Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Child, Youth and Family Services
Office of the Deputy Minister

August 5, 2014

[redacted] s.30(1)

Dear [redacted]: s.30(1)

Re: Your request for access to information under Part II of the *Access to Information and Protection of Privacy Act* *CYFS/006/2014*

On June 30, 2014, the Department of Child, Youth and Family Services received your request for access to the following records/information:

> *"All internal government reports related to the deaths of children in care, as well as reports related to the deaths of children receiving government services, from 2009-2014."*

As per your clarification on July 15, 2014, it is my understanding that your request relates to information on children under the age of 18.

I am pleased to inform you that your request for access to these records has been granted in part. Access to the following records have been granted in full:

- Child/Youth Death Review Protocol
- Quality Assurance Division Death Processes

Partial access has been granted to the following records:

- Summary of Deaths
- Completed File Summaries covering 11 deaths

The Summary of Deaths table provided in the attached package of records shows the deaths by year since the Department of Child, Youth and Family Services was created. This includes children in care, children receiving protection intervention services, and youth receiving services or in corrections.

Access to the remaining information contained within these records has been refused in accordance with the following exceptions to disclosure, as specified in the *Access to Information and Protection of Privacy Act* (the *Act*):

> **Disclosure harmful to law enforcement: Section 22 (1)** The head of a public body may refuse to disclose information to an applicant where the disclosure could reasonably be expected to **(g)** reveal information relating to or used in the exercise of prosecutorial discretion;
>
> **Disclosure harmful to personal privacy: Section 30(1)** The head of a public body shall refuse to disclose personal information to an applicant where the disclosure would be an

unreasonable invasion of a third party's personal privacy.

Information within the records has also been refused in accordance with Section 69 of the *Children and Youth Care and Protection Act* (*CYCP*) which states:

> *Access to Information and Protection of Privacy Act* does not apply
>
> **69.** Notwithstanding the *Access to Information and Protection of Privacy Act*, the use of, disclosure of and access to information in records pertaining to the care and protection of children and youth obtained under this Act, regardless of where the information or records are located, shall be governed by this Act.
>
> **Definition**
>
> **70.** In this Part, "information" means personal information obtained under this Act or a predecessor Act which is held in government records by, or is in the custody of or under the control of, the department, and includes information that is written, photographed, recorded or stored in any manner.

It is the Department's view that Section 69 applies to personal information, which includes the details of the circumstances surrounding the deceased child and his/her family. This information was obtained under the *CYCP Act* and is therefore excepted from disclosure. I would also draw your attention to paragraph 8 of Madam Justice Gillian D. Butler's recent decision in *Canadian Broadcasting Corporation v. Newfoundland and Labrador (Child, Youth and Family Services),* 2013 wherein she stated:

> "..personal information relative to the care and protection of children and youth under the *CYCP Act* would (at a minimum) include identifiable information, such as name, address, telephone number, race, national or ethnic origin, colour, age, sex and a child's health care status or history, including a physical or mental disability. I conclude that personal information would also include details of the circumstances in the child's home or caregiver home that were investigated by CYFS."

Please note that the following pages have been fully redacted under Section 30(1) of the *ATIPP Act* and Section 69 of the *CYCP Act* and not enclosed with the package:

- File 1, Page 2;
- File 7, Pages 2 and 3;
- File 8, Pages 3 and 4; and
- File 9, Pages 2, 3 and 4.

Five additional death reviews have not been provided. Following a line-by-line review, the documents were fully redacted under Section 69 of the *CYCP Act*, and Sections 30(1) and 20(1)(b) of the *ATIPP Act*. Section 20(1)(b) of the *ATIPP Act* states:

> **Policy advice or recommendations: Section 20 (1)** The head of a public body may refuse to disclose to an applicant information that would reveal **(b)** the contents of a formal research report or audit report that in the opinion of the head of the public body is incomplete unless no progress has been made on it for more than 3 years;

In addition, Section 52 of the *CYCP Act* is highlighted below as it relates to the provided file summaries:

> **Publication ban: Section 52.** A person shall not, with respect to a proceeding under this Act,

publish or make public information that has the effect of identifying

(a) a child who is a witness at or a participant in a proceeding or who is the subject of a proceeding;

(b) the child's parent or foster parent; or

(c) a member of the child's family.

As required by subsection 7(2) of the *ATIPP Act*, the Department has severed information that is excepted from disclosure to provide you with as much information as possible.

In accordance with your request for a copy of the records, the appropriate copies have been enclosed.

Section 43 of the *Act* provides that you may ask the Information and Privacy Commissioner to review this partial refusal of access or you may appeal the refusal to the Supreme Court Trial Division. A request to the Information and Privacy Commissioner shall be made in writing within 60 days of the date of this letter or within a longer period that may be allowed by the Commissioner.

The address and contact information of the Information and Privacy Commissioner is as follows:

Office of the Information and Privacy Commissioner
34 Pippy Place
P. O. Box 13004, Stn. A
St. John's, NL. A1B 3V8

Telephone: (709) 729-6309
Facsimile: (709) 729-6500

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Office of Public Engagement's website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any further questions, please feel free to contact the Director of Information Management and Protection, Ali Askary, by telephone at 729-1898 or by e-mail at aliaskary@gov.nl.ca.

Sincerely,

Genevieve (Gig) Dooling
Deputy Minister

cc: Julie Moore, Assistant Deputy Minister Corporate Services, Dept. of CYFS

encl.

Death Review Protocol

Child/Youth Death Review Protocol

Policy no.:	**QA-2014-001**
Effective Date:	**March 31, 2014**
Date Revised:	N/A
Policy Cross References:	Client File Transfer Policy Critical Incidents Protocol Community Youth Corrections Policy Manual Protection and In Care Policy and Procedures Manual
Legislative References:	Adoptions Act *Children and Youth Care and Protection Act (CYCP Act)* Section 7, *Fatality Investigation Act* *Young Persons Offences Act* *Youth Criminal Justice Act*

PURPOSE:

To outline the requirements and process for responding to the death of a child or youth who is or who has received services from the department in the last 12 months and to identify any practice, policy or personnel issues that may need to be addressed to improve service delivery to clients.

The protocol applies to the following services:

a) Protective Intervention (PIP);
b) In Care;
c) Youth Services;
d) Community Youth Corrections (CYC);
e) Adoptions.

A *Response Protocol Flowchart* has been included in Appendix A to be used as a tool for following this process.

POLICY:

1. This policy shall apply where a death has occurred to a child or youth who is or who has received services from the Department of Child, Youth and Family Services (CYFS) within the last 12 months.

2. Where a death of an adult has occurred, who is or who has received services from CYFS within the last 12 months, the region shall follow this Protocol to the extent possible until such time the Critical Incident Protocol is finalized.

3. A social worker shall immediately assess any potential risk to any other children or youth in a family or other environment and continue case management and/or monitoring activities.

4. A social worker shall advise the supervisor as soon as they become aware of the death of a child/youth.

5. All notification procedures shall be adhered to as outlined in the Procedures section of this Protocol.

6. A *Death Notification Form* (Appendix B) shall be completed within 24 hours.

7. All safety procedures shall be followed as per the appropriate policy or procedure manual for the program area.

8. If a file(s) is sent to the Quality Assurance Division for an independent review, the region shall ensure a copy of the last 12 months (or specified time frame) of the file is made before sending the original file so regional staff can continue to have access to the file.

9. All electronic communication completed in relation to application of this policy shall be encrypted or transferred through shared drives per the *Guideline on Email Communication and Encryption.*
http://www.intranet.gov.nl.ca/cyfs_transition/info/email_and_encryption.pdf

10. Any public communication related to a child/youth death shall be managed through the Director of Communications of the Department.

PROCEDURES:

Immediate Response (within 24 hours)

11. The social worker shall immediately assess any potential risk to any other children or youth in a family or other environment and continue case management and/or monitoring

activities. All safety procedures shall be followed as per the appropriate policy or procedure manual for the program area.

12. The Social Worker shall notify the Supervisor of the death of the child/youth who shall then notify the Zone Manager and the Regional Director.

13. The Regional Director shall call the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM SD&RO) as soon as possible who shall then notify the Deputy Minister and Minister of the death.

14. The Manager (or designate) shall notify any parent of the child or youth as soon as possible in the case of the death of a child or youth in the care or custody of a Manager under the *Children and Youth Care and Protection Act.*

15. The Social Worker/Supervisor/Zone Manager shall complete and submit a Death Notification form *http://www.intranet.gov.nl.ca/cyfs_transition/quality/Death_Notification_Form.pdf* to the Regional Director for review who shall then submit the form to the ADM SD&RO and Director Quality Assurance (QA) within 24 hours. This form can be found on the CYFS website under the Forms section of QA.

16. The ADM SD&RO shall notify the Medical Examiner in accordance with Section 7 of the Fatalities Investigation Act in the case of the death of a child or youth in the custody of a manager under the *Children and Youth Care and Protection Act.*

17. The ADM SD&RO, upon reviewing the Death Notification Form, shall determine completeness of the form or if additional information is required:

    a. If no additional information or further action is required, the ADM SD&RO shall notify the RD of same;
    b. If the information is incomplete and/or further action/information is required of the region, the ADM SD&RO shall notify the RD of same.
       A further detailed report shall include:
        1. Details of the critical incident that led to the death;
        2. Family composition;
        3. Outline all actions taken by CYFS related to the death;
        4. The status of CYFS involvement;
        5. Risk management processes/documents (if applicable);
        6. A copy of the case plan i.e. Family Centered Action Plan (FCAP) for PIP cases;
        7. Follow-up action that shall be taken by the Social Worker in the next seven calendar days.

    c. The ADM SD&RO, once satisfied with the required action/additional information, shall approve/sign the Death Notification Form, attach additional

report (where applicable) and return both to the region to be placed on the client's file. A copy shall be sent to the Director QA.

18. The ADM SD&RO shall inform of/distribute the Death Notification Form to the Minister, Deputy Minister, Executive, and Department Officials as appropriate.

File Summary (within 30 calendar days)

19. The ADM SD&RO shall notify the Regional Director if a File Summary is required. If required, the *File Summary Template* in Appendix C shall be used.
    a. If a File Summary is to be conducted internal to the region, the Social Worker, in consultation with the Supervisor, shall complete that Summary, and upon completion, both shall sign and send to the Zone Manager for review and approval. Once the Zone Manager is satisfied that the File Summary accurately reflects the facts respecting this case, the Zone Manager shall send it to the Regional Director for review and approval.
    b. If an independent File Summary is required, the ADM SD&RO shall notify the Director QA who shall secure the file(s) within five business days and designate a QA Auditor to complete the file summary. The QA Auditor, upon completion, shall sign and send the Summary to the Director of QA for review and approval.
    c. The ADM will direct the Zone Manager to add a note to CRMS advising that a File Summary is required and being completed by the region or QA.

20. The File Summary shall be sent to the ADM SD&RO within 30 calendar days. The Zone Manager will add a note to the file indicating the File Summary is completed.

21. The ADM SD&RO shall review the File Summary and distribute to the Minister, Deputy Minister, Director of QA (if internal Summary), and remaining Executive and Department Officials as appropriate. The Deputy Minister or ADMs may provide additional input into the summary. The ADM SD&RO shall provide direction to the Director QA on any regional follow-up and the representation from the various Branches required to attend the regional meeting. The Director QA shall track all items and follow-up with the region.

Follow Up on Key Practice Issues (within 60 calendar days following notification)

22. Key practice issues identified in the file summary will form the basis for a follow up discussion which shall be coordinated and attended by QA, the Provincial Office representatives identified above, Regional Director, Zone Manager, Clinical Program Supervisor and Social Worker to review the issues identified from the file summary, determine any lessons learned and develop an action plan if required.

23. The Zone Manager shall provide a written response to the issues identified and provide a follow-up plan (sample template in Appendix D) to the ADM SD&RO and the Director

QA within 10 calendar days of the meeting outlining steps to resolve the identified issues. The Director QA shall provide a summary of the discussion to the ADM SD&RO.

24. The ADM SD&RO shall provide direction to the Director QA on finalizing the File Summary which shall be securely retained by the QA Division.

25. The original file shall be returned to the appropriate Zone Manager in the region after all the above steps have been completed. All file documentation that has been kept in the temporary file shall be transferred into the original file and the photocopy (temporary) version of file will be appropriately destroyed after this occurs.

Monitoring

26. The Director of QA shall monitor implementation and follow up on action required, including contacting persons responsible for actions by expected completion dates and provide regular updates to the Executive.

EXCEPTIONS TO PROTOCOL:

- Death of a child or youth receiving services under a regulated child care facility, regulated family child care establishment or family resource centre, unless they are also receiving services from one of the areas covered under this Protocol.
- Death of an adult who is or who has received services from CYFS within the last 12 months.

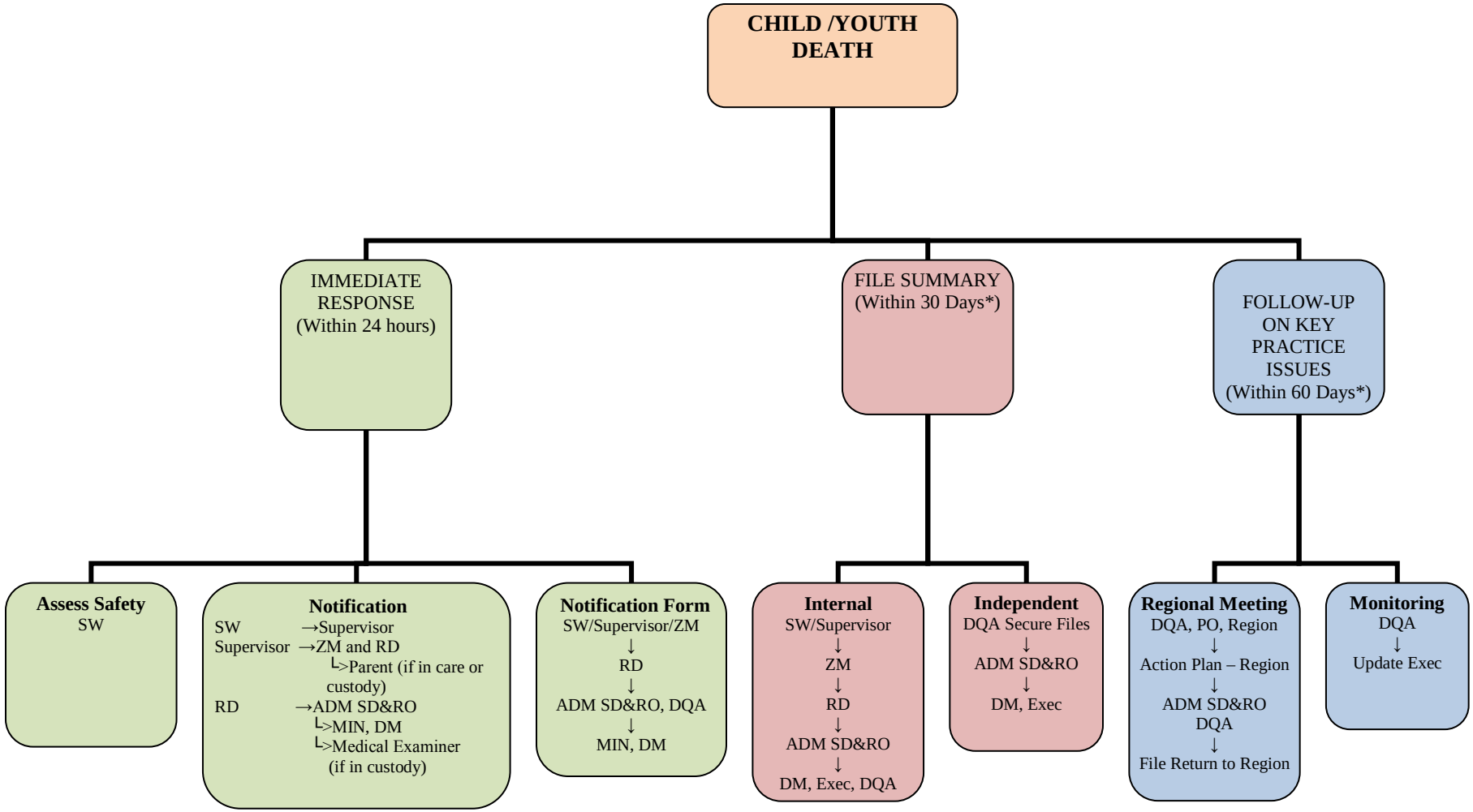
REFERENCE DOCUMENTS:

Adoptions Policy Manual
Community Youth Corrections Policy Manual
Fatalities Investigation Act
Guideline on Email Communication and Encryption
Protection and In Care Policy and Procedures Manual
Risk Management Decision-Making Model Manual 2013
Youth Corrections Residential Services Standards and Practices Manual

CONTACT INFORMATION:

Director of Quality Assurance
Quality Assurance Division
Department of Child, Youth & Family Services
(709) 292-4525

Appendix A -
Response Protocol Flowchart



***calendar days**

Appendix B
Death Notification Form

Newfoundland Labrador

Child, Youth and Family Services

Death Notification

To be completed within 24 hours

Client Information

1

Client	Age	Type File

Family Composition

2

Name	Relationship to Client	Age (if 18 and under)

CYFS Information

3

Region	Office
Clinical Program Supervisor	Zone Manager

Description

4

Date and Time Information Received by Person Completing Form — Date (YYYY-MM-DD) — Time — a.m. / p.m.

Description of Death (What happened, when, where, how, etc.)

Response to event/action taken:
Immediate

To follow next day

Have required notifications external to CYFS been completed? (e.g. Police, parent(s)) If so, to whom?

Signatures

5

Form Completed by (Print Name)

Signature of Social Worker — Date (YYYY-MM-DD) — Signature of Supervisor — Date (YYYY-MM-DD)

Signature of Zone Manager — Date (YYYY-MM-DD)

I, _____ (Name of Regional Director), have reviewed the circumstances and I am satisfied with the immediate actions being taken and follow-up for the next 48 hours.

Signature of Regional Director — Date (YYYY-MM-DD)

Form MUST be submitted to ADM - Service Delivery & Regional Operations, and Director Quality Assurance

6

Section 6 to be Completed by ADM - Service Delivery & Regional Operations

Date Received (YYYY-MM-DD)

Action Required

- ☐ No additional report or follow-up action required
- ☐ Incomplete information/action-in-process noted by region
- ☐ Notification of Chief Medical Officer if child is in custody
- ☐ Recommend further action
- ☐ Recommend full review
- ☐ Minister and DM Briefed

Date of Briefing

Explanation of current status and additional action:

Signature of ADM — Date (YYYY-MM-DD)

51-08-07 **14-1036a** 2013-12

Appendix C
File Summary Template

1. Introduction

- Include name and age of child/youth, region and location of death

2. Family Composition

- Immediate Family Members
- Extended Family and Caregivers

(include the relationship to the child/youth and ages and birth dates of any children)

3. Summary of CYFS Involvement (Past 12 months)

- Family/Case History
- Placement History (if applicable)

4. Key Practice Issues

- Policy/Procedures
  - Risk Management Practices or other Program Practices

- Case Management
  - Assessment and Ongoing Intervention
  - Client Contact
  - Documentation
  - Monitoring
  - Services Provided
  - Coordination of Services; Case Conferencing
  - Case Closure Summaries

- Clinical Decision Making
  - Services, Planning and Follow-up
  - Decisions Made

5. Analysis of Key Practice Issues

- Policy Intervention
- Training Intervention
- Human Resources Intervention

6. Signatures Required

- Internal: Social Worker, Supervisor, Zone Manager, Regional Director
- QA Unit Independent: QA Auditor, Director QA

Appendix D
Regional Follow-up Plan

Newfoundland Labrador

Child, Youth and Family Services

Regional File Summary Follow-up Plan

File Summary (Client Initials)

Date of Regional Meeting

File Summary Findings to be Addressed

1.

2.

3.

Regional Action(s) Required to Address Each Finding

1.

2.

3.

Person Assigned to Implement Actions:

1.
2.
3.

Expected Completion Date for each Action:

1.
2.
3.

Signature of Social Worker _____ Date _____

Reviewed/Signature of Supervisor _____ Date _____

Reviewed/Signature of Zone Manager _____ Date _____

Reviewed/Signature ADM Service Delivery & Regional Operations _____ Date _____

Quality Div. Stat

Quality Assurance Division
Death Processes

[INTERNAL ONLY – *data as of July 2, 2014*]

Death File Reviews:

- Protocol finalized as of March 31, 2014.
- Review completed at the discretion of the ADM Service Delivery & Regional Operations and applies to a child/youth that dies and is receiving services or has received services in the past 12 months.
- 26 children/youth deaths since CYFS establishment in 2009 summarized as follows:

Case Type	In-care: 3 PIP: 18 Youth Services: 3 Youth Corrections: 2
Cause of Death	Medical event/condition: 8 Accidental: 12 (e.g. drowning) Suicide: 6

Prepared/Reviewed By: Sandra Evans/Julie Moore
Date: July 2, 2014

Summary of Deaths Stat

Summary of Deaths

Section 30(1) ATIPP, Section 69 CYCP

No	File No	Name of Client	Region	Age at Time of Event	Case Type	Description	Date of Death	Year of Death	Review Complete
1	[redacted]							2010	Yes
2								2010	Yes
3								2010	Yes
4								2011	Yes
5								2010	Yes
6								2011	No
7								2011	No
8								2011	No
9								2012	No
10								2012	No
11								2012	Yes
12								2012	Yes
13								2012	Yes
14								2012	Yes
15								2012	Yes
16								2011	Yes
17								2013	Yes
18								2013	No
19								2013	No
20								2013	No
21								2013	Yes
22								2013	No
23								2010	Yes
24								2011	No
25								2011	Yes
26								2014	No

File 1

Section 30(1) ATIPP

File Summary - [redacted]

Introduction Section 30(1) ATIPP, Section 69 CYCP

[redacted]

The following documents, provided by the [redacted] Regional Health Authority were reviewed: Section 30(1) ATIPP

- PIP file of [redacted] Section 30(1) ATIPP
- Family of origin file [redacted]
- [redacted] inactive [redacted] files [redacted] Section 69 CYCP

Section 69 CYCP

Section 30(1) ATIPP

Family Composition Section 30(1) ATIPP

[redacted]

Summary of CYFS Involvement

CYFS became involved with [redacted] included: Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted] The file closed in CRMS in [redacted]. Section 30(1) ATIPP

[redacted]

Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

Key Practice Issues

Section 30(1) ATIPP

Policy/Procedures

Section 69 CYCP

Section 30(1) ATIPP

- A [redacted] was completed on [redacted] and was signed by [redacted] identified in the plan included [redacted] in the [redacted] presence.

Section 69 CYCP

Section 30(1) ATIPP

Section 30(1) ATIPP

- There is no formal risk assessment instrument on file; however, notes in the file indicate that during contacts with [redacted] the worker did question [redacted] about various [redacted] family supports, and their current relationships and coping skills.

Section 69 CYCP

3

- From the onset the worker sought consultation and direction from the supervisor regarding the case. This ongoing consultation was documented by the worker in the file on [redacted].

Section 30(1) ATIPP

Case Management

Section 30(1) ATIPP

- Prior to making contact with [redacted], documentation in the file indicates that the assigned worker completed an all program search on CRMS to ascertain any CYFS history with [redacted]

Section 30(1) ATIPP

Section 30(1) ATIPP

- There is no documentation to indicate if the files, most notably the family of origin file, were reviewed prior to meeting with [redacted] however there is inference of awareness of the history as the CRMS notes referenced a need to discuss the [redacted]

Section 69 CYCP

- [redacted]

Section 30(1) ATIPP, Section 69 CYCP

- In terms of coordination of services, there was evidence of contact with other services in the file, including [redacted] From the onset of involvement, the [redacted] like CYFS, [redacted].

Section 30(1) ATIPP

- Referrals were made to the [redacted] claimed to be very open to all services.

Section 30(1) ATIPP, Section 69 CYCP

- There was no evidence of case conferencing or planning on the file.

Based on a review of the facts as they are presented, this report is finalized by

Sandra Evans, Director Quality Assurance
CYFS

[redacted]

Section 30(1) ATIPP

Regional Director [redacted] notified of outcome of review.

File 2

Section 30(1) ATIPP

File Summary - [redacted]

Introduction Section 30(1) ATIPP, Section 69 CYCP

[redacted]

The following documents were reviewed as a part of this review of clinical intervention:

Section 30(1) ATIPP

- [redacted] CYFS Family file [redacted]

Family Composition

Parents Section 30(1) ATIPP

[redacted]

Summary of CYFS Involvement with the Family Section 30(1) ATIPP, Section 69 CYCP

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

[redacted]

Section 30(1) ATIPP

Section 30(1) ATIPP

There was a two month gap in documentation from [redacted] with the first entry for [redacted] at which time a new social worker was assigned and notes on file indicated unsuccessful attempts to locate [redacted] Once [redacted] had been located, there had been a five month period between documented home visits.

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 69 CYCP

[redacted] the file was reviewed for case closure. On [redacted] the clinical program supervisor signed [redacted] A case closure letter was sent to [redacted]

Section 30(1) ATIPP

Section 69 CYCP

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Key Practice Issues

Policy & Procedures

Section 30(1) ATIPP, Section 69 CYCP

Section 69 CYCP

Policy and Procedure practices identified in this file include the following:

- There were a number of [redacted] and all were appropriately prioritized and actioned in a timely manner, however RMS standards were not always met. [redacted] were not completed until [redacted]. RMS documentation, [redacted] was completed five months after [redacted] date.

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 69 CYCP

2

- The Safety Plans that were completed did not use the RMS template. Safety plans were often used beyond the assessment period to address long-term goals such as counseling, more fitting for a Family Centered Action Plan (FCAP).
- [redacted] Risk Assessment Instruments (RAIs) were completed during the period of this review. An RAI completed in [redacted] An RAI Review was completed [redacted] and [redacted] rated as [redacted]
- The most recent FCAP was completed in [redacted].
- RMS standards related to file closure were partially met. Prior to file closure, the worker observed [redacted] The RAI was reviewed and the social worker consulted with the clinical program supervisor prior to case closure. The case closure summary was signed by the clinical program supervisor in support of closing the file.

Case Management

Case management practices noted in the review include:

- Documentation on file for the past 12 months, when completed, was completed in a timely manner.
- [redacted]
- [redacted] was to receive the support of a family support worker, however based on limited documentation; it is difficult to determine whether [redacted] received the service or if the goals of the service were met.

Clinical Decision Making

Key practice issues identified in this file which impact clinical decision making are as follows:

- It appeared that intervention beyond the initial safety planning was not directed from a formal planning process such as the FCAP but instead from the Safety Plan.
- The most recent RAI completed with [redacted] in [redacted] and reviewed in [redacted] was completed by a social worker newly assigned to [redacted] in [redacted] after one in person contact with [redacted] with a recommendation to close the file after its completion.
- This file notes there were many changes in social workers, [redacted] with documentation not always complete.

3

Section 69 CYCP

- It is difficult to determine whether or not [redacted] received the recommended services and interventions.

Analysis

Section 30(1) ATIPP

Training Implications

- Documentation Guidelines were implemented on [redacted] and information sessions were held with all staff to clarify policy requirements and practice expectations.
- Core and Risk Management training is offered to staff through Core and Supervisory training and orientation.

Section 30(1) ATIPP

Update:

Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP

A meeting was held on [redacted] between the Director of QA - Sandra Evans and the Regional Director for [redacted], Zone Manager - [redacted] Supervisor - [redacted] and Social Worker - [redacted] The findings of the File Summary were presented and discussed. It was confirmed in that meeting that the file remains closed and that all documentation was up-to-date prior to closure. While it was re-opened at the time of [redacted] death while CYFS conducted a full 30-day investigation and assessed risk for the [redacted] the file was closed after the investigation.

[redacted]

Based on a review of the facts as they are presented, this report is finalized by

Section 30(1) ATIPP, Section 69 CYCP

Sandra Evans, Director Quality Assurance
CYFS
[redacted]

Section 30(1) ATIPP

4

File 3

Section 30(1) ATIPP

File Summary - [redacted]

Introduction

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

The following documents were reviewed as part of this review of clinical intervention:

Family Composition

Section 30(1) ATIPP

[redacted]

CYFS Involvement

This file was not active on the date of the death of this child. The file had been closed in [redacted] Section 30(1) ATIPP

The Department of Child, Youth and Family Services was involved with [redacted] Initial involvement began in [redacted] and continued

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

[redacted]

Section 30(1) ATIPP Section 69 CYCP Section 30(1) ATIPP

[redacted] the last contact recorded in the file was [redacted] at which time the file was closed as the [redacted] concerns had been addressed, there were [redacted] and [redacted] did not require further [redacted]

Section 69 CYCP Section 69 CYCP Section 30(1) ATIPP

[redacted]

Key Practice Issues Section 30(1) ATIPP, Section 69 CYCP

Policy/Procedures

Overall compliance with the policy and procedures that guide protective intervention cases improved over time on this file, specifically in the last year of intervention: Section 30(1) ATIPP

- From [redacted] Child Protection Reports, Initial Intake Reports, Investigative Summaries, Safety Plans and Safety Assessments completed and signed as required and in a timely manner.
- Safety factors were acknowledged and a Safety Plan in place to adequately address the immediate safety concerns. Safety Plan was signed by the social worker, [redacted] and clinical program supervisor as per policy.
- [redacted] Risk Assessment completed on file dated [redacted] and a Risk Assessment Review was completed and signed off [redacted] when the file was closed.

Section 30(1) ATIPP

Section 69 CYCP Section 30(1) ATIPP

2

- Prior to [redacted], only Child Protection Reports on file [redacted] Initial Intake Report regarding [redacted] Child Protection Report in [redacted], no Safety Plans, Safety Assessments or Risk Assessments documented on file.
- There was no evidence of a Family Centered Action Plans on file.

Case Management

Case management issues noted in the review included:

- There were significant differences between the content of the file when services were received in [redacted]. When in [redacted], the file notes were sporadic, not up to date; documentation was missing and, for the most part, contact with [redacted] appeared to be [redacted]
- It is difficult to determine the effectiveness of case management practices with insufficient documentation to support activities that may have occurred.
- During the last year of involvement, notes were entered in a timely manner, were up to date and contact with [redacted] was regular, primarily one in-person contact per month with additional telephone contact and on occasion [redacted] to interview [redacted]. Safety concerns were addressed and documentation was in the file to support it.
- There was no evidence of a case plan which would have identified specific concerns and interventions required to address the issues.
- Appropriate [redacted] were documented on file for [redacted]

Clinical Decision Making

Key practice issues regarding clinical decision making in this file include:

- Interventions with [redacted] within the last year were appropriately referral driven as the file had been closed and re-opened to address a new Child Protection Referral.
- Intervention addressed the safety and risk factors, was addressed in a timely manner and appropriate collateral contacts were made.
- [redacted] Based on the results of the investigation and the appropriateness of [redacted] response to the situation, [redacted] were deemed safe and not in need of protective intervention.
- [redacted] the social worker's assessment at that time was appropriate.
- There were no concerns noted with the clinical decision making during the last year of involvement with [redacted]

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Policy Implications

Section 30(1) ATIPP

- The Protection and In Care policy and Procedures Manual was developed and distributed in [redacted] with accompanying information sessions to clarify practice requirements.

Training Implications

- Practice improvements for all Social Workers and Supervisors are addressed through mandatory Core & Supervisory training and the Department's work with Memorial University on complex case practice issues.
- Focused webinars and teleconferences with the Child Protection & In Care Division are ongoing and will also assist in improvements in practice.

Based on a review of the facts as they are presented, this report is finalized by

Sandra Evans, Director Quality Assurance
CYFS
[redacted] Section 30(1) ATIPP

4

File 4

Section 30(1) ATIPP

File Summary - [redacted]

Introduction

The following documents were reviewed as part of this review of clinical intervention:

Section 30(1) ATIPP Section 30(1) ATIPP

- [redacted] Protective Intervention File # [redacted]
- CYFS Standards, policy and relevant legislation

Section 30(1) ATIPP

The file is being reviewed from [redacted] (23 month period) to capture both the 12 months leading up to the *client death*, as well as the 11 months following the death, at which time a *critical incident* occurred and the file was secured.

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

The file was requested by Quality Unit on [redacted] and was secured by the Quality Unit on [redacted]

Section 30(1) ATIPP

Section 30(1) ATIPP

Family Composition

Section 30(1) ATIPP

[redacted]

Placement History

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

Summary of CYFS Involvement

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted] There are no documented service notes from [redacted] therefore circumstances surrounding the client death are not documented in the file.

Section 30(1) ATIPP

[redacted]

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

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Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

Key Practice Issues

Policies and Procedures

Policies and Procedures identified in this file from [redacted] include the following:

- [redacted] documented [redacted] Response priority was determined and timely response [redacted] was within policy
- Safety Assessments completed for [redacted]
- Safety plan immediately implemented for most recent [redacted] did not require safety plans
- Assessment Investigative Summaries/Verification documents completed for [redacted]
- Least intrusive course of action was taken to provide safety in the most recent [redacted]
- [redacted] on file support actions taken
- Risk Assessment Instrument completed [redacted]
- FCAP completed [redacted]
- Case notes for [redacted] were entered in [redacted]

Case Management

- Comprehensive assessments to [redacted] were completed and documented as per policy.
- Appropriate, extensive services identified and provided through FSP, and when necessary, these, and additional services were provided through PIP Program.
- FCAP and updated RAI completed after the file requested for review
- Identification and provision of services was consistent in 12 months prior to child death; of the 11 months prior to critical incident, there is no

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documentation indicating any case management practices for 8 months. There is evidence of intensive involvement in the last 3 months following the critical incident Section 69 CYCP

- There is evidence of collaboration with other professionals [redacted]
- Ongoing consults with clinical supervisors, with the exception of the 8-month period where no intervention by CYFS is documented, were evident. Section 69 CYCP
- [redacted] Supports to mitigate other identified risks were also provided.
- Inclusion of [redacted] was demonstrated to provide least-intrusive intervention. Section 69 CYCP

Clinical Decision Making

Key practice issues regarding clinical decision making in this file are:

- Clinical decisions were made using the RMS framework when the file was under a PIP Program. While the Risk Assessment Instrument and FCAP were not completed, service notes document good clinical decisions were made.
- In the 8 months following the child's death leading up to the critical incident, documentation is not in the file regarding any intervention, consultation, planning or monitoring which may have identified possible risk factors that may have contributed to the critical incident.
- Following the critical incident, sound clinical decisions were made. The RAI and FCAP have been completed and have identified risk level and clinical response to mitigate the risk

Analysis Section 30(1) ATIPP

During the 12 month period preceding the child's death, overall good compliance with case management was demonstrated for a Family Services Program, however the updated Risk Assessment and FCAP ([redacted]) was not completed according to policy when the file changed to a PIP in [redacted] Regular monitoring/intervention did occur as evidenced in service notes up to [redacted] Section 30(1) ATIPP Section 30(1) ATIPP

During the 8 months following the child's death, prior to the critical incident, compliance with policy and procedures of a long-term protection file was not evident in the file (including documents or correspondence to indicate CYFS intervention from [redacted] or whether the file was being considered for closure). It is reasonable that CYFS would pull back intervention with [redacted] and allow a short period of grief following the child's Section 30(1) ATIPP Section 30(1) ATIPP

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Section 69 CYCP

death, however [redacted]

Section 30(1) ATIPP

During the 5-week period leading up to the critical incident, a high level of intervention and consultation resumed at [redacted] and policies and procedures were followed. Good clinical decision-making and collaboration with community partners was exercised in identifying risks to [redacted] and appropriate actions were taken to provide safety.

Section 30(1) ATIPP

Policy Intervention

Section 30(1) ATIPP Section 30(1) ATIPP

On [redacted] The Protection and In Care Policy Manual was distributed to staff along with training sessions to clarify policy. This occurred during the period reviewed for [redacted] Adherence to the completion of the Risk Assessment Instrument and development of the FCAP are integral components to supplement clinical case management in long-term protection cases.

Section 30(1) ATIPP

Documentation guidelines were implemented on [redacted] Information sessions were held with all staff to clarify policy requirements and practice expectations. This occurred during the latter period reviewed for [redacted]

Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP

Update:

A meeting was held on [redacted] between the Director of QA and the Regional Director, [redacted] and staff assigned to this case. The findings of the File Summary were presented and discussed. It was confirmed in that meeting [redacted] The Risk Assessment was last completed [redacted] and the FCAP is in process. Last FCAP was done [redacted] All documentation is up-to-date.

Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP, Section 69 CYCP

Based on a review of the facts as they are presented, this report is finalized by

_____

Sandra Evans, Director Quality Assurance
CYFS
[redacted]

Section 30(1) ATIPP

File 5

File Summary - [redacted] Section 30 (1) ATIPP

Introduction Section 30(1) ATIPP, Section 69 CYCP

[redacted]

The following documents were reviewed to complete this summary: Section 30(1) ATIPP Section 30(1) ATIPP

- [redacted] In Care file [redacted]
- CYFS standards, policy and relevant legislation

Family Composition Section 30(1)ATIPP

[redacted]

Significant Others Section 30(1) ATIPP

[redacted]

Overview of Death Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

The Zone Manager and Program Manager were immediately notified of this situation. When the Zone Manager returned the call to the [redacted],

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

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Section 30(1) ATIPP, Section 69 CYCP

Summary of CYFS Involvement

[redacted]

Key Practice Issues

Policy and Procedures

Section 30(1) ATIPP

Section 69 CYCP

- Last Plan for the Child on file is dated [redacted]. [redacted] Individualized Progress Reports were required but not completed.

Section 30(1) ATIPP

- Service notes outstanding in file for over one year at one point; all outstanding documentation was entered and updated after [redacted] death over a period of a few days.
- [redacted]

Section 30(1) ATIPP, Section 69 CYCP

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Case Management/Services Coordination

Section 30(1) ATIPP, Section 69 CYCP

- [redacted]
- [redacted]

Clinical Decision Making

- [redacted]

Analysis Section 30(1) ATIPP, Section 69 CYCP

Policy Implications

Section 30(1) ATIPP

- The Protection and In Care Policy and Procedures Manual [redacted] was developed and distributed to staff with accompanying information sessions to clarify policy and legislative requirements.

- Documentation Guidelines were implemented on [redacted], and information sessions were held with all staff to clarify policy requirements and practice expectations.

Section 30(1) ATIPP

Training Implications

- CYFS has designed and implemented a standardized two week orientation and training program for all new hires. New staff is provided with training in the Risk Management System, legal issues, documentation and other essential areas prior to beginning field positions.

- Risk Management System training is mandatory for all CYFS social workers.

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Update:

A meeting was held on [redacted], between the Director of QA (Sandra Evans), QA Auditor (Kellie Handregan), Zone Manager [redacted] and Supervisor [redacted]. Social Worker [redacted] was unable to attend the meeting as she was off on annual leave. Zone Manager agreed to review the report and findings with the social worker upon her return to work. The findings of the File Summary were presented and discussed.

Based on a review of the facts as they are presented, this report is finalized by

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 30(1) ATIPP

Sandra Evans, Director Quality Assurance
CYFS
[redacted]

Section 30(1) ATIPP

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File 6

Section 30 (1) ATIPP

File Summary - [redacted]

Introduction

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

Provincial Office secured the file from the region on [redacted]. There were [redacted] at the time.

Section 30(1) ATIPP

Section 30(1) ATIPP, Section 69 CYCP

The following documents were reviewed as part of this review:

Section 30(1) ATIPP

- [redacted] CYFS family file [redacted]
- [redacted] file [redacted]
- CYFS standards, policy and relevant legislation

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 30(1) ATIPP, Section 69 CYCP

[redacted] **Family Composition**

Section 30(1) ATIPP

[redacted]

Placement History

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

- [redacted]

Summary of CYFS Involvement with the Family

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

CYFS originally became involved with the [redacted] in [redacted] when [redacted], [redacted] The [redacted] began to receive support from the [redacted] in [redacted] and continued to do so until [redacted] removal in [redacted].

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

Key Practice Issues

Section 69 CYCP

Section 30(1) ATIPP

Policy & Procedures

- There was overall good compliance with policy and procedures once [redacted]
- There was limited, if any, private contact between [redacted] and [redacted] social worker; however, [redacted] within two weeks of the worker receiving the [redacted] file. The worker attended appointments with [redacted] and maintained on-going contact with care providers and [redacted]

Section 30(1) ATIPP

Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

- Prior to removal, there was overall low compliance with risk management standards. An RAI was not completed prior to the removal of the [redacted] in [redacted].

Section 69 CYCP

Section 30(1) ATIPP

Section 30(1) ATIPP

Case Management/Service Coordination.

Section 30(1) ATIPP

- The file contains significant and on-going documentation of interventions throughout the period reviewed [redacted].
- This documentation provides clear evidence of on-going consultation and planning amongst social workers and clinical supervisors involved with [redacted]

Section 30(1) ATIPP

- Court documentation, including Plans of Care and the Plan for the Child were thorough and clearly articulated the assessment of [redacted] conducted by CYFS

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 30(1) ATIPP

- Documentation demonstrates an on-going effort with [redacted] particularly in terms of engaging [redacted] in the care of [redacted] and providing interventions targeted to mitigate risk.

Section 30(1) ATIPP

- There is significant and ongoing contact between CYFS, professionals involved in [redacted]

Section 30(1) ATIPP, Section 69 CYCP

- Copies of case notes completed by [redacted] indicate extensive contact with [redacted] CYFS social workers, [redacted]

Section 30(1) ATIPP

Section 30(1) ATIPP, Section 69 CYCP

Section 69 CYCP

Clinical Decision Making

Key practice issues regarding clinical decision making in this file are:

- Service notes demonstrate efforts to maintain parental contact and involvement while ensuring the safety of [redacted]

Section 30(1) ATIPP

- Overall, the review of interventions for the period outlined indicate sound clinical judgments were made in this case when assessing risk to [redacted] and intervening to ensure [redacted] safety and well-being.

Policy Implications

- Overall, the CYFS interventions with the [redacted] during the period reviewed were in compliance with policy and procedures [redacted]

A meeting was held on [redacted] between the Child Protection and In-Care Program Director (Michelle Shallow), Youth Services Consultant (Jennifer Barnes), and appropriate staff from the [redacted] region including the Regional Director [redacted] one Zone Manager [redacted], one Supervisor [redacted], and one Social Worker [redacted] The findings of the File Summary were discussed by the Child Protection and In-Care Program Director highlighting the key practice issues of concern [redacted] CYA Carole Chafe wrote DM Sheree MacDonald acknowledging receipt of a file review summary that was provided to her [redacted] and she advised that further review or investigation was not required.

Based on a review of the facts as they are presented, this report is finalized by

Report Finalized by

Sandra Evans, Director Quality Assurance
CYFS
[redacted]

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File 7

File Audit

Introduction Section 30(1) ATIPP, Section 69 CYCP

The purpose of this file review is to identify key practice issues regarding policy/procedures, case management and clinical decision making for [redacted] The following documents were reviewed as part of the review of the clinical intervention provided by Child, Youth and Family Services (CYFS) staff during this period.

Section 30(1) ATIPP Section 30(1) ATIPP

- [redacted] **Protective Intervention** [redacted]
- [redacted]
- **Protection and In Care Policy and Procedures Manual**
- ***Children and Youth Care and Protection Act***
- **Risk Management Decision Making Manual** Section 30(1) ATIPP

Section 69 CYCP Section 30(1) ATIPP

The Protective Intervention and [redacted] files were reviewed from [redacted]

Family Composition: Section 30(1) ATIPP

[redacted]

Summary of CYFS Involvement:

Summary of Placement History

- [redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

[redacted]

Key Practice Issues:

Policy/Procedures

Section 30(1) ATIPP

The Risk Management System is the framework for assessment, investigation and ongoing work with families where children are in need of protective intervention. Policies and procedures identified in this file from [redacted] include the following:

Section 69 CYCP

- **[redacted] documented screened-in CPR's. Response priority was determined and timely response to referrals was within policy.** Section 69 CYCP
- **Safety Assessments were completed for [redacted] referrals.**
- **Safety Plans were implemented immediately as [redacted] was deemed unsafe in [redacted] instances.** Section 69 CYCP Section 30(1) ATIPP
- **Assessment Investigative Summary/Verification documents was completed.** Section 69 CYCP
- **[redacted] is well-documented and court documents on file support action taken.** Section 30(1) ATIPP
- **Initial Risk Assessment Instrument was completed on [redacted]**
- **FCAP was completed in [redacted] and notes indicate it was reviewed by client. The FCAP was reviewed again prior to [redacted] returning, however changes in [redacted] circumstances and the planned return of [redacted] were not indicated.** Section 30(1) ATIPP
- **The reviewed FCAP did not have [redacted] signature.**

Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP

Case Management

Case Management integrates all aspects of good child welfare practices including comprehensive assessment and planning, service identification, provision and coordination, monitoring of service delivery through documentation and regular case reviews.

- Comprehensive investigations were completed on [redacted] referrals. Section 69 CYCP
- Identification of necessary services and referrals for services was timely and well-documented.
- RA was completed and rated appropriately.
- FCAP was completed based on results of RAI.
- There is evidence of ongoing and regular contact with PI Social Worker and [redacted] Social Worker. Section 69 CYCP Section 30(1) ATIPP
- [redacted] was seen regularly. Section 30(1) ATIPP
- Regular monitoring of [redacted] needs and service identification.
- Evidence of follow up with counselor for [redacted] Section 69 CYCP
- Financial Services were provided to care for child [redacted]
- Family visits were well-coordinated and were progressive in nature.
- Clinical consultation is evident with supervisor throughout the life of the file.
- Evidence of services such as school [redacted] is well documented. Section 69 CYCP

Clinical Decision Making

Clinical decisions are informed choices social workers make from a number of alternative possibilities based on the social worker's theoretical and practice based knowledge and experience. Child Protection Social Workers determine necessary interventions, determine if out of home placements are necessary and engage client participation in services.

Key practice issues regarding clinical decision making in this file are:

- Clinical decisions were made based on the Risk Management process and reflect sound judgment at many key decision points. The RA was completed in a timely manner. The FCAP was drafted and provided to the client for review. Service notes indicate the decision making process and correspond with what is identified in the RA.
- Key points in the file show regular meetings/consultations with supervisor regarding ongoing planning and case management.
- Ongoing case discussions are documented between the PI Social Worker and the [redacted] Social Worker and reflect good team work in the overall management of the case. Section 69 CYCP
- Notes in the file indicate evidence of Zone Manager being involved in the decision to [redacted] however, RA was not reviewed at this point, but clearly demonstrated through service notes the rationale for the decision. A new FCAP was not completed at this time. It is noted that an RA and FCAP would be completed after [redacted] Section 69 CYCP Section 69 CYCP
- While key issues such as [redacted] were identified as significant risk factors and referrals were appropriately made, no services were provided to address these issues. [redacted] was provided and

Section 69 CYCP Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

- [redacted]
- After notification of the child's alleged death, the supervisor reviewed the file and noted that the Zone Manager was updated and consulted.

Analysis of Key Practice Issues:

Policy Intervention:

Section 30(1) ATIPP

In [redacted] the new Risk Management Decision-Making Model Manual was released. Prior to this, in [redacted] all CYFS staff received training on the changes that would be implemented in the Risk Management process. Also, in [redacted] the FCAP form was revised, allowing for a more user friendly tool and working document.

Section 30(1) ATIPP

Section 30(1) ATIPP

Prior to this, in [redacted] the Protection and In Care Policy and Procedures Manual was distributed to staff along with training sessions to clarify policy. Supervisors may want to review relevant policy with staff during team or individual consultations, to highlight and revisit some of the new policy changes.

Section 69 CYCP

Training Interventions:

Section 30(1) ATIPP

Consideration should be made for training to be completed to review the Protection and In Care Policy [redacted] "Child Returned At Any Time" with the social worker, clinical supervisor and zone manager involved in this case and for the Regional Director to ensure other regional staff are fully advised of the policy.

CYFS has made practice improvements for all social workers and supervisors in the province through CORE and Supervisory training provided through the CYFS Training Unit. Consideration should be made for expanding training to include other areas, such as [redacted] to ensure support is available for managing related cases and to allow staff to keep abreast of best practice research.

Section 69 CYCP

Submitted By:

Geraldine Maher-Fry, BSW, RSW

[redacted]

Section 30(1) ATIPP

File 8

File Review – Child Youth & Family Services

Section 30(1) ATIPP [redacted] Section 30(1) ATIPP

Review Submitted: [redacted]

Completed by: [redacted] **Quality & Clinical Safety Leader**

[redacted] **Senior Manager CYFS**

[redacted] **Professional Practice Consultant, Social Work**

Section 30(1) ATIPP

Siblings of Client:

[redacted]

Section 30(1) ATIPP

1

Summary of Occurrence: Section 30(1) ATIPP, Section 69 CYCP

[redacted]

Review Process: Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP

The review process included a review of [redacted] file, review of information taken from [redacted] interviews with the Program Managers, Case Manager and Senior Manager for [redacted] between [redacted] information taken from an interview with [redacted] representative involved during that period, Section 69 CYCP **review of [redacted] consultation with the current Program Manager for [redacted] information taken from consultation with [redacted] consultation with [redacted]** Section 69 CYCP **consultation with [redacted] consultation with CYFS regarding the death of the [redacted] and consultation with [redacted] regarding possible** Section 30(1) ATIPP **child welfare history for [redacted] There was also utilization of information from the Provincial Clinical Review (2008), The Turner report (2006), Deloitte Review (2007).**

Section 69 CYCP Section 30(1) ATIPP Section 30(1) ATIPP

Timeline:

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

1. **Documentation**

In any protection file, the completion and utilization of relevant documentation in assessment of risk to children is best practice. A clear and accessible history is imperative for incorporation into a comprehensive analysis. A noted deficiency was the absence of documentation in the Client Referral Management System (CRMS) case notes regarding events between [redacted], and the Plans of Care ([redacted] No documentation exists regarding consultation between the Case Manager, CYFS Management and the [redacted] CYFS regarding critical decisions made by CYFS for [redacted] The information regarding consultation was gathered through interviews with the Case Manager, the Program Manager, the Senior Manager and [redacted] CYFS at the time.

The current file has no comprehensive assessment/analysis of risk that includes significant information documented in [redacted] Family of Origin file. The premature Investigative Summary completed in [redacted] prior to any interview with [redacted] makes reference to this history; however, the information provided is mainly factual without subsequent analysis. While the Summary included a recommendation for further assessment/analysis of this history, none occurred.

Between [redacted] there was no compliance with the mandated Risk Management System to include a review of parenting history for incorporation toward any assessment of risk of future harm to [redacted] In the absence of such a review and a subsequent analysis of future risk, any assessment used in the decision to return [redacted] was not supported by the documentation.

2. **Investigative Process**

Significant gaps exist in the process of investigation and analysis of risk undertaken by CYFS during its' involvement with [redacted] between [redacted] During the investigation and subsequent assessment between [redacted] much emphasis was placed on the absence of significant disclosure by [redacted] in determining the need for ongoing protective intervention. Emphasis was also placed on [redacted] Contradictory information provided by [redacted] that would have required further investigation was overlooked. [redacted] was also overlooked and initial referral concerns were deemed "not verified" prior to CYFS' interview with [redacted] regarding same. It was during this interview that [redacted] indicated the need for further investigation. There was a lack of information gathering and subsequent analysis regarding [redacted] associates and possible situations in which [redacted] may have been involved that caused risk to [redacted] however the file was closed without further investigation.

Following the removal in [redacted] and during the short period while [redacted]

Section 30(1) ATIPP, Section 69 CYCP

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Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

Section 69 CYCP

[redacted] regarding such indicators were overlooked in the decision [redacted]
The fact that [redacted] were missed indicates the absence of the analysis required in the assessment of risk and harm to the children.

Section 69 CYCP

The decision by CYFS in [redacted]

[redacted]

[redacted] The omission of [redacted] in the amended Plan of Care did not serve to protect [redacted] In addition, while follow up with [redacted] did occur through some home visits throughout the life of [redacted] no ongoing clinical assessment is evident. The Case Manager at the time reported assessing the file as being one of "low risk" which could be closed.

Section 30(1) ATIPP

Section 69 CYCP

3. Clinical Consultation/Supervision

Section 30(1) ATIPP

Fragmented clinical consultation between CYFS Social Workers, Program Managers and Senior Managers involved with this file between [redacted] is evident. Clinical supervision is a crucial component in facilitating the ongoing professional development of front line social workers and managers in Child Protection practice toward the effective protection of the children served. Clinical consultation between the Social Worker, Program Managers, Senior Manager and other professionals regarding critical decisions made for [redacted] during the period between [redacted] are not documented.

Section 30(1) ATIPP

Section 30(1) ATIPP

Information taken from interviews of those involved for this review indicates that the Case Manager consulted with the Program Manager [redacted]

Section 69 CYCP

[redacted] and the Case Manager consulted with the Program Manager [redacted] regarding the amended Plan of Care filed [redacted] The Program Manager reports consultation with a Senior Manager regarding all of these decisions; however, no Senior Manager reports having any recollection of the consult. The Program Manager did not consult with [redacted] following the initial hearing on [redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 69 CYCP

Section 30(1) ATIPP, Section 69 CYCP

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[redacted] following a change in Program Managers responsible for the geographical area, no discussion regarding high risk files or overall caseload situations occurred between the two. In addition, during a caseload review meeting between the incoming Program Manager and the Case Manager in [redacted] the worker neglected to advise that [redacted] had been [redacted] that there was a [redacted]

[redacted] The Case Manager responsible for the file at the time reports that at no time during [redacted] during [redacted] practice for the area was clinical supervision provided. Most consults with the Manager involved basic casework discussions and were conducted over the phone.

Finally no attempt was made by the Case Manager to collaborate with the [redacted] when the opportunity arose. Collaboration could have led to increased vigilance by [redacted] regarding health and safety concerns for [redacted]

Conclusion:

[redacted] The Case Manager and Program Manager responsible for this file did not adequately make an argument to the [redacted]

Important Family of Origin File information was overlooked and clinical supervision lacked adequate follow up and documentation of same by CYFS. Essential information was not transferred from Case Manager to Program Manager, outgoing Program Manager to incoming Program Manager, and then to Senior Manager which if provided adequately could have assisted in effective decision-making at crucial points. If true and meaningful collaboration had occurred, [redacted] could have been made aware of the hazards [redacted] faced and been another support to recognize these hazards and address them as they presented. Unfortunately this did not occur. All these factors demonstrate that the care provided to [redacted] by CYFS was below the standard of care and as a result exposed [redacted] to further neglect and harm.

Recommendations:

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1. Documentation Issues:
    - Develop a strategy to audit files that are ongoing as well as closed to identify and address quality and content issues
    - Develop a method to clearly and succinctly identify pertinent history and points of transition with a focus on analysis and summary of the file
2. Investigative Process:
    - Develop a method to promote case conferencing within CYFS teams to enhance clinical use of case file history in the assessment/analysis of risk to children
3. Clinical Consultation/Supervision:
    - Develop a policy which outlines the expectations that CYFS staff are to collaborate with relevant and active professionals involved in providing care to clients outside CYFS to enhance information sharing
    - Develop a structured method of consultation between Case Managers, Program Managers and Senior Managers as well as a method of documenting consultation that occurs
    - Develop a formal mentorship program that provides meaning support and guidance and support to inexperienced Social Workers

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File 9

File Review

Child, Youth and Family Services

Section 30(1) ATIPP

[redacted]

Prepared By:
Wilma MacInnis
Department of Child, Youth, and Family Services

Date:

[redacted]

Section 30(1) ATIPP

Section 30(1) ATIPP

Section 69 CYCP

Section 69 CYCP

Section 30(1) ATIPP

Documentation in the file indicates that [redacted] felt supported by CYFS workers in their care of [redacted] CYFS interventions in [redacted] appeared regular and responsive. There was a high degree of collaboration with other community professionals in meeting [redacted] needs. The file references regular meetings and correspondence aimed at [redacted] care.

Section 30(1) ATIPP

[redacted]

Section 30(1) ATIPP, Section 69 CYCP

Section 30(1) ATIPP

File 10

Preliminary File Review

Report of Child, Youth and Family Services Interventions

Parents: [redacted]

Children: [redacted]

Section 30(1) ATIPP

Date: [redacted]

Introduction Section 30(1) ATIPP, Section 69 CYCP

[redacted]

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This preliminary report is based on the review of the CYFS case file [redacted] provided by [redacted] Health Authority [redacted] The report focuses on protective intervention services offered to [redacted] and reviews CYFS involvement including referral history, placement history, client contact, documentation, services offered, and aspects of risk management. This preliminary review does not provide a detailed clinical analysis of the CYFS practice. Section 30(1) ATIPP Section 30(1) ATIPP

Summary of Involvement with [redacted] Section 30(1) ATIPP

Immediate Family Composition Section 30(1) ATIPP

[redacted]

Extended Family and Caregivers

[redacted]

Initial Involvement Section 30(1) ATIPP Section 30(1) ATIPP, Section 69 CYCP

[redacted]

[redacted]

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Referral History

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Section 69 CYCP

There were [redacted] Child Protection Reports on file received from [redacted] noting concerns. There were [redacted] other reported concerns from that time period noted in service notes, letters, and e-mails but not on the required child protection reports. Appendix 1 illustrates this referral history and the varied CYFS responses in this case. [redacted]

Section 69 CYCP

Section 69 CYCP

Of the [redacted] referrals/noted concerns, there was documentation that [redacted] received CYFS follow-up specific to those concerns. A further detailed analysis of the quality of that clinical practice and response priorities regarding the referrals may be warranted. There is no documentation on file of a clinical assessment of the [redacted]

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Placement History

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[redacted]

[redacted]

[redacted]

There is no documentation of an assessment process or case planning for [redacted] placement or when [redacted]

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Client Contact

[redacted]

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[redacted]

There was little change in staffing during the course of this file. The Social Worker, Supervisors, and [redacted] remained relatively constant throughout the course of the file.

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Documentation

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The Child Face Sheet at the beginning of the file [redacted] The referral log (on the face sheet) is not up to date and does not include the [redacted] in the file.

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There are several instances in the file in which there was a gap in documentation. These included:

- [redacted] (3 month period)
- [redacted] (2 month period)
- [redacted] (21 month period)
- [redacted] (2 years, 3 month period)
- [redacted] (15 month period)

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There was no indication in the file that it had closed during the above-noted extended periods of time and there were no closure summaries on file. The family file is effective on CRMS as of [redacted]

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It is noteworthy that the layout of the file makes a review of the file history challenging. This is worth discussion as the Department looks at developing overall documentation standards.

Services

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The file indicates that services were offered or suggested to support [redacted] such as the Child Development Team and the local Family Resource Center. It does not appear that these services were sought by [redacted] CRMS entry and also noted to be utilizing [redacted] since [redacted] There were no case plans on file referencing support services and how they could benefit [redacted] or reduce risk to [redacted]

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Risk Management System(RMS)

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In the early part of the file, significant risk was identified in [redacted] Concerns of [redacted]

[redacted]

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Review of the file identified gaps in: assessing the risk of [redacted] There is limited documentation of conversations having taken place with [redacted] outside of referral

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investigations of the protection concerns and risk factors, their affect on [redacted] and the need to work towards [redacted] to reduce the risk of future harm to [redacted]

Despite reported concerns on [redacted] there is no documentation to suggest any discussion with [redacted] or supervisory consultation about [redacted] of the ongoing issues. While there are indications in the file that most referrals were followed up, interventions were primarily referral driven. There was no documentation of a risk assessment which would have been a requirement after [redacted]

There were [redacted] safety assessments on file (dated [redacted] The Safety Assessment of [redacted] deemed that [redacted] was safe and that no [redacted] required immediate safety intervention. [redacted] documents were added to CRMS in [redacted]

Safety plans were completed on [redacted] The plans solely involve [redacted] but given that [redacted] were living with [redacted] and concerns existed regarding [redacted] these plans could have included and involved [redacted]

Historical file information did not appear to be reviewed or considered in the case management process throughout the file. However, a Social Worker in [redacted] (not prompted by a specific referral) approached [redacted] in a home visit indicating she had read the file and was concerned about [redacted] Worker asked about childcare [redacted] and advised [redacted] Worker further advised there would be unplanned visits to the home to monitor.

Family/case planning has always been a policy requirement for CYFS. There were no family/case plans for [redacted] evidenced in the case file. There was limited documentation in the service notes of case planning

In terms of coordination of services, there was contact with [redacted] who presented concerns regarding the care of the children. In the early years of the file, there was much contact with these professionals regarding the needs [redacted] Contact with other professionals in latter years consisted mostly of referrals being made by these parties. There were no case conferences held. The file does indicate that services were offered or suggested to support [redacted] and Family Resource Center.

What is noteworthy in terms of coordination of services is that there was much contact from and with [redacted] regarding the [redacted] From [redacted] there are no service notes or documentation on the CYFS file. During this timeframe, [redacted] but there was no contact noted with [redacted] or with other service providers.

Similarly in terms of coordination of services and collaboration, a referral was made by a [redacted] to a CYFS staff at home on [redacted] Following supervisory consultation CYFS did not action the referral that evening. [redacted] were also contacted by [redacted] did not notify the on call worker that night. This referral from [redacted] indicating the [redacted]

[redacted] Collaboration and information sharing is essential when working with such high risk families.

Current Status Section 30(1) ATIPP, Section 69 CYCP

[redacted]

Concluding Comments

This report notes areas of concern within both practice and policy that require attention and focus. This review also highlights the challenges of working with issues [redacted] within an [redacted] Section 69 CYCP Section 69 CYCP

As this preliminary review has not been a detailed clinical analysis of the CYFS practice, it may be beneficial to have Departmental Program staff complete an analysis of the quality of clinical practice and response priorities pertaining to the referrals on file. [redacted] would also benefit from completing a review of the file including an analysis of their clinical practice and decision making pertaining to [redacted] Section 30(1) ATIPP Section 30(1) ATIPP Section 30(1) ATIPP

As part of the transition and transformation process, provincial CYFS staff need to meet with the [redacted] Regional Director of CYFS and other staff to discuss the RMS and assessing risk within the [redacted] of practice in [redacted] While this work should initially involve just CYFS staff, a broader strategy involving other service providers (such as Health and Justice) should also be considered as part of the long term planning, as such complex cases require collaborative approaches and strategies.

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