



Press Statement

Advocate for Children and Youth Releases *The Advocate's Report on the Status of Recommendations 2015*

April 26, 2016

Good Morning:

I will be giving a prepared statement, after which I will be happy to take questions.

I am pleased to present *The Advocate's Report on the Status of Recommendations 2015*. Since 2006, a total of eight (8) investigations and four (4) case reviews have been completed:

The eight (8) investigations include:

- *Turner Review and Investigation, 2006;*
- *Lost in Transition, 2009;*
- *An Investigation into Janeway Psychiatry Unit J4D Programs and Services, 2010;*
- *The Child Upstairs...Joey's Story, 2011;*
- *Turning a Blind Eye, 2012;*
- *Out of Focus, 2012;*
- *Sixteen, 2013; and*
- *A Tragedy Waiting to Happen, 2015.*

The four (4) case reviews include:

- *Justice Complaint – Emergency Intake, 2011;*
- *Youth in Adult Holding Facilities: Case 1, 2011;*
- *Youth Corrections – Decisions Regarding Open Custody Placements, 2011; and*
- *Youth in Adult Holding Facilities: Case 2, 2013.*

These twelve (12) reports include a total of 183 recommendations, which have been made to various government departments and agencies including: the Department of Child, Youth and Family Services; the Department of Health and Community Services; the Department of Justice and Public Safety; the Eastern Regional Integrated Health Authority; the Royal Newfoundland Constabulary; and the Labrador-Grenfell Regional Integrated Health Authority.

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For this second Advocate's Report on the Status of Recommendations, the relevant departments and agencies provided information regarding the status of the twenty one (21) outstanding recommendations that were classified as partially implemented or not implemented in the 2014 report, and the status of ten (10) new recommendations made by my office since 2014.

It is important to note that six (6) recommendations for the Department of Child, Youth and Family Services were categorized as "Not Implemented – Response Inadequate and Inappropriate" in the 2014 report. Through continuing consultation with the Department and their ongoing commitment, two (2) have now been implemented and four (4) partially implemented.

Unfortunately, three (3) of those four (4) partially implemented recommendations have not progressed. In November 2014, the House of Assembly passed a motion committing to legislation to respond to my request to amend the *Child and Youth Advocate Act* to ensure mandatory reporting by all government departments and agencies of critical incidents and deaths of children and youth receiving services. Intensive work and collaboration took place from January to June 2015 and the House of Assembly closed before the Cabinet Submission was tabled.

In December 2015, the newly elected Premier Ball included in his mandate letter to the Minister of Child Youth and Family Services "to work with your colleagues and the Child Youth Advocate to develop legislation for the House of Assembly that will make it mandatory to report deaths and critical incidents to the advocate". In the Speech From the Throne, March 8, 2016, Government recognized "the importance of doing everything we can to protect children and youth and will be moving forward with this initiative". It is almost five years since I put forth the first recommendation to establish a protocol of reporting and I truly hope that progress will be made sooner rather than later to ensure the rights of all children and youth are protected and advanced, and their voices heard.

In addition to reporting on recommendations made to government departments and agencies by my office, this year recommendations made by the Child Death Review Committee are also highlighted. The Child Death Review Committee reviews cases involving the deaths of children (under 19 years of age) which have been provided by the Chief Medical Examiner. These deaths are referred to the Chief Medical Examiner's office as specifically outlined in Sections 5 through 8 of the *Fatalities Investigations Act*. In consultation with the Deputy Minister of the Department of Justice and Public Safety, I agreed to coordinate the follow-up process and report on the status of recommendations made by the Child Death Review Committee. As of August 2015, the Department of Justice and Public Safety provided me with nine (9) individual case reviews completed by the Child Death Review Committee. Of the nine (9) case reviews, six (6) had a total of ten (10) recommendations, while three (3) had no recommendations.

These ten (10) new recommendations have been made to various government departments and agencies including: the Child Death Review Committee; the Department of Child, Youth and Family Services; the Department of Health and Community Services; and the Department of Education and Early Childhood Development. In consultation with the Child Death Review Committee, and based on responses from the departments and agencies, I have determined that as of October 2015, 64% of the recommendations made by the Child Death Review Committee have been addressed with 36% requiring further follow-up.

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As of October 2015, the status of all 183 recommendations made by my office since 2006, based on responses from the departments and agencies, is as follows:

- 69% Implemented;
- 13% Implemented Through Alternative Measures;
- 11% Partially Implemented;
- 0% Not Implemented – Response Inadequate and Inappropriate; and
- 7% No Longer Applicable

I would like to take this opportunity to thank the government departments and agencies involved for their ongoing cooperation in this intensive process. I would also like to commend each one for their progress in making policy and procedural changes to services for children and youth.

I must stress that it is of great importance that all government departments and agencies ensure that there are ongoing efforts to enable managers and staff to provide a standardized practice throughout the province. While amendments to policies and protocols are crucial, it is just the first step to making lasting changes. It is only through consistent, high-quality practices that our children and youth will receive the services they truly deserve. There is still work to be done and I look forward to continuing to work with departments and agencies providing services to the children and youth of Newfoundland and Labrador to ensure their needs are met and their rights are upheld.

I have provided each of you present today with a copy of the report and a list of key facts. As well, printed copies of the report are available to the public upon request by contacting our office. The report can also be viewed on our website: www.childandyouthadvocate.nl.ca

Thank you for your time today and I welcome any general questions.

Carol A. Chafe

Advocate for Children and Youth