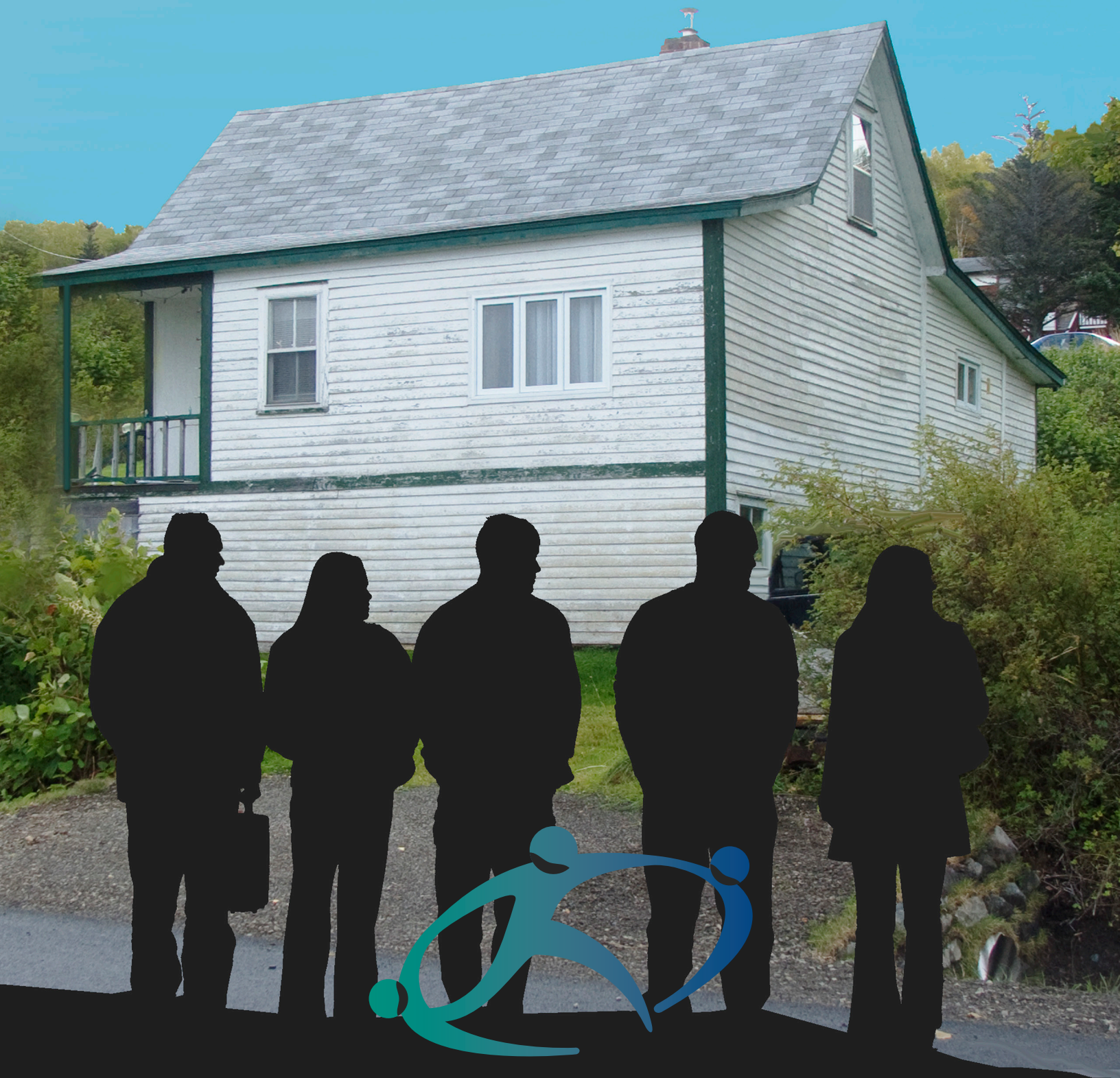


Turning a Blind Eye



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

Turning a Blind Eye.

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

July 2012

INVESTIGATIVE TEAM

Child and Youth Advocate

Carol A. Chafe

Lead Investigator

Connie Pike, BA Police Studies

Researchers & Reviewers

Jennifer Forristall-Prim, BSc, MASP
Roxanne Pottle, BSW, RSW
Karen Gray, MSW, RSW

Administrative Support

Amanda Mercer

Cover Design

Nicole Rogers, Graphic Design Work Term Student

Disclaimer

Prior to being appointed Child and Youth Advocate, I held the position of Director of Children's and Women's Health at Eastern Health. In that capacity, when the investigation was called by the Advocate in 2005 into this case, I reviewed the medical records of the children in the family and assisted in providing them to the Office of the Child and Youth Advocate. The care provided to the children in this family by those who reported to me at Eastern Health was never the subject of the investigation.



Carol A. Chafe
Child and Youth Advocate

“When the lives and the rights of children are at stake, there must be no silent witnesses.”

- *Carol Bellamy*

Table of Contents

Confidentiality Caveat	iv
Foreword.....	v
Executive Summary	vi
Introduction	1
Methodology	3
Mandates of Pertinent Service Providers.....	4
Background of the Family	9
Facts Provided.....	11
Findings and Analysis	81
Recommendations	97
Conclusion	100
Bibliography	101
Appendices	104

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

On a daily basis, it is evident to each of us in the Office of the Child and Youth Advocate that there are so many children and youth in our province who endure far from ideal family situations. There are many dedicated professionals from various government departments and agencies who strive every day to meet the needs of these children and youth. Often they are successful but unfortunately, not always.

This is the second outstanding investigation since 2005 of the Office of the Child and Youth Advocate, that, as the new Advocate appointed September 27, 2010, 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. Telling that story reminds each of us every day that we can never lose sight of the vulnerability of those we serve and that we must always do the best job we can 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 and not just another case or incident. This is the story of "Brian", "Sandra", "Tommy", "Luke", "Jane", "Mary", "Brent", "Adam" and "Mark".

This is the story of nine beautiful children who lived the worst possible nightmare of being abused by the one person who should have been their source of love and protection. This person was their "mother" biologically but was, by no means, in any other way what a mother should be.

For thirteen years, these children suffered in their home while many professionals encountered them numerous times. There were many opportunities missed in identifying what was really taking place in that house. These children were sadly failed by the system – a system that turned a blind eye.

As always, the goal of any investigation is not to lay blame but to identify what went wrong and, most importantly, identify how 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 that should always happen but as evidenced, do not. We must all ensure that such a horrendous story never happens again.



Carol A. Chafe
Child and Youth Advocate

Executive Summary

During the year 2005, the Office of the Child and Youth Advocate (OCYA) undertook this investigation following the federal conviction of a mother for numerous offences against her children, namely her two girls, Jane and Mary. This woman was subsequently sentenced to several years in prison.

The events outlined in this report span a thirteen (13) year period wherein multiple professionals and agencies had contact with the family on a continuous basis. Comprehensive notes were logged during the early 1990's which ultimately led to the 1993 apprehension of Mom's three (3) children from her first relationship. Mom had no further contact with these children following the 1994 custody hearing. Based on the extensive interventions and services provided to this family, the oppressive living conditions of the six (6) children (from the second relationship) should have been preempted well before their removal in 2004. Three (3) of these children, including Jane and Mary, had been taken into care for the first time in 1995 and returned to their mother in 1997. Sadly though, when extra vigilance, reviews, and analysis should have happened over the next several years, file documentation does not mirror the safeguards that were reportedly 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 amongst stakeholders, and enhanced collaborative approaches. Addressing these critical issues will provide the necessary safeguards needed to ensure a child's safety.

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

Introduction

On October 26, 2005, the Child and Youth Advocate at that time served notice to the Deputy Minister of the Department of Health and Community Services (DHCS) and to the Chief Executive Officer of the Regional Integrated Health Authority (RIHA) of her “intention to conduct a Review into the circumstances surrounding the children of ---,” given that they were receiving services from a number of Government departments and agencies. Details of initiating the investigation were outlined in written correspondence to both 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 November 30, 2011 following a careful examination of this family’s circumstances over a thirteen (13) year period. The reasons surrounding the length of time that 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 both the parents and children with pseudonyms. Mom and “Father” had Brian, Sandra, and Tommy. In Mom’s second relationship, she and “Dad” had Luke, Jane, Mary, Brent, Adam, and Mark. Also significant in this report are a number of physicians; the primary two (2) will be identified as Dr. One and Dr. Two.

The investigation deals in particular with the time frame of June 1991 until February 2004 wherein two program areas of the RIHA were continuously involved. There were many service providers engaged with the family: social workers; social work supervisors; teachers; guidance counselors; family doctors; pediatricians; psychiatrists; psychologists; behaviour management specialists; public health (PH) nurses; housing officials; home support workers; day camp counselors and taxi operators. It will be readily apparent to the reader that an exceptionally high number of government funded resources were made available to this family.

Due to the multiple 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 contacts and resources available to the family necessitated the use of calendars for all thirteen (13) years which are included in Appendix D.

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 necessitating such a review.

Case files from Child Youth and Family Services (CYFS) and Public Health (PH) Nursing were provided by the RIHA. The quantity of documents was substantial as the case unfolded over a thirteen (13) year time 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 employees of the RIHA 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 review the documentation. The lack of fluid communications and fluctuating oversight of service providers within the pertinent agencies were additional reasons why the interviews were necessary.

Numerous witnesses gave court testimony in this matter. The transcripts were reviewed and their highlights recorded. Medical records from doctors' offices and hospitals were examined to assist in understanding the nuances of this case.

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

Mandates of Pertinent Service Providers

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.

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). 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 (formerly the Department of Health) 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 thirteen (13) year period of this examination. Information provided by management staff of DHCS stated a commitment from that Department, and HCS in the Region, 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 – but was

not a full-fledged risk assessment process. This tool was normally used in cases of sexual abuse or severe physical abuse. In 2003, the Risk Management System (RMS) was revised; it provided “a standardized framework that would increase consistency and objectivity in the decision-making process” (RMS - CYFS 2003, p.5). Specifically, the direction in risk management, particularly in protective intervention cases, is “to assess risk to children through the development of respectful relationships with children and families” (HCS Memorandum August 17, 2005). While the RMS was developed in 2003 and disseminated to the regions, it was not fully implemented until April 1, 2005. All social workers in the regions had to receive training before they could use the RMS. Until the social worker received training in RMS, only the Risk Assessment Tool was available for use by social work staff trained to use that tool.

During the period 2003 -2004, the DSS 1993 Child Welfare Policy and Procedures Manual specifically stated: “The overall mission of the Child Welfare System is to protect children, to meet the basic and developmental needs of children and to support parents in their parenting role.” (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.

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. 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 cG-12.1 s 14)*

Public Health Nursing

From 1991 to 1995, provincial postnatal programming was offered in the area of the province where Mom resided. Initial contact by a PH nurse following the birth of a child included a home visit. If no immediate issues were identified in a family, the PH nurse called to check on the client in six (6) weeks. If there were still no issues, the client was discharged from the program and offered routine Child Health Clinic services. The number of visits would be based upon identified issues. Although there was no formal program for long term followup, occasionally PH nurses would follow families with complex needs and categorize them as 'Health Maintenance' clients.

From 1991 to 2003, individual regions would have complied with the standards outlined in the Provincial Child Health Clinic Manual. In 1991, PH nurses would have been carrying out the Preschool Health Check Program in accordance with the relevant provincial standards. In 1995, the region involved cancelled the Program but reintroduced it in the year 2000 with slight variations. A number of other programs would have been available to this family in their region from 1991 to 2003. These included: prenatal education and support; communicable disease followup and routine school health programs such as immunization, vision and hearing screening. While the school immunization was considered universal, the other programs were generally initiated on request or referral.

According to the PH Nursing Program Policies and Guidelines, the Healthy Beginnings Program started as a pilot project from December 1994 to May, 1995. The particular region involved in this review was not part of the pilot phase but the program was deemed as a useful tool and was implemented in all areas by 1999. The Healthy Beginnings Program is a voluntary program that is available to eligible families at any time until their child enters school. Services range from postnatal followup to breast-feeding support and preschool assessments. To access services for a newborn and for postnatal followup, the process commences at the hospital and continues to the community level. Referrals may also be received from parents, and other professionals.

Referrals:

Step 1

A Live Birth Notification Form is initiated immediately at every birth in all hospitals in the province. In the city hospital, a priority assessment is commenced by the Community Health Liaison Nurse and then forwarded to the PH nurse for completion once Mom and baby are discharged. In rural hospitals, the Hospital Discharge Planner forwards the form to the PH nurse to commence and complete the priority assessment once Mom and baby are discharged.

Step 2

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

Step 3

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

Step 4

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

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

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

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

Background of the Family

Mom reported growing up in a dysfunctional environment with an abusive father who used physical discipline. When her parents separated, her dad became involved in another relationship. Mom indicated her stepmother was particularly abusive to her and her siblings. The historical file indicated mom was placed in foster care and spent time in a number of foster homes, most of which she says were abusive. At a young age she married a man almost 30 years her senior. Mom gave birth to Brian, Sandra, and Tommy, during this union and left a few years later claiming the relationship was emotionally and physically abusive.

This case occurred over a thirteen (13) year period with many interactions of various professionals (see Appendix D – Calendars). In 1991, Mom became involved with another man (Dad), for whom she would have more children over the next thirteen (13) years. Early in this relationship, referrals were received by DSS about Mom's parenting of Brian, Sandra, and Tommy. Eventually (in 1993), these children were permanently removed from their mother's care due to neglect. By this time, Mom and Dad had their first two children, Luke and Jane, and a third on the way. After 1994, Dad did not reside with her and the children on a regular basis. There was never any indication this man was abusive to his children. Whenever this dad was present in the children's lives, they always appeared happy to see him; however, his involvement with his children was quite limited.

Despite the fact that Brian, Sandra, and Tommy were removed and never returned to Mom's care, the two babies, Luke and Jane, who were present during that first apprehension, were left in her care. According to documentation on file, these two younger children were being treated differently by Mom than Brian, Sandra, and Tommy and protection concerns were not obvious to social workers or noted at that time.

Subsequently, numerous referrals were received about the care of the younger children, Luke, Jane and the newest addition, Mary. Life threatening medical issues for one of the children saw the removal of all the children in 1995. Again, the intervention with the family became intensified and extensive. While Luke, Jane, and Mary were in care during 1996, Mom gave birth to another child, Brent. Officials made the decision to leave Brent in Mom's care but to monitor the situation carefully. During 1997, Luke, Jane, and Mary were returned to their mother at varying intervals and under supervision orders from the court. According to documentation from professionals involved with the family, Mom had learned new parenting skills and was able to cope much better than before. A family support worker was put in place as an additional resource to assist and monitor the situation.

From 1997 until 2004, multiple referrals were received about the family which had grown with the additions of Adam and Mark. Despite the previous history and the heightened need for vigilance, file documentation was insufficient, even sometimes nonexistent, to match that need. The care of the children was often questioned by school officials, medical personnel and others. Overall, it appeared to child protection officials as though Mom was making efforts to do her best, and by having additional resources in place, it was believed the care of the children was being managed appropriately.

In February 2004, all the children were removed and taken into care. Mom was arrested and charged with numerous offences against Jane and Mary.

Facts Provided

1991

Brian	Sandra	Tommy
-------	--------	-------

On June 19th, referral one (1) concerning this family was received. The referral source (RS) was reporting that Mom was neglecting her children and they were being abused by their father; the children, **Brian, Sandra, and Tommy**, were all under 8 years of age. Mom and their father had separated in January. Their father was on probation for uttering threats, and domestic violence had been alleged by Mom. The RS wished to remain anonymous. When questioned by child welfare officials, Mom denied abusing her children. There was no other followup at that time.

On August 7th, referral two (2) occurred when Mom visited the DSS office; she was concerned that a relative had made an allegation about her “beating” her three (3) children and leaving bruises on them. The children were present and there were no bruises noted by the social worker. Mom explained her husband had been recently sentenced for assaulting her and he was not permitted around the house upon release. When Mom expressed uncertainty about their father’s visitation rights, she was advised by the social worker to call court or the police. She was also advised a home visit would be made to follow up on concerns about abuse. The case notes do not reflect a follow-up home visit.

On October 21st, referral three (3) was received. Mom had been evicted from a shelter for a breach of their nonviolence rule. She had taken a block away from her younger son, Tommy, who had struck another child, and she then used it to hit her son; she explained it as her effort to make Tommy understand what it felt like. Tommy had a red mark and bruising on his forehead. (Case notes dated October 23, 1991.) On October 25th, a social worker suggested that a family support worker could assist Mom by monitoring inappropriate discipline and neglect concerns. Before that strategy was implemented, there would be another referral. Mom was also now pregnant with her boyfriend’s first child.

On October 30th, referral four (4) was received about the children. This RS claimed that the children, Brian, Sandra, and Tommy, were being forced to eat off the floor and rather than use the actual bathroom, they were being told by their mother to urinate in the sink and defecate on newspapers that had been spread out on the floor. The RS believed this was happening because Mom thought it too much trouble to be continuously cleaning off the table and scrubbing the bathroom. The social worker made a home visit on November 21st and Mom denied all allegations. A family support worker was put in place to visit weekly.

1992

Brian	Sandra	Tommy
-------	--------	-------

On January 27th, referral five (5) was received by DSS. The RS reported frequent absenteeism at school or the children were not showing up until afternoon classes; as well, there was no involvement from the parents when interview times were scheduled. The children appeared unkempt and Sandra had a mark on her face that seemed to heal and then reappear. Mom was interviewed and stated the children had been sick a couple of times and she had slept in at other times. She also indicated she did not have an alarm clock; but such occurrences would not happen again. Mom explained that the mark on her daughter's face was caused by the child's father hitting her with a stick last summer; Mom suggested the social worker should be present when the children visited with their father. Three (3) weeks later, Mom was advised there was no staff available to supervise any such visits. The social worker suggested to Mom that she seek the help of a friend or clergy in this regard. There is no file documentation to indicate the father was questioned about the 'stick' incident or that Mom sought help from anyone else about parental visitations.

During May, the social worker made a visit to Mom's residence to ascertain her plans for the children while she was in the hospital for her impending delivery. Mom stated her intent was to have the children stay with their father during her hospitalization. The children would not be attending school because of the distance from their father's house; however, the school would be assigning additional homework. The family support worker, who was also present, indicated she would continue with weekly visits to Mom's house to which Mom was receptive.

During this home visit, the social worker noted that Tommy had scratches on the right side of his forehead along with a swollen right eye. Mom explained how he had fallen off his bike on two separate occasions. The social worker suggested to Mom that he should be wearing a bike helmet.

Luke was born and as previously mentioned, he was the first child of Mom's new relationship. Mom, along with Luke, made a visit to the DSS office looking for additional assistance five (5) days after his birth. Mom explained things were going well and that Brian, Sandra, and Tommy would be returning to school the next week. Mom also said the PH nurse had been in to see her. The social worker called the PH nurse to discuss the case and learned the nurse had certain concerns. Apparently, Mom had told her during the home visit that Luke would sleep with his parents in their bed. Mom also said she had a crib and a car seat but did not offer to show her these items. Almost two months later, it was learned there had been no car seat available for the baby since his birth. The family support worker made a visit to Mom's on August 17th and learned that Luke had been hospitalized for two days the previous week due to dehydration.

The family support worker reported same to DSS and a home visit was planned. Before that visit took place, another referral was received.

On August 20th, referral six (6) was received. The RS came to the office to report concerns about the care of the children in this family. The RS stated the kids have only one meal per day prepared; Sandra's hair was very dirty during a visit this person had made to Mom's place; the children were not permitted to eat lunch inside the house, and snacks were passed to them through the door leading outside. A home visit by the social worker was made the same day. The children were outside in the yard. The social worker observed the outside door was locked when she arrived. When asked about Luke's eating habits, the social worker believed Mom exaggerated the number of bottles (8 or 9) per day that he was reportedly consuming. (Case notes dated Aug 20, 1992.) Before any additional followup was completed, another call was received by DSS.

On August 31st, referral seven (7) was received. The RS was expressing concern that the children were home by themselves. Information was also given about an incident over the weekend wherein Mom was assaulted by Luke's dad; she reportedly had a number of bruises and scratches on her face and neck. Mom did not want to report to the police but had asked a neighbor for help. When the social worker spoke to Mom, she denied the allegations and said the children had been with their father over the weekend. During the home visit, made that same day, the family support worker observed Mom had a bruised eye; scratch marks on her body, and a swollen lip. Mom said twice that it was none of the worker's business if anything did take place but that nothing had. A subsequent check of Dad's criminal record revealed he had a history of violent behaviour. The family support worker's notes indicate, "A gut feeling suggests things are not as they appear." (Case notes dated August 31, 1992.) The situation was to be monitored over the next few months. Ten (10) days after this reported incident, the social worker, along with the family support worker, made a home visit. They learned that Luke was sick with a cold and had been since his two month needle; it was determined the following day that he had pneumonia. Mom also told them that Sandra was at the hospital with a broken arm. Mom explained the injury had occurred at a playground when she was visiting with her father. Mom also talked about the 'fight' with Luke's dad the previous weekend. She was evasive about details but informed the social worker she had picked the fight and deserved the black eye. The social worker advised Mom it was not a good environment to have children exposed to such violence.

Mom remained in the region with Dad until early the next year. It should be noted that during the fall of 1992, three (3) home visits were attempted but Mom was not at home. Also, during an office visit by Mom on November 10th, when she announced she was pregnant again, the social worker noted that Luke was not dressed adequately for the weather conditions. Shortly after this visit, Mom moved to another town within the region and her file was transferred. A new social worker was assigned to the case.

1993

Brian	Sandra Luke	Tommy
--------------	------------------------	--------------

The previous social worker had expressed concerns about Mom and the children but could not quite pinpoint what it was that made her uncomfortable. (Case notes dated March 25, 1993.) Her most recent concern had been the lack of medical attention sought by Mom when one of the children was sick. Mom had blamed the sickness issue on the drafty house she was living in. Due to the number of referrals already received, the social worker was concerned about inadequate care of the children and how unhappy they seemed.

Following the family's transfer, the newly assigned social worker called the children's school and officials there expressed no concerns; one child had missed only half a day thus far. The financial assistance officer had also been to the new home and commented that for someone with four (4) small children, the home was unusually clean. The social worker made a home visit and reported the house in immaculate condition. Mom reported she was not with Dad anymore but the social worker had suspicions about same. Assessments were continued as it was believed Mom was still in a dysfunctional relationship with this man.

On March 18th, referral eight (8) was received by DSS. According to the RS, in the past several months, it had been witnessed on a number of occasions that the kids had often been left outside for long periods of time or they had been sometimes left alone in the house. The RS went on to say the windows were barricaded, there were locks on the bedroom doors and the children were not being properly fed. One week later, on March 25th, two (2) of the children were interviewed at school. The social worker confirmed that the children were often outside all day long, that there were locks on the doors, meals were usually take-out, and they had limited time to play with their toys after Christmas at mom's house while Luke (the first child of Mom and Dad) had a bag of toys in his crib. They were allowed to play with toys at their father's house. The social worker documented in her notes that she suspected a double standard of care between the two families.

After the interviews, the social worker spoke to the Principal of the school. The Principal expressed concern about the children's physical well-being as some days they presented in an "unkempt fashion." Dirt appeared to be ground in to the neck of one of the children. This official went on to categorize them as "...the most pitiful kids I have" as they always seemed sad; it was believed they were emotionally neglected. The Principal had additional concerns about their lunch habits. Apparently, a bus was available to take the children home for the lunch period but they never went; plus the food Mom would drop off for them was not always appropriate (frozen pizzas).

The following day, March 26th, the social worker went to Mom's house as there had been no response the day before. Mom explained there were small strips of wood placed on the windows to keep intruders out – not the children in. She said she was fearful about their father (her ex-husband) coming around. Mom also said the hooks were already on the bedroom doors when she arrived there. When asked about their meals, Mom said she cooked regularly but whenever she had extra money, she would take Brian for chicken because he was a fussy eater with an iron deficiency. The social worker checked the children's bedrooms and was shocked as the rooms were devoid of toys except for a doll wrapped in plastic hanging on Sandra's bedroom wall. The beds were made "hospital perfect" and any furniture in the room had absolutely nothing on it. Even though it appeared the house was spotless, Mom claimed she still had vacuuming to do. The social worker found things almost too neat and tidy and the term 'obsessive compulsive' came to her mind which she recorded in her notes. She encouraged Mom to allow the children more access to their toys and Mom agreed. The social worker explained the importance of playtime to their development and that she would need to monitor this situation for some time. Mom was agreeable to this idea.

Monitoring and intervention continued over the next three (3) months. As Mom's due date drew closer, there was concern about how the older children would be cared for while she was in the hospital. Homework was assigned by the school and Brian, Sandra, and Tommy were placed in the care of their father. Mom also requested funding for a new crib but documentation indicated she had been given a new one the previous year. Mom denied receiving same and was told to appeal the decision of not being supplied with another one.

On June 17th, Sandra's school reported that she was quite despondent and withdrawn. She had returned home with Mom and there was a new baby – her half-sister, **Jane**. Sandra had been seen by the school counselor who felt she had poor social skills and was not doing well academically. Based on what the school had seen, there was no help being offered to the children at home whatsoever, and Mom had not attended any parent-teacher interviews; she was uninvolved in their education. The Principal suggested a more proactive approach for September. There is no other information on file relating to this report from the school.

During the summer of 1993, the family moved out of province. It was later learned Mom and Dad had sold all the furniture and purchased a van to make the trip with the children. The social worker received a call from her counterpart in the new location as they had received a referral about this family. The call, about protection concerns, had supposedly been made by a relative of Mom's. Apparently, Mom had struck one of the children – knocking him out. It appeared that before the concerns could be addressed, the family moved back to Newfoundland. Following their return, they did not come to the attention of DSS for a number of months and there is no other information to indicate followup occurred concerning the out-of-province referral.

Months after the family settled back in the province, they approached child welfare officials for new furniture. The financial assistance worker felt it was the family's responsibility to regain their furnishings even if it meant selling the van; they had made the decision to sell off what they had in the first place to buy the vehicle. A home visit early in November by the financial assistance worker, documented in the case notes of November 16th, revealed everyone was sleeping on the floor except the two babies, who were in cribs. The case was subsequently discussed with the social work supervisor and agreement was reached that there were concerns for the well-being of the children.

On November 16th, referral nine (9) was received about the family. Two children were interviewed at a new school. It had taken a number of phone calls to determine the exact school where the parents had registered them. The school's biggest concern was that the children were withdrawn. The social worker concluded that their food intake was not adequate or appropriate; mom had sold all the furniture and even some toys to get money for the move; there was no furniture in the home, only a pullout chair in the kitchen; the children sleep on the floor without pillows; they have no breakfast in the mornings, and they have to stay outside for lengthy periods of time. The social worker also noted that one of the children appeared to be dirty. It was determined their experience while at their father's home was positive.

The social worker believed that purchasing beds would not solve the problems in this family. She was concerned as the children looked pale and thin; it was obvious to her their food requirements were not being met. She also noted the double standard of care with these children and Dad's two babies. A direct quote from her notes:

I was also very concerned that many of the issues brought forward today were similar to issues reported in this file over a long period of time when the family lived in... Their information certainly posed the possibility that they have been neglected for a considerable period of time. (Case notes dated November 16, 1993.)

There had been numerous reports made in the past with similar details provided about the children being dirty; sleeping on the floor; little or no food; being left outdoors for long periods of time, and being inappropriately dressed during inclement weather. A case conference was held to determine the next course of action. (A Case Conference is defined as a meeting of professionals and individuals involved in a case to discuss relevant issues and set strategic direction in a case or file.) The concerns about the children's appearance (dirty, pale, and thin); the lack of nutrition; the sense of a double standard of care, and the fact there had been repeated similar reports over a long period of time made intervention necessary.

Two home visits were made on November 16th and in both instances, Brian, Sandra, and Tommy were found outside in the snow without mittens or boots and away from the balcony. Mom was interviewed and denied all

allegations of neglect. Their stepdad said they were lying about things and he had ended up in jail because the kids had lied before. At this time, the parents reported their house had been broken into and the furniture stolen. The social worker made an assessment on this date that the children were being neglected in their own home; Mom was unable to provide for the physical needs of the children, and there was definite evidence of unwillingness to change the situation. The second visit required a police escort to remove the children who would now be placed with their father. Their stepdad would not give permission for them to take any of their belongings or clothing. Mom reluctantly agreed for them to leave; this voluntary agreement avoided official apprehension notice being given. Three (3) days later, Mom changed her mind about the apprehension being termed voluntary. She voiced her disagreement to officials thereby necessitating a Notice of Apprehension, which was subsequently issued.

Temporary wardship was requested for three (3) months and a recommendation was made for Brian, Sandra, and Tommy to stay with their father. While their father had a history of violence against Mom, officials believed he would not harm the children as there had been no prior evidence of same. Their father also appeared quite anxious to care for them. As the two babies, Luke and Jane, appeared to be in reasonably good condition, they remained with their biological parents. The social worker noted there seemed to be a double standard of care between the first three (3) children and the two babies, who were reported to be physically thriving. Mom would now be expected to purchase the necessary furnishings for the home and a family support worker would help her with nutrition counseling, child care skills, and financial management. Mom was also expected to accept social work intervention. Dad was quite resistant and stated that the family support worker better not show up there.

On the December 7th court date, the Judge granted a temporary custody order for Brian, Sandra, and Tommy to be with their father until January 1994. Their father showed the social worker a Christmas card he received from his ex mother-in-law saying: "Heard you had the kids – Thank God."

Throughout this interim period, Brian, Sandra, and Mom were reinterviewed. The children said their mother would hit or punch them; they were not allowed to use the bathroom facilities, and all three (3) of the children would sleep in one bed because the other beds were made and Mom did not want them messed up. Sandra claimed she had to take care of the younger children. Mom said she did not have her daughter babysit despite the child's specific recollection of dates and events. Mom denied punching the boys or pulling her daughter's hair. She said she provided cooked meals even though the children said this was not the case. All of the allegations made by the children were denied by Mom. She agreed that she liked to be clean but when the term obsessive-compulsive was explained to her, she denied being that bad. The services available that could help her manage this disorder were explained to Mom; however, the social worker told her that she could not be forced to participate. The social worker also told Mom that because the children's physical

and mental well-being was impeded, action had to be taken. It was at this time agreement was reached to have a family support worker come in again and assist with child care of Luke and Jane every Wednesday morning. This family support worker would observe Mom's practices and skills, and offer suggestions and advice.

1994

Brian		Sandra		Tommy
	Luke		Jane	

In January, the Judge granted a forty-five (45) day wardship. He commented that he did not want to get into the custody issues and he thought the Director's case was "shallow." In anticipation of the court date, Brian, Sandra, and Tommy were seen by the social worker; one of them had threatened suicide, if returned to Mom. Despite the children's aversion to seeing their mother, efforts were made for Mom to have some access. The children reluctantly agreed to see her but only if the visit was short. The cumulative issues raised by the children necessitated close monitoring of any visit. There was very little emotion shown by either Mom or the children and there were no displays of affection; Mom had stated the children did not like to be hugged. On February 28th, Mom changed her mind about pursuing custody and voluntarily agreed for the children to live with their father. Her decision came after hearing the testimony of the social worker involved in the case; subsequently, custody was awarded to their father. In total, nine (9) referrals had been received by child welfare officials that eventually led to the apprehension of Brian, Sandra, and Tommy.

Following the court ruling, concerns were expressed by the family support worker about Luke and Jane, the two younger children left in Mom's care. This family support worker had brought to the attention of the social worker that the children were "too quiet." Jane spent most of her time sitting in a small chair in front of the television and could not seem to bear her own weight when placed in a standing position. (Case notes dated February 2, 1994.) The family support worker also noted that this child was unusually quiet. Luke seemed to fare better as he was quite active and given freedom to play. (Case notes dated March 1, 1994.) From the social worker's perspective, noted in her documentation, this was another foreshadowing of a double standard of care; this time, between the genders. The residence was spotless and orderly all the time. The family support worker did see Luke play but could not help notice how new the toys always looked; she wondered if the toys were played with after she left for the day. Dad did appear to be providing some emotional stimulation and it was believed that as long as he was in the home, things may not be too bad. If he were to move out, a reassessment would need to be made. On March 1st, the social worker held a lengthy discussion with colleagues and at that time, justification to leave home support in place could not be found and the service was discontinued. Mom was no longer on the DSS caseload.

In July, Mom called the social worker to express concern about upcoming care for Luke and Jane while she was in the hospital giving birth to her third child with Dad; she was worried he would be drinking. Mom was told to try and find a sitter and the department could probably help fund the service. The social worker did not hear back from Mom. A baby girl, **Mary, was born**. In the next

few months, Mary was referred to doctors concerning a deformity of her feet. Mary also required a special protein-restricted diet. There was a notation in Luke's medical file that he had been taken to the local hospital with a laceration to his head. Mom left with Luke before being seen by a doctor. There was no additional information available on the file.

On September 8th, referral ten (10) was received; the caller was indicating that Sandra was revealing more details about when she lived with her mother. The RS described the allegations as "horrendous episodes of physical abuse by her mother." The examples given by the RS were that Sandra's mom had grabbed her by the ears and threw her against the wall. After an assessment by the social worker, it was felt no additional information would be obtained and the matter was closed. There was insufficient information to lay criminal charges against Mom. Sandra's father was contacted to advise him of the referral and the outcome. He indicated that Mom had not seen or inquired about Brian, Sandra, and Tommy since he had been awarded custody; the children did not mention her name, and they had no desire to visit their mother.

In December, the family doctor referred eighteen (18) month old Jane to Dr. One at the hospital because she was not gaining weight as a child her age should be. In fact, since she was about six (6) months of age, her weight had been decreasing. She was now the same weight as she had been at four (4) months of age. When Dr. One examined Jane he found her in an emaciated condition due to failure to thrive. The child appeared emotionally and physically deprived. He planned to admit her and investigate possible causes.

1995

Luke	Jane	Mary
------	------	------

In January, Jane was admitted to the Janeway Children's Health and Rehabilitation Centre (Janeway Hospital) due to failure to thrive. Despite extensive investigations, no specific cause could be found for Jane's failure to gain weight. The possibility of lack of stimulation and social interaction was discussed as a cause of Jane's slow development and Mom agreed that was likely the problem. Mom and Dad were counseled concerning the importance of proper nutrition and interactive stimulation. It would seem from the information Dr. One recorded that he had been told that all Mom's children were living in the home and there had been no mention of the fact that the first three (3) children had been removed from Mom's care. Jane was discharged home approximately two weeks later, (having gained two pounds while in hospital) with no medications and a plan for Dr. One to follow up.

Dr. One saw Jane again two weeks later for a follow-up examination. Her weight had not changed and the doctor felt the situation was still potentially serious. Again, he outlined his concerns to the family about there being some element of deprivation and the parents agreed to stimulate Jane as much as possible.

On March 21st, referral eleven (11) was received. The RS was concerned about Mary and wondered about the followup that the hospital had completed when she was recently seen. The RS believed the appropriate dietary measures for Mary were not being taken. The social worker noted that the RS was confusing Mary and Jane; she further determined this was not a neglect issue as the relevant caretakers were already familiar with the case.

Dr. One again saw Jane for followup in March. Even though she had gained a little weight and was now walking with support, he still did not believe it was a normal amount of progression for a child that age. The doctor also saw Mary on that date and noted that Mom was not being compliant with the special diet restrictions for her. Over the next two months, further concerns were documented by other doctors involved in Mary's care about the same kinds of compliance issues.

On May 18th, referral twelve (12) concerning Mom and her children was received. The RS reported that Dad was drinking a lot and abusive towards Mom. The RS went on to say that approximately two weeks ago, Mom slept outside under a boat. There was a rumor that Dad had taken a knife to her because she complained about the children acting out. The caller was not aware if the children were being directly abused or if they were witnessing the violence. The social worker determined this referral did not meet the definition of a child in need of protection but provided the RS with the on-call number if an emergency arose wherein the children may be at risk.

Dr. One followed up with Jane in June and because her weight was still the same as it had been in March, he referred her to another doctor at the hospital. In essence, the doctor was not satisfied with the child's development and once again he expressed the element of deprivation was likely present. Dr. One wrote to the family doctor and he was still under the impression (as he had been led to believe in January 1995) that Mom was at home with all of her children. (Correspondence dated July 1995.) Mom had also told Dr. One that the family was intending to leave the province; he wrote to Mom expressing his concerns about the health of both Jane and Mary. (Correspondence dated July, 1995.) Later in July, Dr. One saw Jane again; she was no better and he was awaiting some test results. He noted:

I have a lot of concerns about her. I'm concerned about her environment and her development. This girl has developmental delay and environmental factors may be playing a role in this as she is one of [several] small children and I'm not sure exactly what's going on.

As requested by the family doctor in August, Jane was seen by another specialist in September for an assessment of developmental delay. Mom was still reporting she had all of her children at home despite the fact that three (3) had been removed from her almost two years before. Jane's locomotor development, personal and social, hearing and speech, hand and eye coordination, and her performance were all areas checked against her chronological age. Test results showed "...very significant delay in all spheres of development." This specialist intended to repeat the metabolic investigations on the child. She also recommended dietary counseling and a trial of Vitamin B1.

Another specialist saw Jane in October. This doctor was concerned with the social situation of the family; there were reportedly several children at home with no dad present. He believed further investigation was needed and he planned to admit Jane in the near future to look at possible bowel disease. Jane was seen in November by an orthopedic specialist who was concerned she was not ambulating at two and one-half (2½) years of age and he stated, "...clearly something needs to be done." He wrote to Dr. One as he was aware of his past expression to have her admitted.

Dr. One had lost track of the family as he thought they had moved out of province. He happened to see Mom at the hospital and he asked her to bring Jane to the clinic where he examined her a few days later. Dr. One's examination revealed serious problems which included: bruises on her buttocks; multiple fractures of different ages; emaciation; developmental delay, and withdrawal. He wrote: "This child is having major problems, she has bruises on her buttocks and her left leg which are unexplained." As already stated in this report, over the previous four (4) months, Jane had been seen by other doctors who had agreed the Failure to Thrive component needed further investigation.

In December, referral thirteen (13) was received subsequent to Dr. One's findings. Jane was admitted to the Janeway Hospital for Failure to Thrive and the Director of Child Welfare was notified. Another physician, Dr. Two, suggested to DSS officials that the case be managed urgently. Luke and Mary were also examined and all were removed from their mother's care two days later. Mary was deemed to be in relatively good condition with no signs of abuse. Luke had a scar over his right eyebrow. There were nondescript bruises on his shins and three (3) faint bruises on his right forearm, possibly from being grabbed, according to the doctor's notes. A week later, Dr. Two wrote a very detailed synopsis about the findings on Jane's condition when she was admitted as well as the other children's (as referenced above). This correspondence was sent to the social worker and copied to the Director of Child Welfare. The only explanation Mom could offer to Dr. Two about Jane's condition was that the bruises were possibly inflicted by Jane's brother, Luke. Dr. Two suspected neglect and/or physical abuse which was further cemented by the fact that Jane thrived within days of being in the hospital. Sometime during this hospital admission, it was learned by medical personnel that despite Mom's reports, only three (3) children were in her care.

During the early stages of the police investigation, statements were taken from two relatives who had contact with the family. One person indicated that while she never saw Mom actually strike Jane, she believed there was something strange about Jane never being happy to see her mother. Also strange was the absence by Mom of hugging or kissing this child. While this witness had seen small bruises on Jane, she thought they were of the usual type. She did find it unusual that Jane was not walking yet; she had tried to teach her but the child seemed to be in pain. When this was brought to Mom's attention, the response was Jane was too lazy or too stubborn to walk. The other person interviewed recalled making a trip to the hospital about six (6) months earlier with Mom as both Jane and Mary had appointments with Dr. One. Mom insisted that she not accompany her into the examination room saying: "Stay out, I don't want you in here." Returning from the hospital, this woman bought ice cream for the girls but Mom did not want Jane to have any. Mom made this statement several times and got angry when Jane did have the ice cream. A couple of days later, this witness saw Jane who had a significant bruise on her cheek. She commented: "It looked like a hard slap." Mom stated it was a broken blood vessel and there was no need to worry about it. This person had also witnessed Mom slap "very hard" two of the children across their faces on a previous occasion.

Initially, when Jane was admitted to the Janeway Hospital in December, she weighed nineteen (19) pounds; she was not walking and could only say one word phrases. She began eating to the point of gorging herself and then throwing up. After a few days, her intake of food became normal and improvements were noted. Staff observed she was gaining weight and seemed brighter since receiving attention. A copy of the findings from the hospitalization and examinations was forwarded to the police. Doctors were very concerned about the three (3) rib fractures she had suffered along with a fracture of her right thigh bone and another fracture of her right shin bone. According to the

physicians, these bones were extremely difficult to break. A joint investigation between social workers and the police followed. The parents maintained they had little knowledge of the bruises or fractures. Mom suggested that her son, Luke, may have been responsible as he is rough around the girls. She also stated she had mentioned this in the past and had even looked to DSS for help with daycare for Luke. As a result of her assessment, the social worker concluded that Mom gets mad and hits Jane.

Two weeks after the referral was received, DSS wardship of the children was granted for three (3) months with parental consent and they were placed in the same foster home. File documentation reflects there had been intermittent involvement by social workers prior to this December referral. In December of 1995, the Child Protection file in relation to these children was reopened and remained an active case until their removal over eight (8) years later in 2004.

1996

Luke	Jane	Mary
------	------	------

On January 15th, the first case conference dealing with Mom and Dad's parenting of Luke, Jane, and Mary was held. The progress of the children was discussed since they had been in foster care. It was suspected that Mom was responsible for inflicting the injuries on Jane; however, there was never any admission of guilt and because an offender could not be identified, no charges were laid. The Child Management Specialists were presently completing assessments to provide "...some insight into extent of parents' neglect." Also, the role of the dad in the family unit was discussed particularly around his awareness of the abuse and being a nonprotective parent. It was decided the children would remain in foster care. It should be noted that when Mom was calling the foster parents to speak with Luke, she kept asking him to say he loved her; the child would not, he would only say he loved his dad. Also noteworthy is that Mom would speak to Luke but never asked to speak to the girls.

Later in January, Jane was seen by Dr. One for followup. He wrote: "I could hardly believe it was the same child I had seen six (6) weeks earlier." Continued in his correspondence to the family doctor, which was also copied to two of the social workers, he stated:

This is just further evidence that this child was physically and socially deprived and I hope that this child will never go back with these parents as her life was certainly in danger. She's a beautiful child right now and the Foster Mother has done wonders for her.

In a separate case summary to the family doctor, Dr. One wrote "...the child is at grave risk and should stay in this foster home indefinitely."

The children had their first supervised home visit with their parents on January 25th. There was some discussion between Mom and the family support worker about why the children were removed from their mother's care. Mom stated that Jane had experienced a number of falls but did not cry for long. The family support worker felt this was unusual given that Jane had suffered several serious fractures. The support worker also noted during this visit how spotless the house was, and despite the fact that Mom brought a box of toys into the living room, it was obvious they had not been used very much. Mom questioned why child welfare "pulled out" when the three (3) oldest children went to live with their father. She also wondered, "If I'm so neglectful, why were two other children left with me?" Mom told the family support worker, "...everyone stopped coming without explanation. I am not sure that part is right." Mom and Dad said they would like to know why that happened. Before making a follow-up home visit four (4) days later, the family support worker spoke with the social worker and was able to provide the rationale to their question: Mom's ex-husband had custody of the three (3) older children; there was no evidence of abuse or neglect with Luke and Jane, and the social worker had told the family support worker to

close the case. Mom still did not understand why two children were left in the home when there were allegations of neglect.

In February, Mom was assessed by a psychiatrist. The doctor had concerns about Mom's failure to recognize a severely ill child as she had normal intelligence and experience with children. (Psychiatrist's report dated March 1996.) Despite her assertion in December that she would do whatever she had to in order to get her children back, she told the doctor the only reason she agreed to meet him was because DSS had requested it. According to the doctor's report, Mom's denial of responsibility for her daughter's condition was going to make any successful treatment difficult to achieve.

Coincidentally, on this same date, the police interviewed one of the three older children as part of the investigation into the removal of Luke, Jane, and Mary two months previous. This interview revealed vivid recollections of Mom punching and kicking the child daily, holding the child by the hair, and slapping the child around the face.

On February 12th, Mom asked about the possibility of unsupervised visits with the children. Shortly after that, the social worker agreed that Dad could supervise the visits with their son, Luke, but the visits with the girls would still require that a family support worker be present. A condition imposed on the unsupervised visits with Luke was that both parents would have to attend, thereby providing a 'check' on each other. Child Welfare officials felt there was greater risk to having unsupervised visits with Jane and Mary as they were quite young and they would not be able to communicate if something were to happen. Also, Jane had sustained extensive injuries for which there was no explanation. During these supervised visits, the family support worker noted there was no show of affection between Mom and the children; however, the girls would cling to their dad who paid a lot of attention to them.

Later in February, Dr. One saw Jane for a follow-up examination. A portion of his correspondence to the family doctor, and this time copied to the police as well as the social worker, included the following observations:

I feel that this child has exhibited many of the findings of child neglect and abuse and I feel strongly that if she goes back in this home that she probably will not survive and I think that if we left her in this natural home that she would have died after 2 or 3 months. I feel very strongly that she should stay in this foster home for an indefinite period and that based on my many years of experience with child abuse at the Janeway and my observations of this family I don't think that it is safe for this child to go back into this natural home. I have grave concerns about her and hopefully things will work out for her. She is one of the most severe forms of child abuse that I have seen in my 22 years at the Janeway and it is particularly complicated by the mothers apparent interest in her. She has at various times fooled all of us and

including myself and she certainly appears to be a highly motivated and interested mother but the facts would caution us otherwise. I'm sending copies to all the people involved as I think that this is a very serious problem and I think it's a grave danger for this child to go back into this household. (Letter dated February 1996 from Dr. One to the family doctor.)

On February 26th, a case conference was held. The social worker distributed notes from a case meeting held in January. The purpose of the conference was to discuss the progress of the children and the future plans for them. Updates were provided about medical issues and visitations. The parents were advised to seek legal counsel as DSS would be requesting further wardship. Dad was upset by this decision but it was explained that Child Welfare felt the risk factors were still too high for the return of the children to their parents' care. Mom contested the Director's application for continued wardship and a full hearing was scheduled.

The social workers involved in this case, one who assisted the children, and another who aided the foster family, exchanged numerous electronic messages over the next few months. These e-mail messages were about issues that arose concerning the parents and children. While the children were in care, there were concerns expressed by the foster parent that they had not been seen by a family doctor, even though Mom had been asked to arrange appointments. The children's immunizations were not up to date; in one child's case, 6, 12 and 18 month needles had not been administered. (E-mail dated February 1996.) On one particular e-mail, it was noted that during one child's hospital stay in late February for a scheduled surgical procedure "...staff were not very pleased with Mom and Dad while they were at the hospital. They continuously brought junk food to [the child]. The nurse had to tell them to stop." It was noted that the parents would not actively participate in the care of the child during this hospital stay (E-mail dated March 1996.)

There was also mention made that following the supervised visits with Mom and Dad, the two girls would sometimes be returned to their foster mother with dirty diapers. One note reads, "The children have been upset since they came home today. [---]'s privates was blocked solid with feces dried to her. She is raw sore and had absolutely no sign of diaper rash prior to going to Mom's." (E-mail dated April 1996.) Also in that e-mail, reference is made to a strained visit of that same date. The case notes (dated April 1996) elaborate on the tense visit wherein Mom had words, many profane, with one of Dad's sisters; they were not on pleasant terms. Mom threatened violence if the sister did not leave the driveway. The children were present as this was unfolding. Even the taxi driver who witnessed the exchange remarked how stressful the situation was and that he felt sorry for the kids. In addition, the social worker who heard the details, as described by the family support worker supervising the visit, stated: "I'm concerned about an unsupervised visit happening this week. If Mom behaves

the way she did today during a supervised visit, how will she be without supervision?" (E-mail dated April 1996.)

On April 2nd, referral fourteen (14) was received concerning the care that was being provided to the first three (3) children by their father. The RS had stated the children were unkempt, unclean, and provided with poor school lunches. An investigation was completed and it was determined their father was somewhat overwhelmed with caring for three (3) young children without any help. The social worker confirmed there was no purposeful neglect on the father's part; he just needed some support. This was provided by way of a respite worker and things very quickly fell into place. The social worker made an assessment that the children were very happy to be with their father and it appeared no obvious form of abuse was taking place. There were no concerns about the children's care and long term followup was completed for a year. Throughout the course of that investigation, additional information about Mom's treatment of her first three (3) children was obtained. This included that Mom had kicked one child in the stomach, knocking the child out. Another child suffered a severe cut on the face beneath the eye, apparently from being struck with the cord of a flat iron. In addition, information was received from one of Mom's relatives advising that Mom had struck another child, knocking the child out. This information corresponded to a report received during the summer of 1993, as previously stated. It was also alleged that Mom had pulled one of the children's hair, had banged the child's head against the wall, and constantly called the child ugly. The police became involved and interviewed the children; however, they were not forthcoming with the details needed to formulate criminal charges against Mom.

In April, Jane was seen by another pediatrician. Her progress was noticeable – she had gained considerable weight, she could walk and ride her bike independently and talk in sentences. The doctor summarized:

The documentation supports the diagnosis of previous emotional, environmental and social delay with a severe amount of deprivation and a young girl who is now thriving normally both mentally and physically in a fresh environment. I feel strongly that [Jane] should not go back to her natural parents with the documentation of how severe her condition was prior to entry into foster care. (Pediatrician's report.)

It appears from file documentation that the first private counseling session with Mom took place in May, prior to the wardship hearing scheduled for June. Mom also joined an educational support group for high risk moms, and she was participating in a group at the hospital. Mom seemed to be demonstrating greater cooperation with the social workers involved, and appeared to be accepting of recommendations and willing to make changes. Reports from the professionals indicated that Mom appeared to have made significant changes and was bonding well with each child. On May 8th, Mom advised the family support worker that she was pregnant again.

On May 16th, a case conference was held to review the children's circumstances. The issues that were discussed included: medical updates; social activity plans; visitation schedules; telephone contact with the children, and clarification of the family support worker's role.

In June, Dr. One offered testimony at the wardship hearing and was later commended by the prosecutor for lending assistance in such a difficult matter. His letter stated: "Quite frankly, had it not been for your evidence, the Director would not have been able to substantiate the case presented..." Dr. One's testimony outlined the condition in which he had found Jane during December 1995. He described bruises on her buttocks, multiple fractures of different ages, emaciation, developmental delay and withdrawal. The doctor went on to say, "In summary this is a severe case of alleged physical and emotional neglect which has a high morbidity and mortality and I firmly believe that this child should never return to the mothers home on a full time basis." Temporary wardship was then granted for an additional nine (9) months.

Another case conference was held on June 19th which focused more on the longer term plan for Luke, Jane, and Mary. It was noted that Mom was involved in a number of activities designed to help her resolve her problems and it was too soon to say if they were going to be successful. Mom and Dad were advised that wardship would be reviewed in March. Also noteworthy at this meeting was Dad's sudden temporary departure for another province during the month of May. This had caused upset to the children and he was advised to speak to the children if he should plan any similar hasty departures in future. Dad indicated to the participants at this meeting that he was not in a position to care for his children at this time nor was he prepared to pursue any form of assessment or counseling. Issues around visitation and the expectations for the parents were also discussed.

In the private counselor's first written correspondence to the social worker in June, she indicated that Mom feels her statements about Dad being abusive are not believed by DSS officials. Mom had agreed to "date" him because she thought it would be helpful in regaining custody of her children; she was now expressing reservations about that decision. The counselor explained her own reluctance to have the pair participate in couples' counseling if Dad was being abusive.

On October 9th, a case conference was held where the primary focus was on whether the children should be moved to another foster home. Future plans for the children were discussed and the issue of an independent consultation was raised. Mom stressed that she would accept services in her home, deemed to be an important feature, as no consideration would be given to the children returning without Mom doing so.

A meeting was held between the social worker and the parents on October 21st. The discussion mainly centered on the supports that would be in

place for the new baby if the child was returned home. Dad suggested forty (40) hours per week of home support service for Monday to Friday from 9am to 5pm. Mom voiced her opinion that this would be too much. The social worker provided details about what she saw as the expectations for a support person, namely: helping with the children; doing housework; talking about concerns, and whatever Mom saw as most helpful. The “checking/supervision” aspect was talked about and Mom felt better after the conversation that a person would not be there just to “watch” her. Later in October, Luke, Jane, and Mary were moved from one foster home to a newly approved foster family. The social worker stated this decision was made based on both short and long term benefits.

A private consultant was hired by DSS to review the file and participate in a case consultation on November 1st. Earlier this year, there was written correspondence from the assigned worker to her supervisor suggesting the hiring of the best possible person. (E-mail dated February 1996.) A subsequent message suggested looking for an expert witness to say that the other children, Luke and Mary, will likely become victims if returned to the home. (E-mail dated April 1996.)

The private consultant reviewed the file material and attended the case consultation. While the consultant did not provide a written report, the social worker paraphrased his summations by recording some of the following points in her notes:

- There is no evidence that Mom has acknowledged wrongdoing. She is in denial.
- If this were a sex offender, would we take a risk? No.
- The impact of physical and emotional abuse is greater than that of sexual abuse alone.
- There is a high degree of risk of damage in leaving the newborn child with mom. If Mom were to admit responsibility for the abuse of [Jane], the risk would be moderately reduced.
- Under these conditions, returning [Luke] and [Mary] and permitting Mom to keep her newborn child may be possible with extremely heavy monitoring.
- Mom’s pattern of aggression and her lack of compliance have both improved in the past six (6) months. In assessing her lack of empathy for the children, empathy is designed to be a regulator. Mom exhibits a lack of self-control. There is a high degree of risk that the pattern of neglect/abuse will be repeated. Accurate empathy is the key – is the empathy genuine or strategic? Children learn a high degree of mistrust with strategic empathy. There is indication that the children do not trust their mom.
- Mom has had multiple children, multiple chances, and multiple resources.
- There should be three (3) years of in-depth treatment for Mom to deal with her own issues and even if she is making progress, the risk levels are still high. It would take 2 – 3 years of

- progress to reduce the risk in a sustainable way. In the best interest of the child, the combination of risks and the probability of improvement support the decision to take this new baby from Mom's care.
- Based on family reunification (giving Mom a chance), a very high degree of support and monitoring will be required. Can the department provide a level of monitoring that will pick up on this level of abuse?
 - The monitoring requires identification of not only the observable but, equally important, the nonobservable. [Mary] may be at risk as history had shown the 'girl' in the middle (first, [Sandra] and then, [Jane]) was most vulnerable to harm. If [Jane] was not returned home, then [Mary] would fall into that 'middle' spot. (Consultation meeting notes, November 1, 1996.)

In November, the social worker assigned to the case wrote her supervisor requesting funding to manage this case. She stated in her correspondence, "I am extremely concerned about the potential for harm to this new baby", and she went on to outline why she thought it was acceptable for the baby to be allowed home. Those reasons were:

I believe in the value of biological connections and the importance of bonding between parents and children. The bonding issue is even more important in this case since we know that the lack of attachment is a risk factor in child abuse. There have been significant changes in [Mom's] situation in the past year. When [Jane]'s injuries occurred, [Mom] was a single parent with 3 children under 4 years of age. The children's father was unsupportive and possibly abusive. [Mom] had no supports of any kind and her efforts to seek help from this Department were unsuccessful. Today, [Mom] has no children in her care, she is receiving therapy and attends the Family Resource Centre regularly. The children's father is making efforts to be supportive and helpful. Both parents have been cooperative and are receptive to any services recommended. I acknowledge that the safest route in this case would be to place the baby in foster care. However, there are risks in such a move including the loss of the best opportunity for bonding between the child and parents, the creation of a bond with an alternative caregiver and in the worse case scenario the risk of abuse/neglect in a foster home. I see no point in taking these risks when, in the end, we will eventually be required by the Courts to give these parents another chance. (Letter dated November 13, 1996 from assigned social worker to supervisor.)

The next day, she wrote her supervisor again with additional reasons for allowing the baby to go home, namely: the parents had unsupervised visits with

Luke, Jane, and Mary during the previous five (5) months and there were no significant problems; this social worker felt Mom had been responsible for Jane's severe maltreatment but there was no evidence the other two children had been abused, plus the evidence of maltreatment could be attributed to the demands of caring for three (3) children under the age of four (4) years. In addition, the parents were considering placing Jane for adoption. The social worker felt this demonstrated some admission of maltreatment and Mom's lack of attachment to Jane which probably led to her being victimized so severely.

In handwritten notes from the social work supervisor to the assigned social worker, she concurs that the level of risk to the newborn will be high even with the supports outlined. She noted the consultant's comments about Mom possibly discovering that twists and shakes cannot be detected. The supervisor went on to say:

I know we discussed this briefly and I agreed that close monitoring would be essential and that this baby could go home with Mom at birth with a lot of supports. However, after reviewing this material and thinking this through to some degree, I am not so sure if this is the best plan for this child. (Handwritten note dated November 1996 from supervisor to the assigned social worker.)

In the case conference notes (dated November 15, 1996), it was decided Mom would keep her newborn. Mom agreed to a home support worker submitting weekly reports. Mom's counselor suggested there should be a written understanding of what the roles and tasks of this support worker would be. It appeared the plan was to contract nursing services to assist Mom with childcare. The social worker advised that this nurse would have to be informed of most details but the home support worker would be told only the basics of the concerns and the observations she will need to make. Also, at this case conference, Mom indicated she had not made up her mind about allowing Jane's adoption. The social worker advised Mom that she had every right to fight for custody of Jane.

In the first letter from the social worker to her supervisor, she advised that Mom was seeing a counselor every two weeks and she was making progress. However, the counselor had told the social worker she did not believe she was in a position to make a recommendation as to whether Mom's children should be returned to her. This statement was echoed in documentation by the social work supervisor as well. Yet, in written correspondence from the DSS District Manager to the Regional Manager (dated November 28, 1996), it is indicated the private counselor attended the case conference held on November 15th regarding the new baby going home and supported the plan to have this baby with the natural parents. There were now two different opinions from the same counselor within a two day time frame about the possibility of children living with Mom.

In the counselor's correspondence that month, she outlined that she had seen Mom for a total of eight (8) therapy sessions thus far. The counselor had

also conducted a home visit and observed that Mom was exhibiting a nurturing attitude with her children; she was impressed with the family solidarity. She went on to commend DSS for keeping Jane's issue foremost in their planning; there was a directness of communications with them [the parents] and the efforts by DSS to identify supports and supportive programs had motivated both parents to trust the help available.

To assist with the new baby about to arrive, the requested home support services totaled twenty (20) hours per week. As outlined in the social worker's proposal to her supervisor, the role of the home support worker would be to "...provide support with child care and housekeeping in addition to ongoing monitoring of the quality of care." She went on to say:

These services would be reviewed on a monthly basis with the expectation that a decrease in hours would be possible within 1 to 2 months. I would not see increasing services because any difficulties would likely result in the child being placed in foster care. (Letter dated November 13, 1996 from assigned social worker to supervisor.)

In e-mail correspondence, the Director of Child Welfare wrote to the social work supervisor stating her concern about the plan to place the baby with Mom. She elaborated by stating:

I realize fully that there are risks associated with all the decisions we make but I feel given the information presented to me that the risks to this new baby are too great for me to support the plan. I am especially concerned that no one accepts responsibility for the broken bones or the failure to thrive. We have not allowed any of the children even an overnight visit yet we are prepared to place a newborn in the home, where we don't know what happened to another child who was severely injured, with only limited supervision. I find these positions difficult to reconcile. (E-mail dated December 11, 1996.)

The social work supervisor responded to the Director via e-mail outlining her reasons for the baby to be with Mom and why she supported the assigned social worker's rationale for same. The supervisor noted: "This has been a difficult case for me as her supervisor especially not having the support of the division." (E-mail dated December 13, 1996.)

The new baby, **Brent, was born**. His siblings, Luke, Jane, and Mary, were still in care. Brent was permitted to go home as contracted nursing services and home support services were implemented to help monitor the family. It appeared that Mom was adjusting well to the new baby. The nurse was stopping by Mom's residence daily to check on Brent until the Sunday visits were eliminated when he was three (3) weeks old. On December 30th, Mom indicated to the nurse that she would prefer to have Brent weighed weekly now as opposed to daily.

Over the course of 1996, while the children were in foster care, they thrived, particularly Jane, who had been found in the direst condition. Their family doctor had indicated in June that they had returned to normal development. A summary of Dr. One's comments concerning his follow-up contact with Jane include: "...child shouldn't go back" (January 1996); "Unbelievable recovery...grave danger for child to go back" (February 1996); "...child should stay in foster care" (February 1996); "...this child should never return to the mothers home on a full time basis" (May 1996), and "...I sincerely believe that [Jane] is at danger in this home and that she should not be returned" (June 1996).

1997

Luke	Jane Brent	Mary
-------------	-----------------------	-------------

According to DSS, and as referenced in the correspondence of 1996, critical decisions were made at Brent's birth and debate was held about whether he should return home or not. Much concern had been expressed by the professionals involved about the risk to this baby, given the history with Jane. In the end, the decision to leave Brent with his mother was based on professional judgment that apprehending the child at birth would seriously damage the mother-child bonding process and therefore increase the risk of abuse should the child eventually return to his mother. (Court Summary.)

In January, the private counselor met with Mom and observed her with Brent and Luke. Both children appeared content and the counselor recommended increased time for Luke's visits at home. She commended Mom for her concerns and how she was preparing Luke, Jane, and Mary, now in care, for a new baby in the home. Mom reviewed with the counselor the use of a 'time out' procedure when disciplining the girls for any behavioural concerns. Mom also had phone service now; a very important step according to the counselor's notes.

On January 16th, a case conference was held. The issues discussed included: Luke's impending return home and how it would be handled; concern about Jane's aggressive behaviour and her overeating; discipline techniques; visitation schedule, and respite hours for the foster mom. On January 19th, another case conference was held wherein updates on medical issues and scheduling were provided. The plan to have Luke return home soon was still ongoing. The social worker advised that the Director had requested another six (6) months of foster care for Jane and Mary, which was given with parental consent. Mom indicated she was rethinking her plan concerning Jane's adoption. The home support worker agreed that she would keep daily logs. The social work supervisor offered words of support and congratulated the family on working so well together. Dr. One saw Jane again in January and made the following observation: "...returning her will not only jeopardize this child's development but may be dangerous to her life."

Luke, Jane, and Mary remained in foster care under temporary care orders and eventually there were individual supervision orders from the court. Despite the documentation and urgency of the doctors' pleas not to send the children back to their mother's care, all three (3) were returned home at varying intervals during 1997. Supervision orders were in effect; a six month order for Luke and one year orders for Mary and Jane. According to DSS file documentation, the children were returned home based on a number of factors:

There was never any indication of abuse towards [Luke] or [Mary]; they were removed because of [Jane's] unexplained

injuries and their young ages. Reports, from the professionals involved, about Mom's parenting ability were very positive and she appeared to be demonstrating an ability to care for her children. An offender in relation to [Jane's] injuries could not be identified. The reintroduction of each child back into the home appeared to be working well. (Letter dated January 6, 2005 to Regional Director from the assigned social worker.)

Later in January, Dr. Two notified the social worker of his concerns. Based on rumors that Jane may be returned home, Dr. One had asked Dr. Two if he would document, in writing, the issues of concern from the medical team's perspective. Dr. One was of the opinion returning Jane to her parents was a highly dangerous thing to do and he had great concerns about the well-being of this child if she was returned home. Dr. Two reiterated that based on his assessment of Jane in 1995 "...the abusive situation in her natural home was long-term and chronic. Unless there has been a radical change in the home situation, it is potentially very dangerous to place [Jane] back in that environment." (Letter dated January 1997 to DSS from Dr. Two.) It appears from the file documentation that Jane saw Dr. One for followup two weeks after this. Jane saw her family doctor for a routine examination in September 1997.

Also in January, the social worker assigned to the foster parents wrote in her notes the following comments: "Foster mom observed that Mom does not give the children genuine love – hugs or kisses." Also, "Foster mom said that Mom has made comments to [Jane] about her weight. [Jane] has been saying lately she is too heavy." (Case notes dated January 30, 1997.)

A case conference was held on January 31st to review how the visitation and daycare schedules were going and to further discuss the plan for Luke to be returned home. The girls, Jane and Mary, would be staying in care for another six (6) months. At this meeting, Mom indicated she had no plans to consent to Jane's adoption. There is no other documentation on file to indicate this subject was raised again.

On February 13th, the social worker for the foster family again noted other concerns. In her case notes of that date, she mentioned: "The foster parents expressed concern that Mom does not show affection with the children." During one visit, Mom was supposed to be bathing the girls and she said to Brent, "I'll have to put you down. I got to go throw some water over the girls." The young son of the foster parents thought it strange when he heard the two girls tell their mother they loved her one evening as she was putting them to bed, and they got no response from Mom. The social worker noted: "[Mom] lacks affect with the children, not to say anything about her parenting skills otherwise, but the lack in this area is noticeable." The assigned social worker followed up on additional concerns mentioned about Jane by her foster mom, namely her overeating and her aggressive behaviour. Dr. One was asked by the social worker to see the little girl again. In his assessment of February, the doctor summarized her weight

gain as very dramatic but that her weight and height were in the higher percentiles for her age, still within normal range. He stated: "She is a large child for her age." He suspected the "outbursts" were normal and if necessary, Jane could see a Child Management Specialist although he had no major concerns about that issue. Dr. One went on to say: "She [Jane] seems to have a good relationship with her [foster mom] and I feel that the decision to keep her in this home is a good one." (Letter dated February 1997 from Dr. One to the social worker.)

There is correspondence on file dated February 18th wherein the social worker was seeking approval from her supervisor to reduce the hours of contracted nursing and home support services to this family. The social worker indicated there were no concerns noted by the home support worker or the nurse about the well-being of Brent or Luke since Luke had returned home three (3) days earlier. As the home support worker was considered a "major strength in this case" (correspondence as noted, page 2), it was deemed she needed to remain in the home for twenty-three (23) hours per week. This was a decrease from her current thirty-six (36) weekly hours. The social work supervisor approved the decreased services. A case conference was held on February 28th and there were no major issues arising.

There is a handwritten page of notes (unsigned) in the file that appear to have been jotted down by the social worker following a discussion with Jane's foster mom on March 19th. The notes indicate that the regular weekly visits with Mom are difficult for Jane who does not want her mother bathing or dressing her; she cries, screams, and gets very upset. The notes further indicate the little girl has nightmares and after her visits with Mom, she is in a 'tizzy' for a few days. This was also upsetting for the foster mom.

The contractual nurse had continued her home visits at a rate of five (5) times per week throughout the first months of the year. In March, her visits were slowed to a rate of three (3) times per week. On March 20th, Mom commented to the PH nurse that the abuse perpetrated on Jane was done by Luke. At this time, it appeared that contracted nursing services were gradually being absorbed by Public Health. This PH nurse was unaware of the previous circumstances of the family. As a result, the PH nurse requested a copy of the DSS report which was received by her five (5) days later. During a clinic visit in April, it appeared to the PH nurse that Mom was agitated by all the appointments. There was little emotion shown by Mom and when the nurse suggested a home visit, Mom's response was, "I'm all booked up." The contractual nurse continued to make weekly home visits of one hour from May until September. Nursing services after that time were handled by Public Health.

The social worker made a home visit on April 8th and learned that Mom, Luke, Brent, and the home support worker had gone to an appointment. Dad was present and the social worker took advantage of the opportunity to talk. They chatted about Jane; Dad believed that she should stay in care. He was not comfortable sharing this information with Mom or having her know he had even

discussed it. Dad went on to say that Mom does not have the same feeling for Jane as she does for the other children. He also said he remembered how she had treated her first daughter. In her case notes, the social worker documented her inability to pay a home visit the following week as Mom's schedule was busy and the worker was in the middle of a caseload change. She noted she would aim for a biweekly visit on Wednesdays when Jane and Mary were present. During a telephone conversation on April 18th, Mom advised the social worker that she would prefer if the PH nurse did not make home visits. The social worker told Mom that such a move would be viewed negatively if something were to go wrong.

On April 25th, a case conference was held. Updates were provided about Brent's progress and about Mom's counseling sessions. Mom was concerned about her housing situation and the social worker agreed to advocate on her behalf. It was noted Mary gets upset easily but now seems to settle down faster. Luke and Jane are both displaying anger at times; disciplinary strategies were discussed. Luke went through a transitional phase when he returned home but seemed to be settling in. The comment was made by the social worker, "We don't want to risk the children coming back into care." It was expressed that the home support was going well as were the visits with Jane and Mary. In spite of that assertion, the case notes of the foster care social worker still reference concerns on June 12th. The foster mom indicated she does not trust the things Mom says or does. One incident that is cited explains how Mom cut Jane's hair by putting it in a pigtail and making one cut. Jane had wanted to let her hair grow long. The social worker noted, "I feel this is subtle abuse." When Jane celebrated her birthday, her mother did not attend even though she had been invited to the foster mother's home.

The assigned social worker's case notes indicate a home visit on July 2nd. She stated there had been a lot of telephone contact but it was difficult to arrange a visit between her schedule and Mom's. The social worker also noted that with her caseload switch, it was hard to keep focus on this case and it would be transferred to another worker in the near future.

During a home visit on July 10th, the PH nurse noted Brent had a bruise over his left eye. Mom explained he had fallen on a rattle. Mom did not see the need to have Brent's clothing removed that day as he had been seen in the clinic only eight (8) days before. The nurse contacted the social worker to relay this conversation. The social worker indicated they were aware of the concerns with the family and from the perspective of DSS, Brent could now be seen on a monthly basis. The social worker said she had confirmed the story with the home support worker about the fall on the rattle and did not have any concerns.

A case conference was held on this same date (July 10th). The usual topics of medical updates, Mom's counseling, and daycare were discussed. With respect to behaviours, it was noted that Luke shouts, kicks and bites his mother periodically. The social worker indicated she would talk to the private therapist to help resolve the issue. The impending return of Mary to her home was

discussed and participants wondered about the effect it would have on Jane. The foster mother had told Jane that Mary would be going home first and then it would be her turn. It was agreed home support would continue as it was and the meeting notes indicate the file would be transferred to another social worker before September. This new worker would accompany the present social worker on home visits prior to receiving the file.

In July, Mary returned home. With ample supports in place throughout 1996 and 1997, it appeared to all of the professionals involved in this case that Mom had made positive changes to her life. Not only was she attending individual and group counseling but had now taken on the role of facilitator in similar group work. (Summation of Case Plan meeting notes dated July 1997.)

During August, the private counselor was asked by the social worker for her opinion about Jane returning home. She had no hesitation in commenting on the remarkable parenting that Mom had achieved with Luke, Mary and Brent; therefore, she had no reason to doubt that care would continue for all the children when Jane returned. The counselor stressed the importance of all the support agencies and people involved to continue working together and that supports should remain in place. She also commented on how Mom had taken control of her life and can now parent in a responsible way. Mom was no longer in an abusive relationship and she was determined to give her children priority. According to the counselor's notes (dated September 1997), "Mom can deal with discipline issues calmly; she seeks out medical attention for the baby; she has no difficulty asking for assistance when needed, and her ability to manage with four small children is exemplary." The counselor went on to commend DSS for their approach in working in a collaborative way which had caused Mom to be empowered.

Although concern had been expressed initially by the social worker about Jane returning home, it seemed as if Mom had coped well with the return of each child and since the professionals' reports were positive, a decision was made to return the child under a supervision order. With concern still existing about Jane's well-being, it was felt that reducing risk meant keeping her visible. A team was implemented to assist with this process which included professionals from the home care agency, the Janeway Hospital, a private therapist, Public Health Nursing and a DSS social worker. DSS was of the opinion that both PH Nursing and social workers should monitor the home constantly. Daycare services were also made available to the family. It seemed a significant number of resources were utilized to help ease the transition with returning the children home and to help ensure their physical and emotional well-being.

In September, Jane was returned home. A one year supervision order was in effect for her and Mary. At this time, the PH nurse raised another concern when she advised the social worker that Brent was not bearing his own weight, something he should be doing by this age. The social worker indicated she would be seeing Mom on this day and would discuss the issue with her. File documentation did not reflect any such discussion. Over the next couple of

months, the PH nurse attempted contact but she either could not reach Mom or the appointments for followup were forgotten by Mom.

On September 16th, a request for a daycare subsidy was submitted by the social worker. In her correspondence of that date, she was recommending approval as this was a "...very High risk Child Protection Case." A case conference was held on September 18th. The children's medical issues were updated; Luke's kindergarten progress; Jane's and Mary's daycare attendance, and home support concerns were discussed. The regular home support worker was presently away caring for her father and Mom indicated she would like to change the hours of support. The case had been officially transferred to a new social worker by this date. There was no representation from Public Health at this case conference as it appears they were not invited to the table until a representative sought out an invitation four (4) months later.

In October, correspondence was sent from the social work supervisor to an executive staff person with DHRE indicating all was well with the reunification of the children and their mother. The supervisor went on to say: "This case is one that I am very proud of, [Mom] has improved tremendously and the credit for having her children returned goes to her." In the private counselor's notes, it was recorded that Mom was coping extremely well. She was managing independently but looking forward to the regular home support worker returning. The counselor's notes reflect how she was advocating for Mom with respect to better housing and furniture. Again, the counselor commended DSS for all the effort and support being given to Mom. The social worker made a home visit on October 15th and things appeared to be going well. The next documentation is almost a month later.

On November 14th, a case conference was chaired by the program social work supervisor. A discussion followed about the home activities since Jane had returned over two months ago. Mom reported Jane had adjusted well, as have the other children. Mom also indicated Jane was currently enjoying daycare and no problems were reported from there. The private counselor was in attendance and reported she had observed Mom's interaction with all four (4) children and did not detect any problems. She went on to say the children were thriving, responsive, and happy. The children were calm and Luke was not as angry as he used to be. The therapist reported Mom had a schedule and she was very nurturing. At this meeting, Mom inquired about seeing the three (3) older children whom she had no contact with for the past five and one-half (5½) years. The team felt this was a positive sign from Mom and they were going to follow up by having a discussion with these three (3) children and their father.

Overall, it seemed that Mom had made significant progress over the past two years and was now demonstrating the ability to nurture and care for her children. File documentation reflects how this case became a source of pride for DHRE; it was held up as a positive example of how the provision of comprehensive services to a family could make a difference in reuniting them.

Mom was commended for showing tremendous improvement in her parenting skills and winning the struggle to get her children back.

In December, referral fifteen (15) was received. The RS had observed a bruise on the top of Luke's shoulder that was extremely tender. When Luke was asked how it happened, he said he fell off his skateboard. The social worker called the home support worker the following day to garner more details; she was unaware of the sore shoulder. The home support worker further indicated Luke did not have a skateboard. The doctor who examined Luke got three (3) different versions from him about what had happened to cause the injury. Mom was questioned and said she overheard Luke say he fell out of bed. As nothing definitive could be established, the matter was closed.

Also noteworthy in December, Dr. One wrote to the family doctor concerning Brent's ear and respiratory health issues. This same doctor had also written to the housing authority to lobby for "better accommodations" due to the impact that Brent's physical environment was having on his health (ie: mould; leaks; inadequate septic facilities). The doctor stated, "The system has paid megabucks on multiple antibiotics, visits to physicians..." (Dr. One's report dated December 1997.)

1998

Luke	Jane Brent	Mary
-------------	-----------------------	-------------

On January 16th, a case conference was held; however, the notes made by the program supervisor were very brief. The opening line was: "Christmas was perfect." The other issues touched upon were medical updates; housing; home support; school and daycare, and the children's behaviours; the main issue being that Luke and Jane fight. The house was small and they had nowhere to play. The issue of contact with the three (3) older children was raised again but nothing definitive was decided. During this year, the PH nurse began attending case conference meetings. Both the PH nurse and the social worker noted that it had become increasingly difficult to reach Mom by telephone. On February 19th, the PH nurse was advised by the home support worker that Mom was pregnant again. Case conferences scheduled for March and April were both cancelled.

A case conference was held on May 11th with a representative from the housing authority in attendance. The discussion mainly centered on Mom's living conditions because the children were ill with respiratory problems due to the poor housing environment. Letters of support were requested in order to expedite a transfer of the family to another unit.

From March until June, the private counselor had been writing letters advocating for better housing and transportation for the family. In her correspondence to the housing authority (and copied to the social worker) in June, the counselor also indicated Luke should participate in some type of summer activities. Mom was reporting he had no friends and because he was bored, he tended to bully his sisters; his lack of playmates and activities were contributing to his hyperactivity and aggressive behaviour. The counselor commented that Mom had overcome many obstacles to preserve family unity.

A case conference was held on June 15th and discussion seemed to focus on the home support Mom received and how she and the home support worker had developed a good team approach. This worker shared Mom's concerns about Luke's aggressive behaviour, especially towards Jane. Mom still believed his aggressiveness was triggered by boredom and a lack of playmates. Additional letters of support were requested in order to speed up the housing transfer for the family.

The cumulative lobbying efforts for improved housing saw the family move to a new community in July and another social worker was assigned to the file. There was now a different PH nurse as well. Later in July, the family doctor noted Brent's left eye appeared swollen. There is no other information on file related to his report.

On August 14th, a case conference was held wherein the issues of the children's health, a housing update, and the home support were discussed. There was contingency planning for Mom's impending delivery date and where the children would stay during this time.

On August 19th, referral sixteen (16) was received from an anonymous source who reported concerns about four (4) children living in the caller's neighborhood. The RS called the mother by name stating the family had moved to this location about one month ago. On this same evening, the RS reported being out for a walk and hearing a child screaming and crying loudly from inside Mom's house. The RS heard a woman screaming: "Get in there, get in there." It was the opinion of the RS that a child was being beaten. The RS did not know the children's names and did not really want to get involved but would get their names and call back. The RS's second call was made a half hour later wherein Luke, Jane, Mary and Brent were named as the children living in the house. The caller also stated Jane had been severely abused in the past but could provide no other details. The RS was encouraged to phone again if there were any other concerns in future. There is no other documentation on file relating to this referral.

Adam was born and when the PH nurse made her first home visit concerning postnatal care, she noted Jane was quietly sitting on a chair and did not move. One week later, the nurse, who had been asked by the social worker for her opinion regarding home support, stated:

The relationship between Mom and the home support worker is not as therapeutic as it should be. There has been incidents that should have been reported by the worker but weren't. (ie: Jane left in car; Jane's change in appearance).

There is no other information available to indicate followup regarding this documentation.

On October 1st, referral seventeen (17) was received wherein the RS reported seeing the children with their mother on several occasions. The RS went on to say that whenever Jane is seen by this caller, there are bruises on her head and face. The RS had seen the child about five (5) times. During previous encounters by this RS, when Jane was asked what had happened, she stated she fell on the fence or fell off her bike. The day prior to the referral being received, the RS had seen Jane again and she currently had a bruise on her forehead. In addition, "[Jane's] mouth and nose looked dry and scaly and her hair appeared brittle." The RS went on to say, "The child looked afraid; she didn't make eye contact, laugh or talk and she seemed withdrawn." It also appeared as if Jane had lost weight and "...she was looking too small." The RS added that Mom was always negative about Jane; putting her down by saying things like "she was crooked." Jane's older brother, Luke, had apparently told the RS two weeks previous to this encounter that their Mom was mean and would beat the girls. He later denied this. There is no other documentation on file relating to this referral.

It is unclear whether this visit was related to the referral above but Jane saw Dr. One in October. Even though he did not find any remarkable trauma signs on this date, the doctor stated in his letter:

I still feel that she [Jane] is in a dangerous environment, and it would be extremely important for the Social Workers to keep a constant vidual [vigil] on this child. The other children were never neglected or abused, and for whatever reason, it seems to be this child. This is a well known phenomena in child abuse literature. (Partial medical report of Dr. One dated October 1998.)

A copy of his report was sent to a new social worker who had now been assigned the case. The PH nurse saw Mom on October 13th and asked about Jane. Mom said she had seen Dr. One and he does not feel there is any need for concern.

On October 15th, referral eighteen (18) was received. The RS alleged that the regular home support worker, who had accompanied Mom to the nursing office with Adam, was acting inappropriately. Brent was also with them; he was playing with a toy and the support worker told him, "Put it back or I'll get the belt." When it was time to leave, Mom left with Adam, and Brent was supposed to follow with the home support worker. Brent did not want to leave so the worker left the building and did not look back. She walked toward her vehicle and appeared to purposely wait until the child was really upset before returning to the office. According to the RS, "He had his little hands on the glass and tears were streaming down his cheeks." There is no other documentation on file relating to this referral.

In a handwritten note on file, the home support agency supervisor indicated she would temporarily suspend the home support worker from her duties for one week. The assigned social worker was concerned about permanent removal of the home support worker as there had been reported positive gains made with the family. It should be noted however, that a letter to the Child Welfare officials from the home support worker's employer, dated October 1998, references this incident as being the second referral involving the home support worker in four (4) months. There are no details on file concerning the 'first' referral. The supervisor with the agency also stated in this same correspondence that she questioned the objectivity of this particular home support worker. Nevertheless, the social worker lobbied to have this home support worker returned and the agency did agree to continue on a trial basis.

On October 16th, the home support worker's notes state that Jane had a bump on her eye. The support worker asked Jane what happened and the little girl said she had been bouncing on her mother's bed and fell off. Arrangements were made to take her to the family doctor but there is no documentation in the file to reflect such a visit. Four (4) days later, the social worker went to Mom's house saying she had received a referral about the bump on Jane's eye. Apparently, Jane had told someone at daycare that the bruise on her eye was caused by her mom hitting her. As the home support worker had just left for the day, Mom called and asked her to return. The social worker arranged for Jane to

go home with the support worker for the night. There is no documented referral or case notes on file relating to this incident.

During a case conference on November 3rd, Mom voiced her concerns about home support workers and the issue of confidentiality. She also wondered why so many concerns were being expressed lately about Jane. Mom took issue with the PH nurse keeping charts on her family. The participants at the meeting agreed Mom should have access to the Child Welfare records concerning her family. Two days later, Mom wrote to the Minister of Health and asked for a copy of the Child Welfare files on her children.

Also noteworthy from recordings made in the November case conference minutes was the utilization of home support hours provided to Mom. Despite the concerns expressed about one particular home support worker (in October 1998 correspondence), this woman was returned to the home for twenty (20) hours per week. An additional twenty (20) hours per week was available to Mom for her discretionary use. Less than six (6) months later, the regular home support worker was in the home for forty (40) hours each week.

In November, Dr. One followed up with Jane (as per his letter of October) and Mom reported everything was “perfect.” Mom said she was not missing any school and she has a “perfect” appetite. Dr. One noted: “I still think this child is a risk and I think she will always be a risk. I think it would be very important for Mrs. – [social worker] and her colleagues to keep a close eye on this unfortunate child.” A copy of his report was sent to the social worker.

The regular home support worker’s notes dated November 25th indicate she was now employed by a different agency. A few days later, during a PH clinic visit, the nurse noted that Mom said the home support worker’s employer would be permitting her back in the residence. Mom continued on to say she would not be allowing the home support worker to stay alone with the children.

1999

Luke	Brent	Jane	Adam	Mary
-------------	--------------	-------------	-------------	-------------

On January 15th, referral nineteen (19) was received. Two people had noticed that the children in this family had undergone personality changes in the past month. The children seemed more withdrawn; they were not as outgoing and were not getting along with their peers. The RS had observed bruises on Jane's face since November and also a black eye; Mom said she had hit the bed post. The RS stated that earlier in the week, Mom had pointed out to Jane's teacher some small bruises that were on the child's cheek. Mom stated another child in class (identified by name) had struck Jane with a block. However, this other child had been out of school all week and the teacher had not been informed of any incident involving Jane. The RS did see three (3) small bruises on Jane's left cheek by her ear, almost into her hairline. The child never offered an explanation for any of her bruising. The RS also indicated that Jane was missing some school lately. Correspondence from Dr. One written to the family doctor indicated he saw her in January and she had an inflamed right ear drum; Mom said she was hit in the ear by another child. Dr. One still believed "...this is a very high risk situation." There is no other documentation on file relating to this referral.

On January 18th, referral twenty (20) was received concerning Luke's welfare. Just before Christmas, Luke had been seen at the grocery store by himself at 7:00 pm. The child was under seven (7) years and was riding his bike at the time. The RS also reported that around the beginning of the New Year, Luke was observed in the PH Clinic ... crying. The RS went on to say, "It was very very cold that day; [Luke] was on his bike – he had no mittens or cap and his coat was undone." There is no other documentation on file relating to this referral.

Later in January, the family doctor requested an assessment of Jane's ears by a specialist. She was seen a few days later in February and the specialist found bleeding in her right ear. Mom stated Jane had been hit by a friend two weeks ago.

On February 9th, a case conference was held. The topics discussed at this meeting included home support; medical updates; daycare and school, and a parenting program for Mom. Participants were advised there were no minutes available from the last meeting of November 3, 1998. There were no major concerns expressed by any of the attendees.

On February 16th, the handwritten notes of the home support worker indicated Mary had a mark across her throat. She wrote: "It seemed to be burned or chafed by rope or rough surface." The child was dropped off at daycare. There was nothing to indicate Mom had offered any explanation to the

home support worker or that the child was questioned by that worker or the staff at the daycare facility. It appears there was no other followup and no other documentation is on file relating to this incident.

On May 19th, officials from Jane's school wrote to the social worker about their concerns regarding the little girl. Despite the fact she always seemed to have a large recess snack and reported eating a good breakfast, Jane was in the habit of taking food from other children and also eating snacks discarded in the trash. These behaviors had increased since January. Sometimes, she would even take snacks from bookbags and hide them. She would be anxious and stressed if she could not get these lunches. If confronted, Jane would become angry and cling to the snack, unwilling to give it up. School personnel had met with Mom to discuss a team approach and if necessary, they were prepared to refer Jane to the Janeway Hospital. The other issue the school had serious concerns about was the number of times they had seen bruising on Jane's face coupled with her absenteeism pattern. The examples they outlined included: child absent January 6 – mark on her head January 7; absent April 14 – mark on her face April 15; mark on lower left jaw April 20, and absent May 4 – mark on her cheek May 5. The total number of days absent was twenty-seven (27) or 18% of the school year.

During mid-April, Mom had asked the school why they were questioning Jane about her bruises. Mom later reported that the child bruises easily; she had taken her to the doctor for same but no medical problem could be found. The school officials stated they were obligated to report these findings and they told Mom as much. It seemed as though Jane's explanations for her bruises were accepted and there is little file documentation to suggest any in-depth investigation took place. The information from the school was not treated as a referral.

On June 28th, the second case conference for the year was held. It was noted that one person now provides home support service at forty (40) hours per week. This regular worker also provides respite every second weekend for both Adam and Brent. Mom feels this support is necessary. Praise was given to the home support worker for her extended role in the children's lives. Concern was expressed about Jane's frequent absences from school. Both Mom and the home support worker said they understood from the social worker that Jane should not be forced to go to school. The social worker stated that was a communication mix up and attendance at school is mandatory in this province. The children's school situations and their overall health were discussed and Mom was asked for clarification about Jane's bruises. She stated it was likely from the sports programming at school. Mom was reassured that reports to Child Welfare are not considered in isolation. While reporting is mandatory, Mom should not feel threatened by common everyday bruises. Mom was told the procedure of informing the parents of all reports is standard but not all reports require interventions and some are screened out. Also at this meeting, Mom advised she had made contact with the three (3) older children; they want to have a visit with her and her intent was to try and arrange transportation for them to see her.

There is nothing on file to confirm if this contact happened or what followup, if any, occurred.

On September 16th, a case conference was held and updates on the children provided. There were concerns from the school about Jane and Mary and their lunch habits. It was believed Jane was eating her own lunch on the bus and then taking food from the cafeteria tables afterward. Before recess, Mary was asking her teacher for food from her lunchbag. The social worker was to arrange a meeting with school personnel. Documentation does not reflect such a meeting.

On September 21st, the school again notified Mom, in writing, with a copy to the social worker, of their concerns around Jane's taking and hoarding of food from other students and the trashcan. There were no reports on file to indicate Mom had taken Jane to a doctor for this reason. Although it had been recommended to Mom that Jane seek professional assistance at the Janeway Hospital, Mom was not in agreement with same. The PH nurse outlined (in her own notes) details of a telephone conversation she had with Mom on September 20th. Mom had stated to the nurse that she believed the school was blowing these issues out of proportion. The nurse encouraged Mom to allow the school to become more familiar with the family in order for them to help Jane. The nurse also advised Mom that she would be putting her thoughts in writing to child protection officials. Mom said she would think about the suggestion and get back to the nurse. The PH nurse followed up and wrote to the social worker (letter dated September 20, 1999). She outlined her concerns around Jane's 'stealing' behaviors and made suggestions about intervention, namely a team approach and the completion of an Individual Services Support Plan (ISSP) for Jane. This information was not treated as a referral.

In October, Jane was seen by a specialist following a referral from the family doctor. She had experienced three (3) episodes of limping in the past month. The specialist could not find any medical abnormality or specific reason for the limp but he wanted to follow up. There are no particular incidents highlighted in the home support worker's notes to indicate an accident of any kind. Her notes do reflect that Jane had not been feeling well for intermittent dates during the past month.

In written correspondence to the social work supervisor in October, the private counselor talked about ways in which Mom could provide some positive insights to other moms who have children in foster care. The counselor thought it would be helpful if Mom could share her story with others. As there are no other notes on file from the counselor until March 2002, it appears the suggestion was not actioned at that time.

There were also handwritten notes on file (not dated, but suspected to be circa December 1999 because of certain other references made in the notes) that indicated Jane's teacher had commented on how this child tires easily and she was always out of the classroom.

2000

Luke	Brent	Jane	Adam	Mary
-------------	--------------	-------------	-------------	-------------

In January, during a PH Nursing clinic visit, Brent became upset when the nurse suggested removing his clothes for examination. The nurse opted for a screening test instead. The home support worker suggested his fear was due to his frequent trips to the hospital. There is nothing on file to indicate the social worker was advised of this incident.

On February 2nd, the notes written by the home support worker indicate Jane's eyes were swollen. Although her notes for the following day state Jane attended a doctor's appointment, there is no documentation in the file to reflect such a medical visit. There is no other information on file.

Later in February, Jane's school again took the initiative to write the family doctor and outline quite specifically what their concerns were about this little girl. The school's report stated the following:

[Jane's] hands are almost always red and purple appearing puffy or swollen. When she takes her arms out of her sleeves, she complains of being cold. On a couple of occasions, [Jane] has taken off her socks and shoes in the classroom in order to rub her feet. The teacher observed that her feet were purple in color and swollen. [Jane] sometimes has marks that look like bruises on exposed areas. These marks are usually dark purple in color and often nickel size. Mom reported that [Jane] bruises very easily. [Jane] has presented with unusual behaviors related to eating over the past few years. She takes food from the garbage when she is left unattended in the lunchroom. She has eaten left-over food on the tables and in the garbage. [Jane] has also been found attempting to take food from other people's lockers or lunch tins and hiding it in her own bag. (Letter dated February 2000 from the school to the family doctor.)

The school also advised the doctor they had been trying to work with Mom in an effort to reduce or eliminate the problems. On this same date, Mom had informed the school she would be moving Jane to another location as she felt this school was putting unnecessary pressure on her about Jane's issues. The family doctor referred Jane to Dr. One, the specialist, who saw her three (3) weeks later. Dr. One determined the purplish discoloration was due to deficient oxygenation of the blood. By the end of the month when this specialist saw her, the condition of her hands and feet had improved. In spite of Dr. One's recommendation that Jane not transfer to a different school as it would cause her

unnecessary anxiety, Mom arranged the move. This information was not treated as a referral.

A month later, the PH nurse attempted to contact Mom to arrange a clinic visit for Brent and Adam. A message was left advising of the appointment. A number of telephone contacts had been attempted prior to this message but they were unsuccessful. On March 10th, Mom left a voice message canceling the appointment. On March 30th, the social worker advised the nurse that the family had not been keeping appointments with their office either.

On May 1st, referral twenty-one (21) was received whereby the RS suspected Jane's most recent injury was deliberately inflicted. The gist of this referral began when Mom called the social worker directly (at home) a few days earlier around 9:00pm. She was upset and reporting Jane had fallen off the top bunk while sleeping and possibly suffered a broken leg or hip. The social worker went to the home and made phone calls to arrange the necessary care. When the ambulance attendants arrived, Jane indicated that she did not want her mom to go with her. Instead, she wanted the home support worker to accompany her and in fact, the support worker did. Subsequent to all the necessary arrangements being made, a referral was received from someone at the local hospital who suspected the injury was deliberately inflicted on Jane. The RS felt the injury was not consistent with the explanation; there was a yellow ring around Jane's neck that looked like old bruising; the child wanted the home support worker to accompany her to the hospital instead of Mom, and Jane refused to take off her pajama bottoms to use the bedpan. She was also quite upset when she was uncovered for the doctor to examine her. The RS had heard about past abuse as well. Nursing staff heard Mom say to Jane (following her arrival) that she would be alright. It was noted other than that statement, Mom provided no support. Upon transfer to the Janeway Hospital the next morning, no one else involved in Jane's care expressed any concerns as Mom's story was believable and she appeared to be acting appropriately. Jane said she had done something she was not supposed to do by climbing up onto the top bunk to sleep. Apart from the medical followup, no other action was taken on this matter. Two weeks after the incident, Mom had her phone service disconnected.

In May, a few days after Jane's leg was broken, Mom spoke at a Child Welfare Symposium, as part of a panel. As documented in the file, Mom told her "story" about growing up in abusive foster homes, her abusive relationships, and the difficulties raising several children in a system she did not really trust. Mom talked about now having a different viewpoint; there could be success in the system for people like her. The emotional account of her life was received in a very positive way by all participants at the conference and Mom was hailed as a true success story because she was reportedly breaking free of intergenerational abuse and appeared determined not to inflict the same upon her children.

Prior to Jane's leg being broken, there had been discussion between Mom and the social worker about the possibility of having a door alarm placed on the girls' bedroom door. This was to prevent Jane from getting up during the

night and hurting herself, as she tended to be unsteady sometimes. In early July, this issue was raised again in light of the fall from the bunk bed and Mom's belief that Jane could harm herself when the cast on her leg was first removed. Subsequently, a cheque was issued by social work officials to purchase a door alarm from a local store.

Also noteworthy during this month were the comments of the replacement home support worker assigned to fill in during the annual leave period of the regular worker. The written notes of this temporary worker were vastly different from the regular home support worker's logs. From July 17 – 21, some of her observations included:

Mom showed no affection towards the children. The kids eat and play outside. HSW [Home support worker] not invited inside - weird. Think if Mom had her way, kids would sleep outside. Raining out but kids given lunch outdoors. [Jane] sent to her room for no reason. [Jane] doesn't talk in front of Mom - she seems scared. Kids outside when HSW arrived in morning...empty flask on counter. Kids out in rain - again. Not enough clothes on them – [Jane] frozen. [Jane] sits outside for approximately 7 hours a day. Mom speaks to [Jane] 4 times per day, snapping her fingers. Mom orders [Jane] to sit or stand. Mom seems cruel to this child - threw a doll at her in the SA store. HSW feels really bad for [Jane] - sitting outside for 7 hours. [Jane] sometimes sits without food or water all day - shown no love. Mom emotionally abuses [Jane] and is very capable of physical abuse. (Temporary home support worker's notes dated July 17-21, 2000.)

The notes filed by the regular home support worker were the opposite in content, details, and tone. After five (5) days of having the replacement worker there, Mom contacted the social worker saying she no longer wanted this person in her house. Mom cited her reasons as being: this woman had a long history with Child Welfare; she did not think the worker liked to be with the children, and it was more stressful having her around than if she were alone with the children. The replacement worker was removed but she spoke to another person in her office and reiterated her concerns for these children: the kids were not allowed in the house all day from very early in the morning until suppertime; the children were not appropriately dressed for the weather, and Mom orders Jane when to walk and when to sit. Based on this information, the social worker decided to drive past the house to observe the activities. This happened on four (4) occasions, three (3) of which there was no one in the yard and during one sunny afternoon, everyone, including Mom, was outside. On September 12th, Mom advised she was pregnant. A telephone call from the social worker to Mom went unanswered on September 19th. Sometime during this fall, another social worker took over the case. The next documentation, albeit brief, appears when the next referral is received.

On October 19th, referral twenty-two (22) was received concerning Luke. Apparently, he and a friend had gotten into a confrontation with a third boy and were then chased by that boy's mother who threatened to harm them. When Luke arrived home, he was upset and crying. There is no other documentation on file relating to this referral.

During the spring of this year, an ISSP had been developed for Jane to try and prevent the reoccurrence of her habit of eating discarded food or taking food from others. This behaviour appeared under control at the beginning of the school year; however, the fact there was continuous monitoring of Jane by a student assistant was likely the reason her pilfering had subsided. By the end of this calendar year, the behaviours had returned and were just as extreme as before. Despite all the supervision, Jane was still stealing food and offering no explanation. Mom decided she would come to the school daily and pick Jane up for lunch, either taking her home or out to a restaurant. There is one case note in the file dated November 9th that appears to indicate another change in the assigned social worker. During a school visit of that date, this particular social worker noted Mom was voicing concern about Jane's eating habits: she was gorging her food; stealing food from lockers, and taking food from the garbage. The school expressed no such concerns at the moment as a student assistant was currently monitoring Jane's activities continuously given her history. School officials also indicated that no children had reported their food missing. It appears from the file documentation that an ISSP meeting took place at the school on December 5th.

2001

Luke	Brent	Jane	Adam	Mary
-------------	--------------	-------------	-------------	-------------

On January 15th, during a school visit, the social worker was advised by staff that Jane had returned to stealing and hoarding food. Jane had an assistant with her at all times but the activity had started again. Mom had attended the school the day before and asked if the home support worker could come and sit with Jane all day. The school was not receptive to that idea as it would only serve to segregate Jane. During this school visit, the social worker observed the three (3) children who had been in care during 1995 -1997: Luke, Jane, and Mary. She noticed that Jane appeared very thin and pale. Later that day, the social worker made an unannounced home visit but because all the children were there and quite active, she thought it best for Mom to make an office visit to discuss the school's concerns. After leaving, the social worker made a phone call to the counselor to discuss the merits of seeing Jane on a regular basis.

The next day during the office visit, Mom was receptive to the proposed intervention for Jane. It appeared to the social worker that Mom was genuinely concerned about the well-being of her children. A week later (January 23rd), the school called the social worker to report Jane was now being picked up by Mom and transported home daily over the lunch period. Sometimes she would be taken to a fast food restaurant and was excited to tell others upon her return to school as her siblings did not get to go. There had been no incidents of stealing food over the past week.

On January 31st, the school called to report Jane had been caught stealing lunches yesterday and today. She became upset when she was told her mother would have to be notified. At one point, she lay on the floor in a fetal position. Jane was asked what her mother would do when she found out; Jane indicated that she would have to go to her room and she would only be allowed to come out to eat supper. School officials noted this was the answer she always gave. Also on this date, staff advised that they had noticed a bruise on Jane's cheek January 19th. When asked, it was learned that Luke had hit her with a hockey stick. Staff had no reason to believe otherwise but they were advised by the social worker to contact HCS immediately if there were any questionable marks on the children. An appointment for Jane had been made for February with the counselor but there is no indication in the file that this appointment was kept.

During the early part of February, Jane was out of school for one week, reportedly with the flu. On February 14th, case notes indicate a teleconference was held to review Jane's history of stealing and hoarding food. Participants noted there had been a gradual improvement in that behaviour. Following Jane's return to school, staff noticed she appeared to have lost weight and her skin was a grey color. On February 22nd, the school had noticed another bruise on Jane's cheek and reported it to the social worker. Jane explained the bruise by saying

Mary had accidentally hit her. The social worker attended the school the following day and learned Jane was not there. Mary was asked of her sister's whereabouts and she explained Jane had to get a bath that morning and would be coming in late. Again, the social worker asked the school staff to document any concerns and advise of Jane's pattern of attendance.

On February 27th, the social worker made another visit to the school where she spoke with Jane. The child looked pale on this date and she indicated that her mom had not taken her to the doctor. Jane's hands were quite noticeably red and swollen and felt hot to the touch. The child had a bruise on her right temple and she stated Mary had thrown hard snow at her by accident. She also had a cut on her lip which she said was caused by falling on the ice and driving her teeth through her lip. The social worker noted the child appeared tense and apprehensive during their conversation. The staff described Jane as being very weak and unable to walk up one flight of stairs without staff assistance and having to hold onto the railing. It seemed all of the officials at Jane's school were concerned about her frail appearance.

When the social worker met with Mom the next day (February 28th) to outline the issues, Mom did not seem overly concerned and said the weight loss was likely from the flu she had experienced. From Mom's perspective, Jane's difficulty in navigating the stairs at school was probably from arthritis setting in since her broken leg (April 2000). She went on to say that if Jane was getting attention, she would pretend she could not walk. The social worker voiced her disagreement that this was attention seeking by Jane, and she advised Mom that a referral would be made to the family doctor for an assessment of Jane's condition. The social worker also asked the PH nurse to monitor Jane's weight. On February 28th, Mom gave written permission for Jane's file to be shared with the PH nurse for one year.

Subsequent to the appointment with the family doctor, Jane was referred to a specialist, whom she saw in March. When the social worker spoke with the specialist, the following concerns had been noted in his assessment: Jane looked malnourished with a protruding stomach; the skin on her forearms and hands was slightly red while her lower legs were described as certainly red and particularly the feet; she was below average weight and height, and she had problems escalating and descending stairs. The doctor wanted to admit her to the Janeway Hospital to more thoroughly investigate these issues; a possibility of Failure to Thrive was mentioned. In this doctor's notes, he stated, "I am sure there is some concern about whether or not the child is getting adequate care." He went on to say, "If I didn't know anything about her past history, I would say she is suffering from a malabsorption syndrome with a lot of secondary vitamin and mineral deficiencies from that." The specialist also noted Jane had seen Dr. One during the previous year and there had been improvement at that time; however, in the past year, it seemed there had been deterioration in her circumstances. As no bed was readily available, the admission was not immediate.

A case conference was held in March at the hospital. The medical specialist was in attendance along with the social work supervisor. It was noted that during the (near) two year time frame that Jane had been in care, her weight had increased. Since returning to Mom's care, there had been a decline in her weight. On this date, Jane looked exceptionally well; there was a marked difference in her physical appearance and no discoloration of her hands. Her overall coloring was good. Despite the improvement, arrangements were made for Jane to be admitted to the hospital. When the doctor saw her to prepare the admission, she had shown sufficient improvement that a decision was made to delay admitting her until after Mom delivered her baby. Bloodwork was completed to determine any biochemical signs of malnourishment as a means to begin the investigation into Jane's condition. There are no other social work case notes on file until three (3) months later when a new social worker took over. Mom gave birth to another boy, **Mark**.

Jane was again seen by the same specialist in May as a followup to the March appointment; she was now showing a significant weight gain. He did not see the need for a hospital admission. This specialist followed up by noting his findings in written correspondence to the family doctor. While he said there was no question she had improved, he also stated, "There will need to be careful follow up through Child Health Services in the community to make certain that her progress is continued." (Report of specialist dated May 2001; copied to Area Director of Child Welfare.)

On June 7th, a school official told the newly assigned social worker that she suspected Mary, Jane's younger sister, was now stealing food at school. Jane's hoarding of food had subsided. During this month, Mom had made several requests to the social worker. She requested that the home support worker now take Adam for respite care every weekend; she was having difficulty at night with Mark and everyone in the house was losing sleep. The school had reported to her that Jane was falling asleep while in class. Mom also wanted some recreational programming planned for the children over the summer and she requested a case conference be held soon. It was suggested to Mom that she might consider participating in a mental health program. Mom was not receptive to changing from her current private counselor to another counselor stating if she could not continue with her present counselor, she did not want anyone.

A phone call in late June from the school to the social worker revealed that Jane and Mary had not attended the end of the school year activities. Mary had been continuing to steal but officials were concerned as she now appeared to be losing weight. Mary also had a number of bruises for which she always had an explanation. (Case notes dated June 21, 2001.) A home visit by the social worker was made and everything appeared okay. There is no indication on file from the social worker's case notes that Mom was questioned about the bruises on Mary. Mom did say that Luke was spending time with older boys and sometimes he would not arrive home until 10 or 11 o'clock at night. Her plan was to ground him so he could only go outside in the yard for the rest of the summer.

In August, Jane was reexamined by the same specialist who had seen her in the spring. He noted she still had a slight discoloration in her hands and feet. Jane had slight peeling of her fingertips and her nails were a bit atrophic (wasted away). Mom said Jane tends to pick at her fingertips. During this visit, the doctor also found Jane's white cell count to be a bit low, which it had been for the past year. He intended to see her again in four (4) months and was repeating tests to check her blood.

It appears from case notes that another social worker took over this file in the fall of 2001. During her first home visit on November 8th with Mom, she documented in her case notes a brief description of current interventions with each child. Mom was not pleased that Jane's student assistant was no longer working individually with the child as Jane was experiencing difficulty with spelling and math. It was explained to Mom that was not the intended use of a school assistant; Mom then asked if Jane could have a tutor. Mom also asked about getting a Christmas hamper as it was a difficult time financially. The social worker's case notes (dated November 2001) indicate a telephone conversation with Mom's private counselor. The counselor expressed that the monthly sessions were going well and they were being used to address Mom's concerns regarding the individual children. The therapist was recommending that the sessions continue.

It was noted at an ISSP meeting on November 23rd that Jane had not been caught stealing food this school year thus far but Mary had now begun the same habit and was lying to her mother. The social worker indicated she would be consulting with her supervisor concerning the stealing and lying behaviours. (Case notes dated November 26, 2001.) The worker attempted two home visits over the next several days but no one was at home.

On November 30th, this newly assigned social worker completed a review of the services that were currently in place for the family. They included:

- Forty (40) hours per week of respite services.
- Three (3) hours per week of tutoring for Luke.
- Transportation via taxi to the tutor and return.
- Taxi services to and from the Janeway Hospital re medical appointments.
- Taxi services to and from counseling sessions for Mom – monthly.
- Night respite once per week (or as needed) for Adam with HSW.
- Weekend respite as needed for Adam with HSW. (Service Review dated November 30, 2001.)

The social worker was also now recommending additional transportation costs as Mom would be attending more group therapy sessions. Mom had attended similar sessions in the past.

The social worker made a school visit on December 7th where she spoke to Luke, Jane, and Mary. The worker wanted to introduce herself to the children and assess the current situation. While it is not totally clear if the children were interviewed separately, it appears from certain comments that they were. One of

the children stated things were fine and spoke of friends and being tutored. When the children were asked about being disciplined and the length of time they would spend as “time out”, one of them said five (5) minutes and another said half an hour. The importance of telling the truth was emphasized and if they ever wanted to speak to her, all they had to do was let the teacher know. The children indicated they understood.

Following these conversations, the social worker spoke with school officials. One teacher indicated she had sometimes been detecting a very strong perfume smell from both the girls. This same person commented on the stealing behaviours and how Jane would often be absent from school the day after such an incident had occurred. When the child returned to school, there were often bruises or marks on her which were always explained. The social worker noted that similar notes had been made by staff from the previous school the year before. (Case notes dated December 7, 2001.)

School officials indicated to the social worker on December 18th that again they were noticing a very strong smell of perfume from the girls. In fact, one of the children’s teachers was allergic and the school intended to write Mom about the use of perfume. It appeared as if it was being used to mask the smell of urine. (Case notes dated December 18, 2001.) Also noted was the deterioration in one of the children’s behaviours while at school. This child had gotten into a rather serious fist fight, was ‘mouthing off’ at the bus driver, and had facial scratches that may have been self-inflicted. The school also noticed behavioural problems with another one of the children, but they did not specify what these issues were. Another child was being referred for an assessment concerning hyperactivity along with disruptive and destructive tendencies. There was also aggression with the siblings. Mom said this child did not listen to her and had recently ‘turned over’ a jewelry display at a local store.

The following is a summary (taken from the private counselor’s correspondence to the social worker) of the counseling sessions held with Mom on a monthly basis during 2001:

The primary focus of all sessions has been the childrens’ progress including health, academic and social well-being. Overall, the children continue to mature in a very positive way. Their school attendance is regular and all continue to achieve at a good level. [---] has definitely benefited from the additional work with tutors and recently [---] marks have improved. I am impressed with Mom’s attention to detail for each child. She monitors both their school work and their behaviour carefully and she is a caring and concerned parent who has a basic respect for each child’s differences and needs. Despite the heavy demands of the two youngest children... Mom is able to run an organized household, keep appointments for herself and the children, budget extremely well, provide assistance with homework, take the children to church when weather permits, ensure good nutrition for the

family, and is available for consultations with the school as needed. [Home Support Worker's] presence in the home is invaluable in meeting all these daily demands. Mom is a vital person who works extremely hard but who also loves to see the children have fun. She ensures a safe outdoor environment and monitors their play activity and knows who the children are in contact with. She would like the children to have more neighbourhood children to play with. Mom is a devoted parent and there are really no child protection issues regarding the children. Mom has wondered if there has been a change in the way children's protection views her situation as the number of contacts with yourself has increased and you have called the children out of class to talk with them. The children have complained about the fact that this action singles them out and as a result you have not repeated the practice with [---]. [---] and [---] appear to interpret your contacts as a way of checking on their mother. As a result, [---] in particular, feels [---] can disobey or challenge [---] mother and that you will support [---] in such actions. I think this confusion needs to be addressed as [---] (and perhaps [---]) interviews with you appear to be pitting the child(ren) against their mother. The supports that Child Welfare have put in place for this family certainly continue to be necessary, and I would recommend that counseling sessions on a monthly basis be continued at this point in time. (Letter dated March 2002 from the private counselor to the social worker.)

2002

Luke Brent	Jane Adam	Mary Mark
-----------------------	----------------------	----------------------

On January 11th, Mom reported to the social worker that there were at least two incidents of stealing at the school involving Mary. The first was when she stole her teacher's wallet and then lied about the location of it. The other incident was when she stole the lunch order monies. Mary would admit nothing to the school officials but told her mother she had hidden the money in her shoe. Mom explained to the Principal she had told Mary that she was not supposed to take her shoes off for any reason because she might get cold or slip on the floor. Mary was 'punished' by having to sit in the Principal's office during recess time; she was not allowed to play with the other children, and she now had to be accompanied to the washroom by another student. Eight (8) days after Mom's call, the school also notified the social worker of these two incidents. One official noted the day before the lunch order money was stolen, Mom asked school staff if Mary had ever stolen lunch order money. It was determined that an ISSP for Mary would be delayed but there would be close monitoring in future. The social worker consulted with her supervisor on these matters on January 31st and was advised to speak with the counselor. The social worker made a school visit on February 4th to speak with the girls, particularly Mary, about the recent incidents of stealing. Mary was relatively quiet and could offer no explanation. Jane and Mary were encouraged to be honest and to let someone know if they were being hurt. The next reported incident of Mary stealing was in early March when she took a doll from another student and put it in her book bag. Again, she was required to sit in the Principal's office.

On February 15th, a review of the services currently in place for the family was completed; it was recommended that these services continue. Mom had asked about additional services for her son, Adam, who was hyperactive. The social work supervisor's response was that the review could now serve as the case plan for the family. The title on the document was changed to reflect the direction given and the document was resubmitted. (Case notes dated March 4, 2002.) Also during February and March, it was noted that Luke was "walking a fine line" in terms of behaviour and had to be corrected quite often at school. (Case notes dated March 4, 2002.) The case notes (dated March 7, 2002) indicate Adam was not eligible for Behaviour Management Services; however, a referral was made to the Janeway Hospital about this child; subsequently, it was determined he was eligible for this program as he had a significant social delay. This delay placed him at the level typical of a child of a much younger age. In addition, Brent was being referred to a special education class and for speech assessment.

On March 14th, Mom went to the office to meet with the social worker. Mom indicated she was having trouble with Jane since the worker last attended at their school and asked certain questions. Mom was of the impression that the

worker had asked Jane and Mary, "Does anyone hit you?" The social worker assured Mom they have a requirement to ensure the children are safe and what would have been asked is, "Does anyone hurt you?" Both girls replied that no one had hurt them and they were not scared of anyone. Mom asked the social worker if the comment had been made that nobody was allowed to punish them. Clarification was provided by the social worker saying she had told the children they had not done anything wrong and that no one has the right to hurt children. Mom reported that since this last school visit, Jane had been refusing to listen to her as the child believed she could not be punished. The social worker agreed to speak to Jane and Mary, who were in the waiting room, to clear up any misunderstanding. During this same interview, Mom and her daughters were introduced to a new social worker who would now be assuming responsibility for their file. The social worker subsequently spoke with the private counselor to discuss Mom's progress in therapy. The counselor said Mom was making "really good use of therapy" but she went on to express concerns about the children being interviewed at school. The social worker explained the rationale and the therapist commented she would be following up with written correspondence (see letter quoted at end of 2001).

On April 4th, the new social worker received an office visit from Mom who was expressing concern about finding two of the children lying naked in bed and touching one another inappropriately. One child said they had seen this activity at school with two other children in the bathroom and had told their teacher of that occurrence. When the worker checked with the school, they were not aware of same. Mom was advised of the outcome of the interviews with the children and said she was not surprised because they often told lies. As the information could not be substantiated, the matter was closed. A few days later, Mom was caught in a lie herself when she indicated to the social worker that the supervisor had authorized her trip for counseling. The supervisor assured the social worker this was not the case.

On May 7th, the school reported Mary was again stealing items (e.g. Barbie doll; nail polish, and money) from other students. Also, her teacher had been noticing, on a frequent basis, a strong smell of urine coming from Mary. The school indicated they would be addressing these issues with Mom. There is no other documentation on file relating to this report. Around this time, the file was transferred back to the social worker who had responsibility for it at the beginning of the year.

On June 13th, referral twenty-three (23) was received wherein the RS relayed concerning information provided by Mary. It was alleged that Mom had put her hands around Mary's throat, had put Mary's head under water not letting her breathe and had thrown a boot at the child. On one occasion the RS reported seeing the child with a bleeding tooth and a large scratch on her arm; both were attributed to Mom. There were also concerns expressed about the children having adequate food and drink. The social worker could not confirm these allegations.

Later that day, an interview was conducted with Mom. Before the social worker outlined the concerns, Mom advised that the children's dad was upset with her because she had applied for child support. She went on to say that the social workers could expect an influx of referrals in the coming months as a result of his attitude. When Mom was told that the current referral related to Mary, she indicated that Mary was the only one Dad had spoken to when he was at their house last time. Mom went on to say he had a short fuse and she felt he could get any child to tell lies; either because they wanted to please him or they were afraid of him. Mom was advised that Mary had not substantiated the referral. The details were then shared with her; however, she denied everything saying it was not true and she would never do such things. Mom reported her only method of punishment is to have the children sit on their beds until she tells them to come back out of their rooms. The home support worker was also interviewed and denied any knowledge of these occurrences but stated she leaves at 4:30pm each day and is not sure about what goes on after that. The referral information could not be substantiated and the matter was closed on June 20th.

On July 31st, a financial review of the file was submitted to the social work supervisor by the assigned social worker. This was the fourth such review in the past eleven (11) months. The previous ones were dated August 30, 2001; November 30, 2001, and February 15, 2002. As stated in the previous reports, the social worker was recommending the continuance of service, namely: forty (40) hours of home support per week; private counseling for Mom once per month; group counseling for Mom; transportation to both counseling sessions; counseling for Jane and Mary and transportation to same; night respite for Adam once per week, and weekend respite for Adam as needed.

In August, Jane was seen by a specialist about recurring tonsillitis and ear problems. The child was accompanied by her maternal grandmother on this date. The grandmother was advised to watch Jane while she was sleeping for evidence of sleep apnea. She was also given drops for Jane's ears and sent home with a follow-up appointment in two weeks. The doctor saw Jane again with her mother two weeks later and at this time, her ears were clear. Mom reported she had not been watching her sleeping and again the doctor suggested this strategy for one hour per night for three (3) nights. There is no other file information related to this medical issue.

On September 18th, a staff person from the home support agency spoke to the social worker and reported they had concerns about their inability to complete home visits, which were standard practice. There was either no answer or no one at home. This person also indicated they were not receiving any written logs from the home support worker. A check of the file revealed no written notes for the past year. The support worker was reminded about the need for her to complete her daily logs.

On October 28th, the school called to report more incidents of stealing involving Mary. Recently, she had taken pencils and post-it notes (with messages on them). The punishment involved her sitting in the Principal's office

during recess. Also during the phone call the social worker asked how Jane was doing and was told she recently had a bruise by her eye allegedly from her brother hitting her with a toy. It was also noted Jane had been reprimanded on Wednesday of the previous week for an incident in class. Her mom was told about it when she arrived that day; Jane was not in school for the remainder of the week. It appears there is no other file documentation concerning this reported bruising. The social worker noted she would attempt to schedule a case conference as soon as possible. The case conference took place two and one-half (2½) months after this date.

On November 26th, referral twenty-four (24) was received about Jane and Mary. The girls had been seen at the Remembrance Day Service (11th) where both had experienced weak spells. This RS also said the same thing had happened to Jane just the day before the referral (November 25th). This person was encouraged to keep an eye on the girls and to try and persuade Mom to take them to the doctor. Later in November, Jane was seen by one of the same specialists she had seen last year wherein now she was reporting headaches and eye pain. The doctor found it difficult to pinpoint the cause but suggested to Mom that Jane should have her vision checked as soon as possible. Mom indicated her own past history of migraines. There is no other information on file relating to the actual child protection referral.

In December, Adam was seen at the Janeway Hospital. He was assessed as having extreme behavioural difficulties. The specialist involved referred Adam to a psychiatric service as well as community mental health. She also recommended parenting help and the continuance of working with a Child Management Specialist. It was felt that Adam needed a structured experience with a one-on-one worker. In the Child Management Specialist's written assessment, she noted that part of his behavior may be due to what sounds like a rather chaotic home environment. (Child Management Specialist's report dated December 2002.) She also forwarded a copy of her findings to the social worker.

2003

Luke Brent	Jane Adam	Mary Mark
-----------------------	----------------------	----------------------

On January 15th, a case conference was held at the children's school. Mom advised that Mary was stealing and lying more often this year than last; she further stated she cannot tell the difference anymore when Mary is lying or telling the truth. According to Mom, there were times when Mary would even tell lies about Jane stealing in order to get her sister in trouble. Mom said she does not punish her anymore because if she did, "[Mary] would spend all of her time in her room." The school believed they were at a 'stand still' about what further action to take.

A suspension from school was handed down to Luke on February 6th as he had falsely accused one of his teachers of attacking him with a ruler. Mom asked the social worker to speak to him about the importance of telling the truth because Luke would not listen to her.

On February 26th, referral twenty-five (25) was received. Concern was expressed by the RS that the bedroom doors in Mom's house were closed and locked at all times. Only Mom and the children were allowed in the bedrooms. The home support worker was taking Adam home with her every night. At one point, the support worker was concerned about being in the house for fifteen (15) minutes before Mom arrived home; apparently, she was afraid she might get blamed if something got broken. The children reportedly go to bed very early, usually 6pm with the girls being the earliest to go between 5:30 and 6pm. It was suspected that the bedroom doorknobs were sometimes turned around so they could be locked from the outside but not opened from the inside. The RS reported "...the children appear terrified of their mother and are not permitted to tell things." Mom had been heard to say, "Sit the f--- in there and keep your mouths shut." One report included Mom saying one of the children had pooped in her bed and smeared it over the walls; the child was barred in the room as punishment. The RS indicated there seemed to be no hugging or touching between Mom and the children, although it appeared as if Mom favored the boys; she would buy them things at the mall or when she went out. Mom's rules were described as rigid and she had less attachment to the girls. The foregoing information was deemed insufficient to constitute a referral. (Client Referral Management System (CRMS) notes dated 2003/04/16.)

During early March, there continued to be concerns about the girls' ongoing stealing behaviours at school. According to the hospital, there had been repeated referrals for Mary to receive counseling but Mom had refused to bring her. By the end of the month, Mom asked the social worker if the hospital staff needed consent to talk to Mary as she learned they had questioned the little girl about her room and locks on the doors. The social worker advised Mom to

question the staff person herself as no information had been passed through the social workers.

On March 6th, referral twenty-six (26) was received about the care of the children. The RS expressed concern about their 5:30pm bedtime along with how terrified the children were of their mother. Apparently, there had been an incident where the girls got up overnight and rummaged through their mother's purse and the kitchen cupboards. They had taken money and food and placed it in their book bags. Mom's reported response was: "I guarantee you they won't get out again because they'll be locked in." The RS was afraid the children might not be able to leave their room in the event of a fire. Similar information had been relayed to the social worker on February 26th (as stated above) but did not warrant an investigation. On the same evening as this referral (March 6th), an unannounced home visit was made and despite the lights and television being on, there was no response at the door. The social workers knocked repeatedly but their attempts were unsuccessful. A decision was made to interview the children at school the following day.

Mom called the social work supervisor early the next morning to ask what was going on; she stated her neighbor had told her the social worker and another person were at her door last night. Mom said she did not want any trouble and she had not done anything wrong. She was advised of the referral and she then asked if it meant she would lose the children today. Mom was told she would be advised following the outcome of the interviews with the children. At school, when the first to be seen was asked to count how many people lived at their house, Adam was initially forgotten. This was in reference to Adam staying with the home support worker almost nightly. This child described their room as white with some toys on the wall which was better than the girls' room but could not describe why when asked. There were no hugs or kisses before bedtime. There was no doorknob on their room but the girls' room had a knob with a lock and key.

The girls were interviewed together on March 7th in an attempt to increase their comfort level. They seemed fairly relaxed to the social worker. When asked what their room looked like, they provided a vivid description of a pink and purple room with a door that is sometimes closed at night; it has a lock on the inside. They denied having accidents in their clothes and had no knowledge about poop being smeared on the walls.

Later that day, Mom was interviewed at home by two social workers about the referral information. She denied there being an incident where poop had been smeared on the wall or having said it. She stated the girls' room has a lock but it is on the inside; sometimes when the girls are dressing, the boys barge in without knocking so they need to secure their door. The social workers asked to see the bedroom and were quite surprised to find it was white, not the pink and purple the girls had described. The room was sparsely furnished with one twin size bed and a plastic trunk for toys. The workers noticed a strong smell in the room which was mixed with something else like an air freshener. The lock on the

door was observed as being on the inside and it was difficult for the social workers to determine if it had been changed around. Several times Mom said if it was a problem, she would have it replaced that evening (for a knob with no lock). The other bedroom was white, with bunkbeds and toys hanging on the wall and without a doorknob. As the social workers walked back towards the girls' room, they again noticed a strong smell - like urine. When Mom was asked if she noticed it, she stated all she could smell was the air freshener and proceeded to unplug it from the wall. She held it up to the workers asking if that was the odor they were getting. The workers indicated it was part of the smell but the urine scent was stronger. Mom went on to say the girls had accidents in their bed before; she said it would be no trouble to replace the mattress. One social worker explained that if the children were prone to accidents, Mom could also purchase a liner to protect a new mattress. When Mom was told about the colorful description the girls had given of their room, she said she had trouble with them lying in the past.

While in the home, one social worker could not help but notice how much Jane closely resembled her older sister. Even though Mom had not seen or communicated with her first three (3) children since 1994, there was a large portrait of her older daughter in the living room. Pictures of her current children were noticeably smaller and less prominently displayed in the hallway. The social worker knew that much of the concern in the 'first' case was centered on the older daughter and how she had been treated differently from the boys. She was also the 'middle' child from that marriage and had been abused the most. It was believed by the social worker that Mom saw much of herself in this child. As a result, the social worker (on this date) decided that Jane needed to be monitored closely to ensure the same things would not be happening to her. The worker further recalled how Jane had been quite ill in the past and the doctor having indicated that if she had not been brought to the hospital, she may have died. As the children did not substantiate the details of this referral, it was recommended that the situation with the girls be closely monitored. It was later documented in a Plan of Care dated March 2004 that: "...the worker of record was extremely concerned about [Jane] and [Mary] at that time." A new social worker took over the case on April 1st.

On April 4th, Mary's school advised she had been suspended the previous day for stealing, lying, being defiant and talking back to the teachers. Also, on this date, Jane had been sent home for stealing \$15.00 from a teacher and then lying about it. When she was brought home, her mother found the money inside her tights. The school advised that, historically, Mom had been cooperative with them in discussing the issues with the girls.

On April 15th, the social worker made an unannounced visit to Mom's house. Mary was home and Mom indicated she had refused to get up and go to school that day. The worker spoke to the child and could not help but notice that for most of her visit, Mary stood in the middle of the kitchen floor and did not move. It appeared to the social worker that Mary was standing 'at attention'. When her mother spoke to her, her answers were 'robot like' and appeared

programmed. Mary showed little affect in her speech and generally looked sad; she made very little eye contact. At one point, Mom attempted to have Mary sit on her lap but the little girl appeared uncomfortable and showed no emotion towards her mother. The social worker also heard from Mom that Mary had been stealing the day before at school. It was reported that she stole a bag of chips, a fruit roll-up and other things because she wanted them. The following day (April 16th), the school expressed their serious concerns about the girls' behaviours; other parents were now complaining. The staff person was not aware of the latest incident involving Mary. When the children she allegedly had stolen from were asked, they reported they were not missing anything. Mary was questioned again and said she made up the story.

The school had also noticed and was concerned about the demeanor of the girls in front of their mother. According to school officials, the girls were like robots and they appeared programmed in some way; they often looked to their mother for answers. Their behaviour, in front of Mom, was almost military like; they appeared to stand at attention with their hands by their side; they answered questions promptly and stared straight ahead. (The social worker had observed the same behaviour from Mary during her home visit of April 15.) In contrast, when their mother was not present, the girls were usually very relaxed and easygoing. A telephone consultation was conducted with the social work supervisor and it was felt that most concerns with the family at present were subtle and it was difficult to substantiate anything concrete. It was believed the concerns were not severe or concrete enough to warrant removal of the children.

A meeting that took place between school staff and one of Mom's counselors in May revealed the counselor had similar concerns about the demeanor of Jane and Mary when in their mother's presence. According to CRMS, the social worker indicated that the counselor had said: "1) there was a different dynamic between Mom and the children; 2) the children often look to Mom before answering questions, and 3) the children appear to have lack of affect overall." (CRMS notes dated 2003/05/09.) Both parties discussed concerns about the social isolation of Jane and Mary; they appeared to have few friends; rarely participated in school activities; they did not ride the bus, etc. The counselor had not observed the smell of urine or the bruising that had been seen by school staff and the social workers. She also stated most of her counseling had been with Mom and she had not seen the girls a lot nor did she know them well.

Another unannounced home visit took place on May 13th and the social worker observed the interaction of two of the boys, Adam and Mark, with their mother. From statements made by the boys (CRMS notes dated 2003-05-13), it appeared to the social worker that they were given permission to play in a manner that would not be normally accepted (hiding under the cushions in the couch).

On May 15th, a case consultation was held with the social work supervisor. The common concerns about Jane and Mary from the perspectives of the social

worker, the school guidance counselor and the hospital counselor were shared with the supervisor. It was agreed a case conference was in order to discuss the future plans for counseling involving the two little girls.

This newest social worker saw Jane and Brent for the first time on May 21st and noted that Brent's hair was long. In the school corridor, Jane and Mary spoke briefly with the social worker who was there on another case. The girls were accompanied by the home support worker and appeared to be doing fine; in fact, the social worker noted how Mary's demeanor was quite different than the last time she had seen her at home. On this date, Mary was relaxed, in good humor and interactive.

On June 9th, Mom requested a meeting with the social worker to discuss Adam's out-of-control behaviour. Mom said he was hurting other children. Adam suffered a broken arm one week ago and since the cast was put on, he had been really rough, even knocking out one of Brent's teeth. According to the home support worker, stated when she attended the case conference a few days later, the broken arm occurred when Adam fell off a toy car while he was outside playing.

A case conference was held on June 16th and arrangements had been made for another respite worker to look after the children in order for Mom and the regular home support worker to attend this meeting. Mom had asked if the home support worker could attend in her place as she knew the family quite well. The social worker explained it was more appropriate that Mom be in attendance. When asked about her reluctance to attend, Mom said she was worried about a new respite worker staying with her youngest boys. Following the meeting, Mom advised she had paid a private sitter as opposed to having a respite worker. During the meeting, the hospital counselor advised she had seen Mary three (3) times with respect to her stealing behaviours. Based on the file notes, this arrangement had been made by the social worker during the previous month with the hospital. The counselor was also planning on meeting with Jane soon. It was anticipated that two sessions per month would be held with each of the girls.

Mom called the after-hours social worker on June 25th to report she was finding it increasingly difficult to deal with Adam as his behaviour was getting worse. The following day, she met with a social worker, who was filling in for the regular worker, and outlined how extremely stressful it was to deal with this child, especially since the weekend respite was reduced six (6) months ago. Now, with the children home from school on summer holidays, she anticipated heightened stress levels with respect to everyone's care. It was suggested to Mom that she gather letters of support from any of the professionals she had dealt with in an effort to have respite services reinstated for Adam. Mom commented that most of the discussion with her private counselor had been about her own individual issues and there was little discussion in respect to the children. This statement contradicts the therapist's reports on file. Mom was asked if she had raised these concerns about Adam's behaviour at the last case conference meeting;

she said she did not as most of the discussion was about the girls. Mom further requested transportation costs for the children to attend summer programs.

In June, referral twenty-seven (27) was received by the on-call social worker. The RS was currently with Mom and was reporting Mom was feeling very down. Mom had received approval for transportation to a therapy session but did not feel she could participate. She felt she should go instead to the Emergency Department at the hospital for a psychiatric assessment. The RS was prepared to accompany Mom but needed approval for taxi fares; same was given. The RS was also suggesting Mom needed additional weekend respite for her son, Adam. Mom was seen by a psychiatrist and released. In order to reduce Mom's stress levels, respite for Adam was approved for the coming weekend.

Three days later, the private counselor wrote to the social work supervisor announcing she would be closing her private practice in August. She indicated how she appreciated working with Mom and commented, "...I think her commitment to her family is exemplary." Mom had not requested a referral to another counselor. There is nothing on file to indicate that the counselor's collective comments reflected any awareness of what was happening from other perspectives, nor did she appear to be aware of the ongoing referrals. Also of note, there is a letter on file written in July, from the counselor, advocating weekend respite care for Adam.

The social worker made an unannounced follow-up home visit on July 2nd. Mom answered the door and immediately one of the children could be heard crying. Mark walked into the kitchen wearing only his underwear; the worker noticed he was quite solid looking. When the social worker made a comment about how unhappy he was, Mom said, "Just watch." She took a cookie and waved it in front of him; he went from crying to wearing a wide smile. Mom passed it to him and took additional cookies into the living room for the other children. Mom asked the social worker not to mention anything about her visit to the Emergency Department in front of the home support worker. Despite repeated attempts by the assigned social worker, it could never be determined what Mom's presenting issues were as she always diverted the conversation to other issues and refused to talk privately with the social worker. It was also noted during this visit that Adam was sitting very quietly on the couch watching a movie. His behaviour was the opposite of what Mom had been describing to officials. Mark again walked into the kitchen looking for cookies; the social worker was of the opinion Mom wanted the three (3) boys who were present, Luke, Adam and Mark, to sit on the couch and not make any noise. Jane and Mary were reportedly still sleeping which the worker found somewhat odd given their early bedtime; she did not ask to see the girls. Mom said both girls had been up during the night fooling around but did not elaborate. She went on to say that during the summer months, the children stay up later until 10-10:30pm. The social worker noticed how cluttered the kitchen and living room areas seemed but she did not see any toys.

Mom called the (fill in) social worker a few days later wondering about the approval for the continuation of respite care for Adam. Mom stated she had been talking to the supervisor and had been directed to call this worker; it was not unusual for Mom to call the supervisor directly or to sometimes request a meeting with the supervisor. Mom also inquired about registration and transportation for the children to the summer programs. She was told it had all been approved and confirmation had been left with her neighbor who was a taxi driver. Mom had previously stated she got her phone messages through one of the taxi drivers as she claimed she had no phone service herself.

There is correspondence on file, dated July 17, 2003, written to the social work supervisor from HCS asking about funding. A referral had been received from the hospital (that Mom visited in June) for her to seek counseling to deal with her depression. Apparently, Mom said she wanted private counseling that would be available to her in September, following the retirement of her current counselor. The supervisor's response (a handwritten note on the same letter) indicated she needed the assigned social worker to find out more details about how the referral was made. She also stated, "We are unable to contract private counseling." The parameters of how mental health services were provided to clients had changed significantly since Mom first began therapy in 1996.

Another unannounced home visit was completed on July 22nd by the regular social worker. Adam was in the yard with the home support worker and he was climbing in and out of a children's swimming pool. The social worker chatted with the home support worker about Adam's behaviours. The support worker described him as a "handful." She was asked about his behaviour when he was alone with her (which was almost nightly along with numerous weekends); she indicated that she "sometimes" has trouble with him. The social worker knocked on the door to speak with Mom; the screen door and the main door were shut. No one answered after several attempts. The social worker asked if Mom was alone inside. The home support worker indicated that Mark was in there too. The social worker asked her if she would try the door and she stated, "She usually answers when I knock." After knocking several times with no response, the home support worker entered the house. She returned saying Mom would be out in a minute. Mark appeared in the screen door wearing only a diaper and he shut the main door. A few minutes later, Mary came out. The social worker was surprised to see her as she expected the child to be at her summer program. The home support worker stated, "[Mom] keeps her home because she was stealing." Several minutes later, Jane came outside. The little girl was dressed in stretch pants and a sweatshirt and she was wearing a cap. It was quite hot outside; Mary was wearing shorts and a tee shirt and Adam wore only shorts. Mom came out a few minutes later with Mark who was also dressed in shorts and a tee shirt. Although the worker suggested going inside to talk, Mom said they would stay outside because the kids were out.

The social worker had wanted to have a follow-up discussion about Mom's trip to the Emergency Department but Mom suggested she talk to her supervisor about it. Mom's primary concern appeared to be whether or not further respite

weekends had been approved. She was advised it had been passed onto this social worker's supervisor who, in turn, had to submit it to the Regional Director for a response.

After being outside for several minutes, Mom suggested to Mary that she go in and put on her bathing suit. The child seemed surprised but said she would like to and went inside to change. The social worker then inquired about Jane being so covered up on a hot day. Mom said it was due to a skin condition; she described her daughter as being allergic to hot and cold. She went on to say that in winter, Jane's hands turn black and blue in the cold and it looks like someone put her hands in boiling water. Later, the social worker attempted to find such a medical notation in the file, without success. Mom said Jane was used to being dressed that way in hot weather. There is no indication in the file that the social worker asked to examine Jane with less clothing on. When Mary returned in her swimsuit, the social worker noticed two bruises on her upper left arm and one on her upper left leg; the worker did not ask Mom about same. When Mom was asked about the summer program and if there had been any problems, she said, "No, they go when they want to." Mom was asked directly if the girls had stolen anything, and she responded, "No." When Mom was presented with the reason given by the home support worker that Mary was home from daycamp, she denied same. The social worker noted this contradiction was concerning for her. Again, on this occasion, the worker noticed the girls were somewhat robotic when responding to their mother's questions.

The social worker held an in-person consultation with her supervisor on July 25th to discuss the weekend respite care. The supervisor had asked Mom to forward documentation from her counselor (referenced above) in support of her request. A discussion ensued whereby it was determined this service could not be implemented without a rationale. Based on the observations of July 22nd, as well as the fill in social worker's notes of July 2nd, the assigned social worker could not establish the need for respite care of four (4) weekends per month. Also during this meeting, the need for counseling was discussed as Mom's therapist was retiring; it was determined that Mom could avail of mental health services through HCS.

On July 31st, Mom dropped by the social worker's office to find out more about the weekend respite for one of the children. She was also in possession of a letter from staff at the day camp program outlining problems with two of the children. The letter indicated that one of the boys had been constantly going into the girls' washroom and staff felt this behaviour was quite inappropriate. The letter also referenced the other child's problem with listening stating: "...when he's bad, he's bad." Mom was using this information to support her need for respite care. During this office visit, the social worker noticed again how one of the boy's hair was very long. When she commented on this, Mom said, "He likes it that way." He retorted, "No, I don't." The worker also noticed he was difficult to engage in conversation and he presented as being more active than his brother. The following day, Mom reported one of these children had tried to run away from day camp. Staff had concerns about him getting injured or somehow being

at risk if this continued. The social worker asked Mom if he ever did this at home and her response was, “No, because he has one-on-one supervision.”

Two weeks later, Mom inquired about transportation costs for one of the children to attend a meeting with a child psychologist at the hospital. She also wondered about private counseling sessions continuing for her with another counselor as her current one was retiring. Mom was advised the agency could no longer pay for private counseling but their internal mental health resources could be used. Mom was resistant to accept this arrangement because she felt numerous workers would be reviewing her file. Assurance was given that would not be the case.

On August 19th, referral twenty-eight (28) was received about Mom leaving the children the previous evening and being away all night. Mom had apparently been arrested that evening for entering Dad’s residence. Mom accused her “ex” (Dad) of being with someone else; she was removed by the police and offered a ride home. Mom stated she would be simply returning to his residence; therefore, she was detained overnight to prevent the continuance of the offence but she was not formally charged. The home support worker had been asked by Mom to take the children overnight; the worker said she could not, but she agreed to take them for a few hours. Mom told the worker where she was going and that she may “end up in the lock-up.” Following the incident, Mom insisted the home support worker had agreed to take the children for the night. The RS was worried about Mom’s state of mind and because of her jealousy concerning her “ex”, the RS was afraid Mom may take her revenge out on the children.

The social worker consulted with her supervisor several times throughout the day. It was agreed Mom and the home support worker should be interviewed away from the residence to ensure privacy while discussing the referral concerns. Several attempts were made to reach them by phone but without success. It was also documented that while the referral was significant and serious, there was not enough evidence to warrant removal of the children as they were supervised by a responsible adult. It was noted that should a similar incident occur in future, the children could be removed.

The social worker made a home visit on August 20th, the day following Mom’s release from custody. The worker’s intent was to set up an office visit to discuss the occurrence and she wanted arrangements made for the care of the children. Adam asked the social worker if she was there to “fix the phone.” The social worker had suspected Mom did have phone service but was keeping that information from the agency. Mom insisted she had been using the home support worker’s cell phone. During this visit, it was noted Mark said the word ‘Mom’ a couple of times and then reached his arms out to the home support worker to be picked up. The social worker, after consultation with her supervisor, decided not to confront Mom about the telephone issue as it may pose a risk to the children; Adam may be reprimanded for making the comment about fixing the phone. Also, the relationship between Mom and the home support worker could be jeopardized, if the issue was pursued. It was felt the best approach was to

discuss the telephone over a period of time. The social worker also requested a case conference in the fall with the Regional Director to discuss overall concerns and to ask for further direction. (CRMS notes dated 2003/08/20.)

The home support agency was contacted to arrange a respite worker in order for Mom and the home support worker to attend an office meeting in August to discuss the arrest. One of the agency's supervisors indicated that things would have to be different this year for any relief workers attending at Mom's residence. She went on to outline how the worker who covered during annual leave last summer was not permitted in the house at all, not even to use the washroom; she cared for the children in the yard, even if it was cold or rainy. During inclement weather, the worker would have to take the children to the mall.

The meeting to discuss the latest referral went ahead as planned but Mom did not use a respite worker. She and the home support worker took turns being interviewed and looking after the children. Mom insisted that the home support worker told her in August that she would take the children all night when she went to her "ex's" place. When Mom was asked why she did not call the support worker during the night, she stated the police had not permitted her to use the phone. She went on to say she had been advised by the police not to call or go to her "ex's" residence. Mom was cautioned about the seriousness of the matter and she was adamant there would be no further reoccurrences of this nature.

When the home support worker was interviewed during this meeting, she confirmed she had only agreed to have the children for a few extra hours. She felt she was left in an awkward situation. The home support worker stated the children never asked where their mother was. The social worker advised her that if there should be a similar circumstance, she should not hesitate to call the after hours number. It was explained to her about the safety and well-being of the children and the agency's need to have this information; she indicated she understood. The home support worker said she had a "gut" feeling about the whole incident and she was concerned that Mom's anger with her "ex" may have been taken out on the children the evening their mother came home. She could offer no concrete information in this regard. On this date, the home support worker confirmed that Mom has a telephone. She said, "...only a few people know the number – the children did not." In addition, the worker stated her concern about the school not having the number.

Another meeting took place on August 27th with respect to the home support agency and the expectations for the workers. Mom denied the claim the replacement worker had not been permitted inside the house and said she was not even aware of this issue until after the worker had completed her time there. The social worker noted on this day that one of the children's behaviour was defiant; Mom explained he had been to see a child psychiatrist and had to return in a week or so. The issue of Mom having no phone service was raised and no information was offered by her to the contrary. In September, this same child was assessed by a psychiatrist. This doctor wondered "...if there is more chaos

going on in this family than [Mom] lets on.” (Psychiatrist’s report dated September 2003.)

On September 10th, referral twenty-nine (29) was received concerning Mom’s “ex” being at her residence on a regular basis for overnight stays; it was the understanding of the RS that Dad was not supposed to be in the presence of his children. The social worker verified there was nothing on file to indicate Dad could not have contact with the children. It was noted that Mom had been told by the police to stay away from Dad’s residence. The referral was screened out.

On the same night this referral was received, Mom had hired a babysitter and gone out for the evening with a male friend. Her “ex” had apparently gone to her residence and she called the police saying she could not return while he was there. The police instructed Mom’s “ex” to leave her house. In a reported telephone conversation that Mom had with her “ex”, he allegedly told her, he was meeting with Child Welfare officials on September 16th and he would be advising them about the state of the children’s bedrooms and that Mom had hit one of the children on the head. Mom said the bedroom issue had already been investigated and she denied hitting the child. In a phone call to the social worker, Mom expressed concern that her “ex” would now be making malicious reports against her because of their strained relationship. His reported statement to her was, “I’ll report whatever I can think of” in relation to the children. Mom was told the agency would have an obligation to investigate if a legitimate report was received; she said she understood and that a representative from this agency could interview her children at any time. Mom further indicated she had applied for a peace bond which would be heard next month. Certain statements were made around this time that indicated Mom does indeed have a phone. (CRMS notes dated 2003-09-12.) Again, the social worker found it disconcerting that Mom would keep that information from the agency.

A few days later, Mom reported to one of her counselors and to the social work supervisor that her “ex” was making threats towards her. Again, the issue of phone service came up, and the suspicion that she already had a phone, as part of her safety plan. Mom was adamant she does not have a telephone; she stated she was using a neighbor’s phone. Prior to this, Mom had stated she was using the taxi driver as a telephone contact or she was using the home support worker’s cell phone.

The following weekend, September 19th and 20th, the social work supervisor saw Mom along with her “ex” and several of the children at a local grocery store. The supervisor was quite surprised given Mom’s allegations and reported fear of her “ex.” In a prior telephone conversation with Mom about those very issues, the supervisor had heard the home support worker and children in the background and was also of the belief that Mom had phone service. A few days later, the assigned social worker made an unannounced visit to the home. She observed a male enter the home and go to the basement. Mom advised it was her “ex.” Mom did not understand why the agency would be so concerned about her being seen with him. The social worker expressed

concern for Mom's safety in light of her recent statements. Mom advised she is trying to "keep the peace." She stated, "While [Dad] is happy, everybody's happy." Mom went on to say that he had shown up last Saturday, the day they were seen by the supervisor, to take the children for a drive. She was not comfortable letting them go alone with their dad and felt it best if she went along. Later, she decided to pick up a few groceries. Mom further indicated a court date had been set for October in relation to her peace bond application and that she intended to follow through with that. She indicated that, in the interim, she would allow for contact to "keep the peace." The social worker advised Mom that it was difficult for the agency to complete a safety plan if she is choosing to facilitate contact with a man she is afraid of. Mom said she would contact the police if there was a problem.

During this same visit, the social worker noticed two telephones, however Mom said they are not in service and are just used by the children for play. As the worker was leaving the driveway, Mom indicated she had made arrangements with her taxi driver, who lives across the street, to call over if he saw the front porch light on. The social worker asked what he would call on and Mom's response was that he often loaned his cell phone to her. Again, the worker gave Mom the opportunity to verify having her own phone but Mom insisted she had been using her next door neighbor's. Mom went on to give the name and phone number of her neighbor. The social worker was unable to find any listing for that name or any association of that name to the number given.

The social worker held a case consultation with her supervisor and the Regional Director on October 9th wherein it was determined and documented that the most prominent concerns were: the telephone issue, and the contact Mom was still having with her "ex" in her home and in the community. The supervisor was to make arrangements for a historical file review. A case conference was scheduled for October 15th. The social worker also contacted the courthouse by telephone and was advised that Mom had withdrawn her peace bond application in September. This was in direct contrast to the information Mom had given the social worker during the last home visit.

Prior to the case conference of October 15th, contact was made with the school to determine how the girls were doing so far this year. Staff reported there had only been one incident involving Mary lying thus far and nothing involving Jane. The school also reported having no emergency contact numbers on file for Mom.

During the case conference, the behaviours of the children were discussed. It appeared Adam was doing well in school, mainly because it was a structured environment. Mom said she continues to experience problems with him at home. Overall services to the family were discussed and it was agreed these services would continue. (CRMS notes dated 2003-10-15.) When Mom was questioned about the peace bond, she was adamant she had not withdrawn it. The children's safety was discussed and Mom was unable to provide any concrete examples about Dad harming his children. In fact, she indicated he

would never cause harm to the children. Mom continued by saying she was uncomfortable discussing details about her “ex” today but she was advised it would need to be explored in the future as it was relative to the case. The issue of the telephone was raised yet again and Mom would neither confirm nor deny the existence of same. She stated she did not know what the significance was anyways. The socialization concerns for the children and the safety concerns were outlined to Mom and while she would not confirm having a phone, she did say that in the past, she did not want the children to have the number for fear they would give it to their dad. Mom went on to say the school had the number for her home support worker as well as the taxi company she uses should an emergency arise. Mom was told that visits to the school by the social worker to see the children would now be happening on a more regular basis. Extra living space in the house was discussed with the proposal that two new bedrooms be added in the basement. Mom said she had lived there with the children for four (4) years and preferred not to move. The housing agency had already been contacted about the addition. Mom also indicated at this meeting that she was having difficulty with Luke at school and said he was recently suspended for skipping classes.

On October 20th, the social work supervisor reported she had received a call from Mom after last week’s meeting saying she had to “clear her conscience” and report that she does have a telephone. Mom did not want her “ex” to have the number. The day following this revelation, the school reported to the social worker that Mary was once again stealing items. A similar report was made again the next day. On October 22nd, Mom brought Mary to the agency office where the social worker discussed the stealing behaviours with the child but reached no resolution.

On November 6th, the social worker received a call from an official with the housing authority who had made a home visit two days earlier to assess the need for additional bedroom space. This official was reporting the strong smell of urine in the girls’ bedroom. She also noted that Jane and Mary were sharing a very narrow single bed. When the official asked Mom about the smell, she was advised one of the girls had wet the bed in the past. Mom also asked if it could be the air freshener she smelled. The housing official stated it was definitely the smell of urine. She was now advocating to the social worker on Mom’s behalf for a new bunk bed set and new mattresses for the girls. The official was told that she would have to speak to DHRE on Mom’s behalf as this agency could not provide funding for same. The social worker did consult the case file and noted that the previous social worker had commented on this same issue regarding the smell and the need for new beds on March 7, 2003.

On November 19th, the social worker made a school visit to talk to the girls. One of them was at home on this date with a sore throat. The other girl was asked about school and home. The interview revealed that her brother gets in trouble at home and when one of the children gets in trouble, they must have a timeout in their rooms sitting on their beds. Overall the child talked about bedtime and playtime, sharing a room with her sister and enjoying time with her

dad. -Following this interview, the social worker also asked school staff about one of the other children and was told he was suspected of breaking a car window and he had been reprimanded for beating up a door at school.

An unannounced visit was made to Mom's residence immediately following the school visit. The social worker noticed a great deal of clutter, especially in the kitchen. Mary was very quiet on this day. The worker asked Mom the status of the peace bond application but never received a direct response. Instead, Mom said she had been talking to the social work supervisor and had requested a meeting with her the following week. Mom also requested that the assigned social worker not attend this meeting. A similar conversation had been captured via e-mail dated 10/31/03. Mom reported her "ex" had left the province but prior to leaving, things had been better between them.

The issue of the girls' bedroom was raised, particularly in light of the housing official's home visit. Mom showed the social worker the bedroom and again, there was a strong smell of urine detected. Mom said she did not even notice it anymore and that DHRE had approved bunk beds for the girls. She continued on to say she was planning on painting the room; the girls wanted it pink and purple. Despite the concerns raised by the school about Luke's activities, Mom said she had no problems with him recently. Both Mary and Adam were seeing counselors and Mom inquired about transportation costs for herself to see a counselor for individual work or group work. Mom had been told services were available for people suffering episodes of depression. The social worker indicated she would find out what resources were available. On November 25th, Mom advised she was expecting another child with Dad.

During the early part of December, several consultations on this file were held between the assigned social worker and her supervisor. Mom had been recommended for counseling and was looking for transportation costs. Several calls and e-mail messages were exchanged to clarify if this was a program suitable to meet Mom's needs. Eventually, it was determined that the mental health services of the agency could address this service need. (CRMS notes dated 2003-12-11.) When Mom was advised of this development, she was not interested in the service. During the same phone conversation, Mom asked about the availability of a Christmas hamper for the family. When a particular provider who supplied hampers was suggested, Mom said they were small and not really enough for her family.

On December 18th, referral thirty (30) was received concerning Jane who reportedly had a swollen lip. The assigned social worker had been away on training and did not get the telephone message until the following day. When asked by school staff, Jane indicated she fell on the school steps and that the home support worker had witnessed her fall. The social worker attended at the school on December 19th and was told the same information. She was also told that it happened while Jane was on her way to music class. The fall had not been reported to anyone. The home support worker, who happened to be at the school with Mom on December 19th, as there had been a report of Jane stealing,

stated she did not see the child fall. The home support worker did say she was at school the previous day delivering lunches about the time when Jane said she would have seen her fall, but she definitely did not witness anything. It was possible that Jane thought the home support worker saw her fall. Mom stated she was treating the cut lip with ointment and could not get a doctor's appointment. Jane appeared robot-like in front of her mother during the school visit. It was difficult to determine if Jane's account of the incident was accurate. The social work supervisor was apprised of the situation and she advised the assigned social worker not to treat this as an official referral but rather as a routine visit as a result of the school's concerns.

2004

Luke Brent	Jane Adam	Mary Mark
-----------------------	----------------------	----------------------

On January 9th, the school reported that since Jane and Mary returned from their Christmas break, they had started stealing again. The social worker wondered if there was an ISSP in place at the school. The staff person was going to check on same. Although there were various services in place to address the stealing, the pattern of starting and stopping the activity continued. There is no other information on file related to this report from the school. Mom called on January 13th to determine if the upcoming case conference was going ahead. She stated she had developed a recreation room downstairs where the children could play. When asked if she had purchased new bunk beds for the girls, she said she had not, as nothing could be found at a reasonable price. Apparently, DHRE would not provide any more than \$400.00 to meet this need.

A case conference scheduled for January 14th had to be rescheduled to February 11th as there were issues with the children being home sick and no babysitter available. On January 19th, information was received that Luke had a small mark/scab over one of his eyes. When he was asked about the mark, he reported it happened while he was sliding; it was determined there were no grounds to treat this as an official referral.

On that same day, the social worker made a visit to the school. She spoke with both girls separately and during these discussions she got verbatim information regarding what they had gotten for Christmas and what specific foods they had for dinner. Neither could explain why they were continuing to steal. One of the girls was cold, shivering throughout the interview, but did appear appropriately dressed for winter. Later that morning, the social worker made a home visit. Mom said she was doing fine and the social worker asked her if people knew she was pregnant. Mom stated she was not planning to tell the children; they would find out when she brought the baby home from the hospital. She was asked about the mattresses for the girls and she said she planned to have them soon. The social worker reiterated the importance of same. The worker also noted that whenever she was in the house, Mom appeared nervous. She paced the floor and would not sit and speak with the social worker. Mom appeared to divert questions by asking the children something in an attempt to change the subject.

On January 23rd, the school again reported incidents of stealing. Apparently, while Jane was spending her recess time in the school office, she had taken a hand rosary and prayer beads out of someone's pocket. Jane had been questioned and immediately denied it but later admitted to the theft. School staff noted Jane was emotional and crying during her admission of guilt; this was the first time they had seen her react this way. There was a follow-up meeting involving Mom, and the school indicated the same robot-like behaviour from Jane

when her mother was present. One observer described Jane's answers as "mechanical." Additionally, a teacher had learned that one of the other children was threatening self harm. Later when asked, that child denied this comment. There is no other information on file related to these concerns.

At the case conference held on February 11th, a number of issues were discussed with the supervisor prior to the meeting. They included: the smell of urine in the girls' bedroom and the social worker felt it was much stronger than the smell from an occasional accident; the social worker's concerns about the lack of toys and furniture in their bedroom and she was unsure if it was due to financial restraints or being deprived of stimulation, and the issue of the file review was raised again. The review had been requested but had not been completed to date. Given the case dynamics and history, the possibility of an independent assessor to conduct the review was mentioned.

During the meeting, there was much discussion about the girls' behaviours with respect to stealing. It was mentioned that the girls should stay in school over the lunch break as a form of socialization but Mom expressed concerns about them stealing during that time frame. Some suggestions to combat the stealing included: positive reinforcement for good behaviour; a "buddy" system to help as a deterrent, and joining an organization like 'Big Brothers/Big Sisters'. Another suggestion involved a change in hours for the home support worker so she could spend more time with the girls. Although the idea of Brownies or Cubs had been mentioned to Mom in the past, she stated she did not believe the children would do well there because of the stealing. It was reported that Adam was doing well in counseling; however, Mom said there were still significant behavioural concerns at home. She also said there were concerns with Luke's behaviours. Before leaving the meeting, Mom was asked if she had yet found a bunk bed set but she said she could not find a suitable set within the budget allotted by DHRE. Mom indicated she had bought a second-hand mattress for the girls instead. The social worker indicated her intention to view the mattress during the next home visit.

In February, referral thirty-one (31) was received. Two days earlier, it had been noted by school officials there was a strong smell of urine from one of the girls. She was wearing heavy makeup on that day and reported that her mother put it on her so she would look pretty. One day before the referral, people noticed bruising on the child's wrist and arm. When asked, she said she had fallen down. She appeared sad and had dark marks on the side of her neck and red marks on her hands, eye and cheek. There was some form of glue or adhesive around her wrists. Again, on this day, she was wearing heavy makeup. She said she could not remember where the marks on her arms and wrists came from. Shortly after, it was discovered that her sister had similar marks on her hands and sticky residue on her wrists.

Immediate action was taken to address the referral. The girls would not elaborate on their marks and bruising. The other children were interviewed and confirmed that they had all been hit at various times by their mother. When

hitting them, Mom had used a belt, a broom, her hand or her fist. It was alleged Mom would tape up the girls' eyes, hands, and legs. She would make them sleep without clothes or blankets over them, and they had to sleep on the floor, even in winter and the window was always left open. One child explained how Mom had sometimes tried to choke the girls and had even pushed them through the wall. There were times when Mom grabbed the girls by their throats flinging them around and threatening to kill them with a knife.

According to the children, Mom called the girls bad names and she would laugh when she was doing bad things to them. The girls were not allowed to eat breakfast, dinner, or supper and they were very afraid of their mother. Mom would often make them wear diapers and stand up all night. Many times when the girls were being punished, they had to stand in the hallway facing the wall with their eyes closed. The girls usually had to stay in their room and were only allowed out to go to the bathroom. One of the children said Mom would make them lie and steal things.

All of the children were taken to the hospital for examination and the marks and bruises on their bodies were well documented. Additional details about their horrendous living conditions were gathered over the next several days. The children were temporarily placed in the residence of the home support worker because they knew her well. Subsequently, other arrangements were made about their living accommodations. Mom was arrested and charged. The children were taken into care and were not returned to their mother.

Findings and Analysis

In February 2004, the children from this family were removed from their mother's care. This marked the third time in a thirteen (13) year timeframe whereby Mom had a number of her children removed.

The first apprehension by the Department of Social Services was in November 1993 when Mom's children, Brian, Sandra, and Tommy, from her first relationship, were taken into care due to neglect. Custody was subsequently awarded to their father; Mom had no further contact with these children. During 1995, Jane had been admitted to hospital twice for failure to thrive and it was during her second admission that doctors found unexplained and untreated fractures. In December 1995, Luke, Jane, and Mary, the children from Mom's second relationship, were apprehended.

While there were numerous concerns prior to the second apprehension in December 1995, most were addressed by service providers in an appropriate and timely fashion. It should be noted that whenever Mom had contact with medical professionals during 1995 and prior to this date, she always led them to believe that all of her children were at home, purposely concealing the fact that three (3) children had already been taken from her care. Following the 1993 apprehension, the two babies had been left with Mom; officials believed there was a different standard of care being given to her ex-husband's children when compared to the children of her second relationship. A family support worker was assigned to monitor the care provided to Luke and Jane but by the end of March 1994, it was determined that her services were no longer necessary. There were DSS interventions with the family during 1994 but the social worker determined there was no significant risk to the children. There was another trend noted by social workers during that time whereby Mom gave her youngest son more attention than she did her daughter, Jane. Another child, Mary, was born in 1994. During 1995, there were many contacts with the family; however, most came from the medical community and were centered on Jane's health issues. The majority of the deficiencies identified in the file occurred during the years from 1996 until 2004, while the children were in care and then subsequent to their return home. This section of the report will largely focus on that period of time.

Through the course of this review, paramount for the OCYA to consider was the following question: *"Given that the family was receiving extensive services from frontline government agencies, could the extent of parental abuse have been prevented?"* The investigation revealed multiple opportunities whereby service providers could have become aware of the mistreatment of these children much earlier.

There were three (3) separate noteworthy observations made by different people involved with the family that seemed to summarize the uneasiness

service providers had with this case. Ironically, all of these statements were made one year prior to Brian, Sandra and Tommy being apprehended or during the time that Luke, Jane, and Mary were in care. At a minimum, these prophetic statements can be considered foreshadowing of the events that unfolded but they were also early warning signs that were largely downplayed or ignored. These observations were:

(1) Just over one year after referrals began about this mother and her children, a family support worker's notes indicate: "A gut feeling suggests things are not as they appear." (Case notes dated August 31, 1992.)

(2) In a letter from Dr. One to the family doctor dated February 1996, he noted: "[Mom] has at various times fooled all of us and including myself and she certainly appears to be a highly motivated and interested mother but the facts would caution us otherwise. I'm sending copies to all the people involved as I think that this is a very serious problem and I think it's a grave danger for [Jane] to go back into this household."

(3) In November 1996, as part of an independent assessor's determination about whether the children from Mom's second union should be returned to her care, the assessor reportedly commented that: Mom has had multiple children, multiple chances, and multiple resources. (Minutes of case consultation with Dr. --- November 1996.)

Following the 1995 apprehension of Luke, Jane, and Mary, the children were thoroughly examined by medical personnel. Jane was found to have significant bruising on various parts of her body as well as five (5) very serious fractures of bones that could not be explained and had not been medically treated. These old fractures were at various stages of healing and, according to the attending physician, they would have caused a lot of pain. As part of the police investigation that followed, one specialist, in his written correspondence to police, dated June 1996, stated, "...the fractures were consistent with child abuse and would suggest that this child has been subject to repetitive trauma."

Following the eventual removal of the children in 2004, this same doctor gave testimony in court. Some of his observations concerning his examination of Jane eight (8) years earlier included:

This is a battered child. This child has been subjected to injury on a repetitive basis. This child is being tortured. I cannot believe that this child could have these many fractures and it not be apparent to a caregiver. It just simply is so improbable as to be impossible. There is no question that this child, by December of 1995, was in a precarious position and yes, I would go as far as to say her life was in jeopardy. This child was nutritionally deprived. This child was being subjected to blunt force injury. (Testimony 2004.)

There is no indication from the file review that this doctor's original findings of 1996 were taken into account following completion of the police investigation

during that same year. In fact, there is nothing to indicate that his findings were passed onto DSS by the police; however, social workers did have documentation from other doctors in 1996 that spelled out their many similar concerns.

In June 1996, the children's family doctor indicated that they (Luke, Jane, and Mary) had "returned to normal development" while they were in care. Two other attending physicians had expressed in writing to DSS their serious reservations about returning Jane to her mother. A summary of the comments from Dr. One concerning his follow-up contact with Jane include: "...child shouldn't go back" (January 1996); "Unbelievable recovery...grave danger for child to go back" (February 1996); "...child should stay in foster care" (February 1996); "...this child should never return to the mothers home on a full time basis" (May 1996), and "...I sincerely believe that [Jane] is at danger in this home and that she should not be returned" (June 1996). Over the course of 1996, while the younger children were in care, they thrived, particularly Jane, who had been found in the direst condition. The fact that the children thrived in a nurturing environment was yet another indicator that cemented the medical theory of neglect and malnutrition. The strong opinions expressed by medical doctors were not given sufficient weight in subsequent decisions made about placement of the children. Despite there being pleas from the medical professionals not to send Jane home, DSS forged ahead with reuniting the family.

Adding to an already unsettled home environment was the addition of a new baby in 1996. In correspondence dated November 13, 1996, the assigned social worker wrote to her supervisor and stated, "I acknowledge that the safest route in this case would be to place the baby in foster care." Shortly after, her supervisor wrote her own misgivings about the baby going home. "...I am not so sure if this is the best plan (baby being with Mom) for this child." The assigned social worker did acknowledge this was a high risk situation which would require extensive child protection involvement. She further stated that for the plan to work, this family would have to take priority over everything else in her caseload. She was prepared to make the commitment and she sought the support of her supervisors. Despite there being significant trepidation about Mom taking the baby home and Luke, Jane, and Mary returning home, which was well documented in the file, DSS officials failed to follow their own agenda of ensuring the children's safety. Any planned collaborative or dedicated efforts fell short of genuinely dealing with the children's needs and became less focused on the children as time went on.

In the same correspondence dated November 13, 1996 to her supervisor, the social worker had written:

These services [home support and nursing services] would be reviewed on a monthly basis with the expectation that a decrease in hours would be possible within 1 to 2 months. I would not see increasing services because any difficulties would likely result in the child [new baby] being placed in foster care.

In February 1997, Luke was the first of the children returned home following their apprehension in December of 1995. Only three (3) days following his return, services to the family were reduced. This was indeed a time when social services needed to be more vigilant; these early days of reunification could have proven stressful for Mom, especially with a new baby at home. Also contradictory to the proposed plan was the 100% increase of home support hours in the following year with no review or assessment of the “difficulties” underlying the need for additional hours. These additional hours came at Mom’s request. Ironically, a number of professionals, including Mom’s private counselor, had stated Mom was progressing well and making positive changes in her life. It would not be considered standard practice to increase support services when a parent is doing well; yet, with this mother, it appeared to be the norm. The OCYA was unable to ascertain why.

During 1996, efforts should have intensified in overseeing and recording Mom’s interactions with her children. At this point, Mom’s children from her first relationship had been apprehended permanently from her care in 1993, and her children from her second relationship had also been apprehended in 1995. Twice in her case notes within a four (4) month period early in 1996, the social worker stated that case recording had not been done or it had been neglected. Heavy caseloads may have sometimes prevented social workers from regular note keeping; however, given the history of this case and its current circumstances, having comprehensive notes should have been considered vital. The OCYA was advised by another social worker that she was not good at documentation and had not been for almost two decades but no one had ever held her accountable for lack of record keeping. She commented:

I should have been raked over the coals, but I wasn’t, and I was allowed to work for 17 years... and there’s probably other cases that aren’t documented well either, and I should have been held accountable for that and I wasn’t. Maybe had I been, I either wouldn’t have been there to do that work, I would have been fired, or I would have been a better worker... (Transcript of OCYA Investigation interview, 2011.)

Additionally, it was not always clear whether the social workers consulted with their supervisor on a regular basis. DSS 1993 Child Welfare Policy and Procedures 02-08-06 indicates that: “all case recording respecting child abuse/neglect investigations shall be signed and dated by the social worker and be read, signed and dated by the supervisor.” When this file was initially active, there were thorough handwritten case notes in the early years. However, for the critical years following the children’s return home in 1997, file documentation by various social workers was inconsistent, incomplete and sometimes, nonexistent. There were actual referrals that were not recorded and had no followup completed. This contravened DSS 1993 Child Welfare Policy and Procedures 02-03-02 which states: “Referrals on active cases must be recorded on the active case referral Form 14-635.” The same policy further 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 a file as extensive as this one, record keeping and followup should have been primary considerations.

Part of the rationale for returning Luke and Mary to the home was that Jane, the child most affected by the neglect and physical abuse, would be placed for adoption. The file reflects that as the time drew nearer for a decision to be made, the less interest Mom had in this option. When she dismissed the idea outright at a case conference on January 31, 1997, there was no further mention about the adoption strategy. This was one of many examples in the file wherein Mom seemingly took control of managing her case; as a result, ‘the best interest of the child’ was not paramount.

Luke, Jane, and Mary spent almost two years in care and were returned to their mother at varying intervals during 1997. For almost seven (7) more years, the children suffered at the hands of their mother, enduring physical and emotional pain. While Mom was ultimately responsible for neglecting and abusing her children, especially her daughters Jane and Mary, the length of time these children were exposed to their oppressive living conditions could have been significantly reduced. According to DSS 1993 Child Welfare Policy and Procedures 02-03-01, “Assessment is a structured process which includes the thoughtful integration of fact and observation. It is the means by which all known data from significant sources are weighed.” With thirty-one (31) official referrals received and sixty-seven (67) additional pieces of information that were concerning or could have been referrals, one would think that a critical review and clinical analysis of the file would have been done long before that third removal in 2004. Unfortunately, for these children, it was never done.

As previously mentioned, file documentation should have been essential following the return of Luke, Jane, and Mary to their mother’s care. DSS should have been able to depend on comprehensive case notes as a barometer of oversight. For almost three (3) critical years after their return, very few case notes could be located. During this review, efforts were made by child protection officials to retrieve any existing documents for this time period but none could be located. This particular lack of documentation made it difficult to determine if reunification efforts were being overseen or solidified. Additionally, thirteen (13) social workers in total, an average of one per year, had been assigned responsibility for this family. While some were experienced in their field, others were new to social work practice and a case like this had the potential to quickly overwhelm any worker. The OCYA is of the opinion that cases of this magnitude should only be assigned to experienced social workers who are skilled and knowledgeable in the dynamics of abuse and the victimization cycle. This approach is also in keeping with the spirit of the policies and protocols in place.

DSS Child Welfare Policy 02-03-01 outlines the process of an investigation in its three (3) phases: 1) intake; 2) information gathering, and 3) assessment. The policy clearly states:

The social worker must gather information from as many relevant and appropriate sources as possible. Expertise on

the part of the investigating social worker in acquiring information during the initial investigation phase is essential since it is this information which provides the factual basis for completing the risk management process.

Even with standards and policies in place, each social worker had his or her way of approaching this Mom or her children. While each social worker's strategy in responding to a referral should have been standard, oftentimes it was not. These inconsistencies generally benefited Mom's agenda. While there will always be differences in individual style and understanding, each social worker must have a good grasp of the basics: information gathering; documenting findings; assessing risk, and making clinical judgments. Any missed steps, accidental or purposeful, would likely lend to a negative outcome for the child(ren) involved.

At a time when monitoring of the family should have intensified, namely after September of 1997 as there were now four (4) young children in the home, it seemed this was the very time when the fewest safeguards were actually in place. Luke had returned home under a six (6) month court imposed supervision order while Jane and Mary were each returned under a one year supervision order. DSS 1993 Child Welfare Policy and Procedures 02-03-05 relating to a child in need of protection who remains in the home with court ordered supervision states: "The social worker shall monitor the case through regular and frequent in-person contact with the child and family." All of the preparatory work and discussion of 1996 about whether the children should return home was negated as the monitoring of their environment did not live up to the plans that had been outlined or to the standards in place.

One of the main strategies proposed for monitoring the home environment was the placement of a home support worker to assist with the care of the children. Her initial involvement was for twenty (20) hours per week and as outlined in the social worker's correspondence of November 13, 1996, her role was defined as "providing support with child care and housekeeping in addition to ongoing monitoring of the quality of care." The home support worker would be told only the basics of the DSS concerns and the observations she would need to make. (Case conference November 15, 1996.) It is unclear from the file if the home support worker was properly informed, trained, or skilled to monitor this family. Attempts by the OCYA to locate this witness were unsuccessful.

While the independent assessor in 1996 had recommended a level of 'extremely heavy monitoring' should the children be returned home and Mom be permitted to keep her baby, his caveat was: only if [Mom] admitted responsibility for abusing Jane. This never happened. He went on to say that officials should consider three (3) years of in-depth treatment for [Mom] with sustainable progressive gains to reduce the risk. There appears to be a major discrepancy in what the assessor was intending as heavy monitoring and what DSS officials actually defined it to be. Correspondence from the DSS District Manager to the Regional Manager on November 28, 1996 suggests the original assessment was interpreted differently by DSS. He wrote, "The funding requested will provide a

very high level of support to this family, and will also ensure an 'extremely heavy monitoring' of this case, as suggested by Dr. ---." The funding requested had been for contractual nursing and home support services. In decision-making by DSS, it seemed the monetary issues took priority over the assessor's concerns of protecting the children.

In 1998, the home support worker's hours were doubled to forty (40) hours per week. This increase came shortly after she was fired by one agency and began employment with another. Again, file documentation was scanty but it appeared there had been two complaints made against this woman during 1998; only one was documented. It is believed these two complaints formed the basis of her dismissal. Correspondence on file suggests that DSS lobbied to have her return to Mom's house, through the second agency, as Mom had repeatedly stated she did not want to work with anyone else. For the major portion of the seven (7) years from 1997 until 2004, the same worker provided home support to this family. Most significant about her years of being inside the home was her inability to express to DSS the unhealthy environment in which the children were being raised. As previously stated, the social worker's proposal to her supervisor (correspondence dated November 13, 1996), outlined the expectations of the home support worker requiring that "...provide support with child care and housekeeping in addition to ongoing monitoring of the quality of care." Ironically, the home support worker was supposed to monitor the quality of care for the children but there seemed to be no monitoring of the home support worker's quality of service.

Following the referral and subsequent removal in 2004, the home support worker told social workers how she was always suspicious of Mom's treatment of the children but she had no proof. Despite saying this, she admitted to seeing Mom smack the girls in the mouth and smacking all of the other children with her hand. In the past, she had seen fingerprints on Jane's face. She thought the hitting was constant with the girls but less frequent with the boys. This home support worker thought the children were threatened too much and were too afraid to tell the truth. She also suspected that Mom was making the girls lie and steal. For two years, she witnessed Mom putting Jane and Mary in the hallway, facing the wall with their eyes closed, every school day after they finished their lunch. The home support worker was never inside the girls' bedroom nor would she use the washroom in the home. All of this information would have been significant for the social workers to know but unfortunately for the children, it came to light after their final removal. Based on subsequent statements made by the children, they were quite bitter about this home support worker's complacency as they believed she had witnessed "bad things."

What could have and should have made a difference, if they had been critically reviewed or even read, were the notes of the replacement home support workers whenever the regular worker was on leave. The notes were vastly different in content and tone – to such an extent that they could have been actual referrals. One replacement worker, there for less than a week, made some of the following notations:

...the children would sleep outside if Mom had her way;
 ...the children eat outside even when it is raining; ...[Jane]
 sits outside for seven (7) hours with nothing to eat or drink;
 ...Mom seems cruel to [Jane] and shows her no love, and
 Mom emotionally abuses [Jane] and is very capable of
 physical abuse.

The file does not reflect any type of intervention or response to these disturbing concerns that were being expressed in writing by the replacement home support workers. With respect to the regular support worker's notes, they were almost a carbon copy from day to day, month to month, and year to year. They outlined what the children did after school (homework or watched TV), whether the children were inside the house or outside, transportation to appointments or school, and where they went shopping. The mundane, innocuous, and repetitive nature of her written logs said very little about Mom's interactions with the children or the quality of care being provided.

Another noteworthy, but unsettling, feature of the regular home support worker's documentation was the food the children ate. Their meals were often take-out or they visited a restaurant. At home, they consumed french fries, hot dogs, frozen pizza, canned pasta or canned meatballs. In particular, Luke practically lived on junk food often turning down what was offered in favor of potato chips or candy. It was quite evident from reading the home support worker's notes that the nutritional needs of the children were not being met. When one social worker was asked if the children's diet would have caused any concerns, she responded, "Probably not. It was the lifestyle of a lot of families; as long as the kids were eating." (Transcript of OCYA Investigation interview, 2011.) Following their removal in 2004, almost all were suffering from iron and vitamin deficiencies. Clearly, the original intent of home support services lapsed as the safeguards were not structured, fine tuned or maintained.

The second component of the 'extremely heavy monitoring' was the nursing services provided to the family. By all accounts, the contractual nurses and the Public Health Nurses carried out all the functions pertinent to their role. They visited the home, provided advice to Mom about childcare and nutrition, and they monitored the weight of the children whenever it was deemed necessary. One PH nurse in particular was quite involved and while she initially had to invite herself to be included in case conferencing, her efforts to advocate for the children and lobby for a collaborative approach were commendable. Following her inaugural meeting, she often learned of subsequent case conferences from Mom or the home support worker. Despite there being little contact from the social worker or notifications about any upcoming case conferences, she always made it a point to contact the social worker with any information that came to her attention. In addition, her case notes were succinct and informative. The file review completed by the OCYA could find no significant gaps in the service that was provided by the nurses assisting this family.

In addition to the help provided by the nurses, a substantial amount of information was forthcoming over the years from the schools. Officials there were seeing these children almost daily. They made ongoing reports to the social workers about the children's appearance of being unkempt and sad looking, the girls presenting as having no affect, and their reoccurring bruises or injuries. The issue of stealing and hoarding of food by Jane and Mary was a regular occurrence that was also reported numerous times. Only on rare occasions did these reports get treated as official referrals. School officials participated in phone calls, visits by social workers, and case conferences. They also noticed a connection in 1999 between Jane's absenteeism from school with the appearance of bruises upon her return. This was well documented and the information forwarded to the assigned social worker. Noted in the review was the unusual step taken by the school when they wrote directly to the family doctor in the year 2000 about their concerns for Jane. It appeared they were more than prepared to report their findings but the level of recorded responses did not seem to match their concerns. Based on the file review, the schools were relatively proactive in their approaches but often overwhelmed by the behaviours of the children. In retrospect, it is evident these behaviours were a manifestation of other problems as well as a carefully orchestrated diversion by Mom to veer away from the real issues.

There was a trend noted throughout the review that if Mom did not get the service she requested or did not get it as quickly as she thought she should have it, there would be some type of critical incident involving one or more of the children. It was also readily apparent that whenever the spotlight was on Mom's behaviour, she deflected it onto the children, especially Jane and Mary. The girls' habit of stealing and hoarding food was a constant challenge for school officials and the social workers involved. As Jane and Mary would initially lie about the activity, it would reinforce Mom's assertion that nothing they said was believable. It seemed this strategy was preemptive on Mom's part to divert attention away from the abuse and neglect in the home. As a result, whenever the girls were asked about any activities at home, their responses could be considered questionable. By having Jane and Mary come home from school for lunch, it increased the opportunities for Mom to exercise her control over them and instill more fear. Whenever the girls were in their mother's presence, their behaviour was described as "robotic", "military-like", "standing at attention", and their responses "programmed." These solid indicators of fearfulness were witnessed by numerous officials, including social workers who repeatedly documented these concerns.

There was a clear correlation between the behavioural issues of the children and the continued services from the department. One of the social workers interviewed during this investigation commented, "[Mom] seemed to be able to call the shots from the Director of Child Welfare down." (Transcript of OCYA Investigation interview, 2011.) As time went on, Mom increased her demands for service from CYFS. The family was growing and the requirement for more services grew with each additional child. By 2001, there were several young children at home. Mom was seeing two counselors – one, a private

therapist, whom she saw for over seven (7) years; the children were seeing counselors; the children were registered for daycare or summer programs; there was homecare; there was respite care; there were increasing medical issues and appointments; tutoring services, and taxi service was a constant in all of this. In any given month, there would be several trips for various appointments. One social worker noted in her statement that it became almost a joke around the office – "...if [Mom] needed to go to the bathroom, we'd send her in a taxi." (Transcript of OCYA Investigation interview, 2011.) Since child protection cases were to be given the highest priority in the provision of services to children (DSS 1993 Child Welfare Policy and Procedures 02-01-01), a heightened standard should have applied to this family. Unfortunately, it seemed that many of the supports implemented reinforced Mom's dependence on the system as opposed to addressing the protection of the children.

Another trend noted in the review was how Mom added demands whenever a new social worker took over; it appeared she was continually seeking to control the services provided. As any given worker was not assigned for a lengthy period of time, the lack of a consistent presence only exacerbated the children's situation. It also seemed apparent from the OCYA file review and the interviews conducted that there was no formal mechanism in place to transfer the file from one social worker to another. It happened on an 'ad hoc' basis, often not documented, and that lack of standard fed the lack of a coordinated response. One social worker who took over at a critical time said the file was just handed to her. According to DSS Child Welfare Policy 02-08-04, whenever a file transfers from one social worker to another (within the same office), a full case review with both workers and the supervisor will take place. There is no documentation on file to indicate these full case reviews took place for each transfer nor was any such information revealed during the interview process. With the volume of information that constantly grew in this file, it would be difficult to strategize case planning or to make assessments if one were not properly and consistently apprised of the past.

The minutes recorded from twenty-three (23) case conferences held over an eight (8) year period from 1996 to 2003 provide an overview of the items discussed. These mainly included: medical appointments; daycare; transportation; housing; social activities; school, and the children's behavioural issues. During only one of these case conferences was Mom ever asked directly and specifically about bruising on Jane. Considering that there were ninety-eight (98) incidents that did or could have caused concern, it appeared Mom was not taken to task in any meaningful way about the referrals on her children. Continuously, Mom's explanations of bruises or injuries and the explanations of her children, even though their versions often changed, were accepted by the people asking.

Given the overall history of this Mom's parenting skills and having had several children removed from her care due to maltreatment, with three (3) being returned, it was incumbent upon the social workers to complete thorough assessments. While there were numerous home visits and school visits,

assessing the totality of information, interviewing the children, and examining the condition of the children's environment were all critical steps to ensuring protection. These steps were not always taken. DSS 1993 Child Welfare Policy and Procedures 02-03-05 indicates that for children in need of protection who remain in the home: "the social worker shall maintain regular and frequent in-person contact with the child and family." For the critical incidents in this file, the OCYA review did not find this policy was consistently followed.

The DSS 1993 Child Welfare Policy and Procedures 02-03-03 relating to Investigations and Information Gathering indicates that:

Where abuse/neglect is suspected, the initial steps in the investigation shall include: completion of the Initial Safety Assessment; seeing the child alleged to have been abused, and interviewing the child; in-person interview with the child's parent(s) or caretaker(s); in-person interview with the siblings, and a home visit to see where and how the child lives.

Even when formal referrals were being received, there was often lack of adherence to this policy.

Section 4.(2) of the 1990 *Child Welfare Act* sets out the factors to be considered when determining the 'Best Interests of the Child'. A partial excerpt from that section includes:

a) the right of a child to love, affection and understanding; b) the right of a child to an environment to stimulate and encourage his or her development; c) the necessity for appropriate care or treatment or both for mental, emotional and physical health of the child, and d) the love, affection and ties that exist between the child and each person to whom the child's custody is entrusted, each person to whom access to the child is granted and where appropriate, each sibling of the child.

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:

1. 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.
2. States parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States parties shall ensure that the institutions, services and facilities responsible for the care or protection of

children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision. (UNCRC, Article 3, 1989.)

While many services providers were involved with this family, it appeared there was no concerted or collaborative effort to always initiate responses that were in the best interests of the children. As reunification of families is not always the answer, all options for a child's care should be considered.

There is no doubt that an effective information management system would have assisted the social workers in reviewing the historical data pertaining to the case. Given the profile and dynamics of this family, important information was not readily available as the case moved forward and passed from one social worker to another. With the introduction of the computerized CRMS launched in the year 2000, it was expected that such a system would alleviate some of these issues. In the early stages, CRMS had growing pains and limitations which continued to hinder the search for and the retrieval of historical information. In the absence of the electronic medium, valuable insight and understanding would have been gained if there had been good communication and debriefings amongst the workers. It appears, in most instances, the in-person communication was lacking and therefore did not meet the standards for best practice.

In addition to the lack of documentation, it should be noted there were numerous times during the investigation where dates of occurrences were recorded erroneously or not recorded at all. In fifty-eight (58) sheets of medical records relating to one of Jane's hospital admissions, twenty-nine (29) errors relating to 'dates' were found. Fourteen (14) times, the year was written as 1994 when it should have read 1995. Fourteen (14) times, the date was written as 1994 but it was crossed out and replaced with 1995. One entry in 1995 actually read 1990. Also confusing was the lack of consistency in how various agencies recorded dates. It would be simple to understand a date that read 01/01/01; however, if trying to capture an occurrence dated 03/04/05, unless the fields of day/month/year were also clearly shown, it would be difficult to make an accurate determination about the date. Some of the agencies involved recorded the month at the beginning of their date field while others recorded the month as the second entity within that field. It was not always clear if the day or year came first in many cases. Also noted was correspondence from various sources whereby no date whatsoever was recorded on the official document. These included: a medical specialist's report on Jane; a letter from the family doctor to another specialist; a letter from one community health board to another community health board, a letter from the RIHA and a community health board to the Newfoundland and Labrador Housing Corporation, and a letter from the Department of Social Services to Jane's foster mom. The lack of consistency when recording dates or the omission of basic information served to further highlight systemic problems with record keeping. For any person assigned to conduct a file review, the lack of accuracy and consistency in documentation

could hinder how expeditiously and efficiently a child's needs would be addressed.

During the OCYA investigation, a number of interviews were conducted. One manager suggested that while there were many referrals and reports based on suspicions, these incidents were often treated as collateral information in an ongoing case. One social worker indicated that many of these reports were vague; they could not be substantiated; there were no clear disclosures; the children would recant, and there were no witnesses to the events. Another social worker stated that many of the letters received and reports made were "...treated as ongoing concerns of the same nature that had been going on for years." (Transcript of OCYA Investigation interview, 2011.) In actual fact, if DSS 1993 Child Welfare Policy and Procedures 02-04-05 relating to Risk Management had been followed, these collective and cumulative suspicions would have been viewed differently. That policy stated in part: "Repeated, unsubstantiated reports may also suggest that maltreatment is present but that it may not have been clearly discernible during previous investigations." The OCYA was advised that a lot of weight was placed on disclosure as social workers were using an evidence-based practice. As reports on these children were ongoing, that practice clearly left them at risk and unprotected. Whenever a new occurrence was reported, the risk to the children was being compounded. Many social workers voiced an opinion that they felt uneasy about this case yet it appears they failed to thoroughly explore the reasons for their own suspicions. No one truly made a conscious effort to critically and clinically review all of the documentation at hand. In the discipline of social work, especially in the absence of policy, clinical judgment is often required. One must combine the static information on file with the dynamic elements to ensure a critical analysis of many cases. Since the prevention of child maltreatment is one of the basic principles of social work, clinical judgment was vital; however, it was sadly lacking in this case.

It appeared services, particularly after 1997, were tailored to fit Mom's needs; the protection of the children was secondary. When one of the social workers questioned the limitless resources available to this family, she was told, "They would continue as the decision had been made to return the children and we have to make it work." (Transcript of OCYA Investigation interview, 2011.) This social worker went on to say that Mom only wanted one particular home support worker in her residence; other replacement workers had heard rumors and supposedly made up their minds about Mom before they began work there. The social worker explained that this led her to believe the content in their reports may have been exaggerated. As confirmed by some of the interviewees, there was far too much reliance placed on the regular home support worker to fill numerous gaps. The expectations placed upon this person, who was ill equipped to begin with, were not in keeping with the intent of her presence there. As described by one social worker, this home support worker was deemed to be the "eyes and ears" for DSS and if there had been anything untoward happening, it was believed she would have reported it. The social worker went on to say "...she was all we had; it was the lesser of two evils." (Transcript of OCYA Investigation interview, 2011.)

The private therapist who saw Mom for over seven (7) years continually provided positive feedback to the social workers and their supervisor. It appears she did this without knowledge of the numerous ongoing referrals or the concerns being expressed by other professionals who were involved. The therapist also had limited exposure to Mom's interactions with her children and based on file information, she made one home visit during those seven (7) years of therapy. The counseling sessions seemingly became a place for Mom to vent as the therapist took on the role of advocating for Mom. The opinions and assessments provided by the therapist appeared to be largely based on Mom's self-reporting. This investigation revealed these sessions did not appear to meet the criteria for "in-depth treatment" as prescribed by the independent assessor in 1996; yet, DSS officials gave considerable, but undue, weight to the feedback provided by this therapist.

What was needed in this case was a team approach; however, the reality was very different. The primary home support worker operated in isolation. The private therapist largely operated in isolation. The Public Health Nurses provided a specific function and did what they were asked to do. Many doctors expressed their very serious concerns about Jane, yet it is unclear what consideration, if any, was given to their correspondence. School officials were contacting child protection workers on a regular basis to relay information. Social workers should have been documenting clinical findings and following policy more closely. File reviews were not in keeping with the high service needs and demands of this case. Most importantly, the children were not being seen or heard to the extent they should have been. In the same manner that each referral was being compartmentalized, so too were the agencies. There are a number of program areas that work with a vulnerable population and the ability to communicate and collaborate when child maltreatment occurs is critical. There was insufficient collaboration, communication, review, and documentation to suggest this was a true team approach.

The OCYA investigation garnered insight on how the family received services from the most involved government agency, whether it was named the Department of Social Services, Department of Human Resources and Employment, Health and Community Services, or Child, Youth and Family Services. Examination of the factual circumstances related to this family revealed several key findings which caused the children to remain in an abusive environment.

In summary, the key findings are:

- Lack of adherence to policy.
- Risk Management protocols not utilized.
- Insufficient professional collaborative practice.
- Insufficient internal communication.
- Insufficient documentation and clinical recording.
- Insufficient safeguards in monitoring the family.
- Inexperienced social workers assigned to high risk cases.

- Lack of standards when transferring a file.
- Lack of case reviews and relevant analysis.
- Lack of clinical supervision.
- Frequent staff changeover.
- Fluctuating internal structure.

Whether an internal process was or was not in existence for the review of sentinel events or critical incidents, it did not happen. The demands of high caseloads, inexperienced staff, and lack of risk management assessments all contributed to the failed optimal goal of protecting these children. The lack of clinical supervision in assessment and decision-making was evident. The service providers, in particular the social workers, were so busy managing the case, the all important element of clinically reviewing the case was lost. The investigation revealed dozens of missed opportunities and multiple flaws within the system.

The primary deficiencies identified in this investigation are:

- Nonadherence to policy or lack of policies.
- Lack of in-depth reviews and analysis.
- Lack of documentation and communication.
- Lack of collaboration amongst the service providers.
- Staff changeover.

These deficiencies saw Jane and Mary, along with their siblings, endure years of suffering at the hands of their mother. It has been clear throughout this investigation that if critical case reviews had occurred regularly, these children would have been removed much earlier from the woman who was abusing them. In Jane's case, she should never have been returned following the apprehension of the children by child protection officials in December 1995.

At all times, Mom denied any wrongdoing and when her children predictably recanted, the matter was closed. A historical file review would have highlighted patterns and behaviours far more telling than any interview. When people associated to this file were interviewed, the common belief was that Mom was manipulative. One witness commented;

There was a perverse dynamic with this mom – she wanted us involved. Just when we (CYFS) would ease off or back away, [Mom] would create a crisis through one of her children. I think [Mom] had children just to abuse them. (Transcript of OCYA Investigation interview, 2011.)

Her comments validated the independent findings of this review. She went on to say that [Mom] fooled some of our best workers and that there were a number of skilled experienced people involved in this file. One of those experienced social workers, upon learning of the 2004 removal, said "I let out a sigh of relief. Thank God [---] wanted to protect his sisters." (Transcript of OCYA Investigation interview, 2011.)

As previously and repeatedly mentioned, service providers were wary about this case and every effort should have been made to explore beneath the

surface. All of the cautionary notes and red flags that continuously punctuated this case should have been given due consideration. Instead, they were minimized in favour of family unity. This was a high risk, high serviced case that cried out for reviews congruent with the ongoing revelations about the children and from the children; their voices were not heard.

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 this and ultimately makes recommendations. After completing a Review or Investigation under the *Child and Youth Advocate Act*, SNL, 2001, Chapter C -12.01, the Advocate may, under section 15(1)(g) of the *Act*, “make recommendations to government, an agency of government or communities about legislation, policies and practices respecting services to or the rights of children and youth.”

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

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

Recommendation No. 1

The Department of CYFS must develop policy to ensure that regular reviews, updates and clinical analysis of high risk cases are conducted.

Recommendation No. 2

The Department of CYFS must develop policy to ensure effective transfer of files occur with joint case review and direct communication between social workers.

Recommendation No. 3

The Department of CYFS must develop policy to ensure that all children in a family are physically and critically observed during a referral and during every home visit.

Recommendation No. 4

The Department of CYFS must ensure proper completion of the Child Protection Report. The Report must be completed at the point of Intake to include all relevant and accurate referral information. The appropriate sections/subsections of the *Act* must be reflected in the Child Protection Reports.

Recommendation No. 5

The Department of CYFS must develop policy to ensure that the Risk Management System is applied consistently for identifying, assessing, responding to, and documenting the risk of maltreatment towards a child.

Recommendation No. 6

The Department of CYFS must develop policy to ensure that whenever a home support service provider is contracted, a written standard of expectations must be outlined and there must be written protocols to ensure accountability. Such services must be monitored and assessed on a regular and definitive basis.

Recommendation No. 7

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 occurs in the areas of 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 must receive case management and clinical supervision training.

Recommendation No. 8

The Department of CYFS must ensure service notes are inputted into CRMS as per the prescribed standard. The standard reads: Client documentation related to a 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. Historical data must also be available to social workers.

Recommendation No. 9

The Department of Health and Community Services must ensure that the four Regional Integrated Health Authorities develop and implement policy to provide:

- (a) all new hires in PH Nursing with training in child maltreatment, clinical documentation, and their legislated duty to report, and
- (b) continuing education in child maltreatment and clinical documentation for all PH nurses.

Recommendation No. 10

The Department of CYFS and the Department of Health and Community Services must ensure that provincially:

- (a) collaborative practice initiatives are developed and advanced between the disciplines of social work, nursing, medicine, and education.
- (b) policy and guidelines reflect ongoing collaborative practice.

Recommendation No. 11

The Department of CYFS and the Department of Health and Community Services must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS and PH Nursing programs, province wide.

Recommendation No. 12

Protocol must be developed with CYFS and the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.

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

Conclusion

It is clearly evident from this investigation that there were multiple social work interventions whereby DSS, DHRE, HCS or CYFS could have responded differently and lessened the time these children were abused. Despite the numerous resources in place, the oversight was insufficient and uncoordinated, thereby allowing Mom ample opportunity to continue parenting in an abusive fashion.

While the social work responses were in keeping with some of the policies, standards and guidelines in place over this elongated time frame, there was also evidence of nonadherence to policies 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 Jane and her family and resulted in the earlier detection of neglect, maltreatment and severe abuse. 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 circumstances of these children would have been recognized and acted upon much sooner, thereby ensuring their protection.

When the last referral was received, the children were appropriately assessed and all the necessary steps were implemented to ensure the children were safe and cared for. The subsequent health care provided and the followup by the service providers ensured that all of the children would have better opportunities for their future.

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, Parent and Child Health Division (1998). *Healthy Beginnings: Supporting Newborn, Young Children and Their Families, Program Plan*.
- 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). *Client Referral Management System - Best Practice Guidelines*.
- Health and Community Services, "...", Child, Youth and Family Services (2004). *Client Referral Management System – Best Practice Guidelines*.
- Health and Community Services, "...", Child, Youth and Family Services (2000). *Client Referral Management System - User Manual*.
- Health and Community Services, "...", Child, Youth and Family Services (2002). *Client Referral Management System - User Manual*.
- Health and Community Services, "...", Child, Youth and Family Services (2003). *Client Referral Management System - User Manual*.
- Health and Community Services, "...", Child, Youth and Family Services (Revised 2004). *Client Referral Management System – User Manual*.

- Health and Community Services, "...", Child, Youth and Family Services (1991-2004). Protective Intervention Files "... *Family*".
- Health and Community Services, "...", (1998). *Healthy Beginnings Program*, 1998.
- Health and Community Services, "...", Public Health Nursing (2001). *Client Referral Management System, Best Practice Documentation Guidelines and Processes, Non Pilot –, Community Health Clinics Healthy Beginnings Program*.
- Health and Community Services, "...", Public Health Nursing (2001). *Client Referral Management System, Best Practice Documentation Guidelines and Processes, Non Pilot – Rural Sites, Community Health Clinics Healthy Beginnings Program*.
- Health and Community Services, "...", Public Health Nursing (2001). *Client Referral Management System, Best Practice Documentation Guidelines and Processes, Pilot – Community Health Clinics Healthy Beginnings Program*.
- Health and Community Services, "...", Public Health Nursing (1991-2004). File Contents "... *Family*".
- Health and Community Services, "...", Public Health Nursing (1998-2004). Medical Reports and Assessments for "Adam."
- Health and Community Services, "...", Public Health Nursing (1994-2004). Medical Reports and Assessments for "Mary."
- Health and Community Services, "...", Public Health Nursing (1996-2004). Medical Reports and Assessments for "Brent."
- Health and Community Services, "...", Public Health Nursing (1993-2004). Medical Reports and Assessments for "Jane."
- Health and Community Services, "...", Public Health Nursing (1992-2004). Medical Reports and Assessments for "Luke."
- Health and Community Services, "...", Public Health Nursing (2001-2004). Medical Reports and Assessments for "Mark."
- Health and Community Services, "...", Public Health Nursing (Revised 2003). *Prenatal Nursing History and Assessment Guide*.
- Health and Community Services, "...", (2003). *Working Collaboratively: A Handbook for Interdisciplinary Teamwork*.

“---“ Hospital. Medical Reports and Assessments for “Adam.”

“---“ Hospital. Medical Reports and Assessments for “Mary.”

“---“ Hospital. Medical Reports and Assessments for “Brent.”

“---“ Hospital. Medical Reports and Assessments for “Jane.”

“---“ Hospital. Medical Reports and Assessments for “Luke.”

“---“ Hospital. Medical Reports and Assessments for “Mark.”

Office of the Child and Youth Advocate. Child, Youth and Family Services, and Public Health Nursing (2011). Interview Transcripts of Staff.

Provincial Court of Newfoundland and Labrador, Family Court Division (1996).

Provincial Court of Newfoundland and Labrador, Transcripts (2005).

Regional Integrated Health Authority (2006). Child, Youth and Family Services / Public Health Nursing, Written submissions of Staff.

Regional Integrated Health Authority (2009). Collaborative Practice. Management Working Group.

Regional Integrated Health Authority (2010). --- *File Review, Child, Youth and Family Services.*

Regional Integrated Health Authority (2009). *Health, Quality Review of --- Family Clinical Files.*

Royal Canadian Mounted Police, Interview transcripts of witnesses (2004).

Supreme Court of Newfoundland and Labrador, Transcripts (2005).

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

Appendices

Appendix A Letters commencing investigation

Appendix B Child Protection – Legislative Highlights

Appendix C List of acronyms used in this report

Appendix D Yearly Calendar Highlights

Appendix E Summary of Recommendations

APPENDIX A

Letters commencing investigation



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

October 26, 2005

CONFIDENTIAL

Chief Executive Officer
Regional Integrated Health Authority

NL

Dear

I write at this time to advise you of my Office's intention to conduct a Review into the circumstances surrounding the children of _____ given that they were receiving services from a number of Government departments and agencies. This Review will be conducted in accordance with the provisions of Section 15 (1) (a) of the Child and Youth Advocate Act, which states:

15. (1) In carrying out the duties of his or her office, the advocate may
- (a) receive and review a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the advocate.

In accordance with Section 20 of the Child and Youth Advocate Act, I am now informing you of our intentions.

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.

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

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

(a) in the custody or control of a department or agency of the government; and

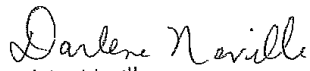
(b) necessary to enable the advocate to perform his or her duties or exercise his or her powers under the Act,

(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 now request that the Regional Integrated Health Authority provide to this Office all information with respect to these children that is in the custody and control of the Health Authority, including any reports that have been compiled as a result of any internal review that was undertaken by your organization regarding this matter. A similar request has been made to Mr. John Abbott, Deputy Minister, Department of Health and Community Services. We will advise you of further requirements as they develop.

Thank you for your cooperation in this matter.

Sincerely,


Darlene Neville
Child and Youth Advocate



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

October 26, 2005

CONFIDENTIAL

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

Dear Mr. Abbott:

I write at this time to advise you of my Office's intention to conduct a Review into the circumstances surrounding the children of _____, given that they were receiving services from a number of Government departments and agencies. This Review will be conducted in accordance with the provisions of Section 15 (1) (a) of the Child and Youth Advocate Act, which states:

15. (1) In carrying out the duties of his or her office, the advocate may
- (a) receive and review a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the advocate.

In accordance with Section 20 of the Child and Youth Advocate Act, I am now informing you as Deputy Minister of our intentions.

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.

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

21. (1) The advocate has the right to information respecting children and youth that is
- (a) in the custody or control of a department or agency of the government; and

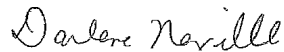
(b) necessary to enable the advocate to perform his or her duties or exercise his or her powers under the Act,

(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 now request that your Department provide to this Office all information with respect to these children that is in the custody and control of your Department or any agencies of your Department, including any reports that have been compiled as a result of any internal review that was undertaken by your Department regarding this matter. A similar request has been made to _____ Chief Executive Officer, _____ Regional Integrated Health Authority. We will advise you of further requirements as they develop.

Thank you for your cooperation in this matter.

Sincerely,



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

APPENDIX C

Acronyms used in this report

Appendix C

Acronym	Official Title
CRMS	Client Referral Management System
CYFS	Child, Youth and Family Services
DHCS	Department of Health and Community Services
DHRE	Department of Human Resources and Employment
DSS	Department of Social Services
HCS	Health and Community Services
ISSP	Individual Services Support Plan
Janeway Hospital	Janeway Children's Health and Rehabilitation Centre
OCYA	Office of the Child and Youth Advocate
PH	Public Health
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 Calendar Highlights

1991

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:  = Professional Contact

1992

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:  = Professional Contact

1993

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:  = Professional Contact

1994

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:  = Professional Contact

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:  = Professional Contact

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: = Professional Contact = HSW 4-6 hours daily

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: = Professional Contact = HSW 4-8 hours daily

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: = Professional Contact = HSW 4-8 hours daily

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:  = Professional Contact  = HSW 8 hours daily & weekend respite

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: = Professional Contact = HSW 8 hours daily & weekend respite

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: = Professional Contact = HSW 8 hours daily & weekend respite

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:  = Professional Contact  = HSW 8 hours daily & weekend respite

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:  = Professional Contact  = HSW 8 hours daily & weekend respite

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:  = Professional Contact  = HSW 8 hours daily & weekend respite

APPENDIX E

Summary of Recommendations

Appendix E

Recommendation No. 1

The Department of CYFS must develop policy to ensure that regular reviews, updates and clinical analysis of high risk cases are conducted.

Recommendation No. 2

The Department of CYFS must develop policy to ensure effective transfer of files occur with joint case review and direct communication between social workers.

Recommendation No. 3

The Department of CYFS must develop policy to ensure that all children in a family are physically and critically observed during a referral and during every home visit.

Recommendation No. 4

The Department of CYFS must ensure proper completion of the Child Protection Report. The Report must be completed at the point of Intake to include all relevant and accurate referral information. The appropriate sections/subsections of the *Act* must be reflected in the Child Protection Reports.

Recommendation No. 5

The Department of CYFS must develop policy to ensure that the Risk Management System is applied consistently for identifying, assessing, responding to, and documenting the risk of maltreatment towards a child.

Recommendation No. 6

The Department of CYFS must develop policy to ensure that whenever a home support service provider is contracted, a written standard of expectations must be outlined and there must be written protocols to ensure accountability. Such services must be monitored and assessed on a regular and definitive basis.

Recommendation No. 7

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 occurs in the areas of 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 must receive case management and clinical supervision training.

Recommendation No. 8

The Department of CYFS must ensure service notes are inputted into CRMS as per the prescribed standard. The standard reads: Client documentation related to a 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. Historical data must also be available to social workers.

Recommendation No. 9

The Department of Health and Community Services must ensure that the four Regional Integrated Health Authorities develop and implement policy to provide:

- (a) all new hires in PH Nursing with training in child maltreatment, clinical documentation, and their legislated duty to report, and
- (b) continuing education in child maltreatment and clinical documentation for all PH nurses.

Recommendation No. 10

The Department of CYFS and the Department of Health and Community Services must ensure that provincially:

- (a) collaborative practice initiatives are developed and advanced between the disciplines of social work, nursing, medicine, and education.
- (b) policy and guidelines reflect ongoing collaborative practice.

Recommendation No. 11

The Department of CYFS and the Department of Health and Community Services must ensure that a quality assurance process is established to address critical incidents and sentinel events that occur within CYFS and PH Nursing programs, province wide.

Recommendation No. 12

Protocol must be developed with CYFS and the OCYA to ensure immediate reporting to the OCYA of any critical incidents or sentinel events occurring with children and youth throughout the Province.