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VERDICT OF CORONER'S JURY

the jury serving on the inquest into the death of:

KASONDE, MARGRET

aged 9 held at OTTAWA

from APRIL 22 to JUNE 24, 1997

by Dr. BECHARD, Coroner for Ontario

having been duly sworn have inquired into and determined the following:

1. Name of deceased: MARGRET KASONDE
2. Date and time of death: 25 - 05 - 95 at 20:30
3. Place of death: OTTAWA CIVIC HOSPITAL
4. Cause of death: Exsanguination from hepatic and splenic perforation from rifle shot.
5. By what means: HOMICIDE

This verdict was received by me this 24 day of June, 1997.

Dr. Benoit E. Bechard

VERDICT OF CORONER'S JURY

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the jury serving on the inquest into the death of:

KASONDE, WILSON

aged 10 held at **OTTAWA**

from **APRIL 22** to **JUNE 24, 1997**

by **Dr. BECHARD**, Coroner for Ontario

having been duly sworn have inquired into and determined the following:

1. Name of deceased: **WILSON KASONDE**
2. Date and time of death: **25 - 05 - 95 at 19:30**
3. Place of death: **1450 Morisset Ave. #9, Ottawa, ON**
4. Cause of death: **Exsanguination from pulmonary and hepatic penetration from rifle shot.**
5. By what means: **HOMICIDE**

This verdict was received by me this 24 day of June, 1997.

Dr. Benoit E. Bechard

CORONER'S INQUEST

We recommend that:

THE GOVERNMENT OF ONTARIO amend *CHILD AND FAMILY SERVICES ACT* to:

1. Emphasize clearly the paramount importance of protection and well-being of children, to ensure that parental rights, due process and the principle of "least restrictive" intervention are subordinate to the safety, protection and best interests of children.
2. Expand the grounds for finding a child in need of protection to include situations where the child is exposed to parental abuse, domestic violence, substance abuse, emotional abuse, and neglect which is likely to result in emotional or physical harm, and/or developmental delay to a child.
3. Define clearly and expand the additional duty to report on the basis of suspicion of neglect and child's exposure to family violence.
4. Review the "substantial risk" threshold of child protection intervention and put into place new criteria for determining that a child is in need of protection.
5. Require the Court to sanction a person for contempt or breach of a Court-ordered condition.
6. Strengthen the investigative powers of child protection workers to include compelling information from collateral sources.
7. Change and clarify confidentiality and privacy provisions to allow on-going sharing of information between Children's Aid Society (CAS) and other professionals providing service to children.

We recommend that:

THE MINISTRY OF COMMUNITY OF SOCIAL SERVICES (MCSS)

Address the issue of funding as follows:

8. Revise its funding policy and formula to ensure the implementation of a rational, equitable, sustainable system of funding for the Ontario child protection system, including the provision for adequate resources to meet agreed upon caseload/workload standards.
9. Recognize in the revised funding formula the full and true costs of work done by child welfare agencies in the prevention of child abuse and neglect, as well as investigation, treatment, and service support to families in need.
10. Reinstate, in the interim, the 6% of operating base funding for Children's Aid Societies withdrawn in 1995 and allocate it across the Province equitably in consideration of the Child Welfare League of Canada workload standards.

Address the issue of workload standards as follows:

11. Develop and adopt caseload/workload standards, in conjunction with the Ontario Association of Children's Aid Societies (OACAS) and Ontario Public Service Employees Union (OPSEU), for the child protection functions prescribed in *Child and Family Service Act*, its regulations and standards and guidelines established for practice.
12. Adopt, in the interim, established workload/caseload standards of the Child Welfare League of America (CWLA) as adopted by the Child Welfare League of Canada (CWLC), and ensure funding to implement and maintain caseload standards, and worker/supervisor standards.

Address the need for accountability, standards, accreditation, reviews and audits as follows:

13. Amend current standards and guidelines for the investigation and management of abuse cases to include neglect and hold CAS's accountable for adhering to a standard of compliance through a provincial audit mechanism.
14. Develop and implement specific standards and guidelines to address the investigation and management of cases where there are custody/access concerns and child protection issues.
15. Develop and implement a common system and standard for case notes, supervisory notes, file organization and file documentation across the CAS system of Ontario.
16. Implement and fund a Quality Assurance Program across the CAS system in the province, to ensure consistency and quality of services delivered to children and families in the system.
17. Reinstate on-going targeted operational reviews of all CAS's in the province, and allocate the appropriate resources.
18. Adopt the current accreditation system for child service delivery and require all CAS's and other child service providers (including private service providers) to achieve and maintain accreditation through a provincial association or independent accrediting body.

Address the issue of Confidentiality and Information sharing as follows:

19. Amend the existing regulations and standards of the Revised Standards for Investigation of Child Abuse Cases to allow the CAS's to share the results of their investigations and information available to them with all organizations and professionals who are expected to monitor and/or support the safety and well-being of the child, as long as it is considered necessary to ensure safety and to plan services for the child.

Address the need for adequate training for Child Protection Workers as follows:

20. Provide additional funding for training of child protection workers.
21. Ensure that all child protection training is competency based on current state of knowledge regarding best practices.
22. Mandate the establishment of an intensive pre-employment child protection training program across the CAS system in the province and allocate the required resources.
23. Establish requirements and standards for provision of intensive internship training for all new CAS child protection workers before they are assigned full case management responsibilities.
24. Develop requirements and standards to maintain a regular in-service training program for existing CAS workers and supervisors.
25. Establish requirements and standards for investigative training skills, in identification of abuse and neglect of children.
26. Develop and implement, in conjunction with the Ontario Association of Children's Aid Societies and other relevant Provincial Ministries, comprehensive training for collateral professionals in the early identification of abuse, neglect indicators, reporting requirements, the role of CAS's, and other related matters such as management of services in child custody/access matters.
27. Establish and implement multi-cultural training courses for all CAS workers and supervisors focussing on the acquisition of knowledge and insight into behaviour and values of other cultures and ethnic groups.
28. Initiate the development, in cooperation with the Ontario Ministry of Education, a child protection specialization in post-secondary social work degrees, certificates and diplomas.

Address the need for on-going investment in computers and information technologies as follows:

29. Provide the funding necessary to equip and train all front-line protection workers in the use of computing technology to facilitate service delivery and efficient management of child protection functions.
30. Develop an interactive provincial data base on children and families receiving child protection services.
31. Develop local computer information network to facilitate interactions and information sharing among community based child protection services.
32. Develop criteria and standards for placing names on the Child Abuse Registry for all the provincial CAS's and, in addition, develop access criteria for use of the Child Abuse Registry by other child service providers in the province.
33. Develop and fund a standard on-line file case management system for all CAS's in the province, including audit and review functions.

Address the need to adopt comprehensive assessment tools, as follows:

34. Implement a comprehensive risk assessment tool and case planning model in child protection for use in all CAS's in Ontario, which includes an eligibility tool, a safety assessment, risk assessment and parental capacity assessment at critical decision making points.
35. Mandate the use of the risk assessment tool to all potential sources of risk to a child involving both custodial and non-custodial parents, whether in the child's principal residence or not.
36. Ensure that the parental capacity assessment includes an assessment of living conditions, including appropriate nutrition, sleeping arrangements, and sanitary living conditions, and applies to the residences of both custodial, and non-custodial parents.

We recommend that:

THE CHILDREN'S AID SOCIETY:

37. Ensure that when conducting investigations and managing cases, the CAS workers comply with all standards and regulations mandated by the Ministry of Community and Social Services.
38. Require a Case Planning and Review Conference in every case in which there is a third or subsequent complaint, referral or case opening.
39. Amend the current CAS policy regarding the sharing of information on a "need to know" basis to make it clear that it is not intended to prevent workers from discussing cases/files for the purpose of seeking clinical assistance and guidance from other workers.
40. Review the internal mail system to ensure that case files are forwarded in an expeditious manner.
41. Require that all transfer of files from one ongoing worker to another be done in accordance with the transfer policy in the Revised Standards for Child Abuse, with a meeting between the workers involved and the family.
42. Require that all incoming complaints and cases be assigned to a well trained, Special Investigation Team, whose responsibility is to complete risk assessments and abuse investigations.
43. Change the current supervisory model of CAS to require supervisors to provide clinical involvement with the case workers.
44. Ensure that on-site clinical supervision is always available to case workers, even when a supervisor is on vacation or leave, through a replacement on-site supervisor or a senior case worker in the unit.
45. Require that when dealing with a child or family, CAS case workers must have direct contact with all persons who have custody and/or access rights to a child when assessing risk to the child.

46. Allocate a specific number of days to CAS employees every year to receive ongoing training, in such areas as case management, interviewing and investigation skills, risk assessment, case note writing, use of computer technology, supervision and management, and ensure the employees are given support through backup workers in the period they are taking the training.
47. Develop a new system for CAS "Plans of Service" to encompass all the child service organizations involved with the child and/or family over the course of service.
48. Develop triage tools for case workers and supervisors to assist them in the prioritizing of cases based on level of risk to a child.
49. Ensure compliance with the existing requirement that CAS must, in all cases, investigate allegations of abuse and/or neglect reported by professionals or service providers in the community.
50. Provide training courses on neglect and child abuse identification for teachers and educators in cooperation with local School Boards, and ensure that local schools routinely receive regular information and literature on CAS services.
51. Ensure that case transfers are kept to a minimum to ensure continuity and consistency of service to child or family.
52. Establish direct links with local schools in high risk cases, and in cases where custody and access issues are problematic.
53. Commission a study of current "Child Protection Folder" to address more effective ways of filing and retrieving critical information from the child protection folder.
54. Review the case management process immediately and on a periodic basis in the future.

55. Ensure that, in addition to the CAS's own internal review of its management of services in the case of a child death, and independent, arm's length review of such deaths, be conducted by an independent body or group, and results submitted to the Ministry of Community and Social Services.
56. Ensure that when there is a death of a child receiving service from the CAS the Board of Directors of the CAS receive a copy of any report directly from the multi disciplinary review committee and monitor the steps taken by the management of the CAS in response to any recommendations in the report.
57. Require CAS Boards of Directors to initiate and promote fund raising activities in the local community and take steps to raise the profile, visibility, and reputation of the CAS.
58. Encourage CAS of Ottawa/Carleton to explore opportunities to establish linkages with the local high technology sector to determine ways in which this sector can assist the CAS in strengthening its computing and information technology infrastructure.
59. Hire employees of varying cultural and ethnic backgrounds to reflect the makeup of the community.
60. Develop a broad-based public awareness and education program addressing the needs of vulnerable children and youth, early identification of abuse and neglect indicators and the duty to report.
61. Mandate the CAS liaison assigned to the CHEO Child Protection Team to follow-up on the recommendations of the Child Protection Team, relevant to the CAS, and report back to the CPT and the CAS Case Planning Review Committee on actions taken.

WEAPONS

We recommend that lethal weapons and firearms be dealt with in the following ways:

62. Implement the Department of Justice Firearms Registry without delay.

63. Amend relevant federal legislation to allow permanent removal of lethal weapons, firearms and permits from the possession of any individual where there is a threat of suicide, domestic violence or child protection concerns and to place a CPIC alert on such individuals.
64. Require that police/CAS protocols for investigations include specific provisions for the management of child protection cases where firearms and/or lethal weapons are present.
65. Require face-to-face consultation between police, family and CAS prior to return of any weapon.
66. Require a Case Planning and Review Conference for every case in which there is a history of domestic violence and a firearm/lethal weapon known to be in the home.

COURTS

We recommend that the Province of Ontario:

67. Establish a bridging system between child welfare legislation and child custody and access legislation to clarify CAS role in this area. In the interim, the CAS must be a party to all custody and access hearings where children under their care are involved.
68. Consider, as an appropriate model, a Unified Family Court dealing with family law, child custody matters and child protection, managed throughout by one judge.

POLICE

We recommend that:

69. An occurrence report must be made and filed in any situation in which the police respond to a incident involving domestic violence or any CAS investigation.
70. When police attend an incident involving a CAS investigation, the police report must be cross referenced to the CAS file.

CHILDREN'S HOSPITAL OF EASTERN ONTARIO

We recommend that:

71. The CHEO Child Protection Team, or any other interdisciplinary group, provide the CAS with complete and accurate minutes of the meeting, as well as recommendations and conclusions.

CHILD DEATH REVIEW

We recommend that when reviewing the death of a child:

72. Local multi-disciplinary review committees should be established to review the recommendations of the Provincial Multi-Disciplinary Pediatric Death Review Committee.
73. In addition to an agency's own review of its management of services in the case of a child death, there must be an independent, arms length review of each such death conducted by the MCSS or an independent body.

OTHER

We recommend that the:

74. Chief Coroner of Ontario provide the Jury with a report on the status of the recommendations within 12 to 18 months, and that this report be made public.

Jury Verdict Explanation

It is traditional for the Presiding Coroner at an inquest to provide a synopsis of the events leading to the inquest and also provide background information. This makes reading the Jury's Verdict easier to understand by putting the Findings and Recommendations into their proper context.

This is based on my own understanding of the evidence and my interpretation of the Jury's Reasons. This is not to be considered actual evidence presented at the inquest. It is offered only to assist the reader. It is not intended in any way to replace the Jury's Verdict and it should be read in conjunction with the actual Verdict.

The jury came back with 74 recommendations, and I will try to put these recommendations in some context to make the understanding of the recommendations and the reasoning behind them easier for the reader. -

I must state at the start, the finding of a homicide in the By What Means section of the verdict is not a finding of responsibility and does not imply accountability. It is a descriptive term for the death of one person being caused intentionally by another.

SYNOPSIS OF CASE

Robert Kasonde is 46 years old, and his wife, Jane Kasonde is 43. He came to Canada from Zambia in 1982. Jane Kasonde came to join her husband in 1984. The couple had four children. Robert Kasonde (Jr.) was born in 1988, but died of sickle cell anaemia when he was 5 years old. Wilson Kasonde was 10 years old and Margret Kasonde was 8 years old when they were shot to death by their father on May 25, 1995. Geoffrey Kasonde, who was 7 years old, witnessed the fatal shootings of his brother and sister, but was not himself shot. Geoffrey had also been diagnosed with sickle cell anaemia.

Jane Kasonde left her husband in February of 1993. She states that she left him because he was abusive towards her and the children. She resided in Nepean. There had been ongoing Children's Aid Society (C.A.S.) contact stemming from concerns over health and welfare of the children and Mrs. Kasonde due to Mr. Kasonde's behaviour towards them.

Mrs. Kasonde had sole custody of Margret and Wilson Kasonde, and joint custody of Geoffrey Kasonde. The children visited their father's apartment at 1450 Morisset - Apt.#9, in the City of Ottawa on Tuesdays, Thursdays and every second weekend as provided by the Court. They attended school at Briargreen Public School.

Starting in 1989, the Children's Aid Society had been involved with the Kasonde family. Over the next six years, C.A.S. had been contacted on six different occasions by parties outside the family unit who reported incidents that concerned the father's behaviour or his treatment of the children and/or Mrs. Kasonde.

In February of 1995, Margret's teacher from Briargreen Public School contacted the C.A.S. to voice her concerns about Margret. She reported that everyday Margret has to go visit her father, she cried all day at school and appeared extremely fearful. Margret was also afraid her father would hit her "like before". She stated that her father drinks too much, gets hyper and she is afraid "he will get the gun". She states that she hides when she is afraid and when her father finds her he hits her. Margret also stated that she is hit because she does not want to go in the bathtub. The reason she does not want to go into the bathtub is because there are cockroaches. Margret also stated that her father had hit Geoffrey.

Several persons had been concerned with the fact that Mr. Kasonde had a gun in his possession. On July 16, 1992, a family friend had contacted the Nepean Police because he was concerned that Mr. Kasonde had called his residence (where Mrs. Kasonde and the children had sought temporary refuge) and told him "I just wanted to say goodbye to my wife and kids and good bye to you." On July 26, 1992, Mrs. Kasonde had called the Nepean Police and reported that a friend of her husband's told her that Mr. Kasonde had threatened to shoot himself with the rifle. The rifle was seized but returned to Mr. Kasonde by the police on August 8, 1992. Margret also reported her concern about her father's gun during an interview with a C.A.S. worker in March of 1995, two months before the shooting.

On February 1, 1995, a social worker from Children's Hospital of Eastern Ontario also called the C.A.S. to voice her concern that the father was a "ticking time bomb." She was concerned because of what she heard through the school and Mrs. Kasonde.

The case was under on-going investigation by the C.A.S. when the father shot and killed his two children. Mrs. Kasonde at the time, was trying to get sole custody of Geoffrey Kasonde and supervised access visits. Neither Mrs. Kasonde nor the C.A.S. knew where Mr. Kasonde resided and he would not provide them with his home telephone number.

On Thursday May 25, 1995, the children were visiting with their father at the Morisset apartment. Several neighbours heard gunshots or screaming but could not tell what apartment the noises were coming from. One neighbour told the police that she heard what sounded like a man beating his wife and that she could hear her screaming.

The officers found Wilson Kasonde lying on the floor in a large pool of blood, checked for vital signs, but the child was dead. Margret Kasonde was also found in the same bedroom, on the floor between a bed and a mattress. She was transported to the Civic Hospital where she was pronounced dead on arrival.

CORONER'S INQUEST

“We recommend that:

THE GOVERNMENT OF ONTARIO amend *CHILD AND FAMILY SERVICES ACT* to:

- 1. Emphasize clearly the paramount importance of protection and well-being of children, to ensure that parental rights, due process and the principle of "least restrictive" intervention are subordinate to the safety, protection and best interests of children.**
- 2. Expand the grounds for finding a child in need of protection to include situations where the child is exposed to parental abuse, domestic violence, substance abuse, emotional abuse, and neglect which is likely to result in emotional or physical harm, and/or developmental delay to a child.**
- 3. Define clearly and expand the additional duty to report on the basis of suspicion of neglect and child's exposure to family violence.**
- 4. Review the "substantial risk" threshold of child protection intervention and put into place new criteria for determining that a child is in need of protection.**
- 5. Require the Court to sanction a person for contempt or breach of a Court-ordered condition.**
- 6. Strengthen the investigative powers of child protection workers to include compelling information from collateral sources.**
- 7. Change and clarify confidentiality and privacy provisions to allow on-going sharing of information between Children's Aid Society (CAS) and other professionals providing service to children.”**

Explanation:

There was repeated testimony that the present wording of the Act in respect to the child coming first is confusing.

There appears to be a tension between the child and the family and this is expressed by words like “autonomy and integrity of the family” and “least restrictive or disruptive course of action”.

The testimony heard was that left the workers in a position of uncertainty regarding how far to go with a specific inquiry.

This is worsened when the family does not consent to the CAS involvement and the worker is faced with the notion of “substantial risk to the child” when trying to get a Court Order. There was ample evidence to support that the threshold of “substantial risk” needs to be lowered if we want the safety of children to be improved.

Testimony was heard that neglect is a strong indicator of potential risk of abuse and homicide and that it should be included in the definition of abuse.

There was evidence that Court Orders can be disregarded with impunity and that there is a need to allow the Court to punish parents who breach these orders. This testimony may have more to do with the training and understanding of the Act or the will to pursue the penalties imposed in the Act on the part of the witness than with inadequate provisions for enforcing the Orders.

We heard that the social workers at CAS were unable to contact collateral sources to verify allegations of abuse. In this case, there was no evidence that consent had been refused. In fact there was no evidence that consent was requested. Be that as it may, if we want the CAS to be able to investigate properly allegations of abuse or neglect, we must give them the tools necessary to complete the investigation appropriately.

A number of witnesses relied on the unproclaimed confidentiality provisions of the Act to explain/excuse the lack of communications between agencies/professionals involved with the children and expected to provide services to them. Again, there was no testimony regarding getting consent from the parent, but even without consent one can see that this kind of communication is in the interest of the child and could contribute to the child’s safety.

“We recommend that:

THE MINISTRY OF COMMUNITY OF SOCIAL SERVICES (MCSS)

Address the issue of funding as follows:

- 8. Revise its funding policy and formula to ensure the implementation of a rational, equitable, sustainable system of funding for the Ontario child protection system, including the provision for adequate resources to meet agreed upon caseload/workload standards.**
- 9. Recognize in the revised funding formula the full and true costs of work done by child welfare agencies in the prevention of child abuse and neglect, as well as investigation, treatment, and service support to families in need.**
- 10. Reinstate, in the interim, the 6% of operating base funding for Children's Aid**

Societies withdrawn in 1995 and allocate it across the Province equitably in consideration of the Child Welfare League of Canada workload standards.

Explanation:

Testimony was heard that there is **no logic** in the present base funding formula, that the funding is on year to year subject to cuts as occurred recently and that deficit can be covered only in part by having access to a contingency fund that covers only direct child protection expenses: for example this can be used to provide additional front-line workers but not supervisors.

It is clear that when actions are mandated in the Act, that the Ministry must provide the necessary moneys to support the mandate. It also means that the funding is based on a rational footing which considers caseloads/workloads.

In the interim, the jury recommends that the Ministry obviates for the deficiencies in their approach by providing a rational bridging mechanism. The jury was aware that the changes recommended will not occur overnight but that the protection of children will not wait for the Ministry to finalise its solution to this problem.

“Address the issue of workload standards as follows:

- 11. Develop and adopt caseload/workload standards, in conjunction with the Ontario Association of Children's Aid Societies (OACAS) and Ontario Public Service Employees Union (OPSEU), for the child protection functions prescribed in *Child and Family Service Act*, its regulations and standards and guidelines established for practice.**
- 12. Adopt, in the interim, established workload/caseload standards of the Child Welfare League of America (CWLA) as adopted by the Child Welfare League of Canada (CWLC), and ensure funding to implement and maintain caseload standards, and worker/supervisor standards.”**

Explanation:

The evidence presented at the inquest left no doubt that to have a rational approach to child protection, there was a need to agree on caseloads standards and that this needed to be done in a collaborative effort from all involved parties.

Again the jury stressed the need for an interim solution, anticipating no doubt that the process could take some time.

“Address the need for accountability, standards, accreditation, reviews and audits as follows:

- 13. Amend current standards and guidelines for the investigation and management of abuse cases to include neglect and hold CAS's accountable for adhering to a standard of compliance through a provincial audit mechanism.**
- 14. Develop and implement specific standards and guidelines to address the investigation and management of cases where there are custody/access concerns and child protection issues.**
- 15. Develop and implement a common system and standard for case notes, supervisory notes, file organization and file documentation across the CAS system of Ontario.**
- 16. Implement and fund a Quality Assurance Program across the CAS system in the province, to ensure consistency and quality of services delivered to children and families in the system.**
- 17. Reinstate on-going targeted operational reviews of all CAS's in the province, and allocate the appropriate resources.**
- 18. Adopt the current accreditation system for child service delivery and require all CAS's and other child service providers (including private service providers) to achieve and maintain accreditation through a provincial association or independent accrediting body.”**

Explanation:

It was apparent from the evidence that there was little in the way of standardised approach to the delivery of child protection services. Also, there was sufficient evidence to warrant including neglect in the ambit of child protection investigation. Moreover, it was evident that the standards promulgated by the Ministry are seen as goals to strive for and not necessarily as the minimum that needs to be done. This is reinforced by the lack of strict auditing of the compliance by the CAS to the standards.

There was evidence that systems of Accreditation of Agencies exist and that this would promote better compliance with “accepted best practices”.

“Address the issue of Confidentiality and Information sharing as follows:

- 19. Amend the existing regulations and standards of the Revised Standards for Investigation of Child Abuse Cases to allow the CAS's to share the results of their investigations and information available to them with all organizations and**

professionals who are expected to monitor and/or support the safety and well-being of the child, as long as it is considered necessary to ensure safety and to plan services for the child.

Address the need for adequate training for Child Protection Workers as follows:

20. Provide additional funding for training of child protection workers.
21. Ensure that all child protection training is competency based on current state of knowledge regarding best practices.
22. Mandate the establishment of an intensive pre-employment child protection training program across the CAS system in the province and allocate the required resources.
23. Establish requirements and standards for provision of intensive internship training for all new CAS child protection workers before they are assigned full case management responsibilities.
24. Develop requirements and standards to maintain a regular in-service training program for existing CAS workers and supervisors.
25. Establish requirements and standards for investigative training skills, in identification of abuse and neglect of children.
26. Develop and implement, in conjunction with the Ontario Association of Children's Aid Societies and other relevant Provincial Ministries, comprehensive training for collateral professionals in the early identification of abuse, neglect indicators, reporting requirements, the role of CAS's, and other related matters such as management of services in child custody/access matters.
27. Establish and implement multi-cultural training courses for all CAS workers and supervisors focusing on the acquisition of knowledge and insight into behaviour and values of other cultures and ethnic groups.
28. Initiate the development, in co-operation with the Ontario Ministry of Education, a child protection specialisation in post-secondary social work degrees, certificates and diplomas."

Explanation:

We heard a great deal of evidence indicating that workers were assigned full caseloads (although undefined) without training in child protection skills. People are hired from educational programs that do not address the specialised skills required for child protection work. The training at the time was often given later on the job. In the case of summer relief personnel this training did not appear to exist.

There also did not appear to be any structured curriculum that a worker would have to keep up with to remain current.

This recommendation addresses the need that other agencies involved in the field must be aware of the early symptoms and signs of neglect /child abuse to be able to discharge their reporting duties adequately.

This case involved people originating from Zambia and there was testimony indicative that there could be language/cultural communication gaps.

Evidence was heard that approaches had been made to institute of higher education to provide a specialty training in child protection work but that these contacts had not been successful. The evidence was that universities and colleges are better equipped to deliver a standard education across the province in this field than the present reliance on individual Society with their disparities in size and funding.

“Address the need for on-going investment in computers and information technologies as follows:

- 29. Provide the funding necessary to equip and train all front-line protection workers in the use of computing technology to facilitate service delivery and efficient management of child protection functions.**
- 30. Develop an interactive provincial data base on children and families receiving child protection services.**
- 31. Develop local computer information network to facilitate interactions and information sharing among community based child protection services.**
- 32. Develop criteria and standards for placing names on the Child Abuse Registry for all the provincial CAS's and, in addition, develop access criteria for use of the Child Abuse Registry by other child service providers in the province.**
- 33. Develop and fund a standard on-line file case management system for all CAS's in the province, including audit and review functions.”**

Explanation:

The evidence presented a picture of the business process of the Society that was not taking advantage of the benefits that modern information technology can bring to case work.

The evidence lead one to conclude that both at the Provincial level and within each agency there was an acute need to adopt Information Technology advances to replace the personnel that cannot be afforded anymore. Also, this would reduce the risk of families moving about in the Province to get out of the reach of the CAS.

“Address the need to adopt comprehensive assessment tools, as follows:

- 34. Implement a comprehensive risk assessment tool and case planning model in child protection for use in all CAS's in Ontario, which includes an eligibility tool, a safety assessment, risk assessment and parental capacity assessment at critical decision making points.**
- 35. Mandate the use of the risk assessment tool to all potential sources of risk to a child involving both custodial and non-custodial parents, whether in the child's principal residence or not.**
- 36. Ensure that the parental capacity assessment includes an assessment of living conditions, including appropriate nutrition, sleeping arrangements, and sanitary living conditions, and applies to the residences of both custodial, and non-custodial parents.”**

Explanation:

The evidence revealed consistently an underestimation of the risk to the Kasonde children. We heard that by the systematic used of a risk assessment tool the chance of gauging the risk accurately is improved in particular if the tool is used over time. This allows for the tracing of a curve showing changes in the risk and would improve the ability to take corrective action. Each recommendation represents situations that were present with the Kasonde family during their contact with the CAS.

“We recommend that:

THE CHILDREN'S AID SOCIETY:

- 37. Ensure that when conducting investigations and managing cases, the CAS workers**

comply with all standards and regulations mandated by the Ministry of Community and Social Services.”

Explanation:

There was ample evidence to show that the standards mandated by the Ministry were not adhered to. This was explained by the lack of time/too heavy workload.

“38. Require a Case Planning and Review Conference in every case in which there is a third or subsequent complaint, referral or case opening.”

Explanation:

The evidence revealed that the file of this family was opened and closed a number of times without proper conclusion being reached. We heard that a Case Planning and Review Conference is the vehicle where cases which are difficult to address are reviewed. The jury obviously felt that after passing through the hands of a number of workers without final resolution, this approach should be used.

“39. Amend the current CAS policy regarding the sharing of information on a "need to know" basis to make it clear that it is not intended to prevent workers from discussing cases/files for the purpose of seeking clinical assistance and guidance from other workers.”

Explanation:

We heard that because of the unproclaimed Section VIII of the Child and Family Services Act, the administration of the CAS appeared to enforce a strict need to know policy regarding the discussion of cases and this was presented to the jury as a cause for a lack of communications within the unit. We also heard that it is useful and common practice in other professional fields to discuss cases amongst peers to share experience and knowledge.

“40. Review the internal mail system to ensure that case files are forwarded in an expeditious manner.”

Explanation:

There was evidence that the Kasonde File was opened and reassigned to the West End Unit in Feb 95 and that it took over a week for the file to get there and be assigned to a worker.

“41. Require that all transfer of files from one ongoing worker to another be done in accordance with the transfer policy in the Revised Standards for Child Abuse, with a meeting between the workers involved and the family.”

Explanation:

The Ministry Standards required that a proper file transfer procedure be followed when a new worker takes over the care. The evidence showed that in particular with vacation coverage, the files were just handed over and in this case to a summer relief worker who was given the complete caseload of the departing worker. This did not appear unusual but more the rule for this kind of situation. The excuse was given that this was only temporary as a caretaker type of capacity. In reality the summer worker closed the file in spite of the expressed opinion of the previous worker that the file should be kept open since this appeared to keep the father in check.

“42. Require that all incoming complaints and cases be assigned to a well trained, Special Investigation Team, whose responsibility is to complete risk assessments and abuse investigations.”

Explanation:

Evidence showed that the continuing care worker do not view their clients with the same perspective as investigators do. This was detrimental in this case in that vigorous investigations of new allegations were not pursued probably because of a false sense of security given by their familiarity with the family.

“43. Change the current supervisory model of CAS to require supervisors to provide clinical involvement with the case workers.”

Explanation:

We heard evidence that the structure of management of the CAS had been changed over the last few years to make supervisors more managers and less clinical supervisors. This left the workers more on their own regardless of their level of experience.

“44. Ensure that on-site clinical supervision is always available to case workers, even when a supervisor is on vacation or leave, through a replacement on-site supervisor or a senior case worker in the unit.”

Explanation:

We heard that the supervisor of the West End Unit had an arrangement with the Supervisor at Kanata to cover during the vacations. This provided coverage in name only since this Supervisor did not attend at the West End Unit and provide any on-going supervision in the active management of cases

“45. Require that when dealing with a child or family, CAS case workers must have direct contact with all persons who have custody and/or access rights to a child when assessing risk to the child.”

Explanation:

The evidence showed that all the information was derived from the mother which was the

custodial parent and that after the separation of the couple, no contact was made with the father although he looked after the children a significant amount of time.

“46. Allocate a specific number of days to CAS employees every year to receive ongoing training, in such areas as case management, interviewing and investigation skills, risk assessment, case note writing, use of computer technology, supervision and management, and ensure the employees are given support through backup workers in the period they are taking the training.”

Explanation:

We heard that training was secondary to case work and that training was cancelled at times because a worker would be expected to attend to a case. There did not seem to be protected time to train.

“47. Develop a new system for CAS "Plans of Service" to encompass all the child service organizations involved with the child and/or family over the course of service.”

Explanation:

We heard that the development of Plans of Care did not involve associated agencies that were expected to be involved with the children during the period.

“48. Develop triage tools for case workers and supervisors to assist them in the prioritizing of cases based on level of risk to a child.”

Explanation:

We heard repeatedly that this case was low priority but there did not seem to be a method structured to help workers determine priority and show that a rational decision had been made when priority was assigned to a case.

“49. Ensure compliance with the existing requirement that CAS must, in all cases, investigate allegations of abuse and/or neglect reported by professionals or service providers in the community.”

Explanation:

Allegations of abuse were reported on at least two occasions but were not investigated following the standards of the Ministry.

“50. Provide training courses on neglect and child abuse identification for teachers and educators in co-operation with local School Boards, and ensure that local schools routinely receive regular information and literature on CAS services.”

Explanation:

Evidence was presented that one of the main sources of referral to CAS is schools. A teacher testified that they need to understand better the issue of abuse and the duty to report to help teachers feel more comfortable in their role.

- “51. Ensure that case transfers are kept to a minimum to ensure continuity and consistency of service to child or family.”**

Explanation:

This case was transferred a number of times. Testimony was that there are benefits to be derived from the involvement of few workers in a case.

- “52. Establish direct links with local schools in high risk cases, and in cases where custody and access issues are problematic.”**

Explanation:

We heard that schools and other agencies involved with children are not updated on Plans of Service or whether a case has become high-risk but are still considered as “monitoring the situation”.

- “53. Commission a study of current “Child Protection Folder” to address more effective ways of filing and retrieving critical information from the child protection folder.”**

Explanation:

The physical component of the Child Protection Folder were examined at the inquest and the jury obviously thought that there is a better way to keep this information in a logical order to allow worker not familiar with the case to have easy access to critical information.

- “54. Review the case management process immediately and on a periodic basis in the future.”**

Explanation:

The evidence showed that case management is not properly structured at present. The jury thought that this needed immediate attention but that this should not be a static situation but should be reviewed periodically as standards of best practice evolve.

- “55. Ensure that, in addition to the CAS's own internal review of its management of services in the case of a child death, and independent, arm's length review of such deaths, be conducted by an independent body or group, and results submitted to the Ministry of Community and Social Services.”**

Explanation:

The internal review that was done in this case left one wondering about the independence of the reviewers, in particular one who had been a long time employee of this CAS.

- “56. Ensure that when there is a death of a child receiving service from the CAS the Board of Directors of the CAS receive a copy of any report directly from the multi disciplinary review committee and monitor the steps taken by the management of the CAS in response to any recommendations in the report.”**

Explanation:

Again, the impression of conflict of interest was left with the inquest when the review is addressed to the CEO of the CAS and not to its Board of Directors.

- “57. Require CAS Boards of Directors to initiate and promote fund raising activities in the local community and take steps to raise the profile, visibility, and reputation of the CAS.”**

Explanation:

We were told that CAS is suffering from chronic underfunding but there was testimony that contrary to what happens at the Children Hospital no fund raising campaign is mounted to help the organisation.

- “58. Encourage CAS of Ottawa/Carleton to explore opportunities to establish linkages with the local high technology sector to determine ways in which this sector can assist the CAS in strengthening its computing and information technology infrastructure.”**

Explanation:

One of the areas that was identified as lacking was the use of computer technology and it would seem that this particular CAS given its geographical location could use the regional expertise in computers to its and the children's advantage.

- “59. Hire employees of varying cultural and ethnic backgrounds to reflect the makeup of the community.”**

Explanation:

There was testimony that at the time of the early contacts with the Kasonde family there was worries that the workers may not have been understanding the family because of its origins in Zambia.

- “60. Develop a broad-based public awareness and education program addressing the needs of vulnerable children and youth, early identification of abuse and neglect indicators and the duty to report.”**

Explanation:

There was evidence that the safety of children is not only the responsibility of the CAS but that the community as a whole share in this duty.

- “61. Mandate the CAS liaison assigned to the CHEO Child Protection Team to follow-up on the recommendations of the Child Protection Team, relevant to the CAS, and report back to the CPT and the CAS Case Planning Review Committee on actions taken.”**

Explanation:

There was a number of meeting of the CHEO Child Protection Team where recommendations for action were developed but there was little feed-back and little action.

“WEAPONS

We recommend that lethal weapons and firearms be dealt with in the following ways:

- 62. Implement the Department of Justice Firearms Registry without delay.**
- 63. Amend relevant federal legislation to allow permanent removal of lethal weapons, firearms and permits from the possession of any individual where there is a threat of suicide, domestic violence or child protection concerns and to place a CPIC alert on such individuals.**
- 64. Require that police/CAS protocols for investigations include specific provisions for the management of child protection cases where firearms and/or lethal weapons are present.**
- 65. Require face-to-face consultation between police, family and CAS prior to return of any weapon.**
- 66. Require a Case Planning and Review Conference for every case in which there is a history of domestic violence and a firearm/lethal weapon known to be in the home.”**

Explanation:

The presence of a firearm in the home of the father was a concern to many people involved in this case but this did not result in action. The jury identified the junctures where action could have been taken and suggest appropriate response.

“COURTS

We recommend that the Province of Ontario:

67. **Establish a bridging system between child welfare legislation and child custody and access legislation to clarify CAS role in this area. In the interim, the CAS must be a party to all custody and access hearings where children under their care are involved.**
68. **Consider, as an appropriate model, a Unified Family Court dealing with family law, child custody matters and child protection, managed throughout by one judge.”**

Explanation:

We heard that the CAS was relying on the divorce and custody court actions to provide a safe environment for the children. Obviously this did not happen. There seems to be a need where the interest of the children be represented and it was suggested that a Unified Family Court may be the way to address this problem.

“POLICE

We recommend that:

69. **An occurrence report must be made and filed in any situation in which the police respond to a incident involving domestic violence or any CAS investigation.**
70. **When police attend an incident involving a CAS investigation, the police report must be cross referenced to the CAS file.”**

Explanation:

We heard that some cases where the police attended at residence with the CAS worker did not make the subject of a report. This lead to important information not being as readily available as it could. The jury felt that this type of call, if the police is needed to keep the peace, it should make the subject of a report.

“CHILDREN'S HOSPITAL OF EASTERN ONTARIO

We recommend that:

71. **The CHEO Child Protection Team, or any other interdisciplinary group, provide the CAS with complete and accurate minutes of the meeting, as well as recommendations and conclusions.”**

Explanation:

We were told that the Committee produces minutes but that these are not distributed to the attendants to the meetings. Reliance is placed on the attendee to report to their own department.

“CHILD DEATH REVIEW

We recommend that when reviewing the death of a child:

- 72. Local multi-disciplinary review committees should be established to review the recommendations of the Provincial Multi-Disciplinary Paediatric Death Review Committee.”**

Explanation:

The Provincial system of death reviews was explained to the jury. The jury thought that it would be advantageous if the various parties involved with a child that died receive and review the findings of the provincial committee.

- “73. In addition to an agency's own review of its management of services in the case of a child death, there must be an independent, arms length review of each such death conducted by the MCSS or an independent body.”**

Explanation:

Evidence was lead that the ministry does not commission a review in the event with a child's death. Likely for fiscal reason.

“OTHER

We recommend that the:

- 74. Chief Coroner of Ontario provides the Jury with a report on the status of the recommendations within 12 to 18 months, and that this report be made public.”**

Explanation:

This recommendation will be implemented.

The sole purpose of this document is to assist the reader to more fully understand the verdict and recommendations of the jury and is not intended to be considered as actual evidence presented at the inquest. It must be read in conjunction with the jury verdict. It is in no way intended to replace the jury's verdict”.

