OFFICE OF THE OMBUDSMAN
CHILD DEATH REVIEW – FINAL REPORT

Department of Community Services
Department of Health and Wellness
Department of Justice

File #50312

July 2014

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PREFACE - SHOULD WE NAME THE CHILD?

The Office of the Ombudsman may be asked why the name of the child who is the subject of this report does not appear in the report.

The question was debated within our own office, and a decision not to do so was taken.

The main reason is we believed naming the child and deliberately bringing the child's family to public attention again would serve no useful purpose. Among other considerations are the siblings of the child and public attention could create more harm than good.

We also were mindful of guidance provided by the Ombudsman Act, the legislation under which this Office operates.

Section 6 of the Act, entitled "Extent of disclosure in report of Ombudsman," reads as follows:

"…the Ombudsman may disclose in a report made by him under this Act any matters which, in his opinion, are necessary to disclose in order to establish grounds for his conclusions and recommendations."

In our judgment, naming the child and by association the entire family, perhaps igniting again the private anguish that attends the death of any child, is unnecessary to meet the objectives set out in the Act.

We understand that publicity at the time of the child's death, along with certain information in the report deemed necessary to meet the requirements of Section 6, could lead to identification. Our preference is that it will not happen.

Christine Delisle-Brennan
Acting Ombudsman

OVERVIEW

The Office of the Ombudsman, at its own initiative, undertook an investigation to assess government systems, and services provided, pursuant to applicable provincial legislative regimes, during a several month period leading up to the death of a child.

The investigation was administrative in nature. It included the roles and responsibilities of provincial government agencies and various decision-making processes. The intended outcome was not to ascribe blame, rather to independently examine government services through interviews and administrative records in relation to a specific child death and, where appropriate, make recommendations to improve services for children identified as in need of protection.

A consultative report of our findings was presented to the government departments involved, and their responses have been factored into this final report. Their input significantly enhanced our understanding of the issues throughout the entire consultative process.

We are especially aware of the challenges of Child Protection Services staff, who work in stressful situations, often with heavy caseloads. We understand too that it is difficult to predict the future consequences of decisions that have to be made quickly, sometimes with incomplete information. However we are equally conscious of our responsibility to report findings that could suggest systemic defects and to question decisions and conclusions.

In this instance, a child died while residing at home. An individual was charged criminally for the child's death and was subsequently acquitted. Our investigation did not revisit that court decision, and this report does not address it.

It should be underscored that we found no evidence of government agents or public servants acting in an uncaring or indifferent manner. Our investigation does not identify specific actions or inactions by government agencies that can be said to have caused or contributed to the death of the child.

The report pays particular attention to the interaction among the key agencies involved during the period preceding the child's death. It raises questions

regarding various processes and systems, and has led to some conclusions and recommendations for change.

What emerged from our investigation might best be described as system fragmentation. In some instances there were a series of disconnects, vague or non-existent standards, and uncertainty of approach. Communications issues pervaded the process, with barriers within and among agencies and departments, and an absence of protocols to facilitate efficient information exchanges. Confidentiality was cited at times as a barrier to information-sharing.

The protection of children requires an insistent approach.

Among our most emphatic conclusions, which are detailed in the recommendations section, are as follows:

- Deaths of children receiving government services should trigger independent, interagency reviews.

- Healthcare professionals with expertise in detecting child abuse should play a more involved role in the child protection process.

- Standards and guidelines for child protection staff must be consistent, unambiguous, and as precise as possible, even at the cost of a degree of traditional discretion and individual decision-making.

We are pleased to note that this Office recently was advised that Child Protection Services have initiated a standards renewal project. It is projected to take two years. This initiative is welcome. In the interim, this Office believes provisional measures should be undertaken to address possible gaps in standards and policy in high-risk areas.

We would like to thank all who participated in this investigation.

SUMMARY OF EVENTS

Child Protection Services (CPS), a division within the Department of Community Services (DCS), were aware of the child for seven months, and were extensively involved with the family during the three months leading up to the child's death. Most of our investigation focused on that three-month time frame. For the final three months of the child's life, there were three overlapping CPS files and investigations underway.

When a report is referred for investigation, CPS investigates the possibility of child abuse, but they have not yet established it as a fact. Investigation files are assessed for urgency and risk. CPS describes these investigations as "active" investigations, as opposed to "open" protection files where allegations of abuse have been substantiated and CPS is providing services. For the purposes of this report, these investigations will be referred to as open or closed to reflect the status of the investigations.

The involvement of CPS in particular is highlighted through the following chronology of referrals and responses regarding the child's health and safety.

Referral #1

- Approximately seven months before the child's death, police reported to CPS a possible domestic disturbance at the child's home. The child's father had been intoxicated and taken into police custody for the night. A notification or referral to CPS is considered routine practice in such instances. CPS records document receiving the notification from police three weeks following the event.

  The incident was classified by CPS as indicating "substantial risk of emotional harm," a comparatively low-risk classification. The decision was made not to investigate this referral. There were no suspicions of child abuse.

Referrals #2 and #3

- Four months later two additional referrals occurred on the same day. Those referrals were not from police but from individuals who contacted

CPS directly expressing concern about the well-being of the child, including supervision of the child. Both referrals reflected some of the same concerns. However one of the referrals also alleged illegal drug use in the home. CPS made a decision not to investigate Referral #2 and immediately made a decision to investigate Referral #3.

Referral #3 was classified as "low risk." This required a response between three and twenty-one days, with the actual timeframe at the discretion of the CPS worker. The Child Abuse Register was checked, the supervisor was consulted, and the investigation plan was updated the next day. The database system indicated that the major presenting problem (inadequate supervision) was substantiated the same day as the referral was received. However, there was no documentation supporting this substantiation, and it appears to have been an error. Documentation resumed when there was a subsequent referral (Referral #4). This referral was received within the twenty-one day response timeframe assigned for Referral #3.

Referral #4

- Referral #4 included a report of unexplained bruising of the child's buttocks and redness in the genital area. This referral triggered immediate action on the part of CPS. It was classified as "high risk" and assigned a "same-day" response time. A CPS worker and police attended the child's home and accompanied the mother and child to a local hospital emergency department for assessment the same day the referral was received. The worker stayed with the mother and children during their wait in the emergency room and consulted the attending physician. The physician who treated the child indicated there were no signs of trauma, diagnosed a skin infection and a skin pigmentation condition, and signed a document to that effect for CPS records. The child returned home with the mother, a decision approved by a CPS supervisor.

- Four days following Referral #4 a CPS worker conducted a follow-up home visit with the mother and child and observed the condition of the home and the interactions between the mother and child. No concerns were noted. An additional sixteen days passed with no further documentation. After a meeting between the worker and a supervisor the major presenting problems (substantial risk of physical abuse and

substantial risk of sexual abuse) in Referral #4 were determined to be unsubstantiated. The investigation completion timeframe for Referral #3 was extended to allow a CPS worker to interview the child's sibling. The file remained open for an additional five days without notation. Documentation resumed when Referral #5 was received.

Referral #5

- Referral #5 was a report of a fall by the child which had occurred approximately eight days earlier, resulting in a head injury. This investigation file was opened and classified as a "moderate risk." It was assigned a response time of two working days due to the length of time since the injury had occurred. The child reportedly had received medical attention for the injury at the hospital. The source of this referral informed CPS that the mother's partner, who is not the child's biological father, had been caring for the child when the incident occurred. The source was interviewed by CPS the day after the referral was received. Also that day, police attended the child's daycare with CPS staff to interview the child, but were unable to obtain relevant information. The family physician's office was contacted, and local hospital emergency department records were examined. CPS established that the child had been seen at the family physician's office and treated at the local hospital emergency department six days prior to the referral. At the local hospital emergency department two physicians assessed the child and a CT scan was carried out. One of the physicians noted they "were not concerned re: abuse." It is not known whether the attending physicians were aware of prior/current CPS involvement with the child. There was no documentation to indicate CPS was contacted by either the family physician's office or local hospital emergency department.

  The mother was interviewed by CPS and police. There were inconsistencies in her account of events. After consulting a supervisor, the CPS caseworker and a colleague re-interviewed the mother and an older sibling that same evening. The sibling's school was contacted for collateral information. Police continued to be consulted and updated on different occasions by the worker.

  As the investigation continued, further concerns were raised about the mother's partner and his involvement with the child. Following

consultations with a CPS supervisor and a risk management meeting, a decision was made to interview the partner (as previously noted in the initial investigation plan), along with an adult house guest of the mother. The interview with the partner occurred eighteen days following Referral #5. During the interview, the partner denied he had been caring for the child on the day the child received the head injury.

- Following these interviews and some brief follow-up contact with the mother, an additional seventeen days passed without any written documentation of investigative activity. On the eighteenth day, the mother called 911 and reported she had left the child sleeping and returned later to find the child unresponsive. Emergency Health Services attended and the child was transported to the local hospital emergency department where efforts to resuscitate were unsuccessful. Police notified emergency duty CPS staff who made arrangements to remove the older sibling from the home. This sibling was subsequently placed in permanent care.

  An autopsy found that the child died of "blunt abdominal trauma." The mother's partner was charged with manslaughter, and subsequently acquitted.

  At the time of the child's death, more than seven months had passed since Referral #1 from police. Almost three months had passed since receipt of Referrals #2 and #3, which resulted in an investigation by CPS that lasted 82 days, and was open at the time of the child's death. The investigation with respect to Referral #5 had been open for 40 days. Two investigations were open and ongoing on the day of the child's death.

AGENCIES INVOLVED

Several agencies and government departments within the jurisdiction of the Office of the Ombudsman were involved in the investigations and services that immediately preceded the child's death.

The Department of Community Services (DCS) is the primary respondent. Within DCS, Child Protection Services (CPS) was the lead agency, with a district office of CPS assuming direct service responsibility in the case.

Employment Support and Income Assistance (ESIA), another division within DCS, was marginally involved. ESIA had been providing income assistance to the child's family off and on for several years and was providing services at the time of the child's death.

The mother of the child had a previous history of involvement in the criminal justice system and child protection. Her previous involvement with CPS had ended four years prior to the child's birth.

A daycare facility licensed by DCS was attended by the child in the months prior to the death.

The Department of Health and Wellness (DHW) was involved to the extent that the department is responsible for provincial health services. In Nova Scotia, there are currently nine district health authorities and regional hospitals report to these district health authorities. The local hospital emergency department where the child was treated twice in the period under review falls under the jurisdiction of a district health authority. Also under the DHW, the IWK Health Centre (IWK) operates its own separate Child Protection Team. Physicians, however, are governed by the Nova Scotia College of Physicians and Surgeons. In this case, concerns connected to the DHW primarily surround information sharing.

The Department of Justice through the Medical Examiner Service and policing services also was involved to varying degrees, as was Public Prosecution Services and local police. Although our focus is limited with respect to those service agencies, we received their full co-operation.

CONSULTATIVE PROCESS

This Office provided a consultative document to the Deputy Ministers of Community Services, Health and Wellness, and Justice. The consultative report outlined information gathered during the investigation, including findings and preliminary recommendations. The responding departments were provided with an opportunity to review the report and provide feedback.

In addition to the written response received from the Deputy Minister of Community Services, representatives from the Department of Community Services and Department of Health and Wellness provided written feedback. This Office also met with representatives from the Department of Community Services

and Department of Health and Wellness separately to discuss their feedback. Responses from the Department of Community Services and Department of Health and Wellness were considered and, where appropriate, are reflected in this report. Relevant policy clarification or standards improvements made by those departments since the child's death are specifically acknowledged.

DEPARTMENT OF COMMUNITY SERVICES

Child Protection Services

Child Protection Services are provided by the Department of Community Services and fall under the Children and Family Services Act (CFSA) and Regulations. District child welfare offices are organized into regions, with district offices within each region. In addition to district managers and regional administrators, there are provincial head office staff who provide support and oversight into the child welfare system. These include a provincial child protection co-ordinator and provincial auditor.

Policy and Standards

The Department of Community Services has a CPS Policy Manual, dated 1996. The manual contains child welfare standards, commentary and guidelines.

During our investigation, CPS staff involved with the child in the three months prior to the child's death consistently raised concerns regarding the CPS policy manual and associated standards. There were inconsistencies among CPS staff about the revision of the standards. The majority of CPS staff interviewed stated the policy manual had not been revised, and indicated that a current, condensed, electronic manual would be beneficial. Those staff indicated that a review of the policy manual is most needed in the areas of caseloads, response time examples, and the impact on protection practice of multiple referrals.

> *This Office believes the Child Protection Services Policy Manual and associated standards require ongoing review and appropriate updating to ensure standards remain adequate and provide clear direction to staff.*

This Office was pleased to learn that a standards renewal project is planned by DCS, and the policy manual has been made available electronically as of

October 2013. CPS head office staff also reported that the manual had been revised over a dozen times previously and the standards renewal project is a comprehensive review of the manual. In addition, a plan to regularly review the standards on a three-year cycle will be implemented, as was recommended in the May 2013 Auditor General's Report.

Intake

Allegations of child abuse are reported to each district office of Child Protection Services (CPS). The 'intakes' or referrals are assessed within a district office to determine if the allegation meets the criteria to proceed with an investigation. Not all referrals meet those criteria. A risk assessment model used through the investigation process determines whether there is sufficient evidence to support an allegation of abuse within the meaning of the Children and Family Services Act.

The mother of the child had been involved with CPS for a period of time prior to the child's birth. This history pre-dated the current CPS database system, and some of the terminology used to categorize those referrals at the time is no longer used. CPS staff acknowledged that a history of child protection involvement is important information to review and consider, but indicated that accessing some historical information can be cumbersome.

CPS Caseload

According to CPS Standards, the recommended average caseload for CPS workers is twenty files, with a mix of low, medium and high-risk cases. During the time CPS was involved with the child, staff reported that district caseloads were averaging thirty files per CPS worker and at times were as high as forty. Workers reported they consistently manage caseloads of twenty to twenty-five files per worker. CPS staff interviewed characterized the bulk of their files to be medium to high-risk.

Supervisors monitor the caseloads of staff and conduct monthly meetings. In addition to the required monthly meetings, several staff interviewed in the local office described an open-door policy between supervisors and staff. Front-line staff also reported comfort in approaching supervisory staff with any concerns or questions. There is also a process in place for supervisors to notify the Regional Administrator should caseloads become unmanageable.

Response Time

The CPS Policy Manual sets standards for initial response time and a guideline for completion of intake investigations. The manual provides examples to guide staff in assessing risk with the response times.

CPS must respond to a high-risk/life-threatening situation within an hour from the point of referral, and a high-risk but not life-threatening situation on the same working day.

Domestic violence referrals are generally assigned a two-day response time. Moderate risk, defined as damaging but not dangerous or life threatening, also is assigned a response time of two working days. A referral assessed as low/no risk has a response time of three to twenty-one days. During interviews with local CPS staff, there were varying opinions as to whether the standards referred to calendar or business (working) days. This issue has been clarified as calendar days, and this information is now included in the electronic version of the policy manual.

Referral #3 was classified as low/no risk and assigned a response time of three to twenty-one days. While a supervisor can assign a specific response time within this period, there is no record in the case notes that this was done. In its absence, the time-frame is left to the worker's discretion. The investigation time-frame, three to twenty-one days for referrals classified as low/no risk, is broad. However, CPS head office staff indicated that placing tighter parameters on this response time could create barriers to staff using their professional judgement. The current practice is for supervisors to assign a response time within the three to twenty-one days, if warranted, in consultation with the worker. In the absence of a standard or guideline requiring a specific response time within this category, the responsibility would fall to CPS workers to determine an appropriate time period. This response time had been flagged as an issue by the department's own internal review into the child's death.

> *It is not the intention of this report to limit the professional judgement of CPS workers. This Office believes a balance can be struck between the development of a standard or guideline to create clear parameters for response without creating an overly restrictive system that would limit professional judgement and discretion.*

An investigative plan was developed following Referral #3. The plan included an interview with the child's sibling, who had been present during the events related to the referral. This interview did not occur until forty-three days following the referral, by which time two subsequent referrals had been received. Documentation of this interview did not include information about issues raised in Referral #3.

The day after Referral #3 was received, the Child Abuse Register was checked, the supervisor was consulted, and the investigation plan was revised to include interviews with police and probation. The first contact with police documented in the case notes, after the revision to the investigation plan, was sixteen days later on the day Referral #4 was received. There is no documentation in the case notes of contact with probation.

Referral #4 was received seventeen days after Referral #3. There was no documentation on the file for the sixteen days preceding the receipt of Referral #4 and after the Register was checked.

On the day of Referral #4, the CPS worker contacted police and accompanied the child and their mother to the local emergency department for a medical assessment. A follow-up home visit was conducted by CPS four days later.

This visit included a discussion with the mother on the allegations of inadequate supervision (Referral #3), which she denied. The worker also made note of the interactions between the mother and the child and the condition of the home, including the amount of food available (Referral #3). No concerns were recorded.

Sixteen days later the worker noted that the allegations in Referral #4 could not be substantiated. Case notes on the same day indicate a supervisor was involved in approving a time extension so that the child's sibling could be interviewed. There was no specific timeline documented for the extension period. This extension was reported to be related to Referral #3 although this file was still within the six-week (forty-two day) guideline for investigations.

This forty-two day timeframe to complete an investigation can be extended through consultation with a supervisor and is expected to be documented in the case notes. Local CPS staff interviewed reported that extensions are requested in situations where more information is required, or where there have been

difficulties in accessing information. While the standards do not prescribe extension periods, staff reported that they are normally short.

CPS head office staff reported that extensions, when granted, apply to all open files. Head office staff report that in November 2013, a directive was forwarded to the district offices clarifying that extensions in investigations must be clearly documented and include the associated extension timeframe.

There had been no activity documented in the file after the extension was granted when, five days later, Referral #5 was received by CPS. In this referral, the child was reported to have sustained a head injury approximately eight days earlier which was classified as a "moderate risk" and assigned a two-day response time.

The day after Referral #5 was received the child was interviewed at the daycare by CPS and police. On the same day, CPS interviewed medical personnel, the source of the referral, and the mother. A second interview with the mother was conducted later that day by two CPS workers. Eight days following the two interviews with the mother, a risk management conference was held. Eighteen days after Referral #5 the mother's partner, who was alleged to have been caring for the child when the head injury occurred, was interviewed by a CPS worker. The CPS worker contacted the mother by telephone four days after her partner was interviewed to obtain contact information for another party. No activity is documented between that telephone contact and the child's death eighteen days later.

In this instance, at the time of the child's death, Referral #3 had been open for eighty-two days and Referral #5 was open for forty days. An extension of Referral #3 was documented thirty-seven days after the referral was received.

Multiple Referrals

There is no standard in the policy manual regarding the impact of new and/or multiple referrals on the investigations timeframe. These activities are monitored through monthly supervision meetings.

Local CPS staff interviewed revealed uncertainty as to whether the forty-two day investigation timeframe is extended automatically, or restarts when new referrals are received.

In addition, there were differing views among those interviewed regarding the impact on response time of multiple referrals. CPS head office staff indicated that the impact of multiple referrals is incorporated into the risk management model in the review of CPS history. The intake forms completed for the referrals involving the child include a summary of the CPS history.

> *CPS workers would benefit from clarity and guidance regarding multiple referrals and their impact on risk assessment and response times. This guidance should be incorporated in CPS policy and/or standards.*

Risk Assessment

In child protection cases risk is assessed through the initial referral process and at key decision points during investigations. Current child protection standards do not require a formal risk management conference until the development of a case plan after an allegation is substantiated and a protection file has been opened. A formal risk management conference must be attended by a supervisor with at least one other staff present. In this instance, documentation in the case notes and referral forms indicate that a supervisor was consulted at key, and various, decision points during the investigations.

In this case, a risk management conference was held with two CPS supervisors and two CPS staff a month prior to the child's death. A CPS worker interviewed indicated that a risk management conference was requested due to the multiple referrals and inconsistency of information provided throughout the investigation. The outcome of this meeting was the investigation plan was revised to interview the adult house guest, access the medical records from Referral #4, and continue with the plan to interview the mother's partner. The house guest was interviewed the same day as the risk management conference, and the mother's partner was interviewed nine days later. Both individuals reported that they were not present when the head injury occurred.

Medical Assessments

There are standards in the CPS policy manual related to medical assessments of a child. However, there is no standard for follow-up with a family physician after treatment/assessment at a hospital emergency department where there are suspicions of abuse or neglect.

In this instance, a CPS worker requested that the mother bring the child to the local hospital emergency department to assess redness in the child's genital area and marks on the child's buttocks (Referral #4). A Medical Report of Child Abuse was completed by the attending physician and located on the CPS file. Documentation indicated that a CPS worker planned to follow-up with the family physician. There is no documentation on file to indicate whether or not this follow-up occurred in relation to this referral.

During the consultative process, CPS head office indicated that family physicians are considered collateral contacts within the policy manual and contact with them is part of the investigative planning and supervisor consultation process.

Local CPS workers interviewed indicated they rely heavily on medical professionals to provide assessments of injuries and opinion as to whether an injury may be a result of abuse. Physicians are asked to complete a Medical Report of Child Abuse Form for the file. CPS staff also reported that occasionally a second medical assessment is requested if staff are not satisfied with the outcome of the first. This practice reflects a guideline in the policy manual. One CPS staff member suggested that the Medical Report of Child Abuse Form should be updated with input from the IWK Child Protection Team. This work has since commenced.

All CPS staff interviewed spoke highly of the IWK Child Protection Team. The CPS policy manual includes commentary on referrals to the IWK and indicates that these referrals are made in consultation with the attending physician. However some staff expressed concern that making a referral to the IWK Child Protection Team, particularly without the involvement of the initial attending physician, may cause tension in their working relationship with local physicians. There are no specific criteria or standards for referrals to the IWK Child Protection Team, with or without involvement of the physician. During interviews with local CPS staff, it was noted that guidance in this area would be helpful.

> *It is the perspective of this Office that the CPS policy manual should include a standard or guideline for follow-up with a family physician in instances where there have been emergency room assessments of a child related to suspicions of neglect or abuse.*

During the consultative process, CPS head office staff indicated the current policy allows staff to make referrals to the IWK and/or request a second medical opinion and a standard or guideline would create an environment where workers would be “hampered by a more prescriptive approach.”

> *This Office believes a balance can be struck between the development of a standard or guideline related to a request for a second medical opinion and/or referral to the IWK, without creating an overly restrictive system that would limit professional judgement and discretion.*

Local CPS staff interviewed reported the challenges in accessing medical opinions include a requirement for physician referrals for a paediatric assessment, and the practice of some family medical clinics to communicate with child protection services only in writing.

CPS staff indicated they do not have a strong relationship with the local hospital emergency department and suggested a liaison person would be beneficial. While there have been meetings between CPS and health authority staff in some regions across the province to promote an understanding of roles and responsibilities, there is no provincial protocol to facilitate information sharing.

Through the consultative process, CPS head office staff indicated current legislation is sufficient to guide the relationship between CPS and local health care professionals. However, the issues surrounding the relationship between the local CPS office and local hospital that existed during these investigations are reported to have continued.

> *This Office believes the development of provincial protocols will assist in addressing issues at a local level, while creating consistencies at a provincial level.*

The Department of Health and Wellness has communicated a willingness to develop provincial protocols in this area.

Child Abuse Register

CPS staff can search the Child Abuse Register (the Register), which is a database of individuals found by the court to have abused children, as a collateral source. The Register is established under the Children and Family Services Act, and there are standards and guidelines respecting its use in the CPS policy manual. These policy and standards emphasize the confidential and sensitive nature of the information on the Register, and access to it.

Designated CPS staff may access the Register. Commentary in the CPS policy manual indicates the information obtained from the Register cannot be disclosed to outside parties and other agency staff not involved in the CPS investigation.

Local CPS staff interviewed advised that in the past the Register was checked upon the initial referral for a child/family. Currently, the practice is to check the Register for every new referral, whether there have been previous referrals or not.

Once a name has been identified on the Child Abuse Register, intake workers gather additional information to determine if this history presents a current risk. CPS staff interviewed advised that this would include follow-up by CPS staff with police.

The assessment of current risk could influence the response time of a referral. CPS staff indicated when an individual is listed on the Register, there can be a direct impact on the investigation, including response times, depending on the original reason for listing and current assessed risk.

During the involvement of CPS in this case, information from the Register did not appear to influence the intake investigation response time. It did appear to guide CPS staff to other sources of information, such as police. The name of the mother's partner was not checked in the Register. After the child died, however, information relevant to the partner was discovered in CPS records.

There are inconsistencies among local CPS staff about how the Register information is documented. One individual reported there has been a recent change by head office in the documentation of information identified in a Register check and this is no longer allowed to be recorded on the case notes. Workers can document only that a check was completed on an individual and the date. Other staff interviewed indicated this information is documented in the case

notes. CPS head office staff advised that findings from a Register search should be documented in the investigation file.

> *CPS staff would benefit from clarification with respect to what information from the Child Abuse Register can and should be documented in CPS investigative files.*

Non-Custodial Parents

There are no standards to guide CPS staff with respect to contacting non-custodial parents. Interviews conducted with local CPS staff revealed inconsistencies in CPS staff perspectives as to when a non-custodial parent should be contacted.

In this instance, the child resided with the mother, while the father lived elsewhere within the same community. According to CPS case notes, the mother reported that the father had very little involvement in the child's life. CPS staff had contact with the mother during the course of their investigations. While a CPS worker indicated they had contact with the father during the investigation of Referral #5, there was no documented contact with the father prior to the child's death. An Ombudsman Representative met with and interviewed the father of the child, who stated that his first contact with CPS was after the child died when he approached CPS to provide information.

Through the consultative process, CPS head office staff indicated the current system enables staff to use their professional judgement regarding when to contact non-custodial parents. It was suggested this could be "hampered by a more prescriptive approach."

> *This Office believes that a balance can be struck between the development of a standard or guideline with respect to contacting non-custodial parents, without creating an overly restrictive system that would limit professional judgement and discretion.*

Supervision

There are standards in the CPS policy manual related to the supervision of staff.

Supervisors are responsible for completing case audits on the file when a case is closed or when a file moves from investigation to an open protection file. A Case Audit Form is available in the CPS guidelines and there are plans by DCS to

update and improve this form. There are regular supervision meetings between the CPS worker and supervisor to monitor the progression of a file, and workers can consult with supervisors during the course of their investigation.

A supervisor signed the referral forms for each intake received involving the child. In addition, supervisors were consulted during the investigations and this is documented in the case notes.

Training

DCS provided training for supervisors in the fall of 2012 and supervisors from across the province participated. It is our understanding these training sessions are ongoing and include file supervision. Supervisors also are encouraged to attend the Core Training as a refresher on any changes since they last received such training. Further, supervisors can access Leadership Development Training through the Public Service Commission.

Newly hired CPS staff must complete the provincial Child Protection Services training modules. They are also required to complete a domestic violence course and interviewing techniques training with police. In addition, CPS workers must be registered social workers and are required through their professional association to complete forty hours of professional development annually. There is a CPS standard respecting training but it is somewhat vague. It states that new CPS staff must receive “appropriate, adequate, and current training” related to “standards and guidelines,” but it does not specify what training is required.

Internal Child Death Review (Policy 78)

There is at the Department of Community Services a designated individual whose role includes auditing the district offices for compliance with the Child Protection Services Policy Manual. The child protection file in this instance was not audited. However, it was subject to an internal departmental child death review, which examined compliance with standards.

DCS Policy 78: Review of the Death of a Child is activated when a child receiving protection services dies as a result of abuse or neglect. This review is administrative and its stated purpose is to examine the circumstances surrounding the death of the child, review the involvement of child protection services, review relevant child protection policies, standards and procedures, and report the findings to the Minister and Deputy Minister.

The policy does not indicate who else receives the report or who is responsible for ensuring recommendations, if any, are implemented. CPS head office officials indicated that the Director of Child Welfare is responsible. The Regional Child Welfare Specialist would be responsible for reviewing any findings with district office staff.

An internal review of the CPS file for the child was completed in accordance with Policy 78. The review team included senior officials within the department, legal representatives, and a physician acting in the capacity of a medical advisor. The internal review was completed more than two years ago and included recommendations. The report does not indicate who is responsible for implementing the recommendations or associated timeframes. During the course of this investigation, it was indicated that these recommendations have not been fully implemented.

CPS staff at the local level indicated they were not aware of any concerns identified through the internal review, and were not aware of the findings or recommendations of the review. It was later determined that there had been a teleconference with the District Manager, Supervisor, two Child Welfare Specialists and the Co-ordinator of CPS after the initial review. The front-line workers had not been interviewed as part of the process. They expressed an interest in the results of the internal review and recommendations. CPS head office staff has verified that, subsequent to our investigation, this information has been shared with the workers.

Child Protection Services have reported they anticipate a review of Policy 78. The revision will include action plans and timeframes to promote accountability.

> *While the internal review of the child's death was completed, as per DCS policy, this Office believes that child death reviews are best conducted in a more comprehensive manner employing an interagency approach, as occurs in other jurisdictions. This issue is discussed later in this report.*

Licensed Day Care

As a private, provincially licensed facility, the child's day care is required to adhere to the Day Care Act and Regulations which make it the duty of every person to report to child protection services when a "child is in need of protective services." In this instance, the day care had policies and procedures, including

reporting suspected abuse to child protection, which is reviewed at staff meetings. The early childhood educators interviewed reported that they feel comfortable contacting CPS with any concerns or questions, and described a positive working relationship with the agency.

The early childhood educators interviewed stated there were no major concerns with the child, with the exception of one incident of unexplained bruising in the buttocks and redness in the genital area (Referral #4). The Executive Director of the child's daycare was notified by the educators and CPS were contacted, as per facility policy.

The educators recalled a period when the child was absent for a week. They had been notified by the mother that the child had bumped their head and would not be in. The educators interviewed stated the child's absence and reason for absence did not raise any concerns.

Employment Support and Income Assistance (ESIA)

Employment Support and Income Assistance, also a division of the Department of Community Services, is organized into regions and districts comparable to Child Protection Services offices. The district managers and regional administrators for CPS are also responsible for the ESIA program.

The child's mother was receiving income assistance during the time period of CPS involvement, prior to the death of the child. Local income assistance staff interviewed stated they were not aware of any recent child protection involvement with the family.

During the review of the ESIA file, it was noted there had been previous child protection concerns reported to the ESIA caseworker. These concerns were related to the child's older sibling and occurred prior to the birth of the child. There is no documentation to substantiate that CPS received these referrals.

Apart from requirements under the Children and Family Services Act, there are no provincial or district information-sharing protocols or policies to facilitate communication between these offices. The ESIA Policy Manual outlines the duty of ESIA caseworkers to report suspected child abuse. Due to the nature of their work, the policy indicates an increased responsibility for caseworkers to report.

The CPS and ESIA offices are located in the same building in the district where this child resided. This fact was regarded by DCS staff as beneficial for communication. In the past communication was less formal. However there have been recent changes in communication processes between these offices and it was reported that ESIA caseworkers are now required to email or set up a meeting with CPS to discuss a referral. ESIA and CPS staff reported challenges in sharing information with one another due to confidentiality.

THE DEPARTMENT OF JUSTICE

Police Involvement

The mother of the child and the mother's partner were known to police. There was a previous incident of police involvement (approximately seven months prior to the death of the child) between the mother and father of the child. Police faxed this information to CPS (Referral #1). There was no further documented contact between CPS and police regarding this referral. The CPS supervisor was consulted and the decision was made not to investigate the child protection referral. Documentation indicated CPS staff consulted with police during Referrals #4 and #5, and police and CPS conducted joint interviews with the mother and the child. Police also investigated the child's death.

There is a provincial Memorandum of Understanding (MOU) to facilitate information-sharing between the RCMP and the Minister of Community Services. Both agencies have policy in place respecting the reporting of suspected child abuse. There is an assigned local RCMP officer to facilitate communication between the RCMP and CPS to address any issues that may arise. Both CPS staff and police interviewed report a good working relationship.

Information sharing protocols exist between police and child protection services in some areas of the province, but are lacking in others.

There is a provincial protocol dated 1994 for a coordinated response between CPS and police to incidents of family violence. It was reported that regional CPS offices and local municipal police departments also have developed protocols. There is a draft protocol (May 2009) in place between CPS and municipal police in the Halifax region. It was reported that there was no protocol in place between

the CPS office and municipal police in the region where the child was receiving services.

Some local CPS staff stated it would be beneficial to have protocols at the local level between police and child protection services to clarify information sharing responsibilities. Freedom of Information and Protection of Privacy legislation was also cited as providing legislated authority to share information with police.

Medical Examiner Service

The Medical Examiner's Report indicated that the child died from an injury due to blunt abdominal trauma. The manner of death was determined to be a homicide.

Public Prosecution Service

The Public Prosecution Service brought the matter before the courts, resulting in a trial and subsequent acquittal.

DEPARTMENT OF HEALTH AND WELLNESS

District Health Authority and District Hospital

The administration of the local hospital where the child was treated and assessed for Referrals #4 and #5 declined to discuss case-specific information without specific consent. They did agree to meet as a group with Ombudsman Representatives to discuss general policies and procedures. Representatives from quality and patient safety, the local hospital emergency department, mental health services, maternal and child services, public health, and a physician attended the meeting.

The child visited the local hospital emergency department twice during the time CPS was involved with the child. The first of these visits was at the request of CPS staff in response to Referral #4. The CPS worker attended with the mother and the child. The child was treated and the attending physician indicated there was no sign of trauma and diagnosed a bacterial skin infection and a skin pigmentation condition. The second visit occurred nineteen calendar days later when the mother brought the child in with a head injury. The child was assessed by two physicians and documentation on the local hospital emergency record indicates the attending physician was "not concerned regarding abuse."

CPS staff were unaware of the second visit to the local hospital emergency department until six days later when CPS received the fifth referral regarding the child. A CPS worker attended the hospital the day after Referral #5 was received and reviewed the emergency room record. As noted earlier, this Office was advised that hospital staff were unable to discuss case-specific information. As a result Ombudsman Representatives have not been able to determine whether the physicians who treated the child were aware of recent CPS involvement.

IWK Child Protection Team

The IWK Child Protection Team was not involved with the child or family during the period under review. There was no referral to this team by CPS, the family physician, or hospital staff.

The IWK Child Protection Team includes paediatricians, social workers and a clinical nurse specialist. The team provides direct medical assessment and works collaboratively with clinicians to provide advice on assessing and reporting abuse.

The IWK team provides outreach and education throughout the province, primarily by request. Local hospital staff familiar with the team indicated it is receptive and responsive. The IWK team was described as “open to sharing information.” There are no criteria or policies within the local hospital regarding referrals to the IWK Child Protection Team.

> *This Office believes that stakeholders and agencies would benefit from the expansion of the IWK Child Protection Team outreach and education initiatives.*

Information Sharing

Based on interviews conducted throughout this investigation, sharing of information between healthcare personnel and child protection staff is challenging. The reasons include legislative requirements, the sensitive nature of personal health information, database differences between district health authorities (DHA’s), and lack of clear protocols.

Regional hospital staff, particularly maternity and public-health personnel, provided positive assessments of their relationship with child protection staff. However this perception conflicts with feedback from child protection staff regarding their relationship with the local hospital emergency department.

General concerns were raised by hospital staff regarding the lack of feedback from CPS after a referral is made by the hospital. In turn, CPS staff interviewed indicated that they must be cautious with sharing information due to confidentiality. CPS head office staff indicated the practice is to send an acknowledgement letter to professional referral sources indicating whether or not the referral will be investigated. District hospital staff reported that the emergency department has regular meetings with CPS. These meetings focus on communication between the respective teams but specific cases are not discussed.

Staff of the local district hospital reported it is rare to see a child in emergency as a result of abuse. However, if there is a suspicion that abuse may have occurred there is an internal hospital reporting system which includes an assessment by a paediatrician. If medical evidence suggests abuse, a referral is made to CPS.

The district health authority in this case has a Legally-Mandated Notifications Policy (May 13, 2009) which includes the requirement to notify the Department of Community Services when there is suspected child abuse. The policy also includes direction to contact the Risk Management Department or administrator on call if there are uncertainties regarding reporting requirements. In addition, there is a duty to report suspicions of abuse under the Children and Family Services Act.

Currently there are three provincial health information systems used in district health authorities across the province. Eight health authorities utilize the same system. There is a provincial program (SHARE) to facilitate access to information across these systems, but at the time of the child's death not all healthcare professionals had access to the SHARE program. This was scheduled to have changed by March 2014. The lack of a single comprehensive provincial database creates a barrier to accessing information in a timely and efficient manner.

The existing database systems include critical care indicators that flag patient files for various reasons, such as drug seeking or history of violence. Previous or current hospital visits due to CPS concerns are not critical care indicators. The inclusion of this child protection information as a critical care indicator was seen by most of those interviewed as beneficial. However, concerns regarding the

understanding of CPS involvement, impact and monitoring of this information are relevant and were also raised.

Healthcare professionals, particularly those working in hospital emergency departments, require information identifying potential risks involving the safety and well-being of children. This information could trigger additional assessments and/or referrals to the IWK Child Protection Team, or CPS.

IWK Child Protection Team members interviewed also reported that information sharing between agencies can be a challenge. The IWK team can request signed consent from parents or guardians for information sharing with law enforcement and child protection services. In the absence of consent to release information, the team can share information with Child Protection Services. The Children and Family Services Act provides authority for them to do so.

As of February 2012, a joint protocol between CPS and the local hospital emergency department existed in draft form. This Office was pleased to learn during the consultative process that this protocol was finalized April 2014 and education sessions have been held between the emergency department and CPS regarding this document. In addition, this protocol is planned to be reviewed annually and amended as needed through consultation and collaboration between these two agencies.The protocol focuses on the requirement of medical employees to report abuse and neglect to child protection. It does not include information sharing protocols between child protection and healthcare professionals.

In summary, information sharing between CPS and healthcare professionals appears inadequate, is not subject to protocols, and is inconsistent among medical services.

> *This Office believes access to medical records between health authorities can provide a more comprehensive history and assist healthcare professionals in identifying potential issues or suspected abuse.*
>
> *Throughout this investigation, this Office observed CPS and healthcare professionals invoke confidentiality as a barrier to*

sharing information. This is a relevant concern. The development of protocols could mitigate this issue to ensure confidentiality while maintaining the safety of children as a priority.

Education of Healthcare Professionals

The Department of Health and Wellness does not require district health authorities to provide their healthcare professionals with education or training for detecting child abuse, leaving the decision to each health authority. It was reported that child abuse education through continuing medical education (CME) is not mandated for physicians, including emergency room physicians. A one-month rotation with the IWK Child Protection Team is a requirement for physicians specialising in paediatrics.

CHILD DEATH REVIEW IN NOVA SCOTIA

Nova Scotia does not have a dedicated and independent structure or body to review child deaths or critical injuries whenever they occur. This review by the Office of the Ombudsman was deemed possible and necessary because key government agencies involved are within the Ombudsman's jurisdiction.

An article in the Canadian Paediatric Society entitled "The Importance of Child and Youth Death Review" (October 2013, Volume 18, Number 8) outlines the mandate of a formal Child Death Review (CDR) as a system to advance understanding of how and why children die, to improve child health and safety, and to prevent deaths in the future.

CDR's are conducted in various forms outside of and within Canada. In some jurisdictions this falls under the legislated authority of the Representative for Children and Youth, in others, the Coroner's Office. In several jurisdictions across Canada, an interdepartmental team reviews child deaths and develops recommendations collaboratively.

As noted earlier, the Department of Community Services currently has a policy that requires an internal review which outlines the process to review incidents where a child has died from a result of abuse while receiving child protective services. This Child Death Review Committee is responsible for the review and

the results are not made public. Authority for this review stems from the Children and Family Services Act.

Within the Department of Justice, the Medical Examiner Service operates under the authority of the Fatality Investigations Act, which currently does not include a provision for the establishment of a Child Death Review committee. In other jurisdictions, Medical Examiner Service or Coroner's Offices take a lead role in the establishment of Child Death and Critical Injury Review Committees.

> *This Office believes that a more independent oversight mechanism is required to conduct child death reviews in Nova Scotia, and this mechanism may require a legislated basis.*

CONCLUSIONS

As indicated in the outset of this report, the purpose of this investigation was not to assign blame for the death of the child, but to identify potential service gaps, including any gaps arising from the applicable legislative framework, and where appropriate to recommend areas of improvement.

There was no specific action or inaction identified during this investigation as a causative factor in the death of the child by any of the involved government agencies or services.

Our general conclusions and observations include the following:

- There is confusion regarding standards, and the lack of standards in some areas. While DCS officials have expressed concerns regarding the need to preserve discretion and professional judgement among workers, we conclude that there must also be greater clarity regarding standards.

- Caseloads were an issue. At the time of the child's death, CPS workers reported caseloads were higher than the standards. Caseloads since have been reduced, but are reported to be consistently at or slightly higher than the maximum caseloads set out in the standards.

- There were gaps in file activity and record-keeping. Multiple referrals and lengthy investigation periods can create confusion. It is unknown whether gaps between entries reflected inactivity on files or had any impact on the nature of responses. However, these concerns were increased by the fact that two investigation files remained open when the child died.

- Communications issues were recurring themes. These issues are most apparent through the absence of provincial information sharing protocols between CPS and other key agencies, such as the Department of Health and Wellness, District Health Authorities, IWK, and police to facilitate communication and collaboration. In addition, there is value to healthcare professionals having efficient access to information regarding previous hospital visits related to CPS concerns. Both CPS and healthcare personnel could benefit from a more collaborative working relationship as well as access to resources and healthcare professionals with expertise in assessing children for abuse.

- As noted earlier in the report, confidentiality is an essential value, especially where medical and other personal information is involved. However, confidentiality should not be absolute or an automatic barrier to information-sharing. In particular, confidentiality considerations should defer to the best interest of a child who may be at risk of abuse or injury or death.

- The IWK Child Protection Team model provides an excellent resource for identifying and addressing potential child abuse. The utilization of experts needs to be standardized and readily accessible throughout the province.

Finally, CPS staff are entitled to adequate resources and clear guidelines to carry out their duties, while also maintaining the ability to utilize appropriate professional discretion in the decision making process. This Office recently was advised that CPS head office staff has initiated a standards renewal project, which will include a review of the CPS standards and the development of an associated resource guide in collaboration with CPS staff. This plan is projected to take two years to complete.

While overdue, the plan is welcomed. In the interim, this Office believes provisional measures should be considered and undertaken to address gaps in standards and policy in high risk areas to guide staff.

While this investigation focused on a specific tragedy, we believe our findings and recommendations have broader application. There have been other child deaths that warrant independent review. That is why an independent oversight mechanism to review child deaths is imperative.

Child death reviews would benefit from a strategic approach that incorporates greater integration of services. Government departments and stakeholders, in the spirit of collaboration and best interest of children, need to develop a comprehensive plan to enhance understanding of how and why children die, to improve child health and safety. Information gained from child death reviews can be utilised to understand the scope of potential issues and ideally will help prevent child deaths in the future.

Our conclusions are reflected in the recommendations below.

RECOMMENDATIONS

Department of Community Services

1. The Department of Community Services undertake a review of the Child Protection Services Policy Manual to revise, update, or develop standards, including but not limited to:

    a. CPS caseload /workload;

    b. clarification of referral response time standards, including specific parameters related to the response time of low/no risk (three to twenty-one days) to ensure an appropriate and timely response;

    c. response timeframes related to key activities in a CPS investigation, such as interviewing children;

    d. impact of multiple referrals on CPS investigation timeframes and risk assessment;

    e. a process for follow-up with family physicians after hospital emergency department treatment and medical assessments where there are suspicions of abuse or neglect;

    f. criteria for a referral to the IWK Child Protection Team or other expert physician(s);

    g. clear documentation on the case notes/file when major presenting problems are addressed;

    h. indication that activities and timelines within an investigation plan are assessed when a Child Abuse Register search is completed;

    i. required documentation once a Child Abuse Register search is completed;

    j. contact with non-custodial parents, and

k. internal quality assurance processes to ensure they are adequate, including file review processes, and extension of intake investigations.

2. The Department of Community Services develop and implement protocols between Child Protection Services and Department of Health and Wellness and District Health Authorities/IWK to facilitate communication and collaboration among these agencies.

3. Review Policy 78 with respect to the scope and depth of the internal review, and establish accountability for addressing recommendations and time frames for implementation.

4. Participate in an initiative to develop and implement protocols between Child Protection Services and Department of Justice, applicable to all municipal police departments, and review existing agreements with RCMP.

5. Participate in the establishment of a provincial inter-agency team to review child deaths and critical injuries, similar to those in other jurisdictions.

Department of Justice

1. Lead an initiative to establish a permanent child death review team. Specifically, mandate a group to examine successful models in other jurisdictions and to develop terms of reference, including the appropriateness of legislation, for a provincial inter-agency team to review the circumstances surrounding child deaths and critical injuries.

2. Develop and implement protocols between Department of Justice, applicable to all municipal police departments, and Child Protection Services to facilitate consistent communication and collaboration among these agencies.

Department of Health and Wellness

1. Ensure the development of standards regarding ongoing education for healthcare professionals in the detection of child abuse.

2. Develop and implement protocols between Child Protection Services, Department of Health and Wellness, and District Health Authorities/IWK to facilitate communication and collaboration among these agencies.

3. Ensure the provincial information management strategy in healthcare settings across the province accommodates the requirements for access to relevant clinical information for child protection purposes.

4. Develop and implement a consistent process/protocol for District Health Authorities/IWK to communicate child protection concerns to appropriate professionals within the healthcare field.

5. District Health Authorities/IWK identify healthcare professionals with expertise in detecting child abuse for consultation purposes across the province.

6. Participate in the establishment of a provincial inter-departmental team to review child deaths and critical injuries, similar to other jurisdictions.

Christine Delisle-Brennan
Acting Ombudsman

APPENDIX

Interviews/Consultation:

- Department of Community Services
    - Departmental representatives
    - Employment Support and Income Assistance staff
    - Daycare staff
    - Child Protection Services staff

- Department of Justice
    - Police personnel
    - Medical Examiner Service
    - Public Prosecution Service

- Department of Health and Wellness
    - Departmental representatives
    - IWK Health Centre staff
    - DHA/Hospital personnel

- Collateral sources of information
    - The mother of the child declined to be interviewed, or provide comment
    - The father of the child

Documents Reviewed:

- United Nations Convention on the Rights of the Child
- Children and Family Services Act
- Children and Family Services Regulations
- Department of Community Services, Child Protection Services Policy Manual (1996) (as provided at commencement of this investigation)
- Department of Community Services Procedures for a Coordinated Response for Victims of Family Violence (1994)
- Department of Community Services Best Practices in Case Recordings: A Guide For Child Protection Social Workers
- Department of Community Services Local Office New Employee Checklist
- Employment Support and Income Assistance Act
- Employment Support and Income Assistance Regulations

- Employment Support and Income Assistance Policy Manual
- Day Care Act
- Day Care Regulations
- Department of Community Services Child Care Classification Services: A Guide to Classification and School Age Approval (September 2013)
- Reporting and Investigating Allegations of Abuse and Neglect in Regulated Child Caring Settings: A Protocol for Licensees, Child Care Staff and Care Providers (Revised June 2012)
- Reporting and Investigating Allegations of Abuse and Neglect in Regulated Child Care Settings: A Handbook for Licensees, Child Care Staff and Care Providers (Revised June 2012)
- Daycare policy manual
- Crown Attorney Disclosure Package
    - Reports from the IWK Child Protection Team
    - Medical Examiners Report
    - Medical reports and forms
- Police records
- Child Protection Services intake files
- Employment Support and Income Assistance file
- Hospital policy – Legally Mandated Notifications
- Draft child protection services and hospital protocol
- RCMP policy respecting reporting to child protection services and joint investigations
- Memorandum of Understanding between Department of Community Services and RCMP (November 26, 2008)
- RCMP Operational Manual: Section 2.6. Child Abuse
- Draft Joint Police/Child Protection Services Protocol for the Central Region (May 2009)
- Canadian Pediatric Society article “The importance of child and youth death review” (October 2013)

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