changes since that time. Up until 1997, the responsibility for child protection matters was under the purview of the Department of Social Services (DSS). In 1997, DSS was renamed the Department of Human Resources and Employment (DHRE). In 1998, The Department of Health was renamed the Department of Health and Community Services (DHCS). 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 Health and Community Services (HCS) Boards (HCS – [Region]). The DHCS then assumed responsibility for the policy direction of child protective services.

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, commonly referred to as the green binder (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 were governed by two policy documents during the period December 1998 - March 2007, a time frame that partially includes the period of this examination. Information provided by management staff of DHCS stated a commitment from that Department to update the existing DSS 1993 Child Welfare Policy and Procedures Manual. It was to be consistent with the new legislation, acknowledge the new service delivery system through the various HCS 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. The DSS 1993 Child Welfare Policy and Procedures Manual (green binder) that accompanied the legislation of the early nineties included a Risk Assessment Instrument. This instrument was adapted from New York State and was reported to be most applicable in alleged physical and sexual abuse cases, with "limited applicability for other protection referrals" (02-04-04). 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, involved assessing risk to children through the development of respectful relationships with children and families. 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 trained to use that tool.

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

In 2005, further restructuring of the HCS 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.

Under the CYFS *Act,* the Protective Intervention Program provides social workers with the legal authority to intervene on behalf of children under the age of 16 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 or a child is being maltreated by another person and the child's parent does not protect the child. 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 CYFS *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)

## Background of Family A

Mom was almost twenty (20) years of age when her first child, William, was born. Altogether, three (3) children were born to Mom and her common-law partner in a twenty-five (25) month time frame. Only Mom's oldest son, William, would remain with her throughout the duration of the time frame being reviewed herein. Her daughter, who was also born during the same year as William, had medical issues that necessitated the baby staying close to a hospital. As Mom and her partner were not prepared to relocate, the little girl was voluntarily placed into foster care. Mom's youngest son lived with his father and grandmother for the major portion of the time covered by this review. Mom and William would move around from community to community a total of thirty-seven (37) times over a thirteen (13) year period.

# Facts Provided – Family A

## 1995

**William**

On December 27th, the first referral was received by DSS about this couple as they had been involved in a domestic dispute. The couple's infant, William, had been present when the dispute occurred. When the information came to light, Mom had just been released from the hospital having just delivered a baby girl. Apparently, there had been an altercation between the parents wherein Dad had kicked his son's crib causing damage to same. Despite Mom reporting Dad had left the residence, hospital staff believed they were still together in the apartment. According to a police records check, Dad had been released from custody approximately two weeks before the incident for an assault against Mom; that charge related to him holding her at knifepoint. He had been placed on an undertaking to stay away from his common-law wife and he was ordered to only visit his children when a third party was present.

As a result of this referral, Dad was arrested for breaching his probation; however, Mom refused to cooperate with authorities denying she knew anything about the conditions of his release. She did indicate they had an argument and Dad had kicked in the side of the crib; according to Mom, William was not in it at the time. Mom was advised she could not return to the apartment if Dad was going to be staying there; she agreed to find alternate accommodations. The new baby, now in Intensive Care, had been born prematurely with numerous medical issues and would be kept at the hospital for approximately six (6) months. Hospital personnel reported concerns about this couple during their interactions when visiting the baby and a hospital social worker referred to their parenting skills as "questionable."

Prior to the actual referral being made, the social worker at the hospital had contacted the social worker in the community where the couple originally resided. The social worker from that community advised the social worker at the hospital that she was familiar with the couple and Mom had been at the women's shelter in the past but no other details were given. According to the social worker's case notes, Mom herself had been a foster child and there was more information in the Child Welfare file on that family. When Mom returned to the community, she went to live with Dad's parents. Dad was required by court order to stay away from Mom. The DSS District Manager advised that the situation did not warrant a social worker traveling to the community; rather the community health representative could follow up if necessary. The manager indicated that if Dad breached his condition, it would be a police issue.

## 1996

**William**

By mid-January, Mom was still residing with William's paternal grandparents. Dad remained near the hospital but officials noted that neither parent showed much interest in visiting with their newborn daughter. The Public Health nurse had commented to the social worker that she had no concerns about Mom and felt there was no reason for her to follow up. Mom was referred for counseling about domestic violence and the DSS file was transferred; it should be noted that Mom, along with William, moved seven (7) different times in the next eight (8) months. On only one occasion, their move was within the same community; otherwise, it was from community to community within one region. Mom's Child Welfare file continued to be active.

During August, it was determined that the little girl, born nine (9) months earlier, should stay close to full medical services. Since her parents were not prepared to relocate, the child was voluntarily placed into foster care. She would never reside with either of her parents. There were no other referrals during this year.

## 1997

**William**

Mom's third child was born this year; he was also premature. In the hospital, the staff expressed concerns about Mom's parenting of her new baby and one hospital official indicated she would be making a referral to Child Welfare because of Mom's poor attitude. Apparently, Mom had left the hospital on one occasion saying she would return in an hour. She returned seven (7) hours later. The next day, she left at 1:00pm and returned 11:00am the following morning.

While it appeared there was no official referral made, the support worker's case notes, dated April 29, 1997, indicated a social worker had spoken to Mom and "felt comfortable with that." There were no follow-up notes from that interview to elaborate on the social worker's discussion with Mom. There was follow-up correspondence written on April 30th to the social work supervisor from the support worker suggesting that Mom needed some support in obtaining a crib and a washing machine. This same worker also recommended that Mom's case plan should include ten (10) hours of respite care a week to help with the care of her two young sons. The writer suggested that if these initiatives were not implemented, then Social Services "…will have to intervene a few months down the road." (Letter dated April 30, 1997 from the support worker to her supervisor.) Mom also reported she was no longer living with Dad but was residing in a different community altogether. The support worker's case notes, dated July 16, 1997, stated that she and the newly assigned social worker made a home visit to Mom's residence and Dad was living with her and their children at that time.

On August 11th, a second referral was received about the family. Apparently, there had been a disturbance at 3:30am in another residence in the town and the police had been summonsed there. Dad had gotten into an argument with his brother and the referral source (RS) suspected alcohol was involved. When Dad was asked where the baby was, he stated, "It's in the van." The baby and Mom were taken to another residence by the RS; William was already at this home. The RS further outlined concerns about the children witnessing violence and "furniture being thrown around," the frequent breakups of the parents, and the baby being left alone in a van.

On August 14th, the social worker followed up on the report by having Mom and Dad attend an office visit. Dad stated he had been "wrestling" with his brother but it was in fun. A few moments later, Mom admitted she had taken her older son, William, to another residence because she was afraid they would get hurt because of the fighting. The social worker congratulated Mom for protecting her older son but reminded her it was not okay to leave the baby alone. Mom and Dad were currently residing in different homes. The police were contacted in order to confirm their response; the police receptionist stated the Child Protection

Report (CPR) would be faxed to the social worker but no such document was on file.

Later in August, the social worker called Dad to follow up. While he reported that Mom and the children were presently in a different community, things were going really well between them and he planned to join her there soon. A month later, the social worker made a home visit to Mom's residence. The couple had now split up and the younger boy was living with his father and grandmother. It appeared from case notes written later in the year that the couple were residing together again for a short period of time. Mom had made a total of four (4) moves from community to community within the region during this calendar year.

## 1998

**William**

Early in the year, Mom and Dad signed consent for their daughter, who was currently in foster care, to be adopted. It appeared the couple was once again residing together. Dad was certain this was the best approach for the child while Mom was more ambivalent. They were advised by the social worker that they had twenty-one (21) days wherein they could change their minds. There was no follow-up call made to the social worker by the parents about this issue. There were no other reports or referrals about this family for the remainder of the year. Only two case notes were documented during this year and it appeared that the family remained together and lived in Dad's community.

## 1999

**William**

In January, the social worker received a telephone call to report that Mom was in attendance at a medical clinic with her oldest son. She was indicating that she and Dad had gotten into an argument and he began pushing her around. Mom had nowhere to go and did not feel safe returning home. Arrangements were made for Mom and William to stay at a local women's shelter. Following a stay at the shelter of a few days, it appeared from file documentation that Mom and William moved twice in the next two months

On May 16th, a third referral concerning William was received. Apparently, the child had been slapped in the face by either his mother or her new boyfriend. The police went to Mom's residence and spoke with her. The officer did not see any evidence of the child being hit (no marks on his face) and the child did not appear distraught. The only documentation that existed concerning this referral was the actual CPR that was contained in the DSS file. There was no other followup on file related to this matter.

On August 9th, a fourth referral was received concerning William. The RS stated that William's mother was out drinking and partying on a regular basis. If Mom did not take William along with her, she left him in the care of babysitters that he did not know. There were no rules for William about a specific bedtime and he mainly ate junk food. Mom currently had no apartment of her own but moved around and stayed with different people.

The following day, the social worker spoke with Mom at the office. Mom stated that William was now visiting with his father in another town. She further denied the allegations made in the referral. She indicated that she does not go to bars and when she does go out, she always has a babysitter for her son. The social worker noted that the person Mom named as her sitter was also on the child protection caseload. Mom denied that William ate a lot of junk food saying she cannot afford to buy much. The social worker told Mom there was not much she could do about the referral because, "we have no proof to back up concerns." (Case notes dated August 10, 1999.) She went on to say the case would be monitored, and she recommended a preschool program for William; Mom agreed with the suggestion.

On October 6th, the fifth referral on the family was received indicating Mom had been taken to the women's shelter overnight by the police. Shortly after her arrival at the shelter, she wrote a note saying if anything happened to her, she wanted William to be placed with her father; that note is on file. Staff at the shelter feared she may be suicidal and sent her to the hospital. At the hospital, it was noted she smelled of alcohol and she told a nurse she had been using cocaine.

William stayed at the shelter while his mother was gone. During that time a shelter worker learned disturbing details about his home environment including that Mom's boyfriend yells at him, hits him and hits his Mom. The worker then wrote, "I feel this is child abuse no child should be left in." (Shelter worker's notes dated October 6, 1999.)

When Mom arrived back from the hospital, she lay down next to William for about fifteen (15) minutes. She then stated she wanted to go home and asked if the worker would call a cab for her. The staff person tried to get her to stay and told her what William had said. She further encouraged Mom to seek help for her and William.

The social worker followed up during business hours that day and learned that Mom had made several calls to the police the previous evening. When they went to her residence, she alluded to having been assaulted but refused to give a statement. It was then that the police decided to escort her and William to the shelter. The social worker also ascertained from shelter officials that Mom had been there three (3) times this year. Each time, Mom's visits had resulted from abuse at the hands of her partners. The worker at the shelter said she was very concerned about William. Further to that conversation, the social worker called the police station to set up a time to meet with Mom and William. They agreed to go to the house unannounced. The police confirmed Mom's boyfriend did have a criminal record and he was considered violent. At present, he was not under any court imposed conditions.

The social worker and the police went to Mom's residence to conduct an investigation into William's statements. The person who answered the door confirmed he was the boyfriend but he stated he had not seen Mom since the evening before when she and William had left; they had not yet come home. There was no documentation on file that indicated he was questioned about the events of the previous evening. It took several hours to track Mom down. She agreed to come into the office to see the social worker. Mom was told that William would have to be interviewed by the police and she agreed.

The social worker drove Mom and William to the police station where Mom refused to give a statement about the assault on her. Mom denied there had been any physical abuse against William, saying that her boyfriend would yell at him if he did something wrong, and in turn, she would tell him not to yell at the child. Confirmation was obtained that William was hit by Mom's boyfriend. Mom said that her boyfriend did not spend a lot of time alone with William so she was unsure how anything would have happened.

The police officer present advised Mom they needed to ask William some questions and that the interview would have to be videotaped; Mom agreed. Again confirmation was obtained that William was hit by Mom's boyfriend and was put in a dark room at bedtime without a nightlight on. The police advised they did not have enough information to formulate a criminal charge. The social worker then drove Mom and William home as Mom indicated she had no

concerns about going back there. The social worker advised Mom of the importance of protecting children from witnessing violence. The worker advised that she would be following up tomorrow.

On October 7th, the social worker made a home visit to Mom's residence. She reviewed the risk factors of Mom's relationship and the home environment. Mom would not admit to any physical violence, only that her boyfriend was yelling and pushing her; she did say she was afraid it might get worse. Mom told the social worker she had only used drugs twice. Mom also said she was not suicidal and had only written the note about William because she was afraid he was going to be taken from her by the social worker.

On October 13th, the social worker received a call to report Mom had gone to the women's shelter in the early morning hours. The social worker proceeded to the shelter where Mom advised that she and her boyfriend had gotten into an argument and he grabbed her head. Her boyfriend warned her if she called the police, he would break her neck. The yelling woke William, and he and his mother left for the shelter; Mom told her boyfriend it was over between them. The police escorted her back to her residence to collect her things. She was prepared to stay at the shelter until she could make other arrangements. The social worker confirmed that William had witnessed his mom and her boyfriend fighting.

On October 19th, the social worker became aware that Mom was not respecting the house rules at the shelter. It was reported that Mom's social life was more important to her than anything else. She was not getting up with her son; she did not want to do any chores, and she was always in a bad mood. An appointment had been set up with a counselor but they were unsure if Mom had kept it. Mom returned the social worker's call and said people at the shelter were "too grumpy – watching every move." Mom said she was still planning a different living arrangement, possibly with her father but she had not called him yet. The social worker encouraged Mom to be patient and follow the house rules.

On November 5th, when the social worker still had not heard from Mom, she called the shelter to check on her. Staff there informed the worker that Mom had left several days ago and she had been seen with her abusive partner. The social worker indicated in her case notes of that date that she would be attempting to locate Mom but if a search was conducted, it was not documented. Based on the file documentation, it appeared Mom made a total of five (5) moves this year. There were no other case notes for the year.

## 2000

**William**

On March 9th, the social worker was advised by one of the support workers that William had moved to another community to stay with his father. Mom was reported to have a new phone number but the first attempt at telephone contact by the social worker resulted in no answer. Four (4) days later, the social worker reached Mom who advised William was now living with her again. Mom also told the worker she had left her abusive boyfriend and had actually pursued charges against him for assaulting her. He had pled not guilty and the court trial was due to begin soon. Mom assured the social worker she would let her know about the court outcome as the worker wanted to assess the case for closure.

The social worker made notations in the file on June 16th, July 4th, and August 16th documenting her attempts to contact Mom. A letter was forwarded to Mom on August 17th at her last known address but no response was forthcoming. On November 6th, the social worker completed a case closure report that summarized her involvement with this family over a two year period. Even though she had been unable to contact or locate Mom or William, she recommended the file for closure pending further referrals. Her rationale was: "[Mom] is no longer with the abusive partner who put her's and [William's] safety and well-being at risk." (Case closure report dated 00-11-06.) The file was closed; it was signed and dated by the social work supervisor on November 7th. There were no other reports on file concerning Mom or William for the remainder of the year.

## 2001

**William**

On March 6th, a sixth referral was received concerning William and the family's file was re-opened. The RS reported the child was missing a lot of school and when he would attend classes, he would say he was hungry. The RS reported Mom's brother and his friend were living with Mom and William in a one bedroom apartment. They stay up all night and they sleep all day. The RS also stated William suffers from constant nosebleeds.

The social worker contacted William's school concerning his attendance record and was advised that he had missed forty-nine (49) days since October 1, 2000. The school also provided a copy of a letter they had received from Mom (dated February 16, 2001) wherein she explained why the little boy was missing so much school. According to Mom, William was sick quite often because he had asthma and was not supposed to be around carpeted areas. Mom stated she was attending school herself in the afternoons from 1-5pm. She went on to say she did not have a phone at present but Mom included her address (a postal box) in the letter, if the teacher needed to contact her.

The following day (March 7th), the social worker located Mom at another residence where she had been babysitting overnight. In her case notes of that same day, the social worker commented that Mom was babysitting for a person who was also on an active child protection caseload; this type of arrangement was not supposed to happen. William was with his mother and not in school on this date. As the homeowner was in attendance, the social worker did not feel comfortable broaching the subject of the referral. The worker indicated she would be following up at Mom's home.

According to her case notes, the social worker made numerous subsequent attempts to reach Mom either by phone or in person. The notes indicated the following attempted contacts: "…unannounced home visit – no answer" (April 27); "…phone message left by Mom but no phone number given" (May 18); the social worker contacted the school: "[William] had been out for the last two weeks but was present today…worker cannot connect with [Mom]" (June 15), and "…worker had requested [support worker] to locate [Mom] but she was unable to do so" (December 11).

On this same date, the social worker noted, "Due to other higher priority cases, this file was neglected unfortunately." (Case notes dated December 11, 2001.) From June 15th until this date in December, William's whereabouts were unknown. The social worker also contacted William's school in December and was advised by the principal that William was now residing in another community with his dad. The worker made a phone call to Dad and confirmed with him that William had been residing there since the summer. The social worker consulted with the support worker in the area who advised that William was currently on a

protection caseload with his Dad and would continue to be monitored by the support worker. No other information was recorded about the protection caseload as it related to Dad. The social worker closed her file on December 11, 2001 as Mom now had no children living with her. There was no case closure report on file and it appeared there was no discussion with a supervisor. The next contact would be midway through the following year when the next CPR was received.

## 2002

**William**

The case notes reflect, but not definitively when, that William moved from his dad's residence back to his mom's community sometime during the school year of 2001 – 2002, possibly around May of 2002. It appeared that when William returned from his father's, he moved in with his uncle as Mom's living situation was unstable. This living arrangement was orchestrated by the family and weeks later, when the social worker learned of same, a Child Welfare Allowance (CWA) was provided to assist with William's care while he resided with his uncle. The first CWA cheque was made retroactive to mid-May.

On June 12th, a seventh referral was received. The RS expressed concerns about William. Even though William was residing with his uncle during the week, the RS indicated Mom would have her son on the weekends and her lifestyle was questionable. This RS went on to say Mom had been moving around a lot and she was partying regularly. This was causing instability for the child and as a result, William was not eating properly or regularly and was missing a lot of school. The RS asked child protection officials for assistance with ensuring William would be raised in a stable environment.

The social worker contacted Mom and set up a meeting at the office for June 17th. The discussion centered on William's need for a stable environment. Mom denied William was missing school but admitted he was staying with his uncle during the week because she was presently in school herself. She also denied going out a lot to party. Mom indicated her desire to finish school and then care for her son.

On June 25th, the uncle advised that Mom had taken William for the weekend. She returned him on Saturday for a couple of hours saying she wanted to go to the gym. Mom did not return for the remainder of the weekend; it was suspected by the uncle that she had been drinking all weekend. The social worker suggested there was no immediate risk to William as he was not around his mother when she was drinking.

In July, the social worker consulted with her supervisor and an agreement was reached that a Special Needs Assessment for William was to be completed. During July and August, there were phone calls to the social worker from both the uncle and Mom. Much of the concern from the uncle was about Mom's lifestyle, while Mom was asking about access to her son. The social worker encouraged the uncle to understand Mom's need for contact and he should help facilitate a relationship between William and his mom. The uncle had no difficulty with that only suggesting that Mom's visits be planned and that she actually show up.

According to William's uncle, Mom had not contacted her son for over a month; however, on August 7th, she indicated she wanted William back as she

was leaving for another town to reside with her own father. The uncle noted that William's grandfather drinks as well and it may not be the best environment for a young child. This move did not happen but the friction between the uncle and Mom continued as she was not regularly calling or making visits. On one occasion, the uncle reported William had cried himself to sleep after his mother said she would call but did not. It was also stated in the social worker's notes that "…whenever [William] visits with his mom, food must be sent along with him." (Case notes dated August 23, 2002.) The uncle indicated this was nothing new as Mom often called asking for food when William did live with her. The uncle also stated he had begun keeping a journal about Mom's activities and contacts.

On August 30th, there was a physical altercation between the uncle and Mom. The police were called but no charges were laid. William's uncle was upset; he stated, "[Mom] has no income, no food to eat, and is sleeping in the back porch at ---." (Case notes dated August 30, 2002.) Following this incident, which William had witnessed, Mom again stated her intention to have her son reside with her. She was presently staying with another couple who said they had room for William to stay there as well. The social worker talked to Mom on September 3rd about the importance of providing stability for William and they should not be moving around as much. At that office meeting, it was noted William was in his mother's arms and they were quite affectionate with one another. The social worker was prepared to have William stay with his mom but said she would be monitoring the situation.

On September 4th, the file reflects there were "…not enough grounds to pursue a warrant to remove, will be supporting [Mom] and [William] staying together." (Case notes dated September 4, 2002.) The uncle, when told of the plan, became quite upset and expressed concerns about the living conditions Mom and William would be in and also stated that the little boy would be malnourished. The uncle was assured the situation would be monitored. The same day, a phone call was received from William's father expressing his interest in having his son reside with him. Officials were concerned about this idea stating, "…worker said he has a right to do so but doesn't sound any more stable than [Mom]." (Case notes dated September 4, 2002.) A subsequent conversation with Mom revealed she was not in agreement with that proposal; she stated she did not even want William to see his dad and would only agree to them having telephone contact.

On September 12th, the social worker made a home visit and things appeared to be in good order. According to Mom, William was adjusting well to living with her again and they were both doing fine. They currently shared a bedroom and Mom was receiving assistance from DHRE.

On October 11th, the social worker attempted another home visit but there was no answer. She noticed a bagful of beer cans beside the steps to the house. Five (5) days later, an anonymous caller reported William was not in

school and had moved again. A phone call to William's school revealed he had transferred to another school and arrangements were made to see him there.

On October 16th, a school visit was completed to interview William. According to the social worker's documentation, he was doing well. The worker determined he was living with an aunt and uncle and that he would only stay home from school if he was sick. They talked about what he ate and the activities he and his mom did together. The worker also learned that his mom did not drink very much and that William was going to live with his dad in thirteen (13) days. This information was concerning given his father's situation. The support worker for that area had commented that Dad's house was full right now and there were always protection concerns. Two days later, the social worker attempted a home visit with Mom but there was no answer. She left a message for Mom to call her.

On October 28th, the social worker called William's school and learned the child had missed three (3) days last week. The school had called the contact number and was told by William's aunt that he would be out of school for one to two weeks. Again, the school had ongoing concerns about his attendance. A home visit was made on this date but Mom was not there. It appeared as if the social worker awakened his aunt. William was dressed and watching cartoons. A message was left for Mom to call the office. Mom called the social worker later that day and a meeting was set for November 1st. Mom failed to show up for the meeting and a follow-up call was made on November 15th to reschedule. Mom stated she had forgotten about the meeting.

During this telephone contact, Mom indicated that William was doing well and had not been sick lately. Another meeting time was scheduled for November 22nd. On that day, Mom called the social worker's number and left a message about rescheduling again; she offered no explanation about why she could not keep this appointment. On December 16th, the support worker contacted William's school to check on his attendance. She was advised by the secretary that in the last three (3) weeks, his attendance had improved. The secretary did state that it had been a problem prior to that. The file showed that Mom and William experienced three (3) moves this year – within the same town. There was no indication of any further activity on this file for the remainder of the year.

## 2003

**William**

On May 26th, an eighth referral was received about William missing school or not arriving there on time; apparently, he was staying up quite late at night. The RS indicated that Mom was drinking, going out frequently and in fact, she had left for the mainland with her current boyfriend, leaving William behind. While she was away for a week, William was staying with another person because his mother had a disagreement with his aunt, where they had been residing. The RS stated the child was getting moved around a lot; he had stayed in three (3) different places since his mother left.

The following day, May 27th, a school visit was made to interview William. To the social worker, he appeared happy and healthy. He talked openly about his mom's trip away and how he missed her. The social worker learned that William liked living with his mom; she helped him with his homework. He only stays up late on weekends and only misses school when he is sick. There were no concerns expressed to the social worker about his temporary living arrangement and no confirmation about whether his Mom drank. The file was transferred to another social worker around this time. On June 4th, a home visit was made to discuss the issues with Mom. She believed her "ex" (William's father) was causing trouble for her. Following the discussion, the social worker appeared satisfied to leave William with his mother.

On September 11th, the social worker contacted Mom by telephone to determine how things were going. Mom stated she needed to find a different living arrangement as her current situation was "wearing out." Mom was offered a letter of support for NL Housing and was told the social worker would be following up to assess her situation for a file closure. Before this happened, the file was transferred to another social worker.

On September 29th, it was learned that Mom and William were living at another friend's house because she said the woman she had been staying with was playing mind games with her own children. During a home visit to the friend's house, Mom suggested to the social worker that CYFS keep an eye on this woman. The social worker asked Mom to call her in the next few weeks as closure of her file was being considered. (Case notes dated September 29, 2003.)

On October 7th, Mom called to report that she would be moving into her own place by the end of the month. A meeting concerning her file closure was scheduled for October 10th at 1:30pm but much later that day, Mom called about transportation to the meeting. The social worker indicated in her notes that she would have to follow up with Mom at a later date as she did not have her current phone number.

On October 27th, Mom reported that her friend, where they were currently residing, had gone out and locked the door. She and William were outside in the cold until after 11pm. The following day, Mom advised she was moving into her new apartment and she needed some furniture. Mom was told to check with other sources as CYFS did not provide clients with furniture. The file was transferred to another social worker on October 29th. There were no other reports or referrals received for the remainder of the year. File documentation indicated William and his mother had moved four (4) times during this year.

## 2004

**William**

The recently assigned (October 29, 2003) social worker's first documented entry for this year states: "Due to high caseload demands, this worker unable to follow up with file til this date." (Case note dated January 7, 2004.)

On February 27th, Mom was at the CYFS office to meet with a social worker, not assigned to her file, concerning a young man who had been authorized to live with her under a Youth Services Agreement. The case notes reflected that the assigned social worker happened to see Mom at the office and requested they meet to discuss the closure of her file. Mom agreed and informed the social worker that things were going well for her and William. They were currently in their own apartment, William was attending school regularly, and she was now employed so things were easier financially. As no referrals had been received since May of the previous year, and there were no apparent child protection concerns, the file was recommended for closure on this date and the actual file closure was signed by the social work supervisor on March 4th.

On May 29th, the on-call social worker received a call stating Mom had gone out the night before and had not come home yet. William was staying with someone who was getting tired of caring for him. The caller indicated apprehensions about Mom's unstable lifestyle and how William was being passed around, again. The following day, May 30th, William's uncle called on behalf of Mom and William. They had been staying at his place but the landlord had requested they leave. They now had nowhere to go. William's paternal grandmother was in the community but was leaving the following day and she was prepared to take William home with her. Mom was with the uncle when he called and the social worker spoke to her directly. The worker expressed her concern about William continuously moving around. Mom said she was prepared to have him go with his grandmother. She further indicated that William would be better off doing that right now and they could make it long term. Since all parties agreed, William left town and remained with his grandmother for the next eighteen (18) months. The file reflected three (3) moves for William during this calendar year. The information outlined above for May 29th and May 30th was located in an e-mail (dated July 17, 2004) and did not appear in any case notes on file.

## 2005

**William**

At the beginning of this year, William was living in a separate community from his mother and was in the care of his paternal grandmother. This arrangement had begun the previous year on May 31, 2004 as Mom had admitted she was unable to care for him. William's grandmother began receiving a CWA shortly after he arrived at her home.

On November 2nd, Mom expressed interest in having William return to live with her. A new social worker, assigned in the community where William resided, had taken over the file. This worker advised Mom that a case plan would have to be developed to assess her current situation. Only then could a determination be made if it was in the child's best interest to have him return to his mother's care. Mom reported her son was unhappy in his present arrangement; he calls her every night and cries that he wants to come back. She was planning on going there and removing him herself. Mom was advised against this type of action. The social worker was steadfast in conveying to Mom the need for a case plan prior to any living arrangement for her and William. The worker went on to say that if Mom took any action and did not leave the child with his grandmother, that William would be removed from her care. This social worker contacted the office where Mom was residing to inquire about their ability to work with Mom on a case plan and to conduct the necessary assessments. The district manager advised the worker that "…the --- office was quite busy, understaff and could not meet with [Mom] until two weeks." (Client Referral Management System (CRMS) notes dated 2005-11-02. These notes were added on CRMS 2006/01/10.)

Also on this date, the same social worker contacted William's grandmother. She reported that William wants to go back and live with his mother and he may be better off doing that. This woman indicated she was experiencing some behavioural problems with William and she no longer wished to care for him. She also stated Mom had gone for long periods of time without contacting William but lately, she had been calling a lot.

The social worker consulted with the supervisor and was told a decision to return William to Mom's care would not be supported. Mom was quite upset by the decision and voiced her opinions accordingly. She had been of the belief there was only a verbal agreement in place between her and William's grandmother and there was no reason for CYFS to be involved now. It was explained to Mom this was not the case. When it was outlined to Mom that the biggest drawback in her case was the lack of stability, she told the social worker she was presently in a living arrangement with another couple. They were willing to have William live there as well; he could even have his own room. Again, the worker stated the need for an assessment before William could change residences, but Mom said she would be going to pick him up. Mom was advised that if she did so, William could very well be removed from her care. She agreed

to wait until the case plan was completed but stated she would like to have William come visit her on November 11th weekend and again for Christmas. Arrangements for those two trips were made.

On November 3rd, the social worker called Mom who reported that William was unhappy and wanted to be with her. Again, Mom was advised a case plan had to be developed first by the office in her area and there would be rules to go along with that plan. The social worker advised Mom that William must have a stable environment; Mom should not be drinking when she is providing care to her son; adequate caregivers must be in place in Mom's absence; she and William must attend counseling sessions, and she must participate in parenting classes. Mom stated she would not wait long and hoped that CYFS would work with her soon.

On November 15th, Mom reported by telephone to the social worker that William had a good time with her when he came to visit over the November 11th weekend. They had gone skating together and William was upset when he had to return to his grandmother's. Mom took the opportunity to ask when the case plan might be done. The social worker advised Mom that the office was currently very busy but that she should continue to make contact with them.

Mom called the social worker again on November 21st and December 15th about her case plan; she expressed frustration and indicated to the social worker she should not have to wait because her case "is not a priority." Mom reported she had not received any response from the office since her initial contact of November 2nd.

On December 19th, information was received by the social worker from an anonymous source that indicated Mom was doing some heavy drinking at her home. It does not appear as if this information was treated as an official referral. The following day, December 20th, Mom was contacted by phone. It was not clear from the case notes why the phone call with Mom was initiated, whether it was in relation to the reported drinking or the impending case plan.

During this telephone conversation, Mom said she had been advised that before William could come and stay with her, she needed to have a social worker assigned to her case. Mom stated she would like to have William stay with her following his Christmas holiday. The social worker said she would consult with her manager and call Mom back. A call later that day to Mom updated her on William's inability to stay following the holiday. She was told the case plan and assessment needed to happen first and William would have to return to his grandmother's after Christmas. Apparently, the manager had told the worker that, "…due to a lack of social workers at the time and workers' Christmas holidays, the assessment and case plan would not be done before Christmas." (CRMS notes dated 2006/01/05 capturing events of December 20, 2005. These notes were added on CRMS 2006/06/11.)

William came to visit with his mother on December 22nd and seven (7) days later, Mom stated she would not be sending him back. This information was made known to the support worker in William's former town, who, in turn, passed it on to the assigned social worker. There were no home visits to Mom's residence during the Christmas season. Mom had been staying at a friend's house so it was suspected William was there as well now.

## 2006

**William**

On January 3rd, the social worker called the residence where Mom and William were staying. Mom's friend advised she was concerned about William not going to bed on time; since he arrived there on December 22nd, the earliest time he had gone to bed was 12:30am. This woman also reported Mom was drinking regularly; she had gone out for New Year's and stayed out all night. She further commented that, "[Mom] has a lot of growing up to do - she thinks that life is one big party." The friend agreed that they could stay there but Mom would have to follow the rules and William would have to go to bed earlier. She also thought Mom would benefit from some parenting courses.

On this same day, the social worker wrote an e-mail to the supervisor indicating Mom had refused to send William back to his grandmother's as she felt CYFS had enough time to assess her situation by now. The following day when Mom asked if she could allow William to attend school, the answer was "yes" as the assessment work was about to begin.

The next day, January 5th, the ninth referral was received about Mom. She had not been at the location where she was supposed to be residing for the past three (3) days. The RS said Mom had been partying over Christmas; William was being left with other people, and he was not going to bed on time. The house where she was reportedly staying had five (5) people residing there and only one bedroom. The social worker attempted to locate Mom to complete a home visit. She was found in the residence identified; she was sleeping in the laundry room with a male friend and William was at the same location sleeping on a bed in the living room. It was 10:15am and Mom was asked why William was not in school. She responded, "…he was up this morning for school but their ride didn't come; also he has no sneakers for school or lunch to bring." (CRMS notes dated 2006/01/05. These notes were added on CRMS 2006/06/11.)

Mom was advised this house was not appropriate for sleepovers as it was too crowded and she was invited to come to the CYFS office in the afternoon to develop her case plan. Even though Mom agreed to get William to school for the afternoon, he was with her when she arrived at the office. Mom stated that the Principal had told her to bring him for the full day tomorrow. Mom was upset with people making referrals about her and she declared that she does look after William. She denied the allegations being made and suggested people were spying on her.

On January 11th, an e-mail written by the social worker in the community where William lived with his grandmother to a supervisor in the community where he was currently residing, suggested that a protection file would be a good idea. This worker also indicated that it was decided there was not enough information to take to court to complete a removal. This social worker wrote, "[Mom] appears

to have a stable home environment, secured HRLE [Human Resources Labour and Employment] and reports she is looking for employment, reports that she wants to go to counseling and perhaps attend school." (E-mail dated 11/01/2006 from the social worker to the program manager.) This worker further commented that the office should have worked with Mom before William went home. Furthermore, that a worker should meet with Mom to develop a case plan and monitor any risks to William. This social worker transferred the file on this date. Another social worker was now taking over the file.

On January 13th, a follow-up call was made to Mom. She asked about getting William's bed from his grandmother's and wondered when her file would be closed. Mom was advised that the case plan had to be developed and in place first.

On January 18th, Mom made an office visit to review her case plan. She did not know why a case plan was necessary and asked again when her file would be closed. In the proposed case plan, reference was made to mental health and addictions counseling for Mom; she refused to sign the document as she believed it implied she had an addiction. The social worker told her she would adjust the wording.

On January 23rd, Mom missed a scheduled appointment at the CYFS office to complete follow-up work on her case plan. There was no explanation provided. The appointment was rescheduled for the following day.

On January 24th, Mom visited the CYFS office to sign her case plan with the adjusted wording concerning her addictions counseling. The goals that had been set for Mom in her case plan included:

> [Mom] is not to consume **any** amount of alcohol or be under the influence of alcohol when caring for [William]; [Mom] is not to have Inappropriate Individuals present while caring for [William]. This includes **anyone under the influence of alcohol and/or drugs** or those with a **criminal history**; [Mom] is to ensure that should [William] be left with a caregiver, it be for appropriate amounts of time and that the individual be deemed suitable, which will not include individuals under the influence of alcohol or drugs, or those with a criminal history; [Mom] must ensure that [William's] basic needs are met while he is in her care. This includes getting [William] to bed at appropriate hours. (Case Plan dated January 24, 2006.)

Further to the plan, Mom said she intended to arrange counseling for both herself and William. It was noted on this case plan, as a result of the December 19th report of Mom's heavy drinking, that "The main concern was not with [Mom] drinking but that she was not drinking while caring for [William]."

On February 11th, an out-of-hours call was received that Mom had been kicked out of her living arrangement for drinking on two different occasions. The

caller also stated that Mom was babysitting for another woman and it appeared that this was an unacceptable practice as the social worker commented, "…although not an approved caregiver as [Mom] has an open protection file." When the social worker visited Mom's location, Mom denied drinking and partying while her son was present. She told the social worker she would be going to the women's shelter with William but she did not offer a reason why nor was she asked. The information concerning her whereabouts was not confirmed. This information was not written as an actual referral.

Mom called two days later to say she was still at a friend's. Her plan was to apply for housing and she was offered a letter of support. The next day (February 14th), Mom called to say she had found a place but needed furniture. She was told that furniture acquisition was not within the CYFS mandate. Mom stated she had to leave her friend's house and she had nowhere to go. The women's shelter reluctantly agreed that she and William could stay there.

Over the next several days, numerous calls were made by the social worker to try and find a suitable living arrangement for Mom and William. Mom had found a location through the housing authority but had no furniture. The social worker acknowledged in her case notes there was a pattern of Mom's living situations breaking down. Mom left the shelter on February 27th and moved into her own apartment.

On March 6th, the on-call social worker received a call about Mom being drunk. According to the caller, Mom had arrived at a residence to see her son who had been there with his friend. The caller said William got upset and left the house alone. When the social worker arrived at the residence, she was told Mom had been in an argument with William's father who was visiting there. Information gathered was now indicating that Mom and William had left the house together walking to their own place. The social worker called Mom and cautioned her about arguing in front of William. The worker also spoke with William by phone and he indicated he was fine. This was not recorded as an actual referral.

On April 25th, another report was made about Mom drinking around her young son and him not going to school. The caller went on to report William was playing alone in an unsafe area that was near the water. A few days later, the social worker made a phone call to William's school to determine his attendance record. The social worker was told he had missed approximately three (3) weeks of school between January and April. William was also not there on this day, May 1st. The social worker scheduled a home visit with Mom for May 3rd.

During that home visit, Mom denied all of the allegations saying she does not drink in front of William. Mom was asked about William's school attendance and she stated he only stayed home when he was sick. This social worker noted she had been told in the past about William's nosebleeds and other ailments. Mom said that there are times when William goes out on his bike with his friends but he was aware of the places to avoid. Mom indicated to the social worker that

she needed to have a two bedroom apartment. A letter of support for same was sent. The report of April 25th was not recorded as an actual referral.

On May 16th, another anonymous call was received indicating Mom drinks quite a lot and William misses a lot of school. The child had been out at 10pm the evening before and could not reach his mother on her cell phone. There was no indication there was any immediate followup to this call.

On June 14th, the next contact with Mom occurred when the social worker made a home visit at 9:30am. The worker noted Mom had now moved downstairs to the basement apartment. Mom cited her reasons for this move as, "…it was too hot upstairs, the windows did not shut, and lots of nippers came in." The social worker asked Mom about recent referrals concerning William not attending school and how late he was staying up. Mom said the school had been in touch with her and she was aware that William was sleeping in class. Mom was quite defensive with the social worker on this date. The social worker tried to explain to Mom that her questions centered on William's well-being. Mom stated the social worker could not tell her what time William should go to bed and what time he should come inside.

The discussion moved to the need for a revamping of Mom's case plan; the old one had expired plus it was not reflective of the latest concerns. Mom indicated she would not be signing a new case plan; instead, she wanted her file closed. The social worker told Mom that would not be happening if concerns about William continued to be expressed. Mom said she had given up drinking and she did not do drugs. Mom told the social worker she was not seeing anyone and will wait until William is a bit older before she gets a boyfriend. During this discussion, the social worker was somewhat surprised when a small child emerged from a bedroom. Mom explained he was a friend of William's and had been there for a sleepover. The conversation appeared to suggest the child was a kindergarten student as he wondered what time he had to go to school. Mom made him breakfast and checked to confirm he was due at school in the afternoon. There was no documentation to suggest any followup concerning this young boy. The worker advised Mom that William would have to be spoken to at some point.

It just so happened that another social worker was at William's school on the same day (on a different case) and she was told about him sleeping in class. She decided to interview William while she was there. The social worker learned that William had his head on his desk because he had a bad stomach and was missing school due to the flu. The social worker noted that this contrasted Mom's reasons about the flies keeping her up all night causing her to sleep in; thereby, she could not get up to get William ready for school. Information was also provided regarding William's bedtime being 9:30pm; however the worker noted that she had seen him out later than that. She also learned that sometimes Mom has people over and sometimes they drink but they try to be quiet when William is sleeping. The social worker's assessment of the interview stated, "I am not convinced that there are just minimal concerns as the teacher

has pointed out on many occasions that he is tired, falling asleep in class, not doing his work while there, or not showing up at all." (CRMS notes dated 2006/06/14.)

The assigned social worker called Mom to tell her about the impromptu interview the other social worker had with William. Mom stated the activities described by William must have been happening a while ago as nobody comes there now and she reiterated, "I told you I quit drinking." She went on to tell the social worker that some of the kids at school were picking on William and she would not be sending him to get picked on. Mom had not shared this information with the worker when the home visit was made earlier in the day. Mom asked again when her file would be closed and was told there needed to be a period of stability before that happened.

Two days after this conversation, the social worker wrote a letter of support to the housing authority for a larger apartment for Mom and William. One month later, Mom called to advise that the housing authority had found more suitable housing for them and they would be moving at the end of July. Arrangements had also been made to have William's bed and bureau shipped from his grandmother's.

On August 14th, an anonymous caller contacted CYFS. This person reported having some questions such as, "Did CYFS think it was appropriate for William to be living at the ---?" When the social worker indicated that William was living with his mother, the caller said he was on their street all the time and further stated he had broken out windows there. The file does not indicate this information was treated as a referral and there was no immediate followup to this call.

On August 21st, another call was received from a person living on the same street referenced seven (7) days earlier. The caller said William was on the street late last night and asked to use the phone to call his mother. The caller overheard William lie to his mother - stating he was elsewhere at the moment. He then left to go home. This person indicated that because William had reached his mother on her cell phone, there was no way of knowing if Mom was at home or not. The file does not indicate this information was treated as a referral and there was no immediate followup to this call.

Subsequent case notes state the social worker attempted to reach Mom by telephone on two different occasions, namely August 25th – no answer, and September 6th – no answer; on the third attempt, September 18th, she discovered Mom's cell phone number had been disconnected. Another social worker was about to be assigned to the file.

The next contact was initiated by Mom on October 26th. She reported both she and William had slept in that morning and she was inquiring about a taxi to school for her son. Mom was advised of the file transfer, effective this date, and that the new social worker would be touching base with her in the near

future. The social worker wrote a note about suggested followup for the new worker. She documented that William and his teacher should be interviewed about his school attendance and performance as well as his lack of supervision. The social worker also recommended to the newly assigned worker that there should be followup with Mom. The need for a new case plan was mentioned; one that should address issues of child supervision and stability in William's home life. It was stated: "[Mom] often asks for her file to be closed, however this worker would not recommend it until a period of followup with school, child, etc. for signs that there are some stability." (CRMS notes dated 2006/10/26.)

On November 16th, a tenth referral was received. The RS stated that at 6:30am that morning there had been a "racket" at Mom's home. Mom and her boyfriend had been fighting and he took off in his truck with Mom hanging onto the door handle. William was seen running from the house crying and chasing after his mother. The RS also suspected that William was often left home alone and that Mom had a major drug problem.

William was interviewed at school that morning. The social worker's notes reflect that the previous evening, William, his mom and her boyfriend had gone to a cabin. Later that night, they arrived back home and went to bed. It appeared there were no questions asked about the time William went to bed or if his mother and her boyfriend had been drinking. At 6:30am that morning there was an argument between Mom and her boyfriend. Mom chased after the boyfriend as he left and clung to the door handle of her boyfriend's truck as it pulled out of the driveway. The truck eventually stopped and the boyfriend was alleged to have made death threats, pulled out a gun but dropped it again. William had been present and witnessed these events. The boyfriend told both of them to get back in the house.

It was alleged that Mom's boyfriend is on drugs but that he does not do them in Mom's house. The social worker determined that after the fight William, got his breakfast, made his lunch and took the bus to school; currently his mom was asleep. The social worker noted that William gets himself ready for school in the morning and wakes his mom up before he leaves so she can lock the door behind him. The social worker, knowing William was concerned that this man might come back, told him she would do what she could to make sure that did not happen.

Several hours after the incident, Mom contacted the CYFS office to say she was at a friend's house. In the afternoon, the social worker met with her; Mom agreed to go to the women's shelter with William for a few days. Mom denied any drug use and offered to be tested for same. She agreed the incident was very serious; she advised the worker she would not be seeing this man anymore. During this interview, Mom expressed the desire to take her son and move back to her former community.

In her investigative summary dated November 23, 2006, the social worker indicated, "In order to avoid having to remove [William], [Mom] would have to

agree to stay at [the shelter] until Monday and agree to NO contact with [boyfriend] ever, and to no drugs or alcohol in front of [William]." Mom agreed to the safety plan and signed it. The social worker applied a moderate rating to the file with respect to risk. She acknowledged that William has a strong bond with his mother and stated he is happy and content at home with her. Mom was open to CYFS involvement and understood the seriousness of the latest referral. Four (4) days after the occurrence, Mom returned to her own house with William.

On December 7th, a home visit was made as a followup to the previous referral. William was in school and Mom was just waking up at 11:00am. Mom told the social worker that her relationship with her boyfriend was over; again, she denied using drugs. She asked about childcare approval for William so he could spend some more time with her cousin who had been providing respite. Subsequent to the home visit and with approval from the social work supervisor, ten (10) hours of childcare per week was approved for William.

On December 14th, another home visit was made. William was not in school on this date; Mom explained that both of them were under the weather and she blamed it on having used a rusty kettle. Mom was presented with her new case plan which she signed. The goals outlined included:

> Illegal drugs are not to be brought into, or used, in the home at **ANY TIME**; [Mom] is not to consume **any** amount of alcohol while [William] is present and/or under her supervision; [William] is not to be exposed to any domestic violence. If [Mom] finds herself in a situation where she is concerned that [William] may be exposed to violence, [Mom] is to leave with [William] immediately and go to [shelter]. (Case Plan dated December 14, 2006.)

Included in the case plan under 'Steps to be taken', it stated, "Parent to meet with worker via home visits/office visits on a biweekly basis providing worker is able to do so and does not have higher priority matters to attend to."

During this meeting, Mom admitted not going to her counseling sessions for some time but said she would call and make an appointment soon. Five (5) days later, Mom left a voice message saying she was going to a Christmas party and wondered if she could take William with her. The social worker tried to call her back but did not get an answer. The file indicated that during this year, William and his mom moved to different residences within the town five (5) times. It appeared from subsequent documentation that they would reside at the last location for the remainder of the time period covered by this review.

## 2007

**William**

On January 10th, referral number (11) was received about a recent visit Mom made to the hospital. Mom had been reporting chest pains and she was seen by a doctor at 6:30am. The RS found it unusual that Mom was accompanied to the hospital in a taxi by an eleven (11) year old child, a friend of William's. Apparently, this young girl had to convince Mom to even go to the hospital and upon arrival had to do most of the talking. The RS reported that Mom had been drinking and also admitted that she had used marijuana during the night.

The social worker had no immediate concerns for William as he had been sleeping at a friend's house during this incident. William was interviewed at school the following day and confirmation was obtained that he was not home on that night. The social worker then made a home visit to speak with Mom. Mom explained that even though William was not at home during the previous evening, the little girl, William's friend, wanted to stay over. Another adult friend had also been there but she was returning to her own community the following day. Mom stated she had not been drinking for some time and she did not think the half dozen beer she had would impact on her like they did. Mom denied any drug use and could not recall making such an admission at the hospital. She could not recall how they got to the hospital or how they got back home. There was nothing on file to indicate that any information concerning the eleven (11) year old who accompanied Mom to the hospital was gathered or investigated.

Mom minimized her activities saying she should be able to have a few beers. She diverted attention from herself by asking the social worker if she ever drank in front of her kids. Mom stated, "If [William] gets taken away from me, I'm going to rat out a lot of people." She told the social worker that there were others who were a lot worse than her. The social worker encouraged her to be forthcoming with legitimate information if she had it, not just to rat people out. Mom said she would make an appointment for counseling and look into the possibility of attending Alcoholics Anonymous (AA). The investigative summary completed by the social worker stated that the allegations and CPR were verified and William was in need of protective intervention. She suggested followup with both Mom and William and the completion of the Risk Assessment Instrument to identify other concerns.

Over the next couple of weeks, there was some phone contact with Mom or there were messages left for Mom to return the social worker's calls. A home visit was made on January 22nd wherein the worker learned Mom was still experiencing some chest pain but was due to see the doctor the following day. Mom also suspected that her son may be dyslexic and hence the reason for his struggles with schoolwork.

There was a follow-up visit on February 6th by the social work assistant. During their discussion, Mom said she was worried about William because he found school boring. Mom told the assistant that AA meetings took place three (3) times a week however she did not indicate whether she was attending these sessions. Earlier that day, Mom had told the assigned social worker that she had attended AA a couple of times since the referral in January. On February 22nd, Mom informed the social worker she was no longer attending AA because she found it very boring. A few weeks later, Mom gave up seeing her counselor even though this had been part of the safety plan Mom had agreed to in previous months.

On March 13th, the social worker attended a meeting with William's teacher and guidance counselor to discuss how he was doing in school. Mom was also present at this meeting. The teacher indicated that William's attendance in the past two months had improved however, he seemed to be very tired in the mornings. The guidance counselor discussed William's academic performance and advised that he is failing math. It was suggested that a tutor would be helpful and the social worker advised that CYFS would cover the cost of this service. Mom advised that William had his eyes tested the previous week and while his vision was fine, the doctor felt he may be dyslexic. The guidance counselor and teacher both indicated they would pass along information regarding their involvement with William to support the referral to the Janeway Children's Health and Rehabilitation Centre. Later the next month, ten (10) hours of tutoring per week was arranged for William.

On May 3rd, referral number twelve (12) was received by CYFS. William had told the RS that his mom sometimes took him to parties until 2am and he was too tired to do his schoolwork. The RS also stated that William had been going to school hungry and just this week, he had been provided with breakfast each day. It was also mentioned that Mom had no involvement whatsoever in his school work. William was interviewed at school on this date and it was learned that things were a lot better now; Mom had stopped drinking and going out to the clubs. The social worker noted William appeared agitated and kept asking when he was going back to class. The RS was asked to pass on any concerns that might arise in future.

While investigating this referral, the social worker learned that Mom had been in the company of a violent male offender on April 26th when he was arrested for drug trafficking. The police advised that Mom had not been arrested. Shortly after the interview with William concluded, Mom called and was quite irate that her son had been spoken to at school without her being informed first. The social worker explained to Mom that whenever a referral was made, they would have to check with the child to see how things were going especially since she was on an open child protection caseload. There was a discussion about the arrest of her "friend" and the impact that could have on her life and subsequently on William's life. Mom's response was, "So, [William] wasn't there." Mom was adamant that things were going well in her life right now and she was not drinking or going out anymore. The social worker told Mom the referral would be

considered as unfounded because William had not verified the information. There was a comment on the investigative summary that indicated the social worker still felt uneasy about William's situation. She stated she was "…concerned that [William] may be afraid to disclose any concerns about his home life." The fact that a tutor visited the home was seen as reducing the risk to William and the social worker suggested close monitoring of the family with the completion of the Risk Assessment Instrument to identify other concerns. (Social worker's Investigative Summary dated 2007/05/03.)

The next day, May 4th, there was an out-of-hours call received by CYFS at 6:35pm. The caller reported an incident that had occurred recently. Mom had been out and when she arrived home she had a female friend with her. It was not clear how long William may have been by himself prior to his mother's return. Mom and the other woman went into a bedroom; shortly thereafter a very loud scream could be heard. According to the social worker's notes, the caller advised that it was a very frightening scream; the type of scream someone would make if they were in a lot of pain. A couple of minutes later, Mom emerged and went to wash her hands. When asked if everything was okay, Mom said it was, adding that her friend was just excited and happy about something. William had been scared by the scream and afterwards he decided to go to a friend's house for the night. The social worker contacted her supervisor to apprise her of the situation; however, it was decided that no further action would be taken as William would not be home that night. It was deemed William would be safe as he was staying at a friend's house. There was nothing on file to indicate that Mom was ever questioned about this incident.

On May 23rd, the social worker consulted with the tutor who commented that William was extremely tired during their sessions. In fact, on more than one occasion, William was asleep and had to be awakened upon the tutor's arrival. William indicated that he went to bed between 9 - 9:30pm. Based on other information in the file, this appeared to be his "standard" answer.

On May 30th, referral number thirteen (13) was received concerning William. It was reported that he had spent the last couple of days at a friend's because his mother was drinking. He wanted to go home but his mom would not let him. The social worker went to Mom's apartment and a man answered the door stating Mom had gone to the store. The worker learned that William was at a friend's house and went there to interview him. She spoke to him about school, his tutor, and how he was doing better with homework. The social worker asked about some of his planned summer activities and learned William was getting a dirt bike contingent on Mom going fishing over the summer. William was asked how he felt about her absence while he stayed with friends and the child did not appear upset by the prospect. The notes indicated Mom was to be interviewed; however, there was no documentation on file to indicate that she was. It appeared another social worker had taken over the case, or at least during this situation, and the referral was not verified.

On June 6th, the social worker again consulted with the tutor. The tutor relayed a difficult interaction with William and his Mom that had taken place this day. The tutor had planned to pick William up at his home and drive him to school. The project material was too cumbersome for him to carry while walking or riding his bike. The tutor arrived at 7:40am; William was not dressed nor was there any evidence that he had eaten breakfast. Mom was not up yet. William wanted to go to school on his bike as his friend was there waiting for him and he also had his bike. The tutor insisted that William go in the car otherwise he would be late and the tutor was not prepared to take his project for him and set it up at school. Mom walked into the kitchen area and told the tutor William should be allowed to go on his bike if he wanted to. The tutor explained the difficulty of carrying the project and Mom told the tutor to stop bossing her son around. The child agreed to go in the car with the tutor who reported the incident to a school official in the event William was upset during the day. Later that afternoon, Mom called the social worker and advised she no longer wanted William to be tutored by this person.

On June 15th, the social worker made a home visit to Mom's residence. Mom reported she was doing much better and was not drinking. She reported having a job and wanted her file to be closed. The worker reviewed her case plan with her and saw no point in redoing the plan as Mom reported improvement in her situation. Mom was advised of the unfounded referral two weeks earlier.

On June 21st, the social worker and an assistant met with William's teacher to discuss his advancement to the next grade level. Mom was also present during the discussion. The teacher confirmed that William had been doing better with homework and his participation in class during the time he was being tutored. The teacher also noted that William does not often pass in assignments or complete other tasks that are supposed to be done at home. Mom's response was that William tells her he has no homework. The school will attempt to set up a 'buddy' system for William in September. The teacher believed that socially, William should advance to the next grade.

On July 4th at 5:09am, referral number fourteen (14) concerning Mom was received. It was reported that Mom had called the police requesting assistance in removing a woman from her residence. When the police arrived, Mom indicated that William was asleep in his room during the confrontation. It was ascertained that Mom, along with two other people, had been at another residence earlier; the woman, subsequently removed from Mom's, had been cut by a sword and they all returned to Mom's house. It was also noted Mom appeared to have been drinking. There was no indication that Mom was questioned about who had been staying with William during her absence, if anyone. Documentation indicated the matter was under investigation but not all parties were cooperating. There was no indication in the file that there was any followup to this call.

On August 13th, referral number fifteen (15) was received regarding the care Mom was providing to William. The RS stated Mom was out drinking all the

time and did not come home until really late, sometimes 8:00am, and she was always bringing strange men home with her. The RS also indicated that William did not have a babysitter each time Mom was out. One evening at 10:00pm, the RS saw William sitting on his step crying because he had come home but his mother was not there. William reported when that happened, "…he had to go to a green building on --- Crescent." According to the report, the RS appeared to be genuinely concerned for William's safety. The investigative summary indicated an attempt was made to interview William during a home visit on the date of the referral; however, William did not want to talk to the social workers. The worker's notes read:

> I asked [Mom] if I could talk to [William], and she agreed with same. She went in his bedroom to talk to him. When I went in to talk with [William], [Mom] advised that he did not want to talk to me by myself. I told [William] that it would not take long. Tried to interact with [William], however he appeared very distant and shy and would not make eye contact. [Mom] then stated that I could not talk to him at this time as he was not willing to do so and I would have to do it later. (Social worker's Investigative Summary dated September 22, 2007.)

Mom denied the allegations and the investigation revealed there was no way to verify them. William was assessed as being safe. The file also indicated a new social worker had taken over at this time.

On August 21st, referral number sixteen (16) was received with similar concerns to the last. The RS stated that three (3) nights ago, Mom and a girlfriend left the house at 12:00am to go partying. They returned at 5:00am and no babysitter had been arranged for William who was at home by himself. Two days earlier, this RS had gone to Mom's residence and William was there alone. William asked this person to stay as he did not want to be by himself. They called Mom on her cell phone and she stated she was out shopping. She returned home at 7:30pm and said they had been out bar hopping. The RS said Mom had been seen drinking and partying in front of William and that one of Mom's female friends is always there, "…passed out on the couch." According to the RS, it was Mom's pattern to wait for William to fall asleep and then leave, without a sitter in place. It was speculated she could not get sitters because she had a reputation of not paying them. This RS also said that in the previous week, there had been no food in the house and food had been taken to William. The RS went on to say that men were always coming and going and Mom should not have William in her home anymore. Mom was using her taxi vouchers, authorized for counseling sessions, for other rides. The neighbors were complaining about the constant party noise. The RS preferred to remain anonymous but would go public, if Mom denied these allegations.

The social worker and an assistant attempted a home visit to speak with Mom on August 22nd. She was not home; William was there alone and told the workers that his mom had just left to go shopping and they could not come in if she was not home. They returned a couple of hours later but got no response at

the door. The workers went to Mom's house again the next day and the day after that. On August 24th, Mom was not at home the first time the workers attended there.

On August 24th, referrals number seventeen (17) and eighteen (18) were received, prior to the former referrals being actioned. During this afternoon, two individual callers reported that during the previous evening at 10:15pm, William had gone to a person's house asking to use the telephone to call his mother. The boy was crying and upset because he had been home alone and was now telling his mother to come home. One RS provided more detail than the other stating the child was "begging" his mother to come home; Mom told him she was not coming home as she was at a friend's drinking but told William she would have a cab pick him up and bring him there. William left for home around 11:00pm and the RS did not know if Mom was going to be there or not. This RS also advised Mom was always out drinking and she drank in front of William. In addition, Mom frequently had strange men at her house and William would walk in on them all the time. The RS further reported that on Monday of this week, Mom left at noon to pick up a burger for William and returned at 8:00pm that evening. The RS had spent the day with William until his mother returned.

At 5:17pm, the social worker and support worker found Mom at home and proceeded to interview her about all of the recent referrals. Mom denied the allegations saying she had not gone out the previous weekend; she became quite upset and was swearing. Mom indicated she knew the referrals came from the woman she had removed from her house last month. It appeared as though Mom tried to divert attention away from the referrals at hand by telling the workers that during the last school interview with William, another social worker's son was present and William was embarrassed by this. Based on this information, arrangements were made for Mom and William to come to the office after the weekend to conduct follow-up interviews about the referrals.

Four (4) days later, Mom and William arrived at the office where William was reluctant to be interviewed alone with the social worker. His mother made the comment to him, "She's not going to take you away." Mom also suggested that he should tell the worker about what happened to him yesterday. The worker learned that six (6) kids had jumped William and had beaten him up; after which he went home and told his mom. There was a discussion about summer holidays and school. The worker learned who William's regular babysitters were and that they watched television with him.

The social worker then met with Mom and discussed the nature of the referrals. She explained to Mom what a safety plan was designed to do but Mom stated she would not be signing anything as she always had sitters in place for William. Mom also suggested she may be calling the police about what had happened to William and the worker agreed that was an option. Mom was given a copy of the new safety plan, which she refused to sign; she and William left the office.

In the social worker's notes concerning the last four (4) referrals, she indicated the allegations of August 13th and August 21st could not be verified; however, both referrals dated August 24th were verified. It was noted that Mom has "…trouble in identifying safety concerns." The social worker went on to say, "There has been an extensive history of involvement from our department with this family regarding [Mom]'s drinking and the lack of supervision for [William]. Therefore, I believe that this puts [William] at high risk." (Social worker's Investigative Summary dated August 28, 2007.) The social worker concluded that an in-depth risk assessment and followup from the protective intervention program were required in this case.

Over the next three (3) months, all of the contact with Mom was by telephone and it mainly centered on the availability of a tutor for William. During the interim, there had been concern expressed by the school that William was tired and on November 6th, they notified the social worker about same. It had been witnessed on several occasions over the past few days that William had been putting his head on his arms to rest. The school asked the social worker if she could contact Mom and encourage her to attend an upcoming parent-teacher interview. Arrangements were made, including a taxi voucher; however, Mom did not show up to the meeting. As of November 20th, Mom still had not found a tutor. Despite this, Mom stated she was …"doing really good", and wondered when her file would be closed. There was no further contact documented with Mom for an additional four (4) months.

## 2008

**William**

On March 14th, Mom contacted the social worker to inquire about transportation for her younger son to come and visit with her at Easter. She was advised to contact the Department of HRLE with her request. The social worker inquired about William; Mom stated he was not bringing home work from school and he still did not have a tutor.

The social worker attempted a home visit on April 7th. There was no one at home but later that day, Mom visited the office indicating her neighbor had seen the social worker there; since she no longer had a telephone, Mom thought she would stop by the office. A home visit was planned for the next day.

On April 8th, the social worker made a home visit and discovered that William had been away from school for the last couple of days because he was getting bullied. Mom was considering a move to one of the former communities where she had previously resided because William wanted to go to school elsewhere. Mom stated apart from that, things were good. The social worker made a return home visit on April 16th. According to the CRMS notes, it appeared the purpose of the visit was to advise Mom that tutoring had been arranged for William which would start the following day. The file documentation does not reflect any other discussion.

On May 27th at 1:15pm, referral number nineteen (19) was received about Mom walking down the street with a beer in each hand and she appeared intoxicated. The RS also indicated Mom was not wearing a shirt. William was riding up and down the street on his bike; it was a school day. This RS had also heard a "ruckus" at Mom's house last week, the police had been called there and they left the area with Mom in the vehicle.

A few minutes after the referral was received, two social workers attended at the scene. There was no answer at the door and a neighbor approached and advised of Mom's location; she had gone to a neighbor's and was "sleeping it off." When the social workers arrived there, Mom was in the backyard wearing pajama pants and a tee-shirt. It appeared that Mom was intoxicated. Mom used vulgar language and insulted both workers with her comments. When asked where William was, Mom responded that he was being taken care of. The social worker asked why he was not in school and Mom told her it was because he was getting bullied by other students. The case notes reflect the social worker's repeated attempts to ascertain William's whereabouts but Mom was unwilling to communicate with the workers or assist them in locating William. Mom's friend was trying to get her to calm down and go to bed. The friend was advised that if William showed up, she should let the social worker know so she could return and talk to him.

The social workers drove around the area looking for William. They also contacted the police to ascertain more details about the call to Mom's residence earlier that morning but the police did not get back to them. Phone calls were made to the usual locations where William had previously been found or interviewed; no one had seen him. The on-call social worker for the evening was notified and was told she could expect a call from some of Mom's acquaintances with a location for William. There was no contact made that evening and William was interviewed at the school the following morning at 10:15am.

The social worker learned that William had been out of school for the last two days because of illness. This contradicted what his mother had said about him getting bullied. In fact, it appears as if William was not even quizzed about the bullying he was experiencing. William's tutoring was going good and he had been at his Aunt Sharon's house (Family B Mom) the previous day; he is usually there three (3) times during the week and she babysits him on weekends when his mom is drinking. The social worker learned that William is never home by himself and is usually outside playing or is on his bike. She advised William that he was allowed to be home alone at the age of twelve (12) but it could not be overnight and he must have someone to call or somewhere to go if something happened. The worker learned that William did have someone to call and somewhere to go; she noted that he knew how to use the phone book to find numbers. William was excited about a plan for him and his mom to move to another community over the summer. The social worker told William they would be talking to his mom that day. After the interview, one school official commented on his belief that William is not a happy child and is tired in class. The topic of bullying came up and the teacher mentioned that he would have the guidance counselor meet with William.

The following day, May 29th, the social worker made a home visit to Mom's. It was pointed out to the social worker by Mom that William is always supervised when she is drinking because "CYFS is on my back." Mom stated that when she drinks, William stays with Sharon (Mom from Family B). Mom was asked whether she drinks on weekdays or weekends and she replied, "Whenever." She went on to explain that she had recently been in a relationship with someone who turned out to be an alcoholic. While they were together, she found she was drinking more herself. She had since broken up with him so she would be cutting down but stated she would not be giving up drinking completely. Mom was asked about the police presence at her home the previous week. Apparently, there had been a raid and the police found a quantity of drugs. Mom blamed it on two guys she had allowed to stay at her home for a few nights. As a result of the raid, she had been arrested and charged. Mom denied using any drugs and said she did not know there was anything illegal in the house. Mom was told that once the police report was reviewed, another home visit would be made. In addition, William's schooling, bullying and tutoring were discussed and Mom was advised about the school's concerns.

The social worker determined that William was not in need of immediate safety intervention. William was not in attendance when the incident happened

and Mom had stated he is not home when she drinks. Mom's behaviour was inappropriate and verbally aggressive when the social workers went to her friend's backyard but there was nothing to indicate she behaved that way towards William. Even though Mom would not disclose William's whereabouts on that day, she insisted he was safe. The social worker noted, "[William] is a 13 year old boy who could remove himself from a dangerous or neglectful situation, and would be able to meet some of his own needs." In the category of 'Vulnerability of the Child' in the Investigative Summary, William was now rated as low because of his age and his increased ability to remove himself from abusive or harmful situations. The risk of maltreatment by Mom was assessed as moderate. The social worker concluded, "…this rating could change to high risk should [Mom] fail to keep open communication with [social worker], and there continue to be referrals." (Social worker's Investigative Summary dated July 8, 2008.) It appeared as if a risk assessment process was completed within the confines of this actual referral document; it was included as part of the investigative summary.

On May 29th, the school advised the social worker that William had missed a total of 36.5 days since school started this year. Five (5) days later, the tutor advised he could no longer continue in that capacity as William was not bringing any work home with him despite repeated requests to do so.

On June 11th, referral number twenty (20) was received about Mom's drinking. The RS said it had been going on for two weeks now. Mom had left town over a recent weekend, leaving William in the care of a sitter for the entire time. The RS went on to say Mom had been at one residence recently where she was engaged in inappropriate behavior in the bathroom. At 3:00am, William had been seen banging at the front door and asking for his mother. The RS said that William can be regularly seen outside on his bike at 10:30pm and 11:00pm and this person suggested CYFS should check the school attendance records.

Coincidentally, concerns about Sharon's (Family B Mom) drinking habits were expressed during the same referral call. Two social workers went to Sharon's house to interview this mother. When they arrived, they found that William and his mom, Marion, were both there sleeping on the couches. The social worker wanted to speak with William but the little boy would not wake up. None of the children with Marion (Family A Mom) or Sharon (Family B Mom) were in school that day; their mothers reported they all had the flu.

Marion was interviewed by one social worker while Sharon was interviewed by another. (See Family B - June 11, 2008 for details of interview with Sharon.) When asked about William's school attendance, Mom reported he had been in school so far this week, just not today. The worker was advised by Mom that whenever she drinks, William is supervised by Sharon. It does not appear as if Mom was questioned about who looks after William when Sharon is drinking; this was an issue raised during the referral. Mom said she and William were moving in thirty (30) days and that William would no longer be participating in tutoring. William appeared safe and the social worker commented, "No

intervention needed at this time." The social worker noted during her assessment, "[Marion] has [Sharon] for a support." (Social worker's Investigative Summary dated July 10, 2008.)

Further in the same assessment, the social worker noted:

> [William] is in school and has a level of independence. [William] is also being seen by his tutor --- on a biweekly basis. [William] has a bike and is able to remove himself from a negative situation. [William] has told this worker in the past that he knows the number to the hospital and he could go to his neighbors if needed.

The social worker did not appear to recall that the tutor had withdrawn services a week ago even though she was the social worker who took that phone call on June 4th. The referral concerning Marion was not verified.

On Thursday, June 19th, a phone call was received from the school indicating that William had been asleep most of the morning on Monday of this week. He was told that if it happened again, his mother would be notified or CYFS could come and get him. William did not attend school the rest of that week. Later that morning, a home visit was made to Mom's residence but there was no answer. The social worker noticed there were no curtains in the window and there was a TV stand outside the door.

On that same day, the social worker made an unannounced visit to Sharon's (Family B Mom) house. The worker had actually gone there in an attempt to locate William and his mom. Sharon's son, Steven, answered the door and went upstairs to get his mother who was sleeping. Sharon told the worker that Marion was asleep on the couch and William was upstairs. A closer examination revealed that the woman asleep on the couch was not Marion; Sharon then indicated it was her stepdaughter. William and his mom were not in the house. It appeared there was no further followup to the call made by the school.

A few days later at 1:10am, the hospital switchboard received a call from Marion who wanted to talk to the social worker on call for CYFS. The on-call social worker contacted Marion and learned she had been at Sharon's house earlier and was now reporting that everyone there was drunk. Marion further reported the police had been called to Sharon's and as a result, Marion had been removed. William was still at Sharon's house and Marion wanted him returned home. Marion revealed to the worker that she and William had words about him smoking and that she had consumed six (6) or seven (7) beers in one and a half hours. The worker attempted to reach her supervisor by telephone but received no response.

The worker then called the police to ascertain more details. According to the worker's notes, the police officer stated, "… [Marion] was hammered drunk and she was causing a disturbance. [Marion] and [William] had gotten into an argument and someone had called the cops." (CRMS notes dated June 2008.

These notes were added on CRMS one month later.) The worker noted that the officer indicated there were six (6) or seven (7) people at Sharon's house, they were respectful towards the police, there did not seem to be a party going on, and the younger children were all in bed.

According to the police documentation, they were called to Sharon's home at 10:03pm. Sharon was requesting that Marion leave and Marion did so without incident however, William refused to go with her. Marion later contacted the police herself asking them to bring William home. The officer advised he would not be picking William up tonight as she (Marion) was angry and intoxicated. The officer noted that Marion was not content with the explanation given and so he referred her to the CYFS on-call social worker, which resulted in the call at 1:10am.

Following the discussion with the police officer, the on-call social worker was finally able to reach her program manager and it was decided that contact should be made with Sharon to determine if William could stay the night. The worker's CRMS notes indicate she called Marion to get a number for Sharon. Marion said she would check her phone for the number and the worker agreed to call her back in a couple of minutes. The next call to Marion revealed she did not have a number for Sharon.

The worker searched Sharon's file for a telephone contact but the number listed was not in service. The worker relayed this information to her supervisor and following their second conversation about the matter, it was decided that William would stay at Sharon's. They also agreed that the worker would contact Marion and advise her of the decision that had been reached, which was based on the police officer's observation that she was drunk. The worker noted that she had tried calling Marion back three (3) times but did not get an answer. These three (3) calls were reported to have been made between 1:46am and 1:51am. Sometime in the early morning, a fire broke out in Sharon's home that claimed the lives of five (5) people, including William, Sharon and her daughter, Hannah. Sharon's daughter Olivia was uninjured however her son Steven was injured in the fire but survived.

## Background of Family B

Mom was just over twenty (20) years of age when her first child, Olivia, was born. Fifteen (15) months later, she and her husband had their second child, Steven. Dad frequently traveled for work. Their marriage broke down a few years after the first two children arrived. Following the divorce, Mom became involved in another relationship and her third child, Hannah, was born. According to the file, Hannah's father played no role in her upbringing. Prior to Hannah's birth, three (3) child protection referrals had been made concerning Mom's neglect of Olivia and Steven. That pattern would continue over an eleven (11) year period.

# Facts Provided – Family B

## 1997

| Olivia | Steven |
|---|---|

On November 5th, the first referral concerning this family was received. The RS reported Mom was out every night drinking and did not arrive home until early in the morning. Her two small children, Olivia and Steven, would have to fend for themselves until their mother woke at noon; they would not be changed or fed until then. There was an incident whereby Mom had Steven on the bed with her; he rolled off and cut his lip but Mom did not respond to him. The RS also reported being aware of one previous occasion whereby Mom had a babysitter, (Marion, from Family A), who was intoxicated when she arrived and was left to care for the two children anyway. The RS reported the children both drink from bottles during the day and they eat tin food. According to the RS, Mom's husband was away working and was not due home for another month or so; even when he was home, Mom did not do much with the children.

Mom was interviewed by the social worker at the office the following day. Mom denied the allegations stating she does go out occasionally but not every night; when she does go out, she returns by midnight. Mom admitted to using various sitters and would not always have complete information about them such as their last names. The social worker suggested to Mom that she should obtain as much information as possible about her babysitters in order to keep her children safe. Mom reported the children have three (3) meals a day plus their snacks. A phone number was obtained for Dad and the social worker called to inform him of the referral. He was of the same opinion as his wife; someone was making up information to get back at her for some unknown reason. The social worker explained how she felt the information was legitimate and that she was concerned for the children.

A home visit was made by the social worker two days after the referral and the children appeared fine. It was explained to Mom that the file would have to be left open until the social worker could meet with Dad when he returned and then the situation would be reassessed. Another social worker was assigned to the file on December 9th; she subsequently made a home visit on December 22nd whereby Dad was present. The children were laughing and playing during the visit and the social worker believed Mom's and Dad's interactions with the children were appropriate. These parents were told another home visit would be made to monitor the situation; both agreed.

## 1998

| Olivia | Steven |
|---|---|

The next follow-up visit took place at Mom's residence on February 17th wherein no concerns were expressed by the social worker. There were four (4) additional adults living in Mom's residence who were providing support to her and the children while her husband was again away for work. Olivia and Steven appeared to be well and the file was recommended for closure on that date. The case closure on file was signed by a supervisor five (5) months later on July 22, 1998. There were no other reports or referrals received during 1998.

The file for this family remained closed during 1999 and 2000.

## 2001

| Olivia | Steven |
|---|---|

On April 18th, the second referral was received about Mom's parenting and the file on this family was reopened. The information was similar to the first referral in that Mom was drinking, staying out late and the children were being neglected. The RS reported there was a pattern of Mom having her friends in during the evening, she would start drinking then and they would all leave for the club later. Usually, she did not return home until the following day whereby she would sleep and leave the children to care for themselves. The older child, Olivia, was missing a lot of school. The RS went on to say the children appeared to be dirty and the house was also dirty most of the time. The children had been seen outside in their pajamas. The RS believed Mom and Dad were having marital difficulties plus Dad had mainly been away working.

The social worker made a phone call to Mom's residence two days after the referral was received; there was no answer. Five (5) additional attempts were made by phone to reach Mom between April 26th and May 7th. There were no additional case notes to suggest further followup until the social worker made a home visit.

The social worker, a different worker from the two that had been assigned in 1997, made a home visit on May 22nd, five (5) weeks after the referral was received. Mom explained that she drank occasionally but did not have parties in her house. She had a babysitter available; her roommate. Mom told the social worker that Olivia was home from school only when she was sick. She went on to say that she got up every morning to get them their breakfast and had to force them into the bathtub. Mom reported that she and the children's father are divorcing. The social worker outlined strategies Mom should use to keep her children safe such as not having crowds around them where people would be drinking. She told Mom she would be keeping in touch by visiting occasionally.

On May 23rd, the social worker spoke to Dad. He confirmed the impending divorce and said the children would be staying with their mother. Dad also commented, "[Sharon] is generally a good mother." He agreed to call if he had any concerns. The worker attempted a school visit to see Olivia on May 30th but the little girl was home sick.

On June 15th, a third referral was received about Mom's care of the children. The RS reported there was evidence of alcohol and possibly drug use in the home. Olivia appeared malnourished and ill-kempt; her hair was dirty and she seemed neglected. The RS indicated Olivia was a starving child – very skinny. The child was not in school on the day the referral was made. Another social worker had taken over the case and thirteen (13) days after the referral was received, she consulted with her district manager. A home visit was to be completed and the children were to be interviewed.

On June 29th, the social worker went to Mom's apartment. There were now three (3) additional people living there. Mom denied the allegations saying she had not been drinking lately nor did she go out anymore. She also stated that there had been no drinking in her apartment and she did not do drugs. While Mom admitted that neither of her children were breakfast eaters, she always cooked for them at 12pm and 5pm daily. The social worker spoke with Olivia and Steven. To her, both children appeared happy and healthy. She learned the children's bedtime was at 8pm, they would get up at 10am and have chocolate milk for breakfast. They enjoyed spending time at the nearby playground but their mom does not go with them. The social worker advised Mom she would be checking in from time to time to monitor the children.

In August, the file was transferred as Mom and the children had moved to another community. In October, the social worker attempted to visit Mom in this community but was told by a neighbor that the family had moved back to the previous community. File documentation was scanty; however, it appeared as if the file was transferred some four (4) months later. There were no other reports or referrals for the remainder of the year.

## 2002

| Olivia | Steven |
|---|---|

In February of 2002, four (4) months after Mom had moved, the family's file was transferred; however, the social worker noted Mom had not left any forwarding address. The receiving social worker recommended that the file be closed "…as CPR have been addressed, no new referrals since June 2001." (Case note dated February 21, 2002.)

On June 2nd, a fourth referral was received about the two children, Olivia and Steven. The RS had reported to the police that the two children were at the local rink alone. The police attended the rink and escorted them home. Mom was told by the police that this incident amounted to inadequate supervision but she said she knew where they were and she was not concerned.

The case notes reflected that the newly assigned social worker did not receive the report until four (4) days after it had been made. Twice, on June 7th and June 10th, the worker attempted to contact Mom by making home visits; there was no response. The social worker spoke to Mom during a home visit on June 11th about the referral. Mom said that ordinarily, the children play in front of the house where she can see them but sometimes, "…they do take off."

The social worker advised Mom that she must supervise the children properly and she was given a copy of the CYFS guidelines for supervision. The children appeared to be happy and healthy. From July 19th until August 23rd, the social worker made three (3) attempts to follow up but Mom could not be found at home on any of these occasions. The social worker recommended the file for closure on September 23rd as there were no apparent concerns and no new referrals had been received. The file was closed on that date.

Mom's third child, Hannah, was born. Hannah had a different father than Olivia and Steven. It appears from file documentation that he had no further involvement with Mom or the little girl.

The file for this family remained closed during 2003.

## 2004

| Olivia | Steven | Hannah |
|---|---|---|

On January 9th, the school passed along information to the social worker. They reported no specific child protection concerns but mentioned the family had moved five (5) times in the past few months. They felt things may be somewhat unstable for the children especially around their schooling and wanted to make CYFS aware of what was happening. The social worker who took the call passed on the information by e-mail to her supervisor and the file was reopened for two months to monitor the family.

On February 20th, the fifth referral was received. A new social worker was assigned. The RS reported that the police had been called to Mom's house about a disturbance involving the grandmother and the babysitter. Apparently, the grandmother believed that the sitter had touched Olivia inappropriately but the little girl denied anything had happened. The grandmother had called the babysitter a pervert and punched her in the face.

On March 1st, ten (10) days after the referral was made, the children were both interviewed at school whereby Steven provided more details than Olivia. The social worker learned that Steven had slept in that day because he was up late the night before. The worker verified that the incident the previous weekend involving the grandmother and the babysitter had occurred. The grandmother was no longer allowed in the home. The worker also learned that Mom goes out in the evenings and does not get up in the mornings.

The social worker could not confirm that anyone had touched Olivia inappropriately at any time. Following the interview with the two children, the details of which were captured by e-mail, the social worker met with school officials who reported their own concerns. They reported Steven was missing a lot of school or showing up quite late; for example, school dismissal was at 2pm and it was not unusual for Steven to arrive at 1:20pm. When he was asked why he would show up so late, he said that was when his mom would drop them off. Steven was often sent to school when he was sick and Mom would tell the teacher to call her if needed. The school noted that frequently, Steven did not have breakfast, recess or lunch. His clothing had sometimes been in tatters and the school provided him with shirts from a clothing box. The same types of concerns were expressed about Olivia. It was apparent that the children had a lot of babysitters.

On March 5th, Mom was interviewed about the incident involving her mother and the babysitter. Based on the referral information, Mom was advised that her mother should not be around the house. Mom stated that was her plan and her mother had already returned to her own community. Mom was told about the concerns with the children arriving late for school or missing school. Mom stated she goes out one night a week but admitted to staying up late during

the weeknights. The social worker reminded Mom about her responsibility to get up with the children in the morning and get them ready for school as they were both still very young. Mom told the worker she would address the concern about the children being up in time for school.

The case notes about the interview, written in an e-mail, do not reflect that Mom was questioned about the food available to the children; their clothing issues, or about why they were sent to school when they were ill. The social worker suggested to her supervisor that the file should remain open for monitoring.

On March 10th, a sixth referral was received concerning a male adult who had been staying at Mom's house; he had recently been arrested at Mom's residence and was now incarcerated. The RS reported it was possible this person may be going back to Mom's house as his girlfriend was still residing there. This man had a long history of sexual assaults against young girls and women. Mom claimed she was unaware of his background and she would not be permitting him back in her house. The details of the interview were captured in an e-mail sent by the social worker to her supervisor. Later in the month, Mom informed the social worker that the couple had moved to another community. Between March 30th and late August, two attempts had been made to contact Mom for followup; both had been unsuccessful.

By September, a new social worker had been assigned to the file. She made contact with Mom on September 7th following three (3) unsuccessful attempts to reach her. The worker was told the children are doing well and going back to school tomorrow.

On October 13th, a seventh referral was received. The RS said that one of Mom's houseguests had been yelling at the youngest child, Hannah, and it was also believed this person had been hitting the little girl. The RS reported there were several people living at the house and this incident happened between 2am and 3am. It was not certain if Mom was home at the time. The RS went on to say there was always partying and drinking going on until the early morning hours. The RS believed the children were being neglected and not going to school on a regular basis. The referral, which had also been faxed to the police on the day it was received, was assigned to the social worker on October 22nd. It seemed there was some delay wherein the police were trying to connect with the assigned social worker and vice versa; it appeared that scheduling between the two service providers was problematic. It is unclear from the case notes exactly what the problem was.

On November 2nd, almost three (3) weeks after the referral was made, the social worker went to Mom's residence. The person allegedly responsible for hitting Hannah answered the door and stated she was the babysitter. The social worker then proceeded to Mom's school and asked her to arrange alternate child care. Mom was shocked by the allegation and said she would go home

immediately. Whether Mom left the school right away, or left at all, was not confirmed by the social worker.

Three (3) days later, the social worker returned to Mom's school and learned that this same woman was still babysitting as Mom had not been able to find anyone else. Mom was advised she would have to go home and make other arrangements. She was quite resistant to the idea but was told until the police investigation was over, she had little choice. Reluctantly, Mom left for home.

On this same day, November 5th, the social worker interviewed Olivia and Steven at school. During the interview with Steven, there were no disclosures about any physical abuse by the babysitter. The young boy talked about his dad and said he was living away right now but would be moving back soon. The social worker learned that there were two other people living in their house but Steven could not remember their names. Through her assessment, the worker also learned that the babysitter had yelled at Hannah to shut up. As a result of these interviews, captured as case notes in an e-mail, the social worker intended to speak with Mom and the babysitter about the concerns of yelling at a small child.

On November 15th, the social worker contacted a police supervisor by telephone and provided an overview of the children's interviews. The officer believed there would not be any charges forthcoming but offered assistance otherwise. He requested that the worker e-mail her notes of the interviews for the police file. A meeting with Mom and the babysitter was scheduled for November 18th but according to the documentation, "…had to cancel meeting with [Mom] due to this worker having to deal with higher priority matter." (Case note dated November 18, 2004.)

On November 22nd, a home visit took place with Mom; the babysitter was also present. The social worker advised of what had been relayed during the interviews with the children. The police would not be pursuing charges; however, the babysitter was advised that yelling at a child was a concern. Although she could not recall the incident, she acknowledged such action would be inappropriate and it would not happen again. Mom was told her file would remain open for a while to monitor the situation. The next contact with Mom would be in January, 2005.

## 2005

| Olivia | Steven | Hannah |
|---|---|---|

On January 27th, the social worker called Mom as a followup to the referral made almost three (3) months previously. Mom reported she was using the same babysitter and everything was fine. The file was closed on January 28th.

On February 8th, an eighth referral was received. Olivia had told the RS that she was sleeping in a basket and her brother, Steven, was sleeping on the couch. Both children were availing of the breakfast and lunch programs at school almost daily. Two months prior to this referral, Olivia had an infected toe. The RS had asked if her mom had taken her to the hospital but Olivia explained her mom did not have time. Eventually, Olivia did go to the doctor and was prescribed antibiotics. Another person had recently found the medicine in Olivia's belongings; it had not been taken. The RS learned from Olivia that the hospital was very concerned about her being underweight. The RS reported that the school had provided the two children with winter clothing. Both children were apparently going to school with faces not washed or their teeth brushed. Olivia and Steven were reported to be in alternate school programs but Mom did not attend any school meetings.

According to documentation, followup with Mom was conducted by phone due to a shortage of staff at the CYFS office and the social worker having the flu. Mom denied any allegations of neglect and said that Olivia was playing in the laundry basket one day and fell asleep there. Mom was asked why Olivia had not taken her antibiotics and her response was that the doctor had advised she should wait a couple of days to see if it cleared on its own. The infection did go away a few days later. Mom was questioned about Olivia's weight and asked if doctors had ever expressed any concern; she said there were no concerns and that she had been small as a child too. Mom was questioned about their hygiene and indicated that she tells the children in the morning to wash up but they end up leaving without it being done; she was reminded of her need to ensure the children were clean. Mom expressed difficulty trying to attend meetings as she was in school herself and did not have a vehicle. The social worker told Mom she would be in contact with the school and the file would stay open. There was no documentation indicating followup and the children were not interviewed. There was nothing in the file to indicate the social worker made contact with Olivia's doctor.

On March 11th, a ninth referral was received. The RS reported that Hannah, who was now approximately 2 years old, was seen outside with an adult. This person reportedly went back into the building and Hannah was left outside. The RS then watched as the little girl wandered down onto the road. The child was not wearing socks, shoes or a coat. She was in the middle of the road when a driver stopped, picked her up and took her to the nearest apartment building. The RS also noted that a bus was approaching from the opposite

direction when the driver stopped to get Hannah. The RS went on to say that the kids miss a lot of school as Mom would stay up late drinking and would not get up to get them ready.

The social worker called Mom's residence and the roommate answered; this woman reported Mom was sleeping and she did not want to wake her unless it was urgent as Mom had been through a traumatic experience yesterday. The worker said it was urgent and Mom came to the phone. Mom was questioned if everything was okay and she replied it was; she did not want to go into detail about what her roommate had said. Mom seemed unconcerned about the issues raised in the referral. The social worker's notes reflect that Mom "…sounded very distant/tired. …[Mom's] voice showed little to no reaction. …seemed very unresponsive." (CRMS notes dated 2005/03/11.) Mom was questioned about who was babysitting Hannah at the time and when Mom relayed the sitter's name, the social worker responded that this was not an appropriate person to have around the children as she had a very violent history. Again, Mom showed little reaction and stated that this babysitter had been watching the kids while she had been at the hospital. The case notes do not reflect that the social worker quizzed Mom about the reason she had been at the hospital. The social worker explained how serious the situation could have been for Hannah; she could have been injured or killed. Once more, Mom seemed very unresponsive. The worker told Mom she would be making a home visit next week. Before that happened, another referral was received.

On March 15th, the tenth referral was received. The RS reported that the youngest child, Hannah, gets hit by her mother and seems to be getting yelled at by another female adult living there. The RS stated that a whacking sound could be heard followed by a child crying loudly. On one occasion, the RS said Hannah could be heard crying for an hour and a half. The RS believed Mom had passed out from drinking and did not hear her. Just this morning, the RS heard the child crying and Mom yelling at her with profanity to stop. There was a party at Mom's last night and the RS suspected there had been drinking and drug use going on. The older children appeared to be missing a lot of school. The allegations involving Hannah were referred to the police for investigation.

Two days later, on March 17th, Olivia and Steven were interviewed at school. The social worker confirmed that they had been sleeping on the floor and couch. It was revealed that Mom had people over, they were drinking and loud, which scared the children. Additionally, Mom was too tired to get up in morning so the children got themselves ready for school. It was also revealed that Mom smacked the children really hard if they were bad and that she had left marks on them.

Following receipt of the information from the children, the social worker consulted with the program manager. Subsequently, the social worker, accompanied by a coworker, made a home visit to Mom's residence. It appeared to both workers that Mom was just waking up. She showed little reaction when told about the seriousness of the situation. Mom reported not being out of the

house since last Thursday night because of something that had happened involving the police. Mom was not forthcoming with any further details. The workers returned to the office and again consulted with the program manager.

The police were contacted to ascertain details of their response to Mom's residence the previous Thursday night. They stated the call was received at 2am on Friday morning wherein Mom was reporting she had been assaulted. The police report stated Mom was intoxicated and one of the children had been asleep in the same room when this occurred.

Based on Mom's past history of involvement with CYFS, the social worker requested a warrant for the removal of the children from Mom's care due to "... incidents of drinking, neglect, and inadequate supervision." (March 2005). Following receipt of the warrant, three (3) social workers proceeded to Mom's residence. The time frame involved between the first home visit on this day and the return with the warrant are not included in the case notes. While in the home, the workers observed that Mom's residence was very untidy and unclean. Downstairs, where Steven and Olivia had been sleeping, there were two mattresses on the floor. Both mattresses were covered in clothing and there was additional clothing piled in one corner and scattered about. There were several piles of dog feces on the floor that appeared to have been there for some time. The workers helped the children get ready to leave; the older children were crying and upset saying they did not want to leave their mother. Mom was told to have the house cleaned up or the children could not go there for visits.

Initially, Mom said she would not give consent for CYFS to have the children for three (3) months. She reluctantly agreed but said she did not believe all of the statements made in the application to be true. Dad was notified and at first was adamant that he wanted custody of the two children. As the case notes progressed, it became evident that this was not further pursued by Dad.

During the first week the children were in care, Mom was showing up at school to see them; she was also going to both of the foster homes and calling there five (5) or six (6) times per day. Olivia and Steven had been placed in a separate foster home than Hannah. Mom had to be told several times by the social worker not to make promises to the children, especially about when they would be going home. Mom had indicated to the children how sad she was and this was upsetting to them. In addition, she had talked to them about adult issues. Mom was told her calls would have to be monitored if she continued with those activities.

Over the next several days, one foster mom reported that Hannah was acting up; crying, kicking, and screaming at times. She would often have to get up with her during the night. During this child's visits with Mom, she was being given chocolate and junk food. Mom was not keeping her appointments with the social worker and in one instance she left a belligerent message on the social worker's voicemail demanding the social worker call her. The visits with the children were cancelled until the outstanding issues could be dealt with.

On April 8th, the social worker met with Mom to address the concerns that had been expressed. Mom agreed to the proposed case plan and the visits were to resume. Also on this date, the teacher reported Steven had been lagging behind in school. Whenever he was with his mom, his bookbag was always a mess. The teacher had not been sending homework or books to his mom's residence with him because she would never get anything back. She also said Olivia and Steven came to school without lunches, when in Mom's care. Since the children were in foster care, the teacher noticed marked improvements in their hygiene, they were listening more and they were more energetic.

In mid-April, the foster mom mentioned to the social worker that Hannah had been returned from a visit with Mom and "…diaper was soaked." Mom had dropped the child off early because she was acting up and she could not do a thing with her. On April 20th, the foster mom relayed information she had gotten from Olivia. The older girl had talked about how her mom would send her alone in a cab to the post office. Mom's friend who stayed with them was drunk all the time and Olivia had seen Hannah drink a bottle of beer that had been left on the table.

In early May, the school reported Steven was doing much better with his assigned work. The social worker noted, based on information from the foster moms, that Mom was cutting short her visits with the children. The main reason she gave was that she did not have any food to give them and they would get hungry. Hannah was continuously getting dropped off twenty (20) minutes early from each visit because she was "fussy." The social worker reminded Mom that these would be the same kinds of issues she would need to deal with if the children were returned to her care. The foster mother noted Mom was not calling a lot or dropping by anymore. On May 10th, the program manager suggested to the social worker that visits with Mom should be increased. To date, no reinterviews of the children had taken place. From case notes on file, it appeared Dad had now changed his mind about pursuing custody.

On June 2nd, the police and the social worker reinterviewed Olivia and Steven. It was determined there was insufficient information to formulate criminal charges. The next day, Mom was advised that unsupervised visits may begin soon and if all continues to go well, the children would return to her at the end of the court order.

On June 13th, the foster mom advised that Hannah had been returned early from a visit with Mom. It appeared as if the child had not slept. She was dirty and there were pen marks all over her legs. The foster mom also indicated she had been speaking with Olivia and Steven's teacher and school officials were "dreading" for them to go home. Other information brought to the social worker's attention was that Mom's neighbor's deck was covered in beer bottles; Mom had been seen drinking at the club and there was always a crowd at her house.

The following day, June 14th, an anonymous call was received about a woman who had stayed at Mom's the previous night; she had overdosed and was transported to the hospital. In addition to this, information was relayed that Mom was buying alcohol. The social worker stated in her notes, "I know that alcohol use is not a concern at this point as there is no stipulation on [Mom] consuming alcohol." (CRMS notes dated 2005/06/14.)

On June 25th, the children were returned to their mother. The following day, Olivia was invited to her former caregiver's to swim in the pool with her friend. A short while later, Steven showed up but no one knew he was coming; his mother had sent him. Later that night (June 26th), Mom had houseguests staying with her; she left the children with them and went out. It should also be noted that during the three (3) month time frame that the children were in care, Mom had at least four (4) additional people staying at her home, one of whom overdosed on drugs; CYFS was aware of these living arrangements.

On June 27th, the social worker received information from a concerned person regarding Hannah. This person had dropped by Mom's residence on this date and observed that the house was in disarray. Hannah was observed to be toddling around with a toothbrush in her mouth, which this person felt was a safety concern. On June 28th, the children's in-care files were closed.

By July 15th, there had been three (3) reports, two of them provided by a staff person within CYFS, about Hannah being seen outside playing alone in the road. It was also reported that Mom had been seen driving around with Hannah in the car and the child was not wearing a seatbelt. The little girl could be seen standing on the back seat or sometimes hanging out the car window. According to the informant, several people had noticed the same thing. These reports were not treated as official referrals.

Near the end of July, Dad arrived to visit with his children, Olivia and Steven. In that same week, the family moved to another community and the file was due to be transferred to another social worker. File notes indicated there was e-mail communication between the former social worker and the newly assigned worker on July 26th. Enough information was conveyed that the new worker felt a visit should be made as the worker was currently in that community.

This social worker made an unannounced home visit on July 27th to the residence of Mom's parents. Mom suggested her file would only be open for six (6) months. The social worker explained this meeting was for introductions and before any comment could be made about closure, the file would have to be reviewed. Dad accompanied the children during the move but then returned to his home. The family had temporarily moved in with Mom's parents and Mom accepted employment with a relative. Her plan was to make this community her permanent home. Mom's file was officially transferred on August 18th.

On September 26th, a report was received that two weeks previously, Olivia and Steven were outside until midnight. The children had school the next

day so the anonymous caller was concerned about their ability to get up on time. There was no file documentation that indicated any immediate followup to this report nor was it treated as a referral.

On October 6th, Olivia and Steven were interviewed at school (separately). In her notes, the social worker commented, "[Olivia] appeared to be anxious and nervous as she was moving around in her seat, looking at the floor and having no eye contact. She was hesitant in answering the questions and only provided brief answers with no elaboration." (CRMS notes dated 2005/10/06. These notes were added on CRMS 2006/06/12.) It was learned that Olivia had seen her grandparents and mom drinking and her mom sometimes yelled at her but did not hit her. The little girl indicated she liked living in this new community.

Steven was interviewed shortly afterward. The social worker learned that he and his sisters are sometimes left alone for about half an hour and they have to go downstairs and play. There was a woodstove in the basement but they are not allowed to touch it. The social worker noted some contradictory details were provided and confirmation was not obtained regarding Steven being left alone. (CRMS notes dated 2005/10/06.) Based on this interview, the social worker ascertained that Mom's drinking had decreased however the children's grandparents did drink and this was verified later in an interview with Mom. The social worker found Steven to be quite talkative and he chatted freely about school and his dad; however she learned at times Steven was concerned for his own safety.

Mom was interviewed later that day. She denied leaving the children alone and when asked why Steven would say that she did, she responded, "[Steven] has a wild imagination and is starting to make up stories." Mom agreed the children still needed supervision because of their ages. She stated she had reduced her alcohol consumption but indicated her parents drink often and she has tried to shield her children from it. When her parents drink, they all leave the house or she sends them to their rooms. Mom indicated she was considering placing Hannah for adoption.

In late October, it appeared Mom moved back to her previous community to complete an eight (8) week training program. She took the children with her and they all stayed at a friend's house. It was unclear from the notes exactly how long this arrangement lasted. CRMS notes, dated 2006/01/18, confirmed that Mom voluntarily placed Hannah with prospective adoptive parents in November 2005. This placement would last for approximately nine (9) months.

On December 14th, Mom notified CYFS by telephone that she had voluntarily placed Hannah for adoption. The Adoption Report indicated that during this phone conversation, Mom stated that she was confident in her decision and was not going to change her mind. "[Mom] was advised that CYFS would need to be involved to assess her plan and determine the best interests of [Hannah]." (Adoption Report, 2006.)

On December 29th, CYFS received a letter from Mom with similar information. She indicated in her letter that she was placing Hannah for adoption. In her letter, Mom also indicated that she could not be there for Hannah physically and emotionally. Mom went on to say that Olivia and Steven were aware of the situation and "they don't mind." She stated she had the support of her parents and family. The file indicated that by the beginning of the next year (2006), Mom had moved back to live with her parents along with Olivia and Steven.

## 2006

| Olivia | Steven | Hannah |
|---|---|---|

There were no referrals received about the family during 2006; however, their file remained open for monitoring purposes. On January 18th, the social worker made a school visit to talk with Steven and Olivia. They were now living with their grandparents and their mom in another community. Steven seemed happy and healthy, and it appeared that his mom had stopped drinking. The social worker's notes in CRMS reflecting this visit on 2006/01/18 were not added until 2006/06/07.

Olivia was doing well in school and liked living in this community. An office visit with Mom on the same day revealed that her parents are no longer drinking on a regular basis. If they decide to have a drink, she goes downstairs with the children, where their bedrooms are located, or they go to a relative's house.

In addition, the issue of Hannah's potential adoption, although not captured in CRMS notes, was discussed at length. The Adoption Report indicates that the social worker traveled to the town to "counsel [Mom] on her plan to place [Hannah] for adoption and have the appropriate documents signed." In this Report, the social worker went on to say that Mom continued to demonstrate her willingness and desire to move forward with the proposed adoption plan. The worker wrote: "While meeting this writer, she did not display any nonverbal behavior to suggest to this writer that she did not want to continue with her plan." (Adoption Report 2006.) The social worker informed Mom that she had twenty-one (21) days to make any changes to the plan to have Hannah adopted. The worker told Mom that she would have to notify CYFS in writing should she require any changes.

On February 16th, the social worker wrote the program manager and recommended that CYFS continue with the adoption of Hannah. The worker wrote: "[Mom] is quite clear in her intentions of placing [Hannah] for an adoption, and this is evident in the letter that [Mom] had drafted and contact with this worker." (Letter dated February 16, 2006 from the social worker to the program manager.) The worker indicated again that Mom had been counseled regarding the effects of adoption but she still felt it was in the best interest of Hannah to continue.

The Adoption Report had also outlined that during the interim (February – May 2006), the prospective parents were in the process of becoming approved adoptive applicants by completing the Parent Resource for Information, Development and Education (PRIDE) training. During this time frame, Mom had not expressed any apprehension or reservations about her plan to have Hannah adopted.

On June 14th, during a school visit, one of Steven's teachers reported that he was below average for children his age but was doing better than when he started school in September. At school, the social worker spoke with Olivia and Steven and learned that sometimes Mom sleeps in and the children are late for school. Overall, things appeared to be going well. The interview confirmed that sometimes Mom yells at the children but it was usually for something serious. Mom is not drinking but sometimes the grandparents had a drink and then the children would go downstairs.

A home visit with Mom on the same date (June 14th) revealed that she was expecting her certificate to arrive anytime qualifying her as a medical assistant officer. Mom had recently completed an eight (8) week course and was commended by the social worker on her achievement. Mom reported she seldom consumes alcohol these days and things were going well. Mom thought it was time to close her file and the social worker told her this may happen soon.

The social worker presented Mom with additional adoption forms for her to complete and they had a discussion about the process. During that home visit, Mom agreed to complete the forms and give them to the social worker the next day. It was on that day, June 15, 2006, Mom advised she wished to terminate her plan to have Hannah adopted. Mom visited the office and submitted a handwritten letter revoking her consent. Mom further indicated that the prospective parents had been pressuring her about Hannah's adoption. Mom was advised to seek legal counsel and the social worker consulted with the Regional Director of Adoptions. Three (3) weeks later, on July 6th, Mom reported that the prospective parents had offered her financial compensation if she would leave the little girl with them. Based on this new information from Mom, Hannah's prospective adoption was halted and the little girl was returned to her mother on July 11, 2006. When the social worker went to the prospective parents' home to pick up the child, her notes reflect that Mrs. --- cried uncontrollably as Hannah was being placed in the car. "Mrs. --- stated that she is afraid that [Hannah] is going to be neglected by [Mom]." (Adoption Report, 2006.) This woman was assured by the social worker there would be monitoring of the situation for neglect. The next contact with Mom and her children was four (4) months after they were reunited with Hannah.

On November 9th, the social worker made a school visit to speak with Olivia and Steven. According to the two children, things were going very well. They were expecting to be in their new home within the next few days and both were very excited about the prospect. No concerns were noted about their grandparents' drinking. Their youngest sister, Hannah, had been back with them since July and it was much better with her back. A subsequent home visit that same afternoon with Mom raised no concerns for the social worker. There were no other case notes for the year.

## 2007

| Olivia | Steven | Hannah |
|---|---|---|

On March 7th, the school advised that both Olivia and Steven were home due to illness. Mom and her children were no longer living with the grandparents but now had their own residence; an unannounced home visit was made. The social worker learned that two other people were also residing with Mom and her three (3) children. According to Mom, this was a temporary arrangement to help the couple out. The house was untidy but not dirty. Mom expressed her relief that she had stopped the adoption plan for Hannah. The social worker advised Mom that her file may be closed soon, if things kept progressing. Mom indicated that she would rather be on a case load. Even though she did not agree with her children being removed in 2005, she now sees the positive aspect of it and stated they have been much happier as a family since reunification.

On April 4th, a school visit was paid to Olivia and Steven. On the same day, Mom came to the office for a follow-up meeting with the social worker. There was no information of concern expressed by anyone; things were continuing to go well. Again, Mom reiterated that she does not care if her file is closed; she does not mind working with CYFS.

On July 23rd, referral number eleven (11) was received about Mom. The RS reported Mom was the subject of a police investigation but no charges had been laid. Mom had been suspected of supplying liquor to minors. There was no other information on file regarding this incident and it did not appear as if Mom was interviewed or seen by a social worker. The next contact with Mom would happen in November when four (4) new referrals were received.

On November 9th, referral number twelve (12) was received from a person claiming to be worried about Mom's children. The RS had heard the family was kicked out of their living arrangement and wanted to find out how the children were. It was unclear from the file if any action was taken immediately on this referral.

On November 13th, referral number thirteen (13) was received. The RS reported that the homeowner, where the children were currently residing, did not have enough room for them. The RS further alleged that Mom had taken off and left them at a particular house but the homeowner wanted them to go somewhere else, and the kids were not attending school. The social worker made a home visit and learned that Mom had left the children in the care of two adults. According to these adults, Mom had prearranged the childcare with them and they had no concerns; Mom was expected back the following day. According to the CRMS notes, the house was warm and supper was being prepared.

On November 14th, referral number fourteen (14) was received. The RS stated Mom was out of town, the children were not attending school and they

were not welcome at the homeowner's residence where they were currently staying. The RS further said the family was sleeping on couches in the living room; their clothes all over the place, and the youngest child, Hannah, was watching television in her underwear one day when the RS walked in. It is unclear if there was any immediate followup regarding this report.

On November 21st, during an office visit with Mom, the social worker learned Mom was planning to move to another community because there had been so much talk about young people coming to her house to purchase liquor. As a result of these rumors, Mom had turned in the keys of her residence to the housing authority. The worker asked about winter clothing for the children and offered to help Mom out with that "…as the children were in obvious need." (CRMS notes dated 2007/11/21.) Mom's immediate plan was to stay at her friend's house as there was indeed enough room for them and this man was leaving for an extended period. She planned to look for her own place after Christmas.

On November 24th, referral number fifteen (15) was received. The RS reported the children were not living in a good environment. According to the RS, "…the children are sleeping on the living room floor under clothes." One morning, the RS went to the house and "…the three kids were sprawled on the floor; [Mom] was smoking a cigarette; she had not fed them, and sometimes she do not send them to school." The RS added that Mom frequents the local bar whenever she can and wondered who was minding the kids. The RS also said "…was concerned about them living in that house with three bachelors." In the CPR, the social worker acknowledged there had been three (3) similar referrals in the past month. On the CPR form under Part C - Service Response, the worker noted there were reasonable grounds to conduct an investigation namely under Section 16: Determine Need for Protective Intervention. This information was forwarded to her program manager who replied, "Would not this be a section 14 as it talks about not feeding the children. If that point was not there, I would have agreed that this was a section 16." (CPR dated November 24, 2007.) There was nothing on file that indicated any followup occurred as a result of this referral. The next contact with Mom would be six and one-half (6½) months later.

## 2008

| Olivia | Steven | Hannah |
|---|---|---|

Since November of the previous year, the file indicated the family had moved again from a friend's house to another community. The case notes stated a file transfer was completed on January 4th. Sometime after that, the family moved back to the previous community. It was unclear when this move happened as there were no follow-up case notes that indicated another transfer of the file. The next contact was documented on May 13th when the social worker in this community prepared to meet with Mom and introduce herself as the new worker; however there was no response at the door. It was not clear from the notes where or how the social worker would have obtained this address.

On May 21st, referral number sixteen (16) was received indicating Mom had gone out of town drinking for the past three (3) days and left the children unsupervised. The RS reported the children had not been in school for days. The RS went on to say that "…there was no food in the fridge, the home is very dirty and the children are left alone all the time for [Mom] to go drinking and use drugs." When the social worker arrived at the residence, Mom was not at home but a friend was there and identified herself as the babysitter. The worker learned that Mom would be home for supper. Subsequent to the visit, the social worker consulted with her supervisor asking if they should return in the evening; this was the strategy that had been recommended by the RS.

The social worker returned at 8:30pm and Mom was asleep. Her friend woke her up and the kitchen area was checked for food which was in sufficient supply. The newly assigned social worker stated in her case notes, "We spoke about the allegations and concluded that they were not verified. I took the opportunity to introduce myself as her Protection Social Worker, as each attempt I had made up until this point she had not been home." The last and only documented attempt to reach Mom this year was the one previously referenced on May 13th.

On Saturday, May 24th, the on-call social worker made an unannounced home visit at 7:50pm to conduct impromptu followup at the request of her supervisor. The CRMS notes did not reflect any such visit; however, an e-mail on file had been sent at 8:30pm that evening to other social workers involved and their program manager. The worker outlined how she had observed Mom preparing supper; the children were outside playing and Mom's plan for the evening was housework. The social worker saw no evidence of alcohol consumption or the presence of it. The two girls, Olivia and Hannah, were expected home soon and Steven was staying at a friend's overnight. Mom advised she had supportive neighbors and she accepted a business card from the worker. (E-mail dated 2008-05-24 from the on-call social worker to the program manager.)

On May 28th, referral number seventeen (17) was received. The RS said Mom had been drunk since yesterday and was still drunk today. The RS went on to say that Mom's friend, Marion (Family A Mom), was also at the residence and was drunk as well. The RS further indicated that Marion's son, William, was there and he was hiding from the police. It appeared another social worker was assigned to follow up.

On the same day, the social worker made a school visit to see Steven and Olivia. Steven was interviewed first. The social worker learned more about his family life and that Mom was getting married next summer to a man they call Dad. There were no concerns about any drinking at the house. Mom takes good care of them and when she goes out, a friend looks after them. The social worker learned that sometimes William stays at their house. The worker noticed a scab on Steven's hand and she learned it happened when he was taking hot grease off the stove while his mother was in the bathroom.

Olivia was interviewed next. The social worker confirmed her mom's wedding plans and that William sleeps over at their house once in a while. The worker verified that there were no drinking concerns. A lady referred to as 'Aunt' babysits when Mom goes out. The social worker asked about the burn to her brother's hand and she learned that Steven had been making french fries but Olivia was not home at the time; neither was their mother. When Olivia arrived home, Steven was sitting on the couch crying and he told her what happened. She had to run to a friend's house to get her mother. They did not go to the hospital for about a week because they did not have a car.

Following the interviews at school, the social worker made a home visit to speak with Mom. Marion (Family A Mom) was there as well. The explanation offered by Mom for the referral was that she had kicked the 'Aunt' out of her house the previous evening. Mom's reason for taking this action was that the 'Aunt' was drunk and trying to hurt the kids. This woman then threatened to call CYFS. The children had not mentioned anything about this during the school interviews but it was now confirmed that the 'Aunt' tried to hurt them. The social worker noted the house was fairly clean and the children seemed okay. Mom was asked about the burn on Steven's hand; she said she was home when it happened. The notes do not indicate that any other questions were asked about how the injury had occurred or if any medical attention had been sought by Mom. There were no efforts to further clarify the three (3) conflicting versions of events. It appeared that no further action was taken regarding this referral.

On June 11th, referral number eighteen (18) was received. The RS expressed concerns about Marion (Family A Mom) and her son, William, but also stated concerns about Sharon (the mom in this family). According to the RS, William was frequently staying at Sharon's and Sharon was drinking all the time.

The social worker first contacted the school. She was advised that Olivia and Steven were not in attendance that day; they had been reported as sick. Two social workers attended at Mom's house and found the children at home

along with William and his mother who were also sick. One social worker interviewed Marion (Family A Mom) while the second worker spoke to Sharon (Family B Mom). Sharon said her children were fine, apart from their current stomach flu, and they were looking forward to summer holidays. The house was cleaner than usual and the dishes were done. The social worker advised Sharon she would be back when everyone felt better; possibly in a week. The referral was not verified.

A few days later at 1:10am, the hospital switchboard received a call from Marion who wanted to talk to the social worker on call for CYFS. Upon contacting Marion, the on-call social worker learned Marion had been at Sharon's house earlier and was now reporting that everyone there was drunk. Marion further reported the police had been called to Sharon's and as a result, Marion had been removed. William was still at Sharon's house and Marion wanted him returned home.

After consultation with the program manager and the police, it was decided that William would remain at Sharon's house for the night. The worker attempted to reach Sharon to confirm that this was satisfactory however, no contact could be made.

During the early morning hours an accidental fire occurred at Sharon's residence. Sharon, Hannah, and William died as a result of the fire, along with two other adults who had been visiting there during the evening. Sharon's son Steven was injured in the fire but survived and Olivia was uninjured.

## Findings and Analysis

An accidental house fire claimed the lives of William and Hannah, children from the two separate families represented in this report. Steven, Sharon's son, was injured in the fire however he survived as did his sister Olivia, who was uninjured. Three (3) adults also died in the fire, one of whom was Hannah's mom, Sharon. When the fire occurred in Sharon's home, William's mother, Marion, was not present; she had been removed earlier from that residence after an altercation. William had stayed at Sharon's as the police determined his mother was unable to care for him due to her level of intoxication. Prior to that evening, twenty (20) child protection referrals had been made about Marion's care of William. Eighteen (18) child protection referrals had been made about Sharon's care of her children, Olivia, Steven, and Hannah.

The purpose of this investigation was to examine if the services provided by Child Protection within the RIHA to William, Olivia, Steven and Hannah met their needs. This report provides a summary of this investigation including findings and analysis and resulting recommendations.

The two mothers, Marion (Family A) and Sharon (Family B), had repeatedly neglected their children and were ultimately responsible for their care. However, numerous social workers had been involved with the families over many years and it is evident there were multiple gaps and lapses in service that could have altered the final outcome for the children. This report also highlights the many times where policies were overlooked, breached, or abandoned.

In addition to the twenty (20) official child protection referrals received on Family A from 1995 until 2008, there were twenty-six (26) additional pieces of information that could have constituted referrals; certainly information that should have sparked concern for William's well-being. The issues that were present for William in his early years, namely: domestic violence; lack of Mom's attachment to her three (3) children; Mom's substance abuse, and limited family support continued to be risk factors throughout the life of the file. If these factors had been properly assessed and addressed, a more accurate determination about Mom's ability and readiness to care for William could have been made.

There were three (3) temporary placements for William during his short life: first, when his sister was born with critical medical issues and Mom had to remain with her; second, when he resided with his uncle during one of the many unstable periods for his mother, and third, when he resided with his grandmother for eighteen (18) months from May 2004 until December 2005. During these placements, there was little, if any, contact with William by social workers. There were no progress reports submitted and little planning or monitoring whenever he was returned to his mother.

Mom had minimal contact with William while he stayed with his grandmother, but during the latter part of 2005, Mom indicated she wanted him

back with her. Based on the CRMS notes, CYFS treated William's living arrangement with his grandmother as a placement whereby she received a CWA to financially support William. When Mom expressed interest in having William return to her, CYFS advised Mom they could not support William returning home as they were unaware of her current functioning, her living conditions, the current CWA circumstances, and why he should return. CYFS further stated that if Mom went ahead with her plan to take William from his grandmother's, they would possibly remove William from her care and custody. (CRMS notes dated 2005/11/02.)

The social worker spoke with William's grandmother who confirmed that she no longer wished to care for William due to his recent negative behaviours. On November 2, 2005, Mom was advised a case plan would need to be developed prior to William's return. The social worker also noted that the office, where the case plan needed to be completed, was quite busy, understaffed and could not meet with Mom for two weeks. Mom questioned why a case plan needed to be done as there had only been a verbal agreement in place between her and William's grandmother in the first place. The social worker documented, "Advised her that [William] was on a CWA since June 2004 and that CYFS was supporting [William] financialy as she was not." (CRMS notes dated 2005/11/02.) Mom reported she had not signed anything nor was she aware that "Social Services" was even involved. Mom reportedly made numerous calls, sometimes expressing frustration, to the office asking about her case plan and up until William arrived on December 22, 2005 for his temporary Christmas visit, she had gotten no response. Just before Christmas, CYFS received a report about Mom being intoxicated; there was no contact, followup, or home visit completed until the New Year. The issue about Mom's drinking was addressed during another new referral two weeks later. Near the end of the holiday season, Mom reported she would not be sending William back to his grandmother. William resided with his mother until a case plan was developed four (4) weeks later in spite of concerns expressed by CYFS.

It was during the years 2006 – 2008 that seventeen (17) of the aforementioned twenty-six (26) additional pieces of information came to light. Throughout the entire time frame, the referral information remained consistent. The concerns were general neglect issues, namely: inadequate care or supervision of William; insufficient food supplies; housing instability; poor school attendance, and Mom's drinking, whether she was at home or taking William elsewhere while she drank. If only incoming information had been used as a barometer of risk, then surely a complete file review should have been considered and completed.

In the case of Family B, eighteen (18) official child protection referrals had been made to the authorities over an eleven (11) year period. There were eleven (11) pieces of additional information on file that should have been of concern to the social workers assigned to the case. The issues that arose were always similar in nature, namely: Mom's drinking; lack of supervision; poor school attendance, and the children being unkempt. Mom had her three (3) children,

Olivia, Steven, and Hannah, removed from her care during 2005; they were returned to her just three (3) months later. During that time frame, a number of negative issues were raised about Mom's lifestyle and behaviours that did not appear to influence the decision about sending the children home again. Whatever the rationale used in returning the children to their mother's care, it was not documented in the file. Additionally, Olivia and Steven were questioned by a social worker and police officer about the original allegations eleven (11) weeks after their removal, and only three (3) weeks before they were returned home. If there had been evidence of neglect or abuse, then reinterviewing the children in a timely manner would likely have resulted in more detailed statements.

CYFS *Act* 1999 Standards and Policy Manual, Placement of Children Section, Page 101, states that while a child is in custody of the Director: "Social workers must maintain monthly in-person contact with the child." Based on the CRMS notes of the social workers during the in-care period for Sharon's children, their sole contacts, apart from the reinterviews, were when the children had to move from one caregiver's residence to another. It was clearly evident that the primary source of contacts about the children was through e-mails and phone calls to the caregivers.

Noted in the file review was the absence of medical examinations for Olivia and Steven when the children were removed from their mother and subsequently returned to her care in 2005. According to the older policy, DSS 1993 Child Welfare Policy and Procedures 04-05-03, "All children must be medically examined within 3 days of entering care or prior to leaving care." The same policy also highlights the requirement for completion of a social and family health history; a Child Placement Report, and an application for Children's Special Allowance. This review did find Child Placement Reports for Olivia, Steven, and Hannah; but apart from the placement medical completed for Hannah, there were no other prescribed documents on file. While this comprehensive policy should have been carried over to the 1999 manual, there was no evidence of same; however, it appeared similar practices were expected to continue.

According to CYFS *Act* 1999 Standards and Policy Manual, Placement of Children Section, Page 103, the standard is outlined as follows:

> A plan of care must be developed for all children in care or custody. An interim plan must be completed immediately upon removal which will include where the child lives and who will have access. A full plan must be completed 10 days prior to the protective intervention hearing and provided to the court and all parties receiving notice of the hearing.

Page 106 of the said manual states: "The child's plan of care is to be reviewed on a monthly basis." Plans of Care for Olivia, Steven, or Hannah could not be located.

In addition, Mom had signed a Service Plan on April 8, 2005 agreeing to certain actions that had been specifically proposed for her to take; portions of the agreement read:

> To attend mental health counseling to help with depression and to further develop parenting skills;
> Shall permit social worker to communicate with mental health counselor regarding progress and status of sessions;
> Attend parenting courses/programs as available;
> Maintain open, working communication with social worker;
> Parent to meet with worker via home visits/office visits on a bi-weekly basis providing worker is able to do so and does not have higher priority matters to attend to.

There was little indication in the file that any of these actions, as proposed, were implemented, monitored, or when July 5, 2005 was set out in the Service Plan for an evaluation, there was no documentation to suggest any followup occurred. The evaluation was scheduled to happen ten (10) days after the children were returned to their mother.

Of particular note are the discussions and reports concerning the prospective adoption of Hannah during the year 2006. The social worker reported in notes dated January 18, 2006 that Mom had been counseled about the adoption process and had signed the pertinent documents. Mom had very clearly expressed her desire to place Hannah for adoption. Additionally, it was explained to Mom by the social worker in January that she had twenty-one (21) days to change her mind plus any such decision had to be in writing. There was no written rescindment provided by Mom within the specified time frame. The social worker emphasized that Mom was eager to continue and she had no reservations "…and quite frequently displayed her happiness that [Hannah] was being adopted by the --- family." (Adoption Report, submitted June 2008.)

Four (4) months went by before Mom began suggesting she had been pressured by the adoptive family to permanently place Hannah with them. Three (3) weeks following that, Mom further alleged the family had offered her a substantial amount of monetary compensation for the child. From file notes, it appears as though no in-depth investigation was carried out in relation to this allegation. When asked, a program manager indicated that the investigation was ongoing and there had been no conclusion to date. (Transcript of OCYA Investigation Interview, 2012.) Mom had provided the names of two people who could verify her story; both were interviewed. Documentation shows that one person reported being told by Mom via telephone call that an offer of money had been made. The other person (a close relative) was unaware of such an offer and reported Hannah was quite happy with the prospective adoptive family. This person also emphasized that Sharon should never have gotten pregnant with Hannah as she had two children already and that was difficult enough. The social worker's summation of the interview with this relative indicated, "It was very clear that [the witness] thought [Hannah] should have remained with the --- family… [the witness] feels that [Hannah] should have been adopted." (CRMS notes dated 2006/08/07.)

It is evident that the management of the entire adoption process can be called into question. In spite of documentation in January 2006 outlining how Mom was thoroughly counseled by a social worker through the adoption steps, CYFS officials claimed in July 2006, "The ---'s were not authorized by CYFS to take the child in the first place." (Notes of conference call conducted on July 7, 2006 with the Provincial Director of Adoptions and Regional staff.) The file documentation does not support the accuracy and validity of that statement. Hannah had been with the "---" family for nine (9) months; if the arrangement had not been sanctioned by CYFS, why did they not intervene when they became aware of Hannah's placement in December of 2005? Throughout the process, there appeared to be no consideration given to the negative consequences for Hannah or what was in her best interest.

The child protection referrals pertaining to Family A began in 1995 and the first referral for Family B was received in 1997. According to DSS 1993 Child Welfare Policy and Procedures 02-03-02, when a child is deemed to be in need of protection, "…the decision to investigate shall be made as quickly as possible and within 24 hours of the receipt of the report." This same policy also states, "The process of investigating a complaint of alleged child abuse / neglect shall be initiated within 72 hours of the receipt of the report." In many of the child protection referrals received about both families, these time guidelines were not always utilized.

The DSS 1993 Child Welfare Policy and Procedures 02-03-03 further outlines the initial steps that must be taken during the information gathering phase of an investigation. This document goes on to say, "The child alleged to have been abused / neglected shall be seen as soon as possible. In every instance, the child will be seen no later than 72 hours after the receipt of the complaint." The most obvious gap in service was highlighted following receipt of a referral on March 6, 2001 that alleged Mom was neglecting William. The report indicated William was staying up quite late, he was missing a lot of school, he was coming to school hungry, and he had constant nosebleeds. The social worker made two attempts to locate Mom (Marion) over a three (3) month period and finally wrote in her notes, nine (9) months later, "…due to other higher priority cases, this file was neglected unfortunately." (Case notes dated December 11, 2001.) After the social worker recorded this comment, the next contact with Mom was six (6) months later when a new referral, with similar concerns, was received. It appeared from the scant notes on file that William was not seen by a social worker for eighteen (18) months following the referral that had been made about his welfare in March 2001. In the case management portion of the policy manual, the record keeping category outlines that, "A detailed assessment of the investigation of alleged abuse / neglect shall be completed as soon as possible and within 21 days of receipt of the allegation." (DSS 1993 Child Welfare Policy and Procedures 02-08-06.)

Another referral received concerning Family A in August 2007 outlined how Mom was out drinking on a regular basis and there was no adequate

supervision for William. Followup was conducted and Mom denied all allegations. During the home visit, it was noted that the social worker asked Mom if she could speak to William. Mom went to his bedroom and a few minutes later, the worker was advised that she could speak to William but he had requested that his mom be there as well. The worker attempted to engage William in conversation; however, he acted very distant and shy; he would not make eye contact. Mom said the interview would have to be completed at a later time. According to policy:

> A person who has custody of a child or a person who is entrusted with the care of a child shall permit the child to be visited and interviewed by a director or social worker, in private where in the opinion of the director or social worker it is appropriate to do so, at a place where the child is located. (CYFS Standards and Policy, 2007, Section 2.11.)

The protocol further states that a private interview is generally necessary in order to conduct an objective assessment.

Eight (8) days later, a second referral was received concerning inadequate supervision of William and two social workers made another visit to Mom's residence where it was learned that William was there alone as mom had gone shopping and the workers were not permitted to come in unless she was home. Despite not having a babysitter, William was not asked any other questions about how long he had been home alone during this contact. Even though William had "confirmed" his apparent lack of supervision, it appeared that no further action was taken until two additional similar referrals were received two days later.

Response to a serious allegation made in October 2004 concerning the youngest child of Family B, fell well outside the required 72 hours stipulated in policy. The RS believed that a person living with Family B was yelling and hitting the child. This referral was faxed to the police on the day it was received but was not assigned to a social worker until nine (9) days later. Twenty three (23) days passed from the time the referral was received to when the two older children were interviewed. There was no documentation to indicate that Hannah, whom the referral concerned, was seen at all. During this three (3) week period, the social worker involved was aware of at least two occasions where the person alleged to have hit Hannah, was still present in the home and was in fact babysitting the children. When asked how Hannah's safety could be assured given there was a three (3) week delay in responding to this referral, a program manager replied "It wouldn't have been if it wasn't followed up on." (Transcript of OCYA Investigation Interview, 2012.)

One particular referral in February 2005 was addressed through phone contact six (6) days following its receipt. The RS had initially expressed concern for the welfare of Olivia, Steven, and Hannah. The RS elaborated by saying the oldest girl was sleeping in a basket while her brother slept on the couch; Olivia and Steven were availing of the breakfast and lunch programs every day at school, and the children were unkempt. In her notes, the social worker stated, "Due to shortage of staff at the office and this worker still recovering from the flu I

was unable to conduct a home visit to address the referral." (CRMS notes dated 2005/02/14.) During the telephone contact made by the social worker, Mom denied the allegations. The worker said the file would remain open for monitoring. There was no further contact documented in the file until a new referral was received one month later on March 11th. Four (4) days after that, another referral was received and the children were subsequently removed from their mother.

Approximately two weeks after Olivia, Steven, and Hannah were returned home on June 25, 2005, an e-mail from a social work assistant to a social worker indicated serious concerns about Hannah's lack of supervision. In fact, the assistant had observed, while driving her own vehicle, on two separate occasions that Hannah was left outside by herself. Once, she had seen the little girl squatting by the side of the road with the door to her house opened; her mother's vehicle was not in the driveway. It is unknown if the worker stopped her car. A few days later, this worker again observed Hannah alone and playing in the middle of the road. The little girl was far enough away from her house that it prompted the worker to stop her vehicle and escort the toddler back to her own yard where, in the worker's own words, "…there was nobody to play with her, she was all alone." (E-mail dated 2005-07-13.) It is unknown if Hannah was left with appropriate supervision. In addition, the worker mentioned in the same e-mail that another person reported having to slam on the car brakes when Hannah was observed playing with her bucket in the middle of the street. None of these observations were treated as referrals nor officially reported, despite a social work assistant witnessing two of the events, and it appeared there was no followup.

In the latter part of 2007, four (4) referrals were made in the same month concerning the children in Family B; all were of a similar nature and talked about Mom's neglectful parenting. One RS had stated the children were not attending school and they were sleeping on the floor underneath piles of clothes; these conditions were reminiscent of the observations made by the social workers during the removal of the children in 2005. It appeared from the CRMS notes that only two of these referrals were actioned whereby Mom denied all the allegations and there was no other followup.

During the times when each family's file was open, namely for "monitoring", there were no structured long term plans in place to reduce risk to the children. The combined thirty-eight (38) referrals for both these families produced only two documented case plans which were completed for the Mom in Family A during 2006. These documents were entitled 'Case Plans' on the file but, according to policy, were supposed to be called Family Centered Action Plans. There were no Case Plans or Family Centered Action Plans on file for Family B. As there was little review or followup, neither of the documented plans fully met the applicable standards set out in CYFS 2003 RMS, 7.1. Mom's promises, by way of her signature on these documents, to change or modify her parenting skills, were often broken and there was no accountability.

Both mothers offered explanations for their behaviours that were often accepted without question, and their continuous denials about neglecting their children were not challenged. There appeared to be a heavy reliance on self-reports from the mothers and very few collateral sources were used to allay, support or verify suspicions. When asked if it would be typical to accept a parent's verbal description of how the family is doing, a program manager stated:

> A lot of the work back then was based on information that you received from the parents after you – once you received a child protection report, and you talk to the parents or see the children, and there was little contact with anyone else other than that. (Transcript of OCYA Investigation Interview, 2012.)

The children in both families, particularly William, repeatedly provided social workers with what appeared to be standard rehearsed responses to their questions. The children were obvious in their attempts to protect their mothers by minimizing, justifying, and rationalizing their activities.

Noticeably absent during interventions was followup on the medical issues of the children that were being reported by both moms. William, Olivia, and Steven seemed to be missing a lot of school due to illness but it appears that no strategy was put in place to seek or ensure medical attention for the children. In particular, William had missed a great deal of school that resulted in academic struggles and lower grade functioning. Throughout the file, mention was made of William's nosebleeds, his asthma, and his need to be tested for Dyslexia. It would seem these issues were largely unaddressed. There was little file documentation to indicate either mom being questioned about medical appointments or any documented followup to medical incidents. There was no evidence of social workers having obtained consent to retrieve medical information from any family doctors or specialists.

Risk management is a formalized system for identifying, assessing, responding to, and documenting the risk of child maltreatment throughout the life of a protective intervention case. A risk management system involves the use of assessment tools and specific risk assessment instruments to supplement the social worker's clinical judgement when determining the level of risk to a child throughout the life of a case. (CYFS 2007 Standards and Policy Manual, Section 2.6.) Such an assessment would ideally consider the total number of referrals received; the time frame of the referral history; the varied referral sources and the similar concerns expressed, and any evidence of change in Mom's parenting. The CYFS *Act* 1999 Standards and Policy Manual, page 77, indicates that a comprehensive risk assessment must be completed to determine if a child can remain in or return to the home safely. There was no full risk assessment on file for any of these children.

The late 1990's witnessed an increased focus on the need for improved risk management in child protection cases, particularly high-risk cases. The RMS was revised in 2003; however, it was not fully implemented until April 1, 2005. Even though this process was to be utilized to assess every case, all

social workers in the regions had to receive training in RMS before they could actually use it. Until the social worker was trained in RMS, only the Risk Assessment Instrument was available to social work staff trained in its use. As prescribed in the CYFS 2003 RMS, Section 6.1:

> The social worker shall complete the Risk Assessment Instrument within 30 days of receipt of the Child Protection Report, where it is determined that a child is in need of protective intervention. The Risk Assessment Instrument shall be completed at minimum once every three months and at critical points in the case. The social worker shall review the Risk Assessment Instrument when a new report is screened in on an active case.

Throughout the investigative course of the combined thirty-eight (38) child protection referrals on these two families, many of which were assigned to the same social workers, there was no documentation to confirm any historical file reviews or full risk assessments had taken place. When asked about file reviews, a program manager commented "… no, we didn't ever sit down and review the file in its entirety and clearly look at the historical issues and how they kept reappearing over and over…" (Transcript of OCYA Investigation Interview, 2012.) One social worker commented "I think it would be fair to say that I would not have done a complete file review." (Transcript of OCYA Investigation Interview, 2012.) Following receipt of two different referrals in one family's case, one social worker suggested a risk assessment be completed. There was nothing to indicate there was any followup to her suggested strategy. When asked why on two separate occasions a risk assessment was recommended within an investigative summary and signed off on by the supervisor, a program manager stated:

> Because at that time there were two or three workers in the office that had completed the training for a risk management process, and would have known that that would have been the standard according to legislation and the policy, and I certainly was well aware that that was the standard and we were really trying to make efforts to meet standards, but it wasn't happening. (Transcript of OCYA Investigation Interview, 2012.)

In addition to the lack of historical file reviews and risk assessments, documentation could not be found to indicate that a case conference had taken place involving either family. A case conference is a meeting of professionals and individuals involved in a case to discuss relevant issues and set strategic direction in a case or file. Such meetings would have provided opportunities to collaborate and share information and to gain greater understanding for the needs of both families.

There was little or no rationale provided by the social workers about why the children were being assessed as safe following only cursory CPR investigations. Equally lacking was rationale about why Olivia, Steven, and

Hannah were returned to their mother in June 2005. Apart from referrals received after 2008, this lack of clinical assessment remained a trend throughout the review period covered. Only weeks before William's death, the assigned social worker documented that he was currently of an age where he could remove himself from harmful or abusive situations, he had his own bike, and he knew how to use the phone book to find numbers. It was difficult to ascertain what the "test" or measurement standard was for his safety prior to him becoming a teenager. It appeared from the social worker's notes that the onus was on William to look after himself and ensure his own safety. This was confirmed in an interview when the social worker explained that the risk to this child's safety was low because, "William was a visible child in the community. He was involved in school, tutoring… on a regular basis. (Transcript of OCYA Investigation Interview, 2012.) Despite Mom's varying levels of intoxication, she would continually report that William was always looked after by someone else when she was drinking, therefore concerns were not viewed as immediate or high risk.

There is no documentation to support any assessment of risk to William given his mother's chronic alcohol use. The same can be said for the children in Family B whose mother also suffered from a substance abuse issue. Social workers repeatedly made statements about drinking not being the main issue but having supervision was paramount. Mom A's case plan of January 24, 2006 had stated: "The main concern was not with [Mom] drinking but that she was not drinking while caring for [William]." In June 2005, just prior to the children of Mom B being returned to her care, an e-mail from one social worker to another stated: "I know that alcohol use is not a concern at this point as there is no stipulation on [Mom] consuming alcohol…" It is difficult to imagine how the abuse of alcohol was not considered as primarily putting the children at risk when these moms were: spending money on liquor while their children were hungry; leaving their children to fend for themselves when they drank or they were drinking at home while the children were in their care; not getting up in the mornings to get their children ready for school because they had been drinking, and exposing them to potentially harmful situations. There were people who intermittently resided with these moms who were drug users, sex offenders, and a person who overdosed on medication. The chronic alcohol abuse should have been dealt with as the root cause of the neglect, not a symptom.

Despite the numerous similar fact reports, each new referral appeared to be treated in relative isolation and was not viewed with a critical or a clinical lens. Many of the interventions that did take place appear to have been referral driven as evidenced in case closures notes; when the parents could not be located, the social worker would comment about waiting for the next referral as a means of finding these mothers. The program managers and supervisors were not questioning the process and the easily identifiable missed steps. In fact, the supervisors were signing off on the decisions being made by the social workers, and it appears they were doing so without any in-depth discussions. DSS 1993 Child Welfare Policy and Procedures 02-04-05 relating to Risk Management reads in part: "Repeated, unsubstantiated reports may also suggest that maltreatment is present but that it may not have been clearly discernible during

previous investigations." These ongoing similar reports about the dysfunctional parenting by both moms were intrinsically related to the incremental risk for the children. Despite the fact that numerous pieces of similar information about these two families were repeatedly brought to light, in addition to the official referrals, there was a severe lack of viewing the cases in a cumulative or holistic fashion.

Complex cases such as these two require strong clinical supervision and case management. The lack of clinical supervision with both these families was evident. At best, management of the cases was almost exclusively reactive. The demands of high caseloads, inexperienced social workers and lack of relevant training surfaced as problematic throughout this review. Compounding this, the social workers appeared to be clinically supervised only in a cursory fashion. Communication and information sharing was sadly lacking at critical junctures in these files. Details about case transfers, interventions, and file closures were not shared, and if they were, it was not documented.

On occasion, there were services offered to the families such as counseling, respite care, and tutoring. Unfortunately, there was very little consistency in how these services were administered and their lack of continuity over time did little to reduce overall risk. No evidence could be found of strategic oversight by the assigned social workers. The steps required, namely: planning; implementation, and followup, to determine if the suggested interventions were producing the desired outcomes, were seriously flawed. Despite the fact that both mothers indicated they would participate in counseling and/or parenting sessions, there is only cursory documentation concerning their limited involvement. There was little accountability and no follow-up evaluation to assess their progress.

The policy and procedure manual highlights the importance of accurate record keeping in child protection cases. Numerous instances were noted wherein social workers added their notes to CRMS nine (9) or ten (10) months after the contact was made. This practice clearly did not meet the prescribed standards and was in direct contravention of guidelines which state: CYFS Social Workers are required to document all service notes in CRMS.

> Client documentation related to Protective Intervention Investigation must be completed within 24 hours of providing a service. All other documentation must be completed within 48 hours of providing a service. This is the standard practice of the organization and promoted as best practice by recognized Child Welfare Organizations. (CYFS 2002 Best Practice Guidelines for using CRMS.)

When asked during an interview what the standard practice was for documentation, a program manager responded:

> ... obviously the message was there that that had to be done as soon as possible, the same day if you could. I know that that's not what happens, or that wasn't what happened then.

> I would have been giving that direction to staff certainly to make every effort to get your documentation done… I know that most staff would have been behind in documentation. (Transcript of OCYA Investigation Interview, 2012.)

The question was then asked whether senior management were aware that documentation standards were not being met, to which this program manager responded, "Oh, absolutely, yes." (Transcript of OCYA Investigation Interview, 2012.)

There were often errors in the static information portion of the referrals, most notably whereby the "old" address for Mom A was shown on an official CPR form some two years after she had moved. In the social work notes over the life of the file, William was referred to by three (3) different incorrect names. His younger brother was misnamed on one case note and Mom B was called three (3) different names in error. In one instance, the search for Mom B under an incorrect last name resulted in no followup on a referral. Ages and birthdates of the children were erroneously recorded (eg: Marion's daughter was referred to as being 24 weeks old when she was 10 days old; William was referred to as 16 months of age when he was 10 months old). The birthdates of Olivia and Steven had to be amended by a judge in the court information pertaining to their removal in 2005. On the night of the fire when the on-call social worker was trying to reach Mom B, the number on file in CRMS was no longer in service; this, in spite of recent referrals and in-person contacts with her.

Most notable of errors in recorded information was found in the CRMS notes for the night of the fire. Upon initial review of the two files, it appeared that the CRMS notes detailing the events of that night belonged to the assigned social worker for Family A, as that was the name listed under "Service Provider". However, upon questioning the program manager and the assigned social worker, it was learned that the notes actually belonged to another worker who was on call that night. The explanation provided was that whomever entered the note in CRMS failed to acknowledge that the note was received from the on-call worker and was not in fact the note of the assigned social worker. A program manager stated that "… this would be common practice that the worker who owns the file would be the one to put the notes into CRMS." (Transcript of OCYA Investigation Interview, 2012.) However, the assigned social worker could not recall whether she had entered the notes or if the on-call worker had done so.

Another issue that surfaced was the documenting of notes in e-mail format as opposed to handwritten or CRMS notes. A program manager confirmed "There was a practice that there would be emails, but more so if one staff was emailing another staff about their case, and then the emails were then put into CRMS instead of summarized in case notes." (Transcript of OCYA Investigation Interview, 2012.) In fact, there were e-mails concerning Family B that originated from a private account of one social worker. Both were written on March 2, 2004 to her supervisor and included information about: birthdates; full names; schools attended, and specifics of a recent allegation. These actions were clearly a breach of confidentiality. When asked about these instances, a program

manager said “It did occur, and this was addressed with her [social worker] as a performance issue, HR issue.” (Transcript of OCYA Investigation Interview, 2012.)

The actual case closures themselves were largely deficient in details. Oftentimes, there were no interviews with Mom or the children; there were few interviews or followup with collateral contacts; there were no recorded details of the risk factors and the interventions that had taken place to reduce risk, and there was little history of what the CYFS involvement had entailed. This history should have included: the number and details of referrals made; the outcomes of interventions by social workers; what the risk reduction plan amounted to for the children; any evidence of sustainable parental change, and the results of the investigation. This review found that in the cumulative seven (7) case closures for both families, there was often lack of detail provided. One particular case closure (2001) was documented in the social worker’s case notes but there was nothing on the file to indicate the involvement of a supervisor. This was contrary to DSS 1993 Child Welfare Policy and Procedures, 02-08-03. As previously mentioned, in some instances, the file was closed because the family could not be found and the social worker suggested waiting for a new referral to determine their location. The program manager signed off on these file closure summaries, essentially approving the file for closure knowing the children had not been seen.

The *Child Welfare Act* and all programs and policies related to the legislation have as their primary theme the protection of the child and the promotion of “the best interests of the child.” It is not only reasonable but it is required by policy to respond to a complaint of alleged abuse or neglect in a timely fashion; such was not the case in these two files. The *Child, Youth and Family Services Act 1998,* Section 9, sets out the factors to be considered when determining the ‘Best Interests of the Child’. A partial excerpt from that section outlines relevant factors that shall be considered in determining a child’s best interests, including: “a) the child’s safety; b) the child’s developmental needs; c) the child’s cultural heritage; d) where possible, the child’s views and wishes, and e) the importance of stability and continuity in the child’s care.”

Additionally, the United Nations Convention on the Rights of the Child (UNCRC) outlines that all actions concerning a child shall take full account of his or her best interests. Article 3 reads “In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.” (UNCRC, Article 3, 1989.) While numerous social workers were involved with these families, it appears there was no concerted or collaborative effort to always initiate responses that were in the best interests of the children.

In considering the best interests of children, Section 15(1) of the *Child, Youth and Family Services Act 1998,* states “Where a person has information that a child is or may be in need of protective intervention, the person shall immediately report the matter to a director, social worker or a peace officer.”

The *Children and Youth Care and Protection Act 2010* has a similar stipulation concerning Duty to Report. Furthermore, Section 15(3) of the 1998 *Act* states "Where a report is made to a peace officer under subsection (1), the peace officer shall, as soon as possible after receiving the report, inform a director or social worker." This is reflected in Section 11(3) of the new *Act*. In an interview with a program manager it was learned that the police in that area seldom make reports to CYFS after hours regarding children who may be at risk. This program manager stated, "Very rarely. I mean, they would the next day if it happened after hours, but very rarely does that happen during on-call." (Transcript of OCYA Investigation Interview, 2012.) Despite the legislation stating that information should be passed along as soon as possible, in some instances it seems negligent and not in the best interest of the child if that information is not relayed immediately to CYFS.

It is evident that for social workers attempting to locate specific policy direction and protocol, the task was monumental. In this section of the review, there is reference to three (3) separate policy manuals, namely: The DSS 1993 Child Welfare Policy and Procedures; CYFS *Act* 1999 Standards and Policy Manual, and CYFS 2007 Standards and Policy Manual. In addition, the 2003 Risk Management System Manual was brief in outlining the specifics of conducting an investigation and detailing findings. For example, in the newer policy manuals there is no reference to: "Repeated, unsubstantiated reports may also suggest that maltreatment is present but that it may not have been clearly discernible during previous investigations," as previously referenced in this section of the review. The 1993 Child Welfare Policy and Procedures Manual, commonly referred to as the "green binder", does contain this well-founded language and guidance; however, reliance on this manual began decreasing with the introduction of the newer manuals. The 1993 protocol was eventually considered obsolete circa 2005.

Despite its being out-of-date, it appears, for a myriad of reasons and issues, that the 1993 protocol document was the most comprehensive "how-to" policy on record. The more recent standards and policy manuals do not include definitive "procedures" as captured in the name of the 1993 document. In the absence of a "how-to" manual, critical concepts and procedural matters are not being addressed in the newer manuals, resulting in an obvious absence of standardized practice.

Throughout this investigative review, there were numerous interventions where the social worker's approach would be considered questionable. Most notable of these were referrals relating to the children not being properly fed or supervised wherein announced home visits or office visits with mom were prearranged. During one referral, the social worker described Sharon (Family B Mom) as being a "support" for Marion (Family A Mom). It is difficult to comprehend the logic of having one negligent parent qualify as a support to another negligent parent. At times, there were other people on child protection caseloads who were babysitting for these two moms and vice versa; this information was made known to the social workers but apart from one referral,

documentation regarding assessment and followup is nonexistent. When asked about this, one social worker responded, "It's not my job to assess everybody's babysitters." (Transcript of OCYA Investigation Interview, 2012.) In one interview with William, he gave one of his standard responses about his bedtime and the social worker was able to refute what he was saying as she had personally seen him outside much later on more than one occasion; the initial report did not indicate any followup. Another report outlined how a woman was overheard screaming at Marion's residence; William was so frightened by the sound, he left for a friend's house. Mom was never questioned about this incident.

In June 2006, one social worker observed a young boy, approximately five (5) years of age, emerging from a bedroom in Marion's residence. Marion indicated he had been there for a sleepover; there was no follow-up documentation about this child. Similarly, a referral in January 2007 reported how an eleven (11) year old girl had accompanied Marion to the hospital at 6:30am in a taxi. The child had apparently arranged the taxi and appeared to be serving as Marion's caregiver. Marion was intoxicated and could not recall how events unfolded; there was no followup concerning the young girl. During other specific referrals, it was noted that relevant and additional questions were not being asked by the social workers; there was very little consistent probing. Collateral sources were rarely called upon for their knowledge of the families and input. At one point while still on an active child protection caseload, Marion was permitted to have a young person live with her under a Youth Services Agreement which is a CYFS program. According to a program manager, "… in Youth Services policy, a youth can choose where they live. I mean, we – the worker probably would have talked to [the youth] about other options, but we wouldn't have asked [the youth] to move, no." (Transcript of OCYA Investigation Interview, 2012.)

While inappropriate and ineffective interventions were cause for concern, the lack of any intervention in some instances was disturbing. Most notable was the lack of intervention on the night of the fire. Despite receiving concerning information from Marion about William's whereabouts and not being able to reach Sharon via phone to determine whether William was okay and could remain at her residence, a visit to the home was not made nor was the child seen. In determining the safety of the child, the social worker and program manager relied heavily on the report given to them by the police officer who attended the residence several hours earlier that evening. When asked whether it was practice to rely on a third party when determining risk, a program manager stated:

> Normally when the RCMP are involved, we do rely on them to tell us what is going on. There are lots of times we do go out with the RCMP or go out after they go out, or before they go out, but at this particular time we didn't do that. (Transcript of OCYA Investigation Interview, 2012).

There were numerous physical moves from community to community by these families, particularly with William and his mother. These relocations exacerbated the continuity of responses that could have been provided by the various social workers. However, from 2006 to 2008 when a substantial portion of the referrals were received about Family A, they were residing in one community. Family B did not move around as much but the majority of the referrals about this family also occurred when they were in the same community as Family A. The numerous changes in assigned social workers should have generated informative discussions amongst the various offices involved. There is little evidence of appropriate file transfers, collaboration, or communication between the service providers. Upon receipt of the file, there were no comprehensive file reviews to gain a full understanding of the children's circumstances and their needs.

It was evident from the investigative review that the CYFS office in this community was lacking structure and organization. Prior to 2002, there did not appear to be a consistent manager in the office to whom social workers would report and receive guidance and supervision. A program manager reflecting back on those years stated, "We went through long periods of time without any manager." (Transcript of OCYA Investigation Interview, 2012.) In addition to this, new social workers inherited dozens of case files upon entering their new jobs and proper orientation did not exist. One social worker commented, "I started and they're like here's your cabinet you got sixty odd files and here's your caseload… we had one girl, I think, did two home visits just to show me how they were done…" (Transcript from OCYA Investigation Interview, 2012.) When asked during an interview if concerns regarding caseloads were expressed to the Regional Director, a program manager indicated they had, "But there was no solution offered really other than just do the best you can and keep working." (Transcript from OCYA Investigation Interview, 2012.)

It also was evident from the investigative review that the social workers' caseloads were prioritized based on the referrals being received. Cases went neglected for months with no contact occurring with the family due to other "higher priority" cases, yet there was no evidence of how the priority of one case was being determined over that of another. The intake process for referrals was detrimental to case management in that the person receiving the referral would often action it rather than the worker who was already assigned to that family. Often times the assigned social worker would be advised of a referral and how it was actioned via email, and it was unclear whether this method of communication was sufficient in relaying the context or urgency of a situation. It would appear that having multiple workers responsible for followup resulted in a disjointed approach to case management; the practice did not allow for a solid historical context, continuity of information or consistency in child protection interventions. Only with a uniform approach and constant presence could potentially serious and high-risk situations be systematically documented, strategically monitored, and thoroughly assessed.

The primary deficiencies identified in the system were:

1) nonadherence to policy or lack of policies;
2) lack of in-depth clinical reviews and analysis;
3) lack of documentation and communication;
4) lack of collaboration amongst the service providers, and
5) staff changeover.

While many of the professionals involved in these files were operating in an environment where a high number of referrals relate to domestic violence and substance abuse, this does not account for the poor practices evident throughout this investigation. In fact, in high-risk situations, a heightened level of due diligence is expected to ensure the safety and protection of children. Similarly, in troubled regions, extra vigilance must be the norm in responding to high-risk families. Geography may present unique challenges but in these two cases, it does not wholly account for: all the delays in responding; total lack of contact at times; insufficient documentation; nonadherence to policies; files open without interventions; little case planning, or inappropriate followup. As previously mentioned, most of the referrals in these two families occurred in the same community; it is therefore difficult to justify that their relocations were a significant inhibitor. Insofar as resources and services were concerned, there may not have been a wide array of options; however, when counseling, parenting courses, or tutoring were offered, there was little or no followup to determine the intended impact on risk.

Following a comprehensive review of all file documentation and interviews, it is evident that the services provided to William, Olivia, Steven and Hannah did not adequately meet their needs. In-depth file reviews and complete risk assessments would have solidified the need to remove the children from the care and custody of their mothers. Marion and Sharon were continuously neglectful but they were never sufficiently held accountable by the service providers. The primary requirement for these moms was to demonstrate significant risk reduction in their parenting skills. The extent of their commitment was a signature or a verbal promise; these were temporary, self-serving, and disingenuous. The lack of focus on what was needed to keep the children safe was evident; the reoccurring risk factors largely remained unaddressed following social work interventions. When alcohol abuse kept resurfacing as a main issue, the focus was not on the impact of drinking on the children but on having an appropriate person watching them while Mom drank. If Mom A was depending on Mom B for oversight and the system acknowledged such an arrangement as supportive, then it failed the children on a number of levels, namely the need for protective intervention.

The UNCRC addresses the right of children to an adequate standard of living in terms of their physical, mental, spiritual, moral and social development. Article 27(2) states “The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.” (UNCRC, Article 27, 1989.) It appears that Marion and Sharon were not fulfilling this responsibility and therefore this duty lay with CYFS. However, the deficiencies in the system, as identified in the analysis of this case, limited the children’s access to an

adequate standard of living that would have fully supported their global development.

It must be recognized that reunification of families is not always the answer; all options for a child's care to ensure the best outcome must be considered. Both mothers neglected their parental duties and hence, their children. When these women showed so little progress in their parenting skills, William, Olivia, Steven, and Hannah should have been removed and placed in homes where they would have been safe. In the absence of protective parenting, CYFS also neglected to thoroughly consider the "best interests of the child." The children in these two families were not the focus and they were truly victims of neglect.

# Recommendations

The mission of the Office of the Child and Youth Advocate (OCYA) 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 these 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 Department of Child, Youth and Family Services (CYFS). The ultimate responsibility for CYFS provincially was transferred to the newly created Department of CYFS during April 2009; the formal transfer of CYFS (RIHA) took place in March, 2012.

The Office of the Child and Youth Advocate will monitor the progress of all existing initiatives and the recommendations of this investigation with the Department of CYFS until they are implemented.

**Recommendation No. 1**
The Department of CYFS must develop policies to ensure:
(a) the appropriate assignment of high-risk cases;
(b) systematic reviews of cases;
(c) regular file updates, and
(d) clinical analysis of all cases.

**Recommendation No. 2**
The Department of CYFS must develop policy to ensure effective transfer of files which would include joint case review and direct communication.

**Recommendation No. 3**
The Department of CYFS must ensure proper and total 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**
The Department of CYFS must ensure compliance with policy that all children in a family are physically and critically observed during a referral and during every home visit. Where appropriate, children must be interviewed – alone, if necessary.

**Recommendation No. 5**
The Department of CYFS must ensure compliance with policies that require the completion of forms related to the assessment and case management of a child in need of protective intervention.

**Recommendation No. 6**
The Department of CYFS must ensure compliance and consistency in the application of the Risk Management System when identifying, assessing, responding to, and documenting the risk of maltreatment towards a child.

**Recommendation No. 7**
The Department of CYFS must ensure strategies and services employed to reduce risk are: appropriate; regularly monitored, and systematically evaluated on a regularly basis.

**Recommendation No. 8**
The Department of CYFS must ensure service notes are inputted into CRMS as per the prescribed standard. Historical data must also be available to social workers.

**Recommendation No. 9**
The Department of CYFS must develop and implement staff education to ensure:
(a) all new hires receive orientation in the area of child maltreatment including: intake, assessment, risk management, and communication;
(b) continuing education and training occurs in the areas of policies and procedures, skill development, clinical documentation, and child maltreatment for all social work staff;
(c) all social workers must receive training in policies and procedures, and
(d) all program managers receive ongoing case management and clinical supervision training.

**Recommendation No. 10**
The Department of CYFS must ensure that provincially:
(a) collaborative practice initiatives are developed and advanced between the disciplines of social work, health, justice, and education, and
(b) policy and guidelines are reflective of collaborative practice.

**Recommendation No. 11**
The Department of CYFS must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS programs, province wide.

**Recommendation No. 12**
The Department of CYFS must develop protocol with the RCMP/RNC to ensure that when officers attend a residence where children are present and in a risk situation, information must be relayed immediately to the local CYFS office.

**Recommendation No. 13**
The Department of CYFS must develop protocol with 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 F) is attached.

# Conclusion

It is clearly evident from this investigation that there were multiple social work interventions whereby DSS, DHRE, or the RIHA which had responsibility for CYFS could have responded differently and lessened the time William, Olivia, Steven, and Hannah were neglected. Despite the resources in place, the oversight was insufficient and uncoordinated thereby allowing both mothers ample opportunity to continue parenting in a neglectful fashion.

It is evident that social work responses were not in keeping with policies, standards and best practices. Sharing information, making clinical judgments, and conducting historical file reviews at various junctures would have revealed a far more accurate picture of both families and resulted in more appropriate interventions of the ongoing neglect. Coupled with these deficiencies was a set of circumstances that revealed flaws within the system which were linked to staff changeover, case management, organizational instability and systemic problems. If the systems had been working in an optimal manner, it is reasonable to believe that the children's circumstances would have been recognized and acted upon much sooner thus ensuring their protection.

Pursuant to Section 24(1) of the *Child and Youth Advocate Act,* the Office of the Child and Youth Advocate will follow up on the recommendations made herein to ensure that all have been appropriately addressed.

# Bibliography


Government of Newfoundland and Labrador, Department of Health and Community Services, Child, Youth and Family Services (2003). *Risk Management System*.

Government of Newfoundland and Labrador, Department of Health and Community Services, *Child, Youth and Family Services Act* (1998).

Government of Newfoundland and Labrador, Department of Health and Community Services, *Child, Youth and Family Services Act* (1999). *Standards and Policy Manual*.

Government of Newfoundland and Labrador, Department of Health and Community Services, Child, Youth and Family Services (2007). *Standards and Policy Manual*.

Government of Newfoundland and Labrador, Department of Health and Community Services (2008). *"File Review Report of Child Youth and Family Services Interventions.*"

Government of Newfoundland and Labrador, Department of Health and Community Services (2010). *"Critical Incident/File Review - Report of Child Youth and Family Services Interventions."*

Government of Newfoundland and Labrador, Department of Social Services (1972). *Child Welfare Act.*

Government of Newfoundland and Labrador, Department of Social Services (1990). *Child Welfare Act.*

Government of Newfoundland and Labrador, Department of Social Services (1993). *Child Welfare Policy and Procedures.*

Health and Community Services, "…", Child, Youth and Family Services (2002). *Best Practice Guidelines for using CRMS*.

Health and Community Services, Child, Youth and Family Services (1995-2008). Protective Intervention Files *"… Families."*

Office of the Child and Youth Advocate. Child, Youth and Family Services (2012). Interview Transcripts of Stakeholders.

Royal Canadian Mounted Police (2008). Interview transcripts of witnesses.

United Nations Convention on the Rights of the Child (1989).

# Appendices

# APPENDIX A

## Letters commencing Investigation

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

August 3, 2009

DELIVERED BY FAX AND BY MAIL
STRICTLY PRIVATE AND CONFIDENTIAL

Chief Executive Officer
Regional Integrated
Health Authority
, NL

Dear

Re: Notice of Investigation Pursuant to the *Child and Youth Advocate Act*

I write at this time to advise you of my intention to conduct an investigation of the services provided by the Regional Integrated Health Authority to the

This investigation has been undertaken pursuant to 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, 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.

In compliance with Section 20 of the Act, I am now informing you of my intention to conduct an investigation of the services provided by the Regional Integrated Health Authority.

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

193 LeMarchant Road, St. John's, NL A1C 2H5
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

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

> 21.(1) The advocate may require a person who, in his or her opinion, is able to give information relating to a matter being investigated by him or her
>
> (a) to furnish the information to him or her; and
> (b) to produce a document, paper or thing that in his or her opinion relates to the matter being investigated and that may be in the possession or under the control of the person,
>
> whether or not the person is an officer, employee or member of a department or an agency of the government and whether or not the document, paper or thing is in the custody or under the control of the department or agency of the government.
>
> 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 Regional Integrated Health Authority provide to this Office all file documentation with respect to , that is in the custody and control of your Department, including any notes/minutes of meetings, teleconferences, correspondence, including electronic correspondence, and any reports that have been completed as a result of any internal review that was undertaken by or at the request of the Regional Integrated Health Authority.

Copies of relevant policy or protocols governing the delivery of programs and services in existence and any subsequent changes to such policies/protocols are also requested. A similar request has been made to Ms. Sheree MacDonald, Deputy Minister, Child, Youth and Family Services, and to Mr. Don Keats, Acting Deputy Minister, Health and Community Services.

Please provide this information by August 14, 2009. 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

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

August 3, 2009

DELIVERED BY COURIER
STRICTLY PRIVATE AND CONFIDENTIAL

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

Dear Mr. Keats:

Re: Notice of Investigation Pursuant to the *Child and Youth Advocate Act*

I write at this time to advise you of my intention to conduct an investigation of the services provided by the Regional Integrated Health Authority to

This investigation has been undertaken pursuant to 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, 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.

In compliance with Section 20 of the Act, I am now informing you of my intention to conduct an investigation of the services provided by the Regional Integrated Health Authority.

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

193 LeMarchant Road, St. John's, NL A1C 2H5
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

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

> 21.(1) The advocate may require a person who, in his or her opinion, is able to give information relating to a matter being investigated by him or her
>
> (a) to furnish the information to him or her; and
> (b) to produce a document, paper or thing that in his or her opinion relates to the matter being investigated and that may be in the possession or under the control of the person,
>
> whether or not the person is an officer, employee or member of a department or an agency of the government and whether or not the document, paper or thing is in the custody or under the control of the department or agency of the government.
>
> 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 documentation with respect to [redacted] that is in the custody and control of your Department, including any notes/minutes of meetings, teleconferences, correspondence, including electronic correspondence, and any reports that have been completed as a result of any internal review that was undertaken by or at the request of your Department.

Copies of relevant policy or protocols governing the delivery of programs and services in existence [redacted] and any subsequent changes to such policies/protocols are specifically requested. A similar request has been made to Ms. Sheree MacDonald, Deputy Minister, Child, Youth and Family Services, and to [redacted] Chief Executive Officer, [redacted] Regional Integrated Health Authority.

Please provide this information by August 14, 2009. 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

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

August 3, 2009

DELIVERED BY COURIER
STRICTLY PRIVATE AND CONFIDENTIAL

Ms. Sheree MacDonald
Deputy Minister
Department of Child, Youth and Family Services
5th Floor, Natural Resources Building
50 Elizabeth Avenue
St. John's, NL A1A 1W8

Dear Ms. MacDonald:

Re: Notice of Investigation Pursuant to the *Child and Youth Advocate Act*

I write at this time to advise you of my intention to conduct an investigation of the services provided by the Regional Integrated Health Authority to

This investigation has been undertaken pursuant to 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, 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.

In compliance with Section 20 of the Act, I am now informing you of my intention to conduct an investigation of the services provided by the Regional Integrated Health Authority.

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

193 LeMarchant Road, St. John's, NL A1C 2H5
Tel: 709-753-3888 • Toll Free: 1-877-753-3888 • TTY: 709-753-4366 • Fax: 709-753-3988
Web Site: www.ChildAndYouthAdvocate.nl.ca

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

> 21.(1) The advocate may require a person who, in his or her opinion, is able to give information relating to a matter being investigated by him or her
>
> (a) to furnish the information to him or her; and
> (b) to produce a document, paper or thing that in his or her opinion relates to the matter being investigated and that may be in the possession or under the control of the person,
>
> whether or not the person is an officer, employee or member of a department or an agency of the government and whether or not the document, paper or thing is in the custody or under the control of the department or agency of the government.
>
> 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 documentation with respect to that is in the custody and control of your Department, including any notes/minutes of meetings, teleconferences, correspondence, including electronic correspondence, and any reports that have been completed as a result of any internal review that was undertaken by or at the request of your Department.

Copies of relevant policy or protocols governing the delivery of programs and services in existence and any subsequent changes to such policies/protocols are specifically requested. A similar request has been made to Mr. Don Keats, Acting Deputy Minister, Health and Community Services, and to , Chief Executive Officer, Regional Integrated Health Authority.

Please provide this information by August 14, 2009. 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

# APPENDIX B

# Legislative Highlights

## Appendix B

| Changes in Policy, Legislation, and Responsibility of Child Protection Issues (1990-2012). | | | |
|---|---|---|---|
| **Prior to 2000** | **2000** | **2003** | **2009** |
| Child Welfare *Act* (1972) revised 1990 “Neglect" included.<br><br>CW Policy & Procedures Manual 1993.<br><br>Risk Assessment in Child Protective Services 1991.<br><br>Aforementioned under the purview of DSS.<br><br>1997 – DSS renamed Human Resources & Employment. Dept of Health renamed DHCS.<br><br>1998 – CW Services under DHCS with responsibility for service delivery delegated to HCS Boards.<br><br>1998 – New CYFS legislation passed.<br><br>1999 – Work began on new Policy & Standards Manual. | CYFS *Act* proclaimed January 5, 2000.<br><br>New policy* to supplement existing policy & reflect changes.<br><br>* If material not contained in new policy, SWers referred to CW Policy & Procedures Manual 1993. (pg 1, 1999 CYFS draft manual)<br><br>HCS Boards continue responsibility for CW service delivery.<br><br>CYFS gained access to computerized Client Referral Management System (CRMS) May, 2000. | CYFS referrals implemented in CRMS April 1, 2003.<br><br>**2005**<br><br>HCS Boards under Regional Integrated Health Authorities (RIHA).<br><br>Interpretation of prov policy & regional service delivery determined by reg directors.<br><br>**2006**<br><br>OCYA releases Turner Child Death Review.<br><br>**2007**<br><br>Integration of policies into CYFS Standards & Policy Manual, March 2007. Manual in effect up to June 2011.<br><br>HCS approves hiring of SW Assistants. | Dept of CYFS established March 9, 2009.<br><br>Dept of CYFS Transition & Transformation process begins.<br><br>OCYA releases Review of Transitioning of Children & Youth in Care May 2009.<br><br>**2011**<br><br>Children and Youth Care and Protection *Act* proclaimed June 30, 2011.<br><br>Protection & In-care Policy & Procedures Manual June 30, 2011.<br><br>**2012**<br><br>Dept of CYFS full transition completed March 31, 2012. |

# APPENDIX C

# Acronyms used in this report

## Appendix C

| Acronym | Official Title |
|---|---|
| AA | Alcoholics Anonymous |
| CPR | Child Protection Report |
| CRMS | Client Referral Management System |
| CYFS | Child, Youth and Family Services |
| CWA | Child Welfare Allowance |
| DHCS | Department of Health and Community Services |
| DHRE | Department of Human Resources and Employment |
| DSS | Department of Social Services |
| HRLE | Human Resources Labour and Employment |
| OCYA | Office of the Child and Youth Advocate |
| PRIDE | Parent Resource for Information, Development and Education |
| RIHA | Regional Integrated Health Authority |
| RMS | Risk Management System |
| RS | Referral Source |
| UNCRC | United Nations Convention on the Rights of the Child |

# APPENDIX D

# Yearly Calendars

# (Family A)

# 1995

## January

| 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 | | | | |

## February

| 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 | | | | |

## March

| 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 | |

## April

| 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 | | | | | | |

## May

| 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 | | | |

## June

| 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 | |

## July

| 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 | | | | | |

## August

| 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 | | |

## September

| 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 |

## October

| 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 | | | | |

## November

| 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 | | |

## December

| 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 | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 1996

## January

| 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 | | | |
| | | | | | | |

## February

| 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 | | |
| | | | | | | |

## March

| 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 | | | | | | |

## April

| 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 | | | | |
| | | | | | | |

## May

| 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 | |
| | | | | | | |

## June

| 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 | | | | | | |

## July

| 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 | | | |
| | | | | | | |

## August

| 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 |
| | | | | | | |

## September

| 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 | | | | | |
| | | | | | | |

## October

| 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 | | |
| | | | | | | |

## November

| 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 |
| | | | | | | |

## December

| 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 | | | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 1997

## January

| 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 | |

## February

| 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 | |

## March

| 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 | | | | | |

## April

| 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 | | | |

## May

| 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 |

## June

| 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 | | | | | |

## July

| 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 | | |

## August

| 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 | | | | | | |

## September

| 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 | | | | |

## October

| 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 | |

## November

| 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 | | | | | | |

## December

| 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 | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 1998

## January

| 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 |
| | | | | | | |

## February

| 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 |
| | | | | | | |
| | | | | | | |

## March

| 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 | | | | |
| | | | | | | |

## April

| 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 | | |
| | | | | | | |

## May

| 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 | | | | | | |

## June

| 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 | | | | |
| | | | | | | |

## July

| 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 | |
| | | | | | | |

## August

| 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 | | | | | |

## September

| 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 | | | |
| | | | | | | |

## October

| 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 |
| | | | | | | |

## November

| 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 | | | | | |
| | | | | | | |

## December

| 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 | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 1999

## January

| 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 | | | | | | |

## February

| 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 | | | | | | |
| | | | | | | |

## March

| 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 | | | |
| | | | | | | |

## April

| 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 | |
| | | | | | | |

## May

| 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 | | | | | |

## June

| 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 | | | |
| | | | | | | |

## July

| 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 |
| | | | | | | |

## August

| 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 | | | | |
| | | | | | | |

## September

| 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 | | |
| | | | | | | |

## October

| 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 | | | | | | |

## November

| 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 | | | | |
| | | | | | | |

## December

| 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 | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2000

## January

| 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 | | | | | |

## February

| 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 | | | | |

## March

| 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 | |

## April

| 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 | | | | | | |

## May

| 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 | | | |

## June

| 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 | |

## July

| 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 | | | | | |

## August

| 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 | | |

## September

| 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 |

## October

| 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 | | | | |

## November

| 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 | | |

## December

| 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 | | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2001

## January

| 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 | | | |
| | | | | | | |

## February

| 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 | | | |
| | | | | | | |

## March

| 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 |
| | | | | | | |

## April

| 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 | | | | | |
| | | | | | | |

## May

| 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 | | |
| | | | | | | |

## June

| 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 |
| | | | | | | |

## July

| 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 | | | | |
| | | | | | | |

## August

| 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 | |
| | | | | | | |

## September

| 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 | | | | | | |

## October

| 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 | | | |
| | | | | | | |

## November

| 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 | |
| | | | | | | |

## December

| 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 | | | | | |
| | | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2002

## January

| 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 | | |
| | | | | | | |

## February

| 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 | | |
| | | | | | | |

## March

| 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 | | | | | | |

## April

| 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 | | | | |
| | | | | | | |

## May

| 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 | |
| | | | | | | |

## June

| 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 | | | | | | |

## July

| 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 | | | |
| | | | | | | |

## August

| 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 |
| | | | | | | |

## September

| 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 | | | | | |
| | | | | | | |

## October

| 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 | | |
| | | | | | | |

## November

| 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 |
| | | | | | | |

## December

| 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 | | | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2003

## January

| 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 | |

## February

| 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 | |

## March

| 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 | | | | | |

## April

| 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 | | | |

## May

| 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 |

## June

| 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 | | | | | |

## July

| 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 | | |

## August

| 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 | | | | | | |

## September

| 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 | | | | |

## October

| 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 | |

## November

| 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 | | | | | | |

## December

| 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 | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2004

## January

| 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 |
| | | | | | | |

## February

| 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 | | | | | | |
| | | | | | | |

## March

| 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 | | | |
| | | | | | | |

## April

| 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 | |
| | | | | | | |

## May

| 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 | | | | | |

## June

| 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 | | | |
| | | | | | | |

## July

| 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 |
| | | | | | | |

## August

| 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 | | | | |
| | | | | | | |

## September

| 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 | | |
| | | | | | | |

## October

| 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 | | | | | | |

## November

| 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 | | | | |
| | | | | | | |

## December

| 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 | |
| | | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2005

## January

| 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 | | | | | |

## February

| 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 | | | | | |

## March

| 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 | | |

## April

| 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 |

## May

| 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 | | | | |

## June

| 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 | | |

## July

| 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 | | | | | | |

## August

| 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 | | | |

## September

| 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 | |

## October

| 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 | | | | | |

## November

| 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 | | | |

## December

| 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 |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2006

## January

| 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 | | | | |

## February

| 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 | | | | |

## March

| 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 | |

## April

| 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 | | | | | | |

## May

| 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 | | | |

## June

| 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 | |

## July

| 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 | | | | | |

## August

| 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 | | |

## September

| 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 |

## October

| 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 | | | | |

## November

| 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 | | |

## December

| 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 | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2007

## January

| 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 | | | |

## February

| 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 | | | |

## March

| 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 |

## April

| 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 | | | | | |

## May

| 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 | | |

## June

| 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 |

## July

| 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 | | | | |

## August

| 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 | |

## September

| 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 | | | | | | |

## October

| 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 | | | |

## November

| 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 | |

## December

| 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 | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2008

## January

| 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 | | |
| | | | | | | |

## February

| 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 | |
| | | | | | | |

## March

| 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 | | | | | |

## April

| 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 | | | |
| | | | | | | |

## May

| 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 |
| | | | | | | |

## June

| 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 | | | | | |
| | | | | | | |

## July

| 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 | | |
| | | | | | | |

## August

| 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 | | | | | | |

## September

| 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 | | | | |
| | | | | | | |

## October

| 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 | |
| | | | | | | |

## November

| 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 | | | | | | |

## December

| 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 | | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# APPENDIX E

# Yearly Calendars

# (Family B)

# 1997

## January

| 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 | |

## February

| 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 | |

## March

| 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 | | | | | |

## April

| 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 | | | |

## May

| 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 |

## June

| 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 | | | | | |

## July

| 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 | | |

## August

| 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 | | | | | | |

## September

| 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 | | | | |

## October

| 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 | |

## November

| 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 | | | | | | |

## December

| 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 | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 1998

## January

| 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 |
| | | | | | | |

## February

| 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 |
| | | | | | | |
| | | | | | | |

## March

| 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 | | | | |
| | | | | | | |

## April

| 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 | | |
| | | | | | | |

## May

| 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 | | | | | | |

## June

| 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 | | | | |
| | | | | | | |

## July

| 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 | |
| | | | | | | |

## August

| 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 | | | | | |

## September

| 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 | | | |
| | | | | | | |

## October

| 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 |
| | | | | | | |

## November

| 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 | | | | | |
| | | | | | | |

## December

| 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 | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 1999

## January

| 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 | | | | | | |

## February

| 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 | | | | | | |
| | | | | | | |

## March

| 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 | | | |
| | | | | | | |

## April

| 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 | |
| | | | | | | |

## May

| 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 | | | | | |

## June

| 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 | | | |
| | | | | | | |

## July

| 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 |
| | | | | | | |

## August

| 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 | | | | |
| | | | | | | |

## September

| 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 | | |
| | | | | | | |

## October

| 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 | | | | | | |

## November

| 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 | | | | |
| | | | | | | |

## December

| 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 | |
| | | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2000

## January

| 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 | | | | | |

## February

| 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 | | | | |

## March

| 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 | |

## April

| 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 | | | | | | |

## May

| 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 | | | |

## June

| 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 | |

## July

| 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 | | | | | |

## August

| 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 | | |

## September

| 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 |

## October

| 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 | | | | |

## November

| 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 | | |

## December

| 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 | | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2001

## January

| 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 | | | |
| | | | | | | |

## February

| 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 | | | |
| | | | | | | |

## March

| 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 |
| | | | | | | |

## April

| 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 | | | | | |
| | | | | | | |

## May

| 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 | | |
| | | | | | | |

## June

| 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 |
| | | | | | | |

## July

| 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 | | | | |
| | | | | | | |

## August

| 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 | |
| | | | | | | |

## September

| 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 | | | | | | |

## October

| 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 | | | |
| | | | | | | |

## November

| 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 | |
| | | | | | | |

## December

| 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 | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2002

## January

| 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 | | |
| | | | | | | |

## February

| 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 | | |
| | | | | | | |

## March

| 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 | | | | | | |

## April

| 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 | | | | |
| | | | | | | |

## May

| 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 | |
| | | | | | | |

## June

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

## July

| 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 | | | |
| | | | | | | |

## August

| 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 |
| | | | | | | |

## September

| 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 | | | | | |
| | | | | | | |

## October

| 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 | | |
| | | | | | | |

## November

| 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 |
| | | | | | | |

## December

| 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 | | | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2003

## January

| 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 | |
| | | | | | | |

## February

| 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 | |
| | | | | | | |

## March

| 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 | | | | | |

## April

| 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 | | | |
| | | | | | | |

## May

| 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 |
| | | | | | | |

## June

| 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 | | | | | |
| | | | | | | |

## July

| 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 | | |
| | | | | | | |

## August

| 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 | | | | | | |

## September

| 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 | | | | |
| | | | | | | |

## October

| 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 | |
| | | | | | | |

## November

| 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 | | | | | | |

## December

| 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 | | | |
| | | | | | | |

**Key:** = Referral
= 2 Referrals
= Information of concern (possible referral)
= File Closed
= Visit (office, home or school)

# 2004

## January

| 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 |
| | | | | | | |

## February

| 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 | | | | | | |
| | | | | | | |

## March

| 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 | | | |
| | | | | | | |

## April

| 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 | |
| | | | | | | |

## May

| 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 | | | | | |

## June

| 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 | | | |
| | | | | | | |

## July

| 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 |
| | | | | | | |

## August

| 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 | | | | |
| | | | | | | |

## September

| 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 | | |
| | | | | | | |

## October

| 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 | | | | | | |

## November

| 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 | | | | |
| | | | | | | |

## December

| 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 | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2005

## January

| 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 | | | | | |

## February

| 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 | | | | | |

## March

| 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 | | |

## April

| 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 |

## May

| 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 | | | | |

## June

| 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 | | |

## July

| 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 | | | | | | |

## August

| 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 | | | |

## September

| 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 | |

## October

| 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 | | | | | |

## November

| 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 | | | |

## December

| 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 |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2006

## January

| 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 | | | | |

## February

| 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 | | | | |

## March

| 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 | |

## April

| 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 | | | | | | |

## May

| 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 | | | |

## June

| 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 | |

## July

| 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 | | | | | |

## August

| 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 | | |

## September

| 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 |

## October

| 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 | | | | |

## November

| 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 | | |

## December

| 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 | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2007

## January

| 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 | | | |
| | | | | | | |

## February

| 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 | | | |
| | | | | | | |

## March

| 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 |
| | | | | | | |

## April

| 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 | | | | | |
| | | | | | | |

## May

| 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 | | |
| | | | | | | |

## June

| 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 |
| | | | | | | |

## July

| 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 | | | | |
| | | | | | | |

## August

| 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 | |
| | | | | | | |

## September

| 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 | | | | | | |

## October

| 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 | | | |
| | | | | | | |

## November

| 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 | |
| | | | | | | |

## December

| 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 | | | | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# 2008

## January

| 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 | | |
| | | | | | | |

## February

| 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 | |
| | | | | | | |

## March

| 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 | | | | | |

## April

| 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 | | | |
| | | | | | | |

## May

| 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 |
| | | | | | | |

## June

| 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 | | | | | |
| | | | | | | |

## July

| 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 | | |
| | | | | | | |

## August

| 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 | | | | | | |

## September

| 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 | | | | |
| | | | | | | |

## October

| 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 | |
| | | | | | | |

## November

| 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 | | | | | | |

## December

| 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 | | | |
| | | | | | | |

**Key:** = Referral = 2 Referrals = Information of concern (possible referral) = File Closed = Visit (office, home or school)

# APPENDIX F

# Summary of Recommendations

## Appendix F

**Recommendation No. 1**
The Department of CYFS must develop policies to ensure:
(a) the appropriate assignment of high-risk cases;
(b) systematic reviews of cases;
(c) regular file updates, and
(d) clinical analysis of all cases.

**Recommendation No. 2**
The Department of CYFS must develop policy to ensure effective transfer of files which would include joint case review and direct communication.

**Recommendation No. 3**
The Department of CYFS must ensure proper and total 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**
The Department of CYFS must ensure compliance with policy that all children in a family are physically and critically observed during a referral and during every home visit. Where appropriate, children must be interviewed – alone, if necessary.

**Recommendation No. 5**
The Department of CYFS must ensure compliance with policies that require the completion of forms related to the assessment and case management of a child in need of protective intervention.

**Recommendation No. 6**
The Department of CYFS must ensure compliance and consistency in the application of the Risk Management System when identifying, assessing, responding to, and documenting the risk of maltreatment towards a child.

**Recommendation No. 7**
The Department of CYFS must ensure strategies and services employed to reduce risk are: appropriate; regularly monitored, and systematically evaluated on a regularly basis.

**Recommendation No. 8**
The Department of CYFS must ensure service notes are inputted into CRMS as per the prescribed standard. Historical data must also be available to social workers.

**Recommendation No. 9**
The Department of CYFS must develop and implement staff education to ensure:
(a) all new hires receive orientation in the area of child maltreatment including: intake, assessment, risk management, and communication;
(b) continuing education and training occurs in the areas of policies and procedures, skill development, clinical documentation, and child maltreatment for all social work staff;
(c) all social workers must receive training in policies and procedures, and
(d) all program managers receive ongoing case management and clinical supervision training.

**Recommendation No. 10**
The Department of CYFS must ensure that provincially:
(a) collaborative practice initiatives are developed and advanced between the disciplines of social work, health, justice, and education, and
(b) policy and guidelines are reflective of collaborative practice.

**Recommendation No. 11**
The Department of CYFS must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS programs, province wide.

**Recommendation No. 12**
The Department of CYFS must develop protocol with the RCMP/RNC to ensure that when officers attend a residence where children are present and in a risk situation, information must be relayed immediately to the local CYFS office.

**Recommendation No. 13**
The Department of CYFS must develop protocol with the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.