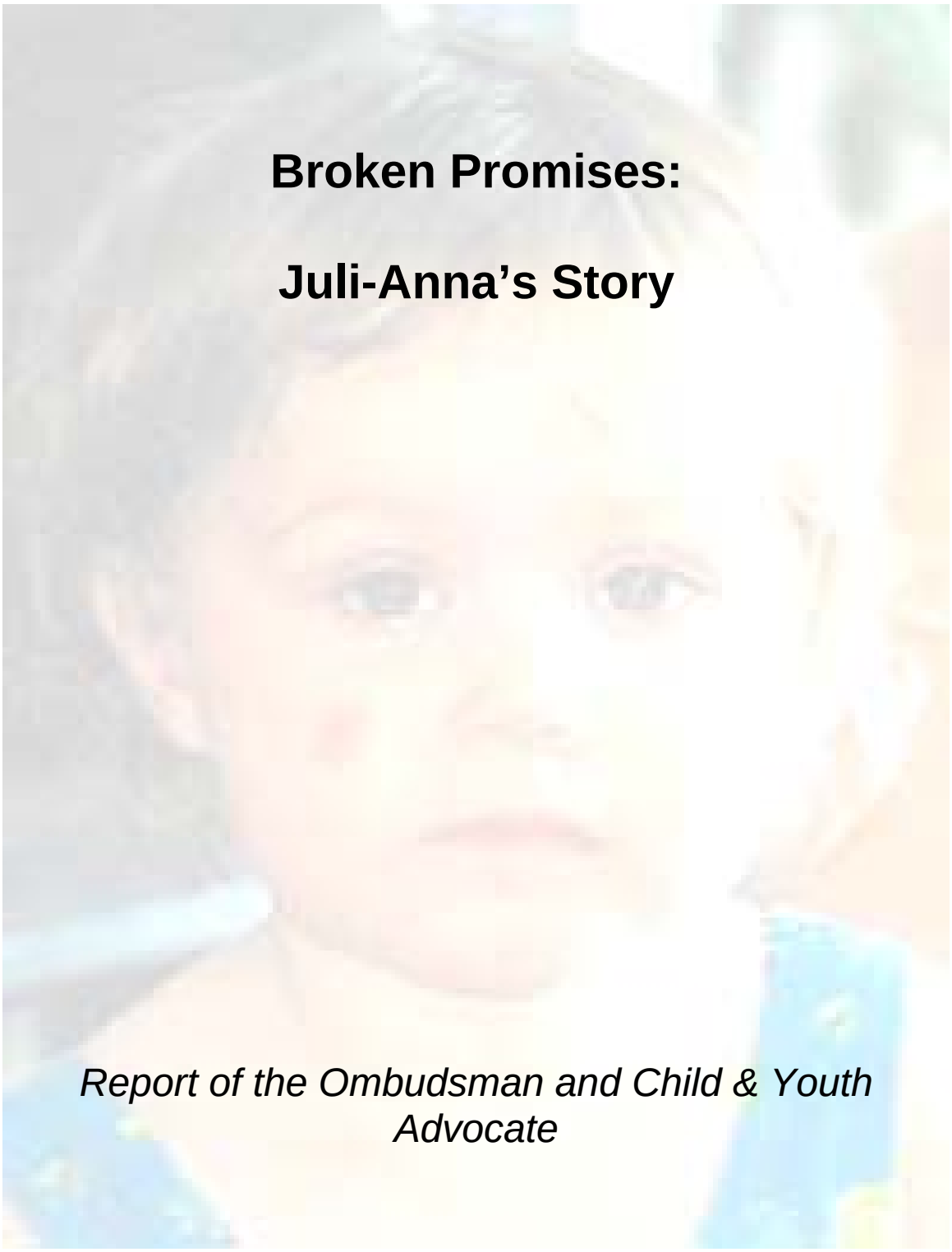

Broken Promises:

Juli-Anna's Story

Report of the Ombudsman and Child & Youth Advocate

January 17, 2008

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"…As painful as it is to be aware of abuse and neglect which a child has suffered at the hands of some other individual it is perhaps more painful personally to witness further harm to a child as the result of the malfunctioning of a system in which one has some part."

Jeree Paul, PHD, Infant-Parent Program, Department of Psychiatry, San Francisco General Hospital, University of California.

A Note about Confidentiality

Subsection 19(2) of the *Ombudsman Act* states that 'the Ombudsman, employees of the Office of the Ombudsman and any person appointed to assist the Ombudsman pursuant to a contract for professional services shall keep confidential all information and other matters that come to their knowledge in the exercise of their duties or functions under this Act, unless required to disclose it by law or in furtherance of the Ombudsman's mandate under this Act'. Subsection 11(2) of the *Child and Youth Advocate Act* states that 'Before performing any functions or duties under this Act, a person appointed under subsection (1) shall take an oath, administered by the Advocate, that he or she will not divulge any information that is received under this Act, except for the purpose of giving effect to and in compliance with this Act'. In particular, information that would identify a person who gives information under section 30 or subsection 35.1(1) of the *Family Services Act* is not to be disclosed. I take the duty to keep information confidential very seriously and therefore no referral sources or social workers have been identified unless their information was already public. I have however decided to use the first name of the child who this report is about and her mother's, as both are already well known to the public by the media and as I did not want to disrespect Juli-Anna by not identifying this as her story.

1.0 INTRODUCTION

Words could hardly express the anger and frustration I have felt over the last two years in attempting to ascertain if all that could be done had been done to prevent the untimely death of Juli-Anna, a two-year-old girl, on April 13, 2004. Questions about my Office's authority to investigate such a matter and concerns about protecting the family's privacy were both raised as the Department of Family and Community Services resisted my request for full disclosure. At the very same time as employees were discreetly contacting me to say that I should be digging deeper, senior officials were telling me that frontline workers would rather not talk to me.

Taking the department to court and sending subpoenas to employees of FCS involved with the file, both firsts in the 40-year history of this Office, indicate to what extent extraordinary measures were needed to get at the facts.

Eventually, the *Child and Youth Advocate Act* and the *Ombudsman Act* were both amended to provide my Office with better access to files while investigating complaints. But even these improvements had to be fought for in the arena of public opinion in the face of weighty and unrelenting bureaucratic resistance. Yet I remain convinced that we are all driven by the best interests of those vulnerable children who need us to be vigilant on their behalf.

I also know that no child in a province like New Brunswick, in a country like Canada, should have to endure what Juli-Anna was forced to live through. The safeguards that were in place at the time did not work, and our main goal has been to find out why, to learn from the answers, and to suggest changes for the better. From the very beginning, I formed the view that this tragedy could have been prevented. For any reader of this report, it will become obvious why this impression became a conviction.

Despite the pain that one feels on reviewing the events of Juli-Anna's life and death, we have shied away from pointing the finger of blame at any individual. Throughout our work, we have been doggedly determined to find gain rather than to look for fault. It is in this spirit, inspired by the haunting look on Juli-Anna's face, that this report is published.

2.0 REVIEW PROCESS

This investigation took significantly longer than most Ombudsman or Child and Youth Advocate investigations. It consisted of reviewing the files and documents from various parties, including the Department of Family and Community Services (FCS), family members of Juli-Anna, and other service providers. We also met with various officials from FCS on numerous occasions regarding various aspects of Child Protection Services. We interviewed most of the social workers, supervisors and program delivery managers involved with Juli-Anna's file. We also met with FCS senior management on several occasions. Research was conducted on several issues. The various policies, procedures, tools, and training modules used by Child Protection Services were analyzed. We reviewed the Child Death Review Committee reports on the deaths of John Ryan Turner (1996) and Jacqueline Brewer (1998), as well as the Department of Family and Community Services report *Children Come First,* which was released in 2000. We also had informal discussions with other stakeholders, including Early Intervention and the New Brunswick Association of Social Workers.

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3.0 FAMILY AND COMMUNITY SERVICES PROCESS

THE CHILD PROTECTION PROCESS

To understand Juli-Anna's story, it is important to understand the child protection process. In other words, how a child protection case is initiated and investigated. Child Protection Services are provided under the mandate of the *Family Services Act*. The first step is known as access and assessment. This is when a referral source, that is, anyone who has concerns about a child's situation, contacts the Department of Family and Community Services, and the social worker assesses the information to determine if the department should investigate. There is also the option to close the file at this stage. If it proceeds to the investigation stage, the worker determines, at the end of the investigation (which could take up to a few weeks) if the file should be open for ongoing service. If it is determined that there are no child protection concerns, then the file can be closed. If the file is open for ongoing service, a plan will be put in place on how best to provide services to the family. The services are voluntary, unless the department seeks a supervisory order. An ongoing child protection file was never opened during Juli-Anna's short life.

Step 1 – Access and Assessment

The child protection process begins when the department is informed by a professional, a service provider, a neighbour, or anyone else that they believe a child is in danger. This is what constitutes a referral. It is based on subsection 30(1) of the *Family Services Act (FSA)*.

Section 31 of the *Act* outlines what may be considered a danger to the security or development of a child. It includes:

> *(a) the child is without adequate care, supervision or control;*
> *(b) the child is living in unfit or improper circumstances;*
> *(c) the child is in the care of a person who is unable or unwilling to provide adequate care, supervision or control of the child;*
> *(d) the child is in the care of a person whose conduct endangers the life, health or emotional well-being of the child;*
> *(e) the child is physically or sexually abused, physically or emotionally neglected, sexually exploited or in danger of such treatment;*
> *(f) the child is living in a situation where there is domestic violence;*
> *(g) the child is in the care of a person who neglects or refuses to provide or obtain proper medical, surgical or other remedial care or treatment necessary for the health or well-being of the child or refuses to permit such care or treatment to be supplied to the child;*
>
> …..

Referrals come to the access and assessment unit. For most of her life, Juli-Anna's family lived in the Fredericton region of FCS, which encompasses an area that reaches all the way to Perth-Andover. The screening of referrals is done in Fredericton, although before

Juli-Anna's death, this was also done in Woodstock. A worker determines whether an investigation is necessary and how quickly a social worker should respond by contacting the family. Two documents guide FCS workers in making these decisions, one dealing with risk management and the other with standards and guidelines for child protection practices.

Step 2 – Investigation

If it is decided an investigation is warranted, a social worker is assigned to undertake one. The first priority is to assess the child's immediate safety, which is a paramount factor in deciding whether or not to open a child protection case.

Step 3 – Ongoing Service

If a child protection case is opened, it is assigned to a child protection worker, who determines what should be done. If it appears the child is at risk, then a decision can be made to remove the child from the family. Similarly, when the risk has been removed, the child may be returned to the home.

4.0 JULI-ANNA'S STORY

Juli-Anna's family was well known to the Woodstock office of Family and Community Services even before she was born. The family had been investigated by Child Protection Services many times because of concerns for the safety and welfare of other children in the family. FCS had also received seven referrals regarding Juli-Anna's mother, Anna, when she was a youth, and about Anna's sisters, too. The department was aware that Anna had been pregnant at 18, was in a transition house, allegedly used drugs and was in conflict with her family.

When Anna started her own family, there were more referrals. An incident in a parking lot, where Juli-Anna's father hit Anna's eldest son, prompted FCS to open a child protection file on the family. The file remained open from July 23, 1999, to April 4, 2001. During this period: the family regularly missed or cancelled appointments, and moved frequently; a family member accused another of a sexual assault; and referrals were made regarding the use of drugs and inappropriate housing. On April 3, 2001, a decision was taken to close the file, but with the understanding that should the file be reopened, the department should consider obtaining a supervisory order to force compliance of certain parenting requirements. Seven days after the file was closed, FCS received a new referral about the family.

But this is Juli-Anna's story. So we'll begin with her short and tragic life, drawing upon information in the files of the Department of Family and Community Services.

Juli-Anna was born January 17, 2002, at the Dr. Everett Chalmers Regional Hospital in Fredericton. She was the third child and second daughter of Anna, who was then 22. Her father was Anna's 24-year-old, on-again, off-again boyfriend and common law partner. Juli-Anna was his second child with Anna.

From the hospital, the little girl went, on January 20, to a home in Benton, where the family had moved just the previous month. Also there, in addition to Anna, was Juli-Anna's half-brother, aged four-and-a-half, and her full sister, aged two. Her father was also there at the beginning, but he soon became a sometime presence, because her parents were in frequent conflict. The father worked only sporadically, and Anna mostly relied on income assistance. So Juli-Anna was born into poverty.

She was just eight days old when a Family and Community Services social worker paid a first visit to Juli-Anna. The social worker had come because, on January 8, FCS had received a child protection referral from a source who advised that both Anna's son (who sometimes stayed with her parents) and the boyfriend were back living with her in Benton. The source knew about the earlier incident, where the boyfriend had hit the boy, and she was concerned about the two living under the same roof. She further advised that the family had moved three times since August, 2001, and that Anna was pregnant again (with Juli-Anna).

The social worker went to the home on January 25 accompanied by a public health inspector. Anna, surprised by the visit, was nonetheless co-operative. She was alone with Juli-Anna that day. The house was messy, but the new baby was clean, as was the area around her.

The public health inspector stressed to Anna the importance of cleaning the floors, of disinfecting and of keeping food properly stored. She agreed to clean up the house and agreed to a return visit by the social worker and public health inspector a week later.

On January 28, FCS was advised that Anna had not paid any rent since moving in.

On February 1, the public health inspector returned to the home (the social worker could not make it because of poor weather), but no one was there. He noted garbage had not been put out for pick-up, as he had advised.

On February 27, FCS was told Anna was discontinuing her public health services, because she did not want their involvement.

Subsequently, a social worker twice attempted home visits to Anna and her children (on March 1 and 6), but no one answered the door or telephone.

On March 11, Anna's income assistance was discontinued for non-compliance. It had been learned that the father of the two girls was not reporting income. Anna claimed he was no longer living with her and wanted him removed from her case.

The social worker tried again to visit on March 18, but Anna refused entry to the house, saying she was not allowed to let anyone in when she was alone. She said she would have Juli-Anna's father call the worker to set up an appointment. She also indicated the family might move again, because the landlord was not fixing things up. The social worker noted that Anna was very defensive saying she thought the investigation would be closed by now. But the worker told her another visit would be required before the file could be closed.

On March 25, the social worker tried to contact Juli-Anna's father to set up an appointment, but discovered their home telephone had been disconnected.

Three days later, FCS was advised the family had been given an eviction notice (with 10 days to vacate) because the rent was still unpaid.

In completing a risk assessment on the family on April 5, the social worker rated it at low risk: "Worker notes no issues arose during investigation which would warrant this family be reopened as a case at this time. Worker rates the risk for these children as low. Current whereabouts of family at completion of investigation is unknown."

On May 9, the department received a referral from a member of the community, relating that Anna and her boyfriend were supposedly placing a child (possibly Juli-Anna) in a

bucket of water to clean her diaper. The referral source also alleged drugs were being used in the home. According to the file notes, this information was from a third party and considered third and fourth hand, and since it also wasn't known when the incident occurred, the source was advised to have the person with first-hand knowledge make the referral. The source said they would not do that. As a result, the referral went no further.

Meanwhile, on May 13, Anna applied for income assistance as a single parent. She had moved to a new address in Canterbury.

Another referral came from the community on July 3. The caller had witnessed a situation in the parking lot of a local gas station. It was noted: "Witness reported a woman approximately 20 years old behind a child, saying, 'Wait until you get home, you little shit.' The witness then went into the Irving and upon coming back out she saw an older women about 50-55 years old shouting at the same child saying, 'Do you want to get in the fucking front or back'?' and then. 'Shut your fucking mouth.' The witness further reported that this older woman then grabbed the child by the arm half pulled him out of the truck, and began to wail on him. The older woman repeatedly struck the child about the head, face, back and buttocks with her hand and screamed at the child to 'quit your fucking crying.' The witness recorded the license plate of the truck. This license plate was eventually tracked down to a vehicle owned by a family member.

The day after the incident, the social worker went out, without police assistance, to the family member's house to investigate. Anna's son was running around outside in his bathing suit. The worker did not see any marks on him. Anna would not permit the worker to interview her son. She said she would bring him to the office the next day, but then did not show up. On July 8, the worker called Anna, who said she would try to come in the next day. Again, she did not show up.

The social worker subsequently made several attempts to contact Anna by phone. All were unsuccessful. On July 12, Anna left a voice mail message for the worker indicating she would come in on the Monday while the son was at the park. She did not do so.

The worker finally reached Anna on July 24, and she agreed to come to the office July 30. She did arrive that day, 30 minutes late, and without her son. Finding the worker on the phone, she left almost right away, leaving a note saying she had another appointment and would call to re-schedule.

On August 6, the social worker visited Anna in Canterbury, where she had moved. She was at home with her daughters, but her son was at his grandparents' house. Anna refused entry to the house. She said she would call to set up an appointment for the son to meet with the worker. Anna wanted to see the witness account of the incident at the gas station and to be present when the social worker interviewed her son. A meeting was set up for the following Thursday. Anna did not keep the appointment.

Eight days later, the department decided to close the file. The decision was based on several factors: Anna was being uncooperative and denying the incident; the worker had

seen no marks on the boy the day she saw him in his bathing suit (he was never examined by a doctor); there was no proof that her son was the child at the gas station. In other words, the concerns could not be substantiated.

In October, 2002, the department learned that Anna and her children had moved to the Perth-Andover area. A referral came in from that community on November 14, indicating that the older daughter (who was two-and-a-half-years old) and Juli-Anna (now 10 months) had red patches on their skin, sore spots on their faces, rashes on their bums, were poorly dressed for cold weather, had no food, and were sleeping on the floor. The caller also expressed concerns that Anna was irresponsible in managing her money , (she was, in fact, apparently at risk of being evicted again for not paying her rent), that she had a history of drug usage, and that she might be returning to her alleged habit of using cocaine. The caller added that Anna had walked about three miles one day, in cold weather and with the children in tow, to ask for food, milk and money.

According to the social worker's notes, when she went to the home that day to investigate this referral, Anna, who was getting ready to leave with the children, was very aggressive toward her. Anna refused access to her home and told the worker that she would have to come back with the police. The worker did return with the police a short time later, only to find that Anna and her daughters had left. The social worker then contacted the referral source again, who now said the children did not have diaper rashes, that all she wanted was for someone to help Anna buy groceries, and to help her with her self-esteem issues. The worker told the source that Anna did not want FCS's involvement that she could get grocery money from income support, another branch of FCS and, if she had self-esteem issues, they were best dealt with by mental health services, not child protection workers. Despite the seriousness of the caller's initial allegations, the file was closed, with no further investigation.

In early December, Anna and her children moved again, this time to Aroostook

On December 27, a referral called FCS alleging that family members residing at Juli-Anna's grandparent's home smoked pot and used cocaine. They left the children unattended near a woodstove and went outside to smoke; and were not paying any attention to children in the home.

In mid-January, 2003, Anna and her daughters moved to the Woodstock area. She applied for income assistance as a single parent with two children, but did not keep appointments to be assessed.

A month later, Anna and her daughters moved yet again, this time to her parents' home, in Canterbury.

On February 25, February 28, and March 3, referrals came in, indicating Anna's five-year-old son was undressing and exposing himself on the school bus. As his maternal grandparents were considered his primary caregivers at this time, they were notified.

They were cooperative and were following up with the school about this behaviour, so the referrals were closed.

Anna called the income assistance office in March to ask for extra money for diapers, but she had not been to the Food Bank, which issues them (although she claimed she had), and was told to go there first.

In April Anna went back to the Perth-Andover area and applied for income assistance as a single parent with one child—her three-year-old daughter. Juli-Anna, 15 months old, was living with her father and his mother in the same community. By May, the family was reunited, both parents and the two children living together. Since the father was working, Anna called on May 7 to cancel her income assistance.

At the end of October Anna requested income assistance because the father had left for Toronto to work. Since he had just received an Employment Insurance cheque, she was screened out.

Anna and her daughters took up residence in a transition house at St, Stephen, and she again applied for income assistance. She was now 18 weeks pregnant with a fourth child. The department received a referral that Anna had to be constantly reminded to care for her children and keep them clean. It was also reported that the children had lice when they came, and although Anna was shown proper hair care, they would still have lice when they left.

Issued a special benefit of $1000 to set up a household in the St. Stephen area, she got an apartment, but paid neither the rent nor the damage deposit.

Over the next while, which turned out to be the last five months of Juli-Anna's life, the situation got worse. According to the file, Anna moved eight more times, and eight more referrals were made to FCS.

One of those came on November 18, while Anna was still in the St. Stephen area. It reported that her daughters had lice and that their clothes and bodies were dirty. She had also been seen hitchhiking with the girls.

A social worker in St. Stephen attempted to investigate, but despite going several times to Anna's apartment, could never find her at home. After determining that Anna and the children had left the area, she called the Woodstock office to refer the case there. Meantime, FCS in St. Stephen got a referral informing them that, in addition to not paying the rent and damage deposit, Anna had left the apartment filthy. The social worker later verified this, finding the apartment rife with garbage, moldy food, dirty dishes, and abandoned household effects.

The Woodstock office did not act on the referral from St. Stephen. Not knowing Anna's whereabouts, they closed the case as being unsubstantiated.

Her whereabouts were not a mystery for long. On December 5, , Anna applied for income assistance as a single parent of one child—her three-and-a-half-year-old daughter, living in the Plaster Rock area. On the same day, Juli-Anna's father applied for income assistance as a single parent with one child (Juli-Anna, now 23 months old) living at the same address in Plaster Rock, but in a different apartment.

Another referral came in concerning Anna's care of her children on December 9. They had been seen in the Perth-Andover area wearing no shoes, socks or jackets, despite the season and cold temperatures. The report also said that the baby (Juli-Anna) had a bad diaper rash.

A social worker went to Anna's apartment to investigate this report on December 18. She found Anna to be passive-resistant She asked the worker to return at another time, because she was on her way to the church to pick up a Christmas box. The worker agreed and went back an hour later. Anna was still resistant and asked the worker to return some other time, because she was having a bad day. As a consequence, none of the allegations received November 18 and December 9 were investigated until the following Tuesday, December 22.

On that day, Anna appeared less stressed and was more cooperative. She denied the children had lice or that she took them outside without appropriate clothing. The worker reported there was lots of food in the home, and the children were clean. Also, Anna indicated an openness to receiving early intervention services, despite her history of non-compliance with voluntary services.

According to records, several allegations were not addressed on this visit. They included the diaper rash, lice, the filthy apartment in St. Stephen, her transient behaviour, hitchhiking with young children, her new pregnancy, and the misuse of income support. The history of the case suggests that, apart from the lice, none of the problems was new.

Again the department decided there was insufficient information to open a case. As in the first instance, this decision was taken in consultation with a supervisor. The recent referrals were deemed unsubstantiated, and no comprehensive risk assessment was undertaken.

In January, 2004, Anna and her children moved to another apartment in Plaster Rock. In February, they returned to Perth-Andover. On the 18th, a professional source called the department to express concern that Anna had again moved to a community where she had little family support. Her three children were now aged six, four and two, and the birth of her fourth child was expected in just six weeks. Despite Anna's history of transient behaviour, and the fact that her children were very young and vulnerable, this call was considered only as information, and the case remained closed.

Another referral, also from a professional source, came in on February 25. This caller expressed concern about two large Rottweiler dogs in Anna's home. The caller said two young children in the home, two-year-old Juli-Anna and her four-year-old sister, were

"approximately face to face in height to these dogs." He was very worried they might attack the children. He also reported a strong smell of marijuana coming from the home, so palpable that the smoke could be seen.

After consulting with a supervisor, a social worker called Anna to tell her that it was her responsibility to ensure the safety of her children. The call was made on March 11, and Anna's response was that the dogs were very calm, and never growled at the children or barked at babysitters who came to the home. The social worker did not ask about the smell of marijuana, and the referral went no further.

Documentation shows that, in March, Anna and her children were again living in the Plaster Rock area.

A referral on March 1 concerned Anna's son, now six-and-a-half. He was apparently getting little supervision at home. He had taken to riding his bicycle long distances from the home, and the police had twice intervened with him. The boy said a family member sometimes hit him with a piece of kindling wood. Past drug issues in the home were mentioned, too. Although the case was given a high priority, which called for investigation within 24 hours, the supervisor advised the social worker to wait until after March break (still some days away) to interview the son in school. There is no documentation of why the supervisor did not follow standards and guidelines when deciding to postpone the interview, which finally took place, at school, on March 11. On the same day, the social worker attempted to visit the grandparent's home, but no one was at home. Anna, meanwhile, was claiming that the son was again living with her.

After further consultation with her supervisor, the social worker again advised Anna of her responsibility to ensure her children's safety. She was told she must make sure the dogs were "safe to be around children." The family member did not return the social worker's calls. A file note indicates the social worker was to inform Anna of her son's allegation against the family member, but it appears FCS abandoned efforts to complete this part of the investigation. The situation was again assessed as being at low risk.

On March 19, a referral reported Juli-Anna had been brought to the hospital the previous day with mouth ulcers. The report noted several old bruises on the child's body (forehead, face, legs and back) and burn marks on one of her hands. Anna claimed this had been caused when the child tried to retrieve a toy from a heater. Lack of supervision and negligence in the home were suspected.

The referral source also reported that Anna had a new boyfriend and that he and his two young children were living at her home. The source made the observation that, "Listening to the family history, I really think some supervision through social services is important here."

The social worker consulted with her supervisor, then called the hospital to say that an investigation would be opened but that Juli-Anna could be released into her mother's care. The hospital was told a social worker would visit the family in the next few days.

FCS records show that it considered this latest information to have come from a "credible, professional referral source/witness to child's injuries." This, coupled with the child's age and FCS's history with the family, prompted the kind of priority response the department gives to situations considered "damaging, but not life threatening or dangerous." It called for a social worker to investigate the complaint within four days.

The social worker did attempt to investigate within four days, but when, on March 23, she visited Anna's home in Canterbury, to which she had recently returned, she was not at home. She had gone to Plaster Rock to complete some tasks related to the move. The social worker did not attempt to go into the house at Canterbury because she saw dog collars and chains in the yard and thought the family's large dogs might be loose. Instead, she called the home on her cell phone. A relative who was babysitting the children told her Anna would be back after dinner. The worker also called a social worker at the local hospital and asked to be informed when Anna delivered her baby.

Records show that the social worker completed a safety assessment form and made a decision on Juli-Anna's immediate safety on March 23. The safety statement said: "Child (ren) not considered to be in immediate danger of serious harm or neglect." A question on the form asking, "Are there other interventions/actions required?" was answered "yes." As to what these were, she wrote: "Social worker to revisit home when Anna delivers child/Anna due in four days/March 27th". She also wrote that the "visit is needed to ensure safety of new baby."

It is crucial to understand that the immediate safety assessment of these children that day was made without the children or the mother having been seen, or without any other evidence having been obtained that would allow an informed decision about their safety.

On April 6, another referral came in from the community about the two dogs at Anna's home. She was now a week overdue in her pregnancy. She had agreed to voluntary services, but she was not keeping appointments, nor was she at home when service providers visited. A nutritionist, an early intervention worker, and a public health nurse had all tried to meet with her, but without success. The social worker who received this latest referral consulted a supervisor, who decided there were no protection concerns, and to treat it as an information referral only.

In the early morning hours of April 13, 2004, Juli-Anna, aged two years, three months died at the Carleton Memorial Hospital in Woodstock. She had been rushed there by ambulance, after her mother discovered that she was not breathing. A valiant effort was made to resuscitate her, but it did not succeed. Later in the day, Anna gave birth to her fourth child.

As described in the Coroner's Report, an autopsy determined that the immediate cause of Juli-Anna's death was "peritonitis and sepsis due to perforated recto sigmoid (foreign body)." The foreign body was a green-coloured plastic pen 8.5 centimeters long that had somehow found its way into her small body and perforated her bowel. Anna and her

boyfriend were jointly charged with failure to seek medical assistance for her, thereby causing her death.

Extensive medical evidence at a subsequent trial revealed that Juli-Anna had been gravely ill for at least three days before her death and would have suffered greatly. Her death was agonizingly painful.

On October 25, Anna was found guilty. Her ex-boyfriend was acquitted because the judge ruled he did not have a duty of care for Juli-Anna.

In her 27 months of life, Juli-Anna had lived, with her family, in at least 14 different places. These ranged all the way from St. Stephen to Plaster Rock, and also included Benton, Canterbury, Woodstock, Perth-Andover and Aroostook. Child Protection Services had received 16 referrals about the situation, but, in the end, this little girl was not safe in her own home, and the system intended to protect her did not do so.

5.0 RISK FACTORS

One of the surprising things about this case history is that, even with all of the referrals from professionals and members of the community, a child protection case was never opened during Juli-Anna's lifetime. There were frequent investigations, but none led to an ongoing child protection case during the 27 months of Juli-Anna's life. Ongoing child protection services were only provided twice for this family: once when Juli-Anna's father was found guilty of hitting Anna's son in 1999 (the case was open for approximately 20 months), and the other after Juli-Anna died suddenly and unexpectedly.

When evaluating the safety and well-being of a child to determine if a case should be open for ongoing service, social workers take 22 risk factors into consideration, as specified in an established risk management system. In reviewing the history of Juli-Anna and her family, it is important that we mention some of these risk factors and how they were continually underrated, minimized, and misread by the social workers involved with this family. As a consequence, an ongoing case file was not opened.

5.1 Allegations of drug use

Allegations of drug use by Anna and Juli-Anna's father were raised often in the history of this family with FCS, and by credible sources. Even when Anna was a teenager, concerns were expressed about her alcohol and drug use. On one occasion, during a meeting with them at FCS, the smell of marijuana was detected on both parents. Numerous professionals visiting the home also reported the smell of marijuana. On the few occasions when they were confronted with this issue, they always denied using drugs.

5.2 Child physical and sexual abuse allegations

We found three allegations of physical abuse against Anna's son during the course of our file review. The first happened in July, 1999 when Juli-Anna's father violently shook Anna's two-year-old in the parking lot of a Fredericton mall, an assault that is described elsewhere in this report. The father was convicted and had conditions to meet as part of his probation order. Although he did not meet those conditions (attending, for example, only four out of eight anger management sessions), FCS did not hold him accountable, and eventually allowed him back into the house without raising any questions.

The second allegation of physical abuse came in July, 2002, when a woman allegedly assaulted the son at a gas station. The license plate of their vehicle was traced back to a family member. The police were not brought into this investigation, and the reason was not documented as it should have been according to existing practices. This investigation was not adequately completed.

The third allegation of physical abuse against the son was made when the child was interviewed at school on March 3, 2004. He said a family member had hit him with kindling, sometimes with his pants up, sometimes with them down. According to the

documentation, the police were never called, and the family member was never confronted. Anna was simply told that it was her responsibility to protect her son. This investigation was never completed.

In addition to the allegations of physical abuse, there was one disclosure of sexual abuse. In July, 2000, a family member reported that Anna's son told them that a family member had touched him inappropriately. The next day the source recanted, saying they were talking about a hypothetical situation. Two unsuccessful attempts were made to question the child. A physician examined him and noted no physical evidence of abuse or trauma. The police were not called, and the individual in question was never confronted with the allegation.

In February, 2003, the son's sexualized behaviour became a concern. On one occasion, he totally undressed on the school bus. The referral concerning this incident was recorded as an information-only call, and there was no follow-up.

5.3 Transient behavior of Anna

From the time Anna began receiving services from Family and Community Services as a parent, to the time of Juli-Anna's death, she moved at least 24 times that were documented. In the 27 months of Juli-Anna's life, the little girl lived in 14 different residences. Anna's transient lifestyle put her young children at risk in many ways. A lack of stability, security and continuity is known to be detrimental to children, but social workers assessing the family consistently ignored this important risk. In documenting this risk, they consistently rated it as low, for the stated reason that Anna's transient behaviour was not being assessed, but rather the physical condition of the home when they visited. However, the risk management system they use actually addresses not only the possibility of hazards, but also the instability caused by the housing situation, the loss of residence, and multiple relocations. According to the documentation, no effort was made to assess the effects of this extremely transient lifestyle on the development of these very young and vulnerable children.

Anna's transient behaviour also jeopardized, time and time again, her source of income. Every time she moved, her case had to be reassessed. Every time, she put at risk a stable income and her ability to meet her children's basic needs of food and shelter. It was well documented that Anna had difficulty paying her rent, buying food, and paying for diapers. More than once, NB Power threatened to cut off her electricity, and she had to resort to extreme measures that included calling on the Salvation Army to provide money for basic necessities. This factor was often ignored when social workers assessed the risk of neglect to the children.

On three occasions, it was reported to FCS that she had left her apartment, sometimes without paying rent and or giving notice. More disturbing was the condition of the apartment when she left. Apartments were reported to be full of garbage and laden with

cat feces, dirty diapers, unfinished children's medications in the fridge, moldy food, and filth. There was also, in one instance, extensive damage to an apartment.

Although social workers consistently reported that housekeeping standards were acceptable when they visited, the information that came from landlords refuting those assessments should not have been ignored. With vulnerable young children in the home, it should have been noted as an indicator of negligence. Sometimes the workers' assessments were confusing and illogical. In one situation, it was reported that the baby and the area immediately around her were clean, but that the rest of the residence was dirty.

5.4 Mother being uncooperative

On numerous occasions, Anna refused entry to social workers, making it impossible for the child protection authorities to check on her young and vulnerable children. In only one instance is there documentation that the social worker called the police for assistance, and, on that occasion, Anna and the children were gone when the worker returned with the police. Nevertheless, this particular investigation was closed without most of the allegations being checked. Anna also refused to let her son be interviewed by a social worker. She often expressed hostility towards FCS and, at times, disappeared for long periods, leaving authorities unaware of the children's whereabouts. Again and again, she discontinued the services offered her, or simply cancelled or did not appear for appointments. This, compounded by her history of transient behavior, and her record of refusing entry to social workers, represented a major risk to the family. It appears that in many instances, when FCS could not find the family or gain access to the children, the department simply concluded that the allegations were unfounded and the case was closed.

5.5 Vulnerability of the children

The vulnerability of these children, due to their young ages, was one of the biggest risk factors in this family. Serious allegations of child neglect were repeatedly made to the authorities, with claims of newborn infants having bloody diaper rashes and being dragged from apartment to apartment. But, according to the documentation, nobody attempted to verify this important information.

Adult supervision and protection of the family were questionable. Dogs large enough to intimidate social workers trying to enter the home roamed freely about the house, while young children belonging to both Anna and her partner played. FCS was not able to persuade the parents to find another home for the dogs, nor was the department willing to ensure a level of protection for these children by obtaining a supervisory order.

5.6 Availability of social supports

Anna's history, as we know it, implies a strained and conflictual relationship with her family of origin. Although she has said her parents were helpful to her, the stories she told suggested otherwise. This is why it is so surprising to see, time and again in the documentation, that Anna's parents were considered an important and reliable source of support. There were also episodes where her parents were very hostile towards FCS. Surely this should have been enough to cast serious doubts on their supposedly supportive relationship with their daughter, on their helpfulness to her in her parenting role, and on their reliability to protect the children. Based on all of this, we believe FCS workers constantly misread the availability and reliability of Anna's social support network.

6.0 ANALYSIS AND RECOMMENDATIONS

(1) CHILD PROTECTION STANDARDS

(a) Assessing the Risk Factors

The narrative of the previous section makes it very difficult to understand how the family's past history was ignored when it came to assessing the risk to the children. Drug use, the family's blatant lack of compliance with services, Anna's serious transient behaviour, the allegations of physical and sexual abuse, and the strained relationship between Anna and her parents were all well known to authorities. Why were these factors consistently ignored?

The risk assessment process outlined in the Risk Management System Manual and the actual risk assessments done in this case were often in contradiction. On page 70 of the manual, it says: "Where services are being provided at the time of the risk assessment, assign the rating which would apply to each factor if services were withdrawn." It appears social workers were relying on the voluntary services being provided to the family to monitor child protection issues. This is contrary to the risk assessment instruction, and we know how unreliable it would be, given Anna's track record with voluntary services.

It is difficult to understand how the social workers, supervisors, and permanency planning chairs have, on numerous occasions, concluded allegations were unsubstantiated when, in fact, the referral sources were extremely credible and reliable. For example, someone whom our office considers *very* reliable, saw the children with no socks, mitts or hats on a cold day, and looking dirty and hungry. Yet an FCS social worker deemed this report unsubstantiated.

Even when social workers saw the situation for themselves, they did not take crucial information into consideration. The issue around drugs is the perfect example. Many professionals reported the smell of marijuana in Anna's home, and on Anna's person. Moreover, the police told FCS that Anna's home was well known as a place with drugs. A roomful of FCS professionals at a meeting with Anna detected the smell. Anna denied the drug use and that seemed to end the matter.

One of the most puzzling things about this case is the fact that FCS repeatedly chose to close referrals at an early stage and not to conduct an investigation. Although we believe the violation of the standards, as noted above, was serious, the decisions to close the case without adequately assessing these children's needs is the most distressing element to emerge from our review of the FCS file.

We find it extremely strange that, after the first incident of physical abuse on Anna's son (her oldest child) and a 20-month period of FCS involvement with the family, the child protection file was closed, and no comprehensive assessment of the family's functioning was ever undertaken. Between the time the case closed in 2001 and Juli-Anna's death in

2004, two more children were added to the family, and another was on the way. During this period, the family moved many times, and FCS received several complaints of child neglect. Our review of the file produced no evidence of an effort to interview Juli-Anna's older sister, who was four when the baby died. Nor, according to the documentation available to us, was much effort made to assess the 22 risk factors outlined for social workers and supervisors in the Risk Management System Manual. For example, the caregiver's expectations of the child, which would have assessed Anna's understanding of appropriate child development, her discipline methods, and her capacity to provide emotional support to her children. The parents' mental capacity to care for a child should also have been assessed. How, for example, did the financial stress Anna experienced affect her and her family life? How did it affect her coping mechanism? Did she ever act on impulse, or experience feelings of hopelessness, anxiety, and low self-esteem, and how did these emotions affect her parenting? Another factor was the family influence. How were conflicts handled between Anna and her partner? Did the children ever witness physical altercations between Anna and any of her partners? And there is the issue of the child's vulnerability and response to the caregiver. Who does the child seek out when he/she is upset or sad? How did the children react to their mother's affection?

These are only a few examples of what the workers should have been assessing when a new referral came in, to make informed decisions on the well-being of these children. Even more alarming is the fact that historical information about the family was carried over from previous risk assessments, without new information being verified.

Recommendation #1
The Department of Family and Community Services should ensure that risk factors are being properly read, interpreted and rated.

(b) Using the permanency planning committee
One of the processes used when a case is being serviced in child protection is the Permanency Planning Committee. This committee is a regional decision-making body which oversees and approves major case decisions in child protection and child-in-care services[1]. The committee consists of three or more people, two of whom must be the social worker and supervisor involved in the case. The mandate of the Permanency Planning Committee is:

- provide a forum for decision-making and support to the social worker and supervisor;
- ensure consistency in decision-making;
- provide a broader knowledge base when decisions must be made;
- lessen bias and error in decision-making;
- prevent foster care drift of children in care;
- provide a monitoring and review process for case plans that is based on the principles and standards of permanency planning.

[1] All information regarding the Permanency Planning Committee is taken from FCS's Child in Care Standards.

Decision-making in the committee is by majority rule. If committee members cannot reach a decision, the chairperson decides.

A reading of this file leaves one puzzled, to say the least, as to why FCS did not at some point seek a supervisory order from Family Court. A supervisory order is a court order allowing FCS to monitor the family. Conditions that the family must meet are usually attached to an order. A supervisory order signals that child protection authorities have concerns about the safety of the children and that it cannot work on a voluntary basis with the family, one of the possible reasons being that the family will not accept their involvement. It is a step taken which might lead eventually to the removal of the children from the home if the parents do not comply with the conditions set out in the order (although a supervisory order is not a prerequisite for the removal of children from their home nor is the removal of the children automatically the next step if the parents do not comply). In this case, it was twice suggested that a supervisory order should be obtained. The first time was at a permanency planning meeting on December 7, 1999, when a social worker recommended a supervisory order in order to get the parents involved in different services (parent aid, anger management, home support). Instead, the committee chair, who was the program delivery manager, negotiated a voluntary agreement with the parents. We believe this was inappropriate because, even at this early stage, the parents were known to be difficult to serve, uncooperative, and non- compliant. The chair was quoted as saying he did not want to "over-service" the family or duplicate its services. We question this decision, which seems to show that child protection concerns were being minimized to accommodate the parents.

The second missed opportunity was at another permanency planning meeting, in April, 2001. A social worker was in the process of deciding to close the case. Professionals involved in the case voiced their concerns about it being closed. The suggestion was made that, if the case were re-opened, a supervisory order should be sought to obtain compliance. Within a week, a new referral came in. No supervisory order was sought then, or at any time after 6 more referrals were received up to April 13, 2004, the day Juli-Anna died. In fact, the file was never re-opened in child protection until April 20, 2004, a week after Juli-Anna's death. Over that period, the case was occasionally opened for investigation upon receipt of the referral, but it was never moved along to long-term child protection services. This was because the chances of future harm to the children were constantly rated at low risk.

Recommendation #2
The Department of Family and Community Services should review the function of the Permanency Planning Committee to ensure it is being properly used.

(c) Following practice standards & guidelines
Practice Standards
FCS has practice standards and guidelines for its child protection services. According to the manual, which was revised in January, 2007, the practice standards are "mandatory and establish a minimum level of performance," while the guidelines are optional procedures considered desirable but not mandatory. The guidelines and standards

constitute a minimum threshold that should be met and are intended to complement, but not replace, good social work practice. The practice standards are used in conjunction with the department's risk management system, which assists workers in assessing the risk while making the following decisions:

1. To investigate or not to investigate (made at "intake," i.e., when the referral first comes in).
2. To determine the response time to a referral (also made at "intake").
3. The child's immediate safety (made during the investigation).
4. Verification and conclusion of the report (made during the investigation).
5. Assessment of risk of future harm/neglect to the child, and whether or not to open the case for further FCS involvement (made during the investigation).
6. Determining the level of service/case plan (made during ongoing service).
7. Periodic re-assessments of risk (made during ongoing service)
8. Should the child be removed from, or re-united, with the caregiver? Also, decisions made as a result of significant events. (Made during ongoing service).
9. To close or not to close the case (made during ongoing service).

The manual specifies, in practice standard 8, that the social worker must consult with the supervisor and have all decisions of the types listed above approved.

Child protection practice standards exist for several reasons:

- To implement the provisions of the *Family Services Act*, and regulations, by providing operational direction.
- To describe an expected level of performance for the delivery of child welfare services.
- To state what families and the public can expect.
- To assist regions in monitoring the performance of staff.
- To assist the department in monitoring its performance by facilitating measurement.

<u>Guidelines</u>

The child protection guidelines, meanwhile, are procedures considered optional but desirable. Unlike the practice standards, they are not mandatory. They help clarify how to carry out practice standards.

Guidelines may be set out for several reasons:

- To allow greater flexibility and discretion of practice.
- To indicate a preferred practice.
- To indicate desired behaviours and interactions that cannot be thoroughly measured or precisely stated.
- To indicate a desired state or level of performance.

Officials of the Department of Family and Community Services did not meet some practice standards on several occasions in this case. A clinical audit conducted by the department after Juli-Anna's death indicates there were also instances where practice standards (mandatory) were not met.

Recommendation # 3
The Department of Family and Community Services should ensure that practice standards are being adhered to, not just in Woodstock, as per their internal recommendations, but all over the province. If staff are unable to adhere to the standards due to workload issues, the department should determine why, and make adjustments accordingly, i.e., hire more staff, if workload necessitates.

Particular standards not followed

Physical abuse allegations
In July, 2002, it was alleged that a woman hit a boy at a gas station. The license plate of the woman's vehicle was taken down and traced to a family member. In reviewing the file, we found no indication that the following standards were met: (a) practice standard 23 – informing the police, (b) practice standard 21 – receipt of a report of third party abuse, (c) practice standard 26—impeding or denying access to child or to documents during an investigation.

(a) *Practice standard 23--informing the police:* This standard states: "After consultation with supervisor, unless otherwise exempted by supervisor, the social worker will contact the police immediately in all cases of sexual abuse, child abuse and neglect cases where criminal activity is suspected. The decision must be documented when we decide not to contact the police." It is not clear why the police were not called to investigate, or at least to assist, nor, if a decision had been made not to call them, was the reason documented.

(b) *Practice standard 21--receipt of a report of third party-abuse:* This standard states that, "when a report is received that a person other than the parent has abused/neglected a child, decision to investigate or not shall be made in consultation with a supervisor unless otherwise exempted by supervisor. If there are reasonable grounds to begin an investigation, you will have to determine two things: a) Could the parent(s) have prevented the abuse/neglect? (b) Has the parent taken steps to protect the child in the future from the alleged perpetrator"? It is not documented whether or not the worker at any time discussed with Anna her role in the incident. Neither her version of the event, nor her role in protecting her son against such outbursts of anger from family members in the future, are documented.

(c) *Practice standard 26:--access to child or access to documents is impeded or denied during an investigation:* This standard says that when access to a child is impeded or denied during an investigation, a social worker must:

- Inform those impeding or denying access that the department has a responsibility to proceed to court if access is denied.
- If it is necessary to pursue an intervention, and if voluntary cooperation is not possible, proceed with the required court alternative
- Consult with the supervisor about applying to the Family Court for an order authorizing an investigation under subsection 31(2.2) of *the Family Services Act*.
- Contact the police immediately when their participation is needed to carrying out an Order authorizing an investigation.

Denying access to a child during a child abuse investigation is very serious. Our review indicates that, each time Anna became hostile with FCS, the department left her alone. It appears, from the department's incomplete investigation, that FCS focused too much on accommodating Anna instead of meeting its obligation to investigate the child abuse allegation.

Physically viewing the child

Practice standard 25, in place at the time of this child's death, read as follows: "In every situation you must determine if the child's security and /or development is or may be in danger." This applies to the investigation phase, when it has already been determined that an investigation is necessary. On March 19, 2004, when Juli-Anna had been brought to the hospital with mouth ulcers, and the doctor subsequently made a referral to FCS, stating that he thought the child might be a victim of a lack of supervision or child neglect, FCS determined that an investigation was warranted. Under "investigation process," the practice standard instructs: "Meet the child to observe or interview in order to validate the referral." The social worker did as she was supposed to and attempted to visit the family on March 23, four days after the referral was received. However, as noted earlier in this report, she did not see the family then and decided to return when Anna delivered her fourth child. The worker's notes show that she was under the impression this would happen shortly, since the due date was only a few days later. As it turned out, the mother did not deliver until April 13, the day Juli-Anna died. The worker did not see the child after the March 19 referral, nor did she attempt to visit the family after her failed visit on March 23.

I was pleased to see, in the "Child Protection Services Practice Standards and Guidelines," updated in January, 2007, almost three years after Julie-Anna's death, that certain changes had been made to practice standard 25, which is now practice standard 27. Under this new standard, which is titled, "Risk Decision: Verification and conclusion of the report,", it is written: "In order to accurately assess risk to all children and to determine the level of intervention and appropriateness of services, the Child Protection Social Worker **must** see all children who have not entered the public/private school system or children who are disabled, in their home environment during the investigation phase and directly observe the children's living situation." (Emphasis added.)

However, a few lines down, under "Guidelines," in the English manual the text is a little different: "In order to accurately assess risk to all children and to determine the level of intervention and appropriateness of services, the Child Protection Social Worker **should** see all children whether in the public/private school system or children who are disabled, in their home environment during the investigation phase and directly observe the children's living situation." (Emphasis added.)

To eliminate any doubts and ambiguity about the fact that the children must be seen by the social worker during the course of the investigation, the text under the guidelines must be removed altogether.

Recommendation #4
The Department of Family and Community Services should alter the practice standards and guidelines as follows: Practice standard 27 should continue to read as follows: "In order to accurately assess risk to all children and to determine the level of intervention and appropriateness of services, the Child Protection Social Worker must see all children who have not entered the public/private school system or children who are disabled, in their home environment during the investigation phase and directly observe the children's living situation." I further recommend that the similar text under "Investigation Process" be removed.

(d) Looking at the entire history of FCS's involvement with family
The child protection practice standards outline, under standard 18, the expectation that, when a new referral comes in on a family, a check will be made of prior contacts the department may have had regarding that family. This means the social worker receiving the complaint, and the social worker assigned to the investigation, must retrieve all information available on the family from FCS's files, including earlier referrals. This information has to be reviewed and, most important, it has to be considered along with the new referral. In other words, when a new referral comes in, the entire previous history must be examined, too. The new information should never be assessed in isolation.

The information in this report makes it obvious that this family had an extensive history with FCS. Many of the referral forms filled out by the social worker at the "intake" stage indicate that the family's history was retrieved. Evidence suggests, however, that this previous history was seldom taken into consideration. A review of the case shows that, time and again, referrals were assessed in isolation from the family's previous history with FCS.

In revisions, finalized in January, 2007 to standards in place at the time of Juli-Anna's death, a few changes were made to practice standard 18, which became standard 19 in the new document. None of the changes, however, relates to checks of prior contacts, and none relates to how the family's previous history must be analyzed against the new referral. Moreover, in the risk management system manual, the text that deals with the issue of previous involvement of the family with FCS reads: "Determine if there has been prior involvement and specify nature of such." In my opinion, this is insufficient.

Recommendation #5

The Department of Family and Community Service should modify practice standard 19 in the risk management system manual to include a clear statement that, when assessing every new referral on a family, all findings from the family's previous involvement with child protection services must be taken into account with the new referral information. As well, clear instructions should be provided about how the information in the records of the family's previous involvement with FCS's child protection services must be part of the decision to investigate or not to investigate the new referral.

(2) CHILD NEGLECT

It was important for me to speak in this report on the issue of child neglect. FCS has described the story of Juli-Anna and her family as a case of neglect. There were three reports of physical abuse on Anna's son, (two of which were never fully investigated), and one report of alleged sexual abuse. There was also a report of inappropriate sexualized behavior. But the majority of complaints to FCS about this family concerned the mother's neglectful behaviour regarding her children.

Child neglect is defined in the following ways: "Physical neglect refers to acts of omission on the part of the parent/caretaker. This includes failure to provide for the child's basic needs and appropriate level of care with respect to food, clothing, shelter, health, hygiene, and safety, as determined by the community's minimum level of care standards."

"A child whose physical, mental, or emotional condition has been impaired or is in danger of becoming impaired as a result of the failure of the child's legal guardian to exercise a minimum degree of care in supplying the child with adequate food, shelter, or education, medical care, supervision, or protection from harm." Eilleen Bisgard, J.D. (Staff Attorney, Rocky Mountain Children's Law Center, Colorado Bar Association, page 1)

"Neglect is a parent's failure to meet the various needs of her/his child. It is defined more in terms of a lack of behavior beneficial to the child and less in terms of harmful parental conduct."[2]

In my opinion, the following excerpt summarizes well the case of Juli-Anna's mother Anna:

"The majority of neglect is due to ignorance and chaos in the caregiver's life. In many situations, the lack of adequate childrearing information, skill or resources contribute to a neglectful situation. In many cases, neglectful parenting exists on the same continuum as adequate parenting. Neglectful parents may not be aware that their actions (or lack of actions) are of a sufficient degree to potentially result in harm to the child. Overwhelmed parents are often uncertain of what to do to get help with care giving and are reluctant to bring negative attention upon themselves. For example, fear of intervention from child protection agencies provides compelling pressure for some to minimize or deny neglectful conditions. While other forms of child maltreatment, such as physical and sexual abuse, may occur in episodic patterns or as single events, neglect tends to be chronic patterns of inadequate or age-inappropriate care."[3]

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[2] Éthier, Bourassa, Klapper, Lajoie, Gough, Léveillé, 2007-Centers of Excellence for Children's Well-Being, 2007

[3] Perry, B.D., Colwell, K. and Schick, S. *Child Neglect* in: **Encyclopedia of Crime and Punishment** Vol 1 (David Levinson, Ed.) Sage Publications, Thousand Oaks pp 192-196, 2002.

Child neglect represents the majority of child protection cases referred to child welfare agencies in Canada and the United States. In some jurisdictions, studies have shown that 40 to 60 per cent cases investigated by child welfare agencies involved child neglect.[4]

According to FCS's report, "Children Come First," published in 2000, neglect cases in New Brunswick have represented the majority of referrals as far back as 1985. Since 2002, this trend has continued, with referrals concerning the neglect of children running higher, at 53 per cent, than the physical (28 percent) or sexual (19 per cent) abuse of children. (This breakdown does not include referrals involving emotional abuse and neglect.)

The Canadian Incidence Study of Reported Child Abuse and Neglect is a national child health surveillance initiative which collects data every five years on instances of child maltreatment reported to child welfare agencies in Canada (excluding Quebec). The study found that, between 1998 and 2003, the number of investigated child maltreatment cases increased by 86 per cent, while the number of substantiated child maltreatment cases (those that investigation proves founded) increased by more than 125 per cent (Trocmé et al, 2005). For the same period, the number of substantiated child neglect cases almost doubled (Trocmé et al, 2005). (Note: these numbers reflect an increase in the number of cases reported, not necessarily an increase in child maltreatment in the country.)

It has become evident that the increase in substantiated child neglect cases has contributed considerably to the increase of child welfare caseloads in Canada. This pressure on the child welfare system, combined with cuts in social programs, leaves social workers and the families they serve very vulnerable. High caseloads and dwindling resources prevent social worker from building relationships with families (Farris-Manning and Zandstra, 2003).

Many people feel child protection has become an overwhelmed, reactionary, crisis-driven system that deals with the most urgent and obvious situations, like physical injuries, but one that has become incapable of focusing on issues of child neglect, let alone the prevention of such conditions. Research shows that the consequences of child neglect are as severe as other forms of child abuse (physical or sexual). "Indeed, neglect in early stages of life may lead to severe, chronic and irreversible damage" (Child Trauma Academy, 2007). In addition, we know that child neglect "is the least studied and most poorly characterized form of child maltreatment" (Child Trauma Academy, 2007).

"Early identification is the most important element of intervention. Unfortunately, several factors hinder detection of neglect. In our current social structure, many families are physically or socially isolated. This means that the neglected infant, toddler and young child may not be seen by any other responsible adult. When a child does come to the attention of other adults, in school or other settings, there are no overt bruises or marks left behind, to serve as indicators" (Child Trauma Academy, 2007).

[4] Lacharité, Chamberland, Baraldi, Centre of Excellence for Child Welfare, 2004;Tomnyr et Doering, Santé Canada; Trocmé et al. 2001

Many professionals refer to a "neglect of neglect" among policy-makers and professionals. In other words, neglect, possibly the most detrimental form of child maltreatment, receives less attention from government and media than do physical or sexual abuse.

In addition, child neglect has "traditionally been linked to poverty and economic challenges for Canadian families." ("The Welfare of Canadian Children: It's Our Business," published by the Child Welfare League of Canada, 2007.) A Quebec research group focusing on child neglect "have come to refer to neglect as a 'world,' a sort of neighborhood, in which isolated, vulnerable families--the poorest of the poor--struggle to survive" (Centre of Excellence for Child Welfare, 2004).

Reviewers of the Jacqueline Brewer case, another New Brunswick child whose death highlighted weaknesses in the child protection system, found that most referrals to child protection authorities at the time of their review were cases of child neglect. The situation was virtually identical in Juli-Anna's case. FCS officials considered the Brewer case less serious than other cases of chronic neglect being supervised by child protection services in the Saint John region. The reviewers also noted few departmental documents existed that clearly defined neglect, let alone directed staff on how to deal with the cases. In addition, the reviewers commented on the challenge facing social workers when they must balance the child's right to protection with preservation of the family.

Similarly, departmental staff involved in Juli-Anna's case confided in interviews with my staff and me that, although it was well known in their office from numerous referrals over the years, it was not seen as a serious neglect case. In fact, it was not seen as a case needing a lot of attention from child protection authorities.

As a society, we should be extremely concerned with these findings. Not only have we failed Juli-Anna and her family, we continue to maintain a system that allows the poorest and the most vulnerable to be marginalized and excluded. Canada's wealth and prosperity have not benefited everyone, especially not those needing it most. Being horrified when a case like this reaches the media is not enough. Nor is laying all the blame on the child's mother. It must be shared by all of society, because we have all made choices that landed us in this situation.

The two times a child protection case was opened for ongoing service to this family were: when Anna's son was physically abused before Juli-Anna's birth; and after the little girl died. It was never opened for ongoing service because of the numerous neglect issues. We think this is alarming, considering the research outlined above. As indicated, neglect is serious, perhaps more detrimental than, and deserving as much attention as, physical abuse.

Although, since the Brewer Child Death Review, changes have been made to some child protection standards used by staff in conducting investigations and providing services to families, it appears a lack of clear understanding and direction regarding cases of child neglect persists, and three recommendations made almost 10 years ago still apply.

Consequently, I am adding them to the recommendations resulting from on our review of Juli-Anna's case.

Recommendation # 6
The definition of child neglect should be reviewed with a view to providing child protection workers and other support workers with clear and unambiguous guidelines for assessing cases of chronic neglect, and establishing risk levels.

Recommendation # 7
All child protection workers and other related services providers should be given clear direction and training in identifying, understanding and working with cases of chronic child neglect.

Recommendation # 8
Greater clarity should be provided on the dual function carried out by child protection workers in helping to preserve the family while ensuring the best interest and safety of the child.

(3) CHILD PROTECTION WORKERS

Child protection workers go into everyday some of the worst situations that exist outside of a war zone.

Dr. Andrew Turnell

The life of a child protection worker

Child protection social workers have one of the most challenging jobs in New Brunswick. And although errors in professional judgment by social workers on this file cannot be overlooked, it is evident they occurred in extremely stressful circumstances. Management, too, must take responsibility, for not listening to their repeated requests for help.

It is important to note the work situation in this particular FCS office during the time in question. After senior management was made aware that the work environment in FCS's Woodstock office was less than ideal, an environmental scan was done there in the early months of 2001. FCS then developed an action plan in response to the report. Later, a workplace assessment was carried out. Recommendations resulting from the environmental scan included -increasing the number of administrative positions from two to four, obtaining more physical space, and providing additional training for staff. The only recommendation made from the workplace assessment was that the deputy minister and regional manager should put forth a consistent message of empowering social workers.

Separate from the scans and action plans, the most telling document describing the desperate nature of the workplace near the time of Juli-Anna's death is an email sent to the program manager responsible for overseeing the child protection services in that area on April 6, 2004, seven days before the child died. It sums up concerns raised by the workers in this unit (letters have been substituted for the names of individuals):

> "I am sending this email as I feel the need to express my thoughts concerning the ongoing issues with staffing within my unit. I have been working within this unit for close to five years, during which I have noted a continual staff turnover due to overwork, stress, and the ever present "casual" position number we have for our second screener.
>
> "Yesterday I was very disappointed to learn that our current casual screener is leaving our office for a permanent position. X was an excellent addition to our "team" who fit in well, enjoyed the work (and environment) and would like to stay in our unit. I can't fault her for her choice to leave, as I would do the same in her place. Y is also leaving our unit for a more permanent position in another region. Z as you know is currently out on sick leave for an indefinite period of time.

> "Our unit has now hit an all time low, though I must say this is just another blow to a team which has been working in constant crisis (but for a few months here and there) for the whole of my employment….The "team" has risen to every challenge during my time here: i.e. carrying CP cases for over a year and a half; constantly working short staffed as one member of the team is always "in training" (or we have a position open); completing more investigations per month this is considered a 'full' work load.
>
> "I know that we have put forth statistics time after time which have supported the need for more staff but our efforts have gone unheard. I personally feel that the time is coming when I will have to look for employment elsewhere or end up on stress leave. Have we not been addressing our concerns to the right people? Do we all have to end up "burnt out" – **Do clients have to suffer and possibly a tragedy happened?** Standards are not being met and I don't see this changing in the near future without changes being made to have the staffing issue dealt with once and for all." (Emphasis added.)

Another worker in the unit sent an email on April 5, 2004, to the same individual with the words "SOS We are Sinking" in the subject line. This email contained a similar message and begged for help.

Staffing

The email excerpt quoted above gives an indication of the staffing issues during the period of this case. Staffing was also an issue in the Brewer case. In its report on that case, the Child Death Review Committee noted: "Budgetary pressures within the department have led to child protection worker positions being left unfilled for extended periods of time due to the application of the 'vacancy deflator' policy of government. This has resulted in cases being handled in transition for extended periods of time as extra workload for remaining staff." [5] While "vacancy deflator" was not a factor in the Juli-Anna case, other staffing issues existed as a result of difficulty in attracting people to Woodstock, partly because the positions were casual and not permanent.

From Fall 2003 to Spring 2004, there were workload pressures and staffing concerns that the access and assessment unit in Woodstock tried unsuccessfully to communicate to senior managers in Fredericton, who reportedly told the unit to do its best with what it had. At that time, the unit's screening function was done in Woodstock, but the regular screener was on sick leave, and so the unit's child protection investigators had to do the screening in addition to their own investigatory responsibilities. This increased workloads considerably and caused great stress to the social workers, whose morale was faltering because their cries for help were going unheeded. They have told me they repeatedly warned senior management of being unable to meet child protection standards.

[5] Creaghan et al, 'Report on the Death of Jacqueline Dawn Brewer', Department of Family and Community Services, July 7, 1998 at page 31.

Shortly after Juli-Anna's death, the screening function in Woodstock was permanently moved to the Fredericton office. In addition, by September, 2004, responsibility for supervising all region 3 screeners had been assigned to a Fredericton-based supervisor.

In January, 2005, a term position was added to the access and assessment unit in Woodstock, but because of on-going difficulties in recruiting and retaining child protection social workers, the position is frequently vacant. Turnover of social workers in the Woodstock office is constant. New social work graduates often go there for their first job, but move on whenever an opportunity presents itself. It remains a concern of mine that maintaining a full complement of fully-trained staff is an ongoing challenge in the access and assessment unit at Woodstock.

Recruitment and retention of child protection workers

I am aware that social work in child protection is complex, demanding, and time-consuming. It gets little support from the community, which normally hears about this important work only when things go wrong, as in Juli-Anna's case.

I am also aware that, in the last several years, the Woodstock office, in particular, has had considerable difficulty recruiting and retaining front line child protection staff. Since Juli-Anna's death, a full-time child protection position has been added to the complement of staff in the access and assessment unit in that office, but keeping this position staffed remains highly problematic. And when that vacant position and others in the unit do get filled (usually by new graduates and inexperienced workers), the turnover rate is high.

From our review of the literature, it seems the most effective retention and recruitment strategies are ones that encourage job flexibility and mobility, as well as training and career advancement in a supportive environment where the work accomplished is both recognized and validated.

Recommendation #9

The Department of Family and Community Services should plan and implement workplace strategies to address the shortage of trained child protection workers, including an examination of the work environment and working conditions.

Training

FCS offers its frontline child protection workers training in child welfare, including "The Core 100 Series Modules for Child Welfare Social Workers." The five modules of this series are:

1) Family-centered child protection services
2) Case planning and family-centered casework
3) Effects of abuse and neglect on child development
4) Separation, placement and permanence
5) Legal aspects of child welfare

FCS also offers its child protection supervisors a 12-day in-service training curriculum called "The Core Curriculum for Child Welfare Supervisors and Managers (Core 500 series)."

The four modules of this series are:

1) Managing within a child welfare system: leadership, administration and education
2) Managing work through other people: diversity in the work force
3) Transfer of learning: the supervisor's role in developing staff
4) Supervising and managing group performance: developing productive work teams

In addition to the four modules, supervisors and managers attend a two-day follow up session in which the theory, practice and skills taught in the series are reinforced.

There is a plan to add a fifth module, dealing with clinical supervision, to the Core 500 series in the Spring of 2008.

Additional training offered to front-line child protection staff includes risk management and risk assessment training prior to Juli-Anna's death, signs of safety, writing skills for case documentation, and investigative interviewing.

Since child protection social workers and supervisors involved in this case all received the core training outlined above, as well as additional training, we cannot conclude that lack of formal training was an issue in this case.

Clinical reviews

After the death of Juli-Anna, the Department of Family and Community Services went beyond their usual internal review and conducted a clinical review of child protection files in the Woodstock office. The clinical review revealed some troublesome trends in that particular FCS office, which prompted the department to take corrective measures. It is impossible for us to say if these trends are limited to this office only, since, as far as we know, these file reviews were not, and are not, being conducted in other regions of the province. The Office of the Ombudsman and Child and Youth Advocate believes this type of review should not be reactive but proactive, and should form part of the overall supervision of child protection services, in particular.

The purpose of conducting clinical reviews of child protection cases is:

-to determine the current level of practice across a sample of cases;
-to validate and confirm already existing good practice;
-to identify areas of improvement in existing practice;
-to assess current practices as they relate to the legislation;
-to identify challenges in the delivery of quality services to children and families;
-to assist in identifying training needs;
-to measure compliance with departmental standards;
-to inform policy changes;
-to assist social workers and managers in keeping children safe.

In the Department of Health and Community Services January, 2000, report, "Children Come First," it was recommended that Health and Community Services ensure that child welfare programs are audited routinely and on schedule to ensure adherence to standards and to identify gaps for improvement. The Office of the Ombudsman and Child and Youth Advocate does not believe this is being done.

Recommendation: - #10
The Department of Family and Community Services should implement a provincial clinical review system to be conducted on a regular basis, at a minimum yearly, on open and closed child protection investigations and on-going open and closed cases, for the purpose of measuring standards and regulation compliance, as well as best practice in clinical child protection service delivery. These reviews should be conducted by a monitoring and accountability team with staff experienced in child protection. The team would be responsible for outlining the results of these audits in a case practice audit report. FCS would then be responsible for disseminating the findings to the regions to improve services to children and their families, and to ensure follow-up on the findings.

Rotation of child protection social workers
In the course of this investigation, and since I have been appointed Child and Youth Advocate, my investigators and I have met dedicated social workers, who do a tremendous job of protecting children every day, in very difficult conditions. A lot of workers travel an uncounted number of hours to get to the most isolated areas of this province to support children and their families. When visiting a home to investigate a new case, they never know what they will find on the other side of the door. They regularly put their own safety at risk, and they struggle to understand the painful situations they often see children in. They also struggle, with limited government and community resources, sometimes with no resources at all, to serve families. Needless to say, the stress level for these workers is extremely high.

We have also met social workers who have been working in child protection for some time and feel they are unable to continue. I have been told that, in child protection circles, especially among young graduates, many feel they have to "do their time" in child protection, hoping to do it for a few years and then "get out," into less stressful social work. I don't think I will get any arguments when I say that having workers who are unable to continue child protection work because of the stress level is not in anyone's best interest, let alone a child's.

During the course of our investigation, our office had several discussions regarding the rotation of social workers. An environmental scan of the Woodstock FCS Office had been done before Juli-Anna's death. In his report on the results, the author addressed the issue of rotation of social workers and determined that a structured rotation was not necessary, but that it should be looked at on a case-by-case basis.

There are pros and cons to having a mandatory rotation of social workers. A regular rotation would provide people with the opportunity to move out of the child protection

area if desired; however, it might also remove individuals interested and experienced in that type of work, and who continue to be satisfied with it for years. A mandatory rotation could disrupt services to children and their families as workers change. I am hesitant to support a "built-in" change of workers for families. Families experience enough of those as it is, for many different reasons. On the other hand, not having a mandatory rotation may mean that social workers who want to change jobs may be unable to do so because of a lack of alternate positions. Again, it serves no one well to keep a workers in a position in which they find it difficult to cope. I would even argue that, in child protection, it is a dangerous practice. This is a complex issue that requires more study.

Recommendation # 11
The Department of Family and Community Services should ensure that child protection workers who have indicated they need to be transferred from child protection services be given the opportunity to do so. The Department of Family and Community Services should examine the issue of staff rotation and make recommendations on whether or not it should be implemented and , if so, how.

Cooperation between Professionals
While FCS was involved with Juli-Anna's family, there was at least one occasion, at a permanency planning meeting, when professionals from other services voiced their concerns about child protection's decision to close the case. Also, more than once, professionals working with the family, or who became aware of certain information about the family, made referrals to FCS. Yet there did not appear to be a coordinated effort to work with this family. While it is true that child protection services are ultimately responsible for making decisions on cases, other professionals working with families often have privileged access to children and can observe directly the kind of care they are receiving. It is of great concern to me that, on many occasions, referrals made by professionals were deemed unsubstantiated.

As stated in the recommendations of a report submitted to the Department of Health and Community Services, after the death of John Ryan Turner in 1996, there is a need to "coordinate service to vulnerable children and their families." That report suggested a mandatory, hospital-based child-at-risk committee and a shared computer database that would give mental health and public health personnel and FCS access to relevant service interventions in high risk child protection situations. I am not sure a shared database is the solution; however, it is clear that information needs to be shared more easily.

The Child Death Review Committee, in their 1998 report on the death of Jacqueline Brewer, recommended that "a consultation team approach must be the norm, with all service providers, departmental and non-departmental, being consulted when critical decisions are being made."

In the Department of Health and Community Services' January, 2000, report, "Children Come First," it was recommended that the regions and the central office "find ways of improving linkages and 'building bridges' between service providers who must collaborate in order to provide an effective service to children."

In July, 2005, the departments of Family and Community Services (FCS) and Health and Wellness (DHW) jointly completed a program review of early childhood initiatives. It is incredible that the report then sat for almost two years before being publicly released in May, 2007. I find this unconscionable, given the seriousness of the concerns with the program, and the priority that must be given to remedies.

Home-based early intervention services are one of the seven core health and social services programs in the early childhood initiatives (ECI) the Department of Health and Community Services established in this province in 1994. One of the primary goals of the ECI was to improve developmental outcomes for preschool children who were at risk of abuse or neglect. A great emphasis was to be placed on targeting these services to these children and families at risk.

The review pinpoints several problematic issues with the ECI, including the one most troubling to me in Juli-Anna's case, which was the communication problem between early interventionists and child protection workers. The review indicated that communication between the two was primarily one-way, from early intervention to child protection, but seldom from child protection to early intervention.

Juli-Anna's family was referred for early intervention services (EIS) on two occasions, one in the Fall of 2000 and another in January, 2004 when Juli-Anna was turning two years old. Like other service providers working with the family, the early interventionists found Anna difficult to serve, since she frequently missed or cancelled planned home visits by them. She was very good at eluding services set up to help her.

Of even greater concern to most service providers, however, was that when they expressed reservations about Anna's case being closed as an ongoing child protection case in April, 2001, they felt their concerns were undervalued and not taken seriously by child protection staff. They did not feel included in the case planning process. They were not informed of case status and felt that important information was withheld from them, which could have compromised their safety.

According to the Department's own review, the cause of communication problems between early intervention and child protection needs to be explored and strategies developed to increase collaboration and information-sharing in high-risk cases like this one. I strongly believe that communication between all service providers should be open and ongoing to better serve families and protect children. In addition, ways must be found to engage the families that could most use these services.

The protection of personal information is often cited by child protection as a justification for withholding important information from other service providers, but where the safety and security of a child is concerned, there should be no confusion. It is essential that professionals work together and share information to meet the best interests of children. Juli-Anna's case indicates that work still needs to be done in the area of cooperation between the department and other service providers. It is imperative that the professionals

involved communicate with each other. The recommendation made in the Jacqueline Brewer case, pertaining to professionals working together on cases, is one I am also including in this report.

Recommendation # 12
As per the Child Death Review Committee report in 1998, after the death of Jacqueline Brewer, a consultation team approach must be the norm, with all service providers, departmental and non-departmental, being consulted when critical decisions are being made.

Support to front line child protection staff
Having a child die while receiving, or having received, services from child protection is the worst nightmare of every child protection social worker and supervisor. When such a terrible tragedy occurs, professionals who provided care often suffer considerable distress. FCS outlines, in Appendix 2(A) of the Child Protection Services Practice Standards and Guidelines, a procedure called "Critical Incident Stress Management: a program dedicated to New Brunswick's Front Line Workers." The document lists situations that call for particular support to workers. Two of these apply to this case: "Incidents that attract considerable media attention" and "death of or violence towards a child." The support program "is intended to reduce the buildup of stress in people who work in high burnout jobs. At the same time, it promotes good mental health for New Brunswick's valued front line staff…." Understanding the impact of critical incident stress and applying appropriate interventions when incidents do occur have been found to be very helpful to front line workers in dealing with the abnormal stress they may encounter in their daily work. It has also been proven to be a cost-effective program. Research has shown that for every dollar spent in prevention services for critical incident stress, seven dollars in remedial employee services are saved.

"Worker 'burn-out' appears to be high and there is a strong feeling among front-line social workers in child protection that they do not get continual support from management in serious situations such as the aftermath of the Brewer case."[6]

Contradictory information has been presented to me about the support social workers and their supervisor in the Woodstock office received from the regional and central offices of FCS in the aftermath of Juli-Anna's death. Having carefully weighed this information, I am not convinced the department offered the support needed by the front line staff. I do note that the above mentioned policy was only created after Juli-Anna's death; however that does not change the ethical obligation to provide support. There is also evidence the department was not offering on-going support to front line staff in the Woodstock office before the death. The email the social worker sent to the program manager seven days before Juli-Anna died testifies to that fact.

We need to support child protection social workers and supervisors in this province who do work most of us cannot imagine doing. The failure to better serve this family cannot be rationally explained, nor should it be excused. Some of the social workers' decisions

[6] Ibid.

in this case are questionable. Huge difficulties faced them as they struggled, amid high caseloads and a reduced staff complement, to meet standards and offer high-quality child protection services. These facts cannot be denied and must be balanced in the analysis of this case. One element of it, however, defies all explanation and logic. It is the way the Department of Family and Community Services, at both the regional and central offices, have treated staff involved in this case, both before and after Juli-Anna's death.

Recommendation # 13
The Department of Family and Community Services should ensure that, when similar incidents occur, staff are *promptly* provided with support and, and that the department's policy with regards to these incidents is followed both at the time of the incident and throughout the processes that may follow, i.e. court proceedings.

(4) CHILD DEATH REVIEW COMMITTEE

On November 26, 1997, the provincial government announced creation of a Child Death Review Committee. This committee reports to the Minister of the Department of Family and Community Services. As presented on the department's website, the committee's objectives are:

- To review the manner and cause of death.
- To comment upon relevant protocols, policies and procedures, standards and legislation as to whether they were followed and as to their adequacy.
- To comment upon linkages and coordination of services with relevant parties as to whether they were sufficient and adequate.
- To make recommendations that would lead to improvements in order to prevent future deaths or improve services to children.
- To submit a written report within 45 days of official notification from the Minister. [7]

The committee consists of a chairperson who is a retired judge of the Provincial or Family Court of New Brunswick (and appointed by the attorney-general), and a police officer, pediatrician, social work professor (appointed by the director of the social work department at a New Brunswick university, a representative from the office of New Brunswick's chief coroner, and a First Nations representative.

The Office of the Ombudsman and Child and Youth Advocate believes in the importance of the committee, its structure and composition. However, during the course of our investigation, we became concerned about the perceived lack of independence of the committee in reporting to the minister. The potential pitfalls of a review body's lack of independence were illustrated in June, 2007, when the Department of Family and Community Services released its Early Childhood Initiative Review more than two years after it was completed. Independence from the executive branch of government is essential. Although I am encouraged the government decided to move the Child Death Review Committee to the coroner's office, I feel additional measures could be put in place to ensure its independence from government and from the Department of Public Safety. For a host of reasons, not least public perception of the committee's credibility, we offer the following recommendation:

Recommendation # 14
In order to ensure independent monitoring of the Child Death Review Committee and its recommendations, additional measures should be put in place to increase the committee's independence from government.

[7] http://www.gnb.ca/0017/protection/childdeath/terms-e.asp

(a) Putting Children First

In 1991, Canada signed the UN Convention on the Rights of the Child, a convention that is committed to ensuring the protection and development of children. Up until 1998, New Brunswick's *Family Services Act* stated that "this Act shall be liberally construed to the end that the integrity of the family will be protected and family breakdown averted." While I believe preservation of the family should be a goal of child protection, I also feel it should never take priority over the welfare of children.

In July, 1998, the Child Death Review Committee released a report on the death of Jacqueline Brewer and recommended that: " the *Family Services Act* be amended to clearly provide that in the cases of chronic neglect, when there is a conflict between risk to the child and preservation of the family unit, that the best interest and safety of the child prevail." Following this recommendation, some changes were made to the *Family Services Act* to address these concerns.

In the Department of Health and Community Services January, 2000, report, "Children Come First" it was recommended that the philosophy of "best interest of the child" be "communicated to all staff in Child Welfare and that policy development, program planning, and collaboration with partners will be conducted with this philosophy in mind."

As recently as July 27, 2007, the Supreme Court of Canada stated: ". . . "but it is not the family's satisfaction in the long term to which the statute gives primacy, it is the child's best interests."[8] . Additionally, the court reaffirmed their belief that pursing and protecting the best interests of the child must take precedence over the wishes of the parent.[9]

Children should come first. They *must* come first. With this in mind, we once again reiterate the recommendation made nine years ago by the Child Death Review Committee after the death of Jacqueline Brewer.

Recommendation # 15

The preamble to the Family Services Act should be amended to <u>clearly provide</u> that, when there is a conflict between the risk to the child and preservation of the family unit, the best interest and safety of the child must prevail.

(b) Previous work of the Child Death Review Committee

The purpose of this report has been to review the child protection services FCS provided to Juli-Anna. It has not been to examine other child death reviews in this province and their recommendations. However, in the course of this investigation, my staff and I have wondered about other children of this province who have died and had received, or were receiving, child protection services at the time of their deaths. The similarities we have found among the cases of Jacqueline Brewer, John Ryan Turner and Juli-Anna were troubling enough to be raised in this report.

[8] Syl Apps Secure Treatment Centre v. B.D. (2007) S.C.C. 38 at para 43.
[9] Ibid para 45.

We want to point out another of the similarities between the Jacqueline Brewer case and Juli-Anna's case:

Taking parents explanations at face value
Reviewers in the Brewer case referred to the fact that social workers relied mainly on information given to them by the parents. Much of this information was apparently misleading. The report says: "Mark (the father) gave excuses and explanations. As a result the front-line workers continued to have confidence in his good intentions. He misled some of them on many occasions." Later, the report says: "The possibility of deception and the heavy reliance on parent self-reporting underscore the need for enhanced assessment procedures." (P. 16)

From Juli-Anna's file, it is also obvious that workers relied heavily on explanations from the mother and family members to assess the children's safety and determine the level of intervention required. Referrals from the community and other highly credible sources were made to FCS numerous times about the same protection concerns (drug use in the home, lack of appropriate clothing for the children, poor level of hygiene and cleanliness in the home). It appears that time and again, when social workers asked the mother for explanations about these complaints, they took at face value her version of events.

Recommendation #16
The Department of Family and Community Services should ensure that the recommendations from the previous Child Death Review Committees are implemented by creating a process to follow up on the recommendations on a biyearly basis.

7.0 CONCLUSION

The John Ryan Turner report was published in 1996, the Jacqueline Brewer report in 1998, and the "Children Come First" report in 2000. These reports contain many significant recommendations to ensure such deaths could be prevented in the future. Yet, when Juli-Anna died on April 13, 2004, many of those recommendations had not been implemented. In fact, as I put these lines to paper in late November, 2007, several important recommendations respecting the provision of better resources for child welfare, particularly child protection, have yet to be entirely fulfilled. How many such reports will it take before we decide that enough is enough?

At one point during this excruciating investigation, a senior official of FCS advised me that "not the system but rather a few employees had failed Juli-Anna." With respect, I cannot exculpate the department and successive governments so easily. There can be no doubt that the signs of neglect in Juli-Anna's life should have provoked a more diligent response from professionals tasked with the responsibility of protecting her. But it is also undeniable that the delay or reluctance to adopt the improvements put forward by successive Child Death Review Committees and the department's own report cannot be imputed to frontline workers.

Why is "chronic neglect" still not viewed by child protection officials to be as detrimental to a child's best interest as "abuse"? Why is information-sharing between agencies still problematic in cases that cry out for collaboration? Why do we still not have in place appropriate review and audit functions to ensure that best practices are adhered to? Why do we still not have enough social workers at the frontline of child protection services, despite FCS's own recommendation to that effect in 2000?

My own sense is that it will take political will and clear direction to ensure that the most vulnerable among us get the attention they deserve. As a first follow-up to this report, I have asked FCS to provide this Office with a response to the many recommendations that have been made since 1996 in the Turner report, by several Child Death Review Committees, in the "Children Come First" report and in this report. These are the promises we have made to children like Juli-Anna. We have failed to keep some of those promises. I undertake to make public both FCS's answers and my comments on the matter.

It is hard to end this report on a positive note, but I am encouraged by the new preventative approach to child protection announced last year and talked about again in the November 27, 2007, Throne Speech. I must, however, add this caveat: if it is not sufficiently resourced, it, too, will fail. We owe it to the memory of these lost children that it be successful.

8.0 SUMMARY OF RECOMMENDATIONS

Recommendation #1
The Department of Family and Community Services should ensure that risk factors are being properly read, interpreted and rated.

Recommendation #2
The Department of Family and Community Services should review the function of the Permanency Planning Committee to ensure that it is being utilized properly.

Recommendation # 3
The Department of Family and Community Services should ensure that Practice Standards are being adhered to, not just in Woodstock, as per their internal recommendations, but all over the province. If staff are unable to adhere to the standards due to workload issues, the Department should determine the cause of the failure to meet standards and make adjustments accordingly, i.e. hiring of staff if workload necessitates.

Recommendation #4
The Department of Family and Community Services alter the Practice Standard and Guidelines as follows : Practice Standard #27, continue to read as follows: "In order to accurately assess risk to all children and to determine the level of intervention and appropriateness of services, the Child Protection Social Worker must see all children who have not entered the public/private school system or children who are disabled, in their home environment during the investigation phase and directly observe the children's living situation." In addition, I recommend that the similar text under "Investigation Process" be removed.

Recommendation #5
The Department of Family and Community Service should modify practice standard #19 in the Risk Management System manual to include a clear statement that when assessing every new referral on a family, that all the findings in the family's previous involvement with child protection services must be factored in the new referral information. In addition, clear instructions should be outlined on how the information in the records of the family's previous involvement with FCS child protection services must be weighed in the decision to investigate or not to investigate the new referral.

Recommendation # 6
The definition of child neglect be reviewed with a view to providing child protection workers and other support workers with clear and unambiguous guidelines for assessing cases of chronic neglect, and establishing risk levels.

Recommendation # 7
All child protection workers and other related services providers be given clear direction and training in identifying, understanding and working with cases of chronic child neglect.

Recommendation # 8
Greater clarity be provided on the dual function carried out by child protection workers in helping to preserve the family while ensuring the best interest and safety of the child.

Recommendation #9
The Department of Family and Community Services should plan and implement workplace strategies to address the shortage of trained child protection workers, including an examination of the work environment and working conditions.

Recommendation: - #10
The Department of Family and Community Services should implement a provincial clinical review system to be conducted on a regular basis on open and closed child protection investigations and on-going open and closed cases, for the purpose of measuring standards and regulation compliance, as well as best practice in clinical child protection service delivery. These reviews should be conducted by a monitoring and accountability team with staff experienced in child protection. The team would be responsible for outlining the results of these audits in a case practice audit report. FCS would then be responsible to disseminate the findings to the regions to improve the services to the children and their families, and to ensure follow-up to the findings.

Recommendation # 11
The Department of Family and Community Services should ensure that Child Protection workers who have indicated they need to be transferred from child protection services be given the opportunity to do so. The Department of Family and Community Services should examine the issue of staff rotation and make recommendations on whether or not it should be implemented and , if so, how.

Recommendation # 12
As per the Child Death Review Committee report in 1998 after the death of Jacqueline Brewer – A consultation team approach must be the norm, with all service providers, departmental and non-departmental, being consulted when critical decisions are being made.

Recommendation # 13
The Department of Family and Community Services ensure that when incidents occur staff are *promptly* provided with support and the Department's policy with regards to these incidents is followed both at the time of the incident and throughout the processes that follow, i.e. court proceedings.

Recommendation # 14
In order to ensure independent monitoring of the Child Death Review Committee and its recommendations, additional measures should be put in place to increase the committee's independence from government.

Recommendation # 15
The preamble to the Family Services Act be amended to clearly provide that when there is a conflict between the risk to the child and preservation of the family unit that the best interest and safety of the child must prevail.

Recommendation #16
The Department of Family and Community Services should ensure that the recommendations from the previous Child Death Review Committees are implemented by creating a process to follow up on the recommendations on a biyearly basis.