May 28, 2018

Dear [Redacted]

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [Our File #: CSSD 15-2017]

On May 23, 2017, Department of Children, Seniors and Social Development received your request for access to the following records:

“All correspondence related to the mandatory reporting of deaths and critical incidents of children and youth to the CYA. This should include correspondence between CSSD (formerly CYFS) and the Departments of Education, Health and Community Services and Justice, as well as the Office of the Child and Youth Advocate. This request would cover the time period Dec 1, 2015 to May 23, 2017.”

I am pleased to inform you that a decision has been made by the Deputy Minister for Children, Seniors and Social Development to provide access to some of the requested information. In particular, access is granted to the following records:

Correspondence relating to the mandatory report of deaths and critical incidents of children and youth to the Child Youth Advocate. This includes correspondence between CSSD, the Departments of Health and Community Services, Education and Justice and Public Safety.

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


PO Box 8700, St. John's, NL, Canada A1B 4J6 t 709.729-1027 f 709.729-6382 TTY 1.855.729.2044
ATIPP Act

Section 27: Cabinet Confidences
(1) In this section, "cabinet record" means
   (i) that portion of a record which contains information about the contents of a
       record within a class of information referred to in paragraphs (a) to (h).
(2) The head of a public body shall refuse to disclose to an applicant
   (a) a cabinet record; or
   (b) information in a record other than a cabinet record that would reveal the
       substance of deliberations of Cabinet.

Section 29
(1) The head of a public body may refuse to disclose to an applicant information
    that would reveal
    (a) advice, proposals, recommendations, analyses or policy options
        developed by or for a public body or minister;

Section 30: Legal Advice:
(1) The head of a public body may refuse to disclose to an applicant information
    (a) that is subject to solicitor and client privilege or litigation privilege of a
        public body; or
    (b) that would disclose legal opinions provided to a public body by a law
        officer of the crown

Section 35: Disclosure Harmful to the Financial interest of a Public body
(1) The head of a public body may refuse to disclose to an applicant information
    which could reasonably be expected to disclose
    (a) trade secrets of a public body or the government of the province;

Section 40: Disclosure Harmful to Personal Privacy:
(1) The head of a public body shall refuse to disclose personal information to an
    applicant where the disclosure would be an unreasonable invasion of a third
    party’s personal privacy.

The ATIPP Act does not apply where,

CYCP Act Section 69:
Notwithstanding the Access to Information and Protection of Privacy Act, the
use of, disclosure of and access to information in records pertaining to the
care and protection of children and youth obtained under the Act, regardless
of where the information or records are located, shall be governed by this Act.

Patient Safety Act Section 10: Release of information
(3) Notwithstanding subsection (2) or another Act or law, a person shall not
disclose, release or access quality assurance information, even where it contains
his or her personal health information, except as permitted under this Act.

As required by 8(2) of the Act, we have severed information that is unable to be
disclosed and have provided you with as much information as possible.
In accordance with your request for a copy of the records, the appropriate copies have been enclosed.

Please be advised that you may appeal this decision and ask the Information and Privacy Commissioner to review the decision to provide partial access to the requested information, as set out in section 42 of the Act (a copy of this section of the Act has been enclosed for your reference). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner. Your appeal should identify your concerns with the request and why you are submitting the appeal.

The appeal may be addressed to the Information and Privacy Commissioner is as follows:

Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Str. A
St. John’s, NL A1B 3V8

Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the Act (a copy of this section of the Act has been enclosed for your reference).

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

If you have any further questions, please contact me by telephone at (709)729-1027 or by email at patriciamcgrath@gov.nl.ca.

Sincerely,

[Signature]
Patricia McGrath
ATIPP Coordinator

Enclosures
Access or correction complaint

42.(1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16(2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.

(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52(1) or 53(1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21;

(b) a decision respecting an extension of time under section 23;

(c) a variation of a procedure under section 24; or

(d) an estimate of costs or a decision not to waive a cost under section 26.

(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.

Direct appeal to Trial Division by an applicant

52.(1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42, the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.
(2) An appeal shall be commenced under subsection (1) not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16(2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner’s refusal under subsection 45(2).
Executive Correspondence
hi, apparently there's an issue with the cu form. I have reattached. hopefully it will work this time.

Hi everyone,

Attached please find the updated policy direction document, which will form the basis for policy revisions, and a revised CI/Death form based on our last meeting.

Meeting minutes will be sent out tomorrow for review in advance of Thursday's meeting. Please review the document and the form and advise me of any changes on Thursday. Thanks JC
Child Death / Critical Incident Notification

Section 1: Client Information

Last Name: ___________________________  First Name: ___________________________

Date of Birth: (YYYY-MM-DD)  Age: _______  Gender: _______  CRMS ID for Child: _______

Child/Custody Status: ___________________________

Aboriginal Status/Identity

☐ Aboriginal  ☐ Non-Aboriginal

If child is Aboriginal, please select:

If not applicable please specify:

Section 2: Family Composition

Parent(s) Name: ___________________________

Step Parent(s)/Partner(s) of Parent(s):

Current Care Provider (if applicable) and relationship to child:

siblings (if 21 years of age and under):

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<tr>
<th>Name</th>
<th>Age</th>
<th>Date of Birth (YYYY-MM-DD)</th>
<th>Child’s Status</th>
<th>Where Not Applicable Specify Child’s Status</th>
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Section 3: CYFS Information

Social Worker assigned to follow up on death / critical incident:

Region:

Clinical Program Supervisor for Social Worker:

Zone Manager for Social Worker:

Current Open Program(s) (Check all that apply & include CRMS ID#)

☐ Protective Intervention  ☐ Youth Services
☐ Kinship  ☐ Adoptions
☐ In-Care  ☐ Community Youth Corrections
☐ No Open Program

Please specify program:  ☐ Secure Custody  ☐ Open Custody

If no open programs, please explain: (include dates programs closed)

Page 1 of 3
Section 4: Details of Death / Critical Incident

Date & Time Child, Youth and Family Services notified:

Name of Social Worker notified of death / critical incident:

Date Notified: (YYYY-MM-DD)  Time Notified:  □ A.M. □ P.M.  Date of Death / Critical Incident: (YYYY-MM-DD)

Type of Notification:  Type of Critical Incident:

□ Death  □ Critical Incident

Description of death or critical incident:

Supplementary Attachment?  □ Yes  □ No

Section 5: Response to Death / Critical Incident

Immediate:

Further follow up, if required:

Please specify the internal/external service providers who have been notified about the death/critical incident:

Please specify the internal/external service providers who will be notified about the death/critical incident:

Section 6: Review

Social Worker completing form: (print name)

Date: (YYYY-MM-DD)

Name of Supervisor (print name)

Date: (YYYY-MM-DD)

Name of Zone Manager (print name)

Date: (YYYY-MM-DD)

Final Review:

I, ___________________________ have reviewed the circumstances and I am satisfied with the plan for further follow-up.

Name of Regional Director

Regional Director’s Signature

Date: (YYYY-MM-DD)

Form MUST be submitted to the ADM - Service Delivery & Regional Operations, and Director of Quality Assurance.
Section 7: ADM Review (to be completed by the ADM - Service Delivery and Regional Operations)

Date Received:
(YYYY-MM-DD)

Action Required:
☐ No further action required of regional staff
☐ Further action required of regional staff
☐ Quality Assurance to complete file summary

Date Chief Medical Officer Notified: (If applicable) (YYYY-MM-DD)
Date Child & Youth Advocate Notified: (YYYY-MM-DD)
Date DM Initially Briefed: (YYYY-MM-DD)
Date Minister Initially Briefed: (YYYY-MM-DD)

Explanation of current status and action required of regional staff:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

ADM’s Signature

Date: (YYYY-MM-DD)
From: Norman, Katie
Sent: Friday, December 18, 2015 1:50 PM
To: Cochrane, Rachelle; Brown, Milly; Dooling, Genevieve (AES)
Cc: Tilley, Jean; Rodgers, Paula; Healey, Rick M.; O’Neill, Melony; Hunt, Deanne
Subject: RE: JPS Note for Review

Good Afternoon Rachelle,

Thank you for your input.

Katie

From: Cochrane, Rachelle
Sent: Friday, December 18, 2015 1:02 PM
To: Norman, Katie; Brown, Milly; Dooling, Genevieve (AES)
Cc: Tilley, Jean; Rodgers, Paula; Healey, Rick M.; O’Neill, Melony; Hunt, Deanne
Subject: RE: JPS Note for Review

Katie

From: Norman, Katie
Sent: Thursday, December 17, 2015 3:21 PM
To: Brown, Milly; Dooling, Genevieve (AES); Cochrane, Rachelle
Cc: Barfoot, Scott; Gardiner, Bob B; Tilley, Jean; Oliver, Patricia; Blackmore, Diane
Subject: JPS Note for Review

Good Afternoon,

Cabinet Secretariat has received an information note from JPS entitled, “Child Death Review Committee Reports.” Your review of the note is requested as there is material that relates to your respective mandates.
Patricia is in the process of placing this note in DCP for your review. If you have any difficulty accessing, please call her at 6598.

Please advise me by 2 pm tomorrow, Friday, December 18, if your Department has any comments.

Thank you,
Katie

Katie Norman | Cabinet Officer
Cabinet Secretariat, Executive Council
Government of Newfoundland and Labrador
709-729-6527
Dear Deanne,

Please add to the agenda discussion/plan for on-call response to critical incidents/deaths. Thanks, Paula

---

From: Hunt, Deanne
Sent: Wednesday, January 06, 2016 10:49 AM
To: Bragg, Dana; Cochrane, Rachelle; Healey, Rick M.; O'Brien, Donna; O'Neill, Melony; Roberts, Denyse; Singleton, Debbie; Tilley, Jean
Subject: Agenda Items Executive Committee Meeting
Importance: High

Good Morning,

The next Executive Committee meeting is scheduled for Friday, January 8th. If you have any items you would like to add to the agenda, please let me know. I will be circulating the agenda on Thursday afternoon.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Child, Youth & Family Services
95 Elizabeth Avenue
P.O. Box 8700
St. John's, NL
A1B 1J6
Tel: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dshunt@gov.nl.ca
Melony
Can you prepare messages for Minister.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: O'Neill, Melony
Sent: Monday, January 11, 2016 9:19 AM
To: Cochrane, Rachelle; O'Brien, Donna; Tilley, Jean; Healey, Rick M.; Rodgers, Paula
Cc: Hunt-Grouchy, Michelle
Subject: FW: CDRC Release for Review

---

Melony O'Neill
Director of Communications
Department of Child, Youth and Family Services
95 Elizabeth Avenue, P.O. Box 8700
St. John's, NL A1B 4J6
709-729-5148

Newfoundland
Labrador

Child, Youth and Family Services

---

From: Joyce, Luke
Sent: Monday, January 11, 2016 8:29 AM
To: Tompkins, John; O'Neill, Melony
Subject: CDRC Release for Review
Importance: High

John, Melony:

We intend to issue this advisory today.

Thanks

Justice and Public Safety
January 11, 2016

Public Advisory: Child Death Review Committee Case Reviews
Under section 13.5 of the *Fatalities Investigations Act*, the Minister of Justice and Public Safety is required, within 60 days after receiving a report from the Child Death Review Committee (CDRC), to make public those recommendations relating to:

- Relevant protocols, policies and procedures;
- Standards and legislation;
- Linkages and coordination of services; and
- Improvements to services affecting children and pregnant women.

The CDRC forwarded a report to the Minister of Justice and Public Safety on December 4, 2015. The report examines the facts and circumstances surrounding two unrelated deaths of youth in Newfoundland and Labrador that occurred in August, 2014 and February, 2015.

**Case 1:**
A youth died suddenly while living in residence at Memorial University.

**Recommendation**
Memorial University of Newfoundland review policy and establish protocol related to entering residence rooms when there are concerns about the health, safety and well-being of a student.

**Case 2:**
A youth died of hypothermia.

**Recommendations:**

1. CYFS develop a transition program for youth as they leave care (suggest one-year in duration), in which youth are provided with support and mentoring.

2. CYFS collaborate with the Innu health and social services programs in the development of this program for Innu youth.

This report has been forwarded to the Child and Youth Advocate.

- 30 -

Media contact:
Luke Joyce
Director of Communications
Department of Justice and Public Safety
709-729-6985, 725-4165
lukejoyce@gov.nl.ca
Luke Joyce
Director of Communications
Department of Justice and Public Safety
Government of Newfoundland and Labrador
709-729-6985 (office)
709-725-4165 (cell)
lukejoyce@gov.nl.ca
Hi, I am cancelling our meeting this coming Thursday at 11:00. Process of Operationalizing the New Definition of Critical Incidents and will not reschedule another at this time. We will keep you informed as to our progress. Paula Rodgers MSW RSW
Executive Director
Child, Youth and Family Services
95 Elizabeth Ave (P.O.Box 8700)
St. John’s, NL A1B 4J6
Tel: (709) 729-7213 Fax: 709-729-1699
Email: PaulaRodgers@gov.nl.ca
□ Child Death / □ Critical Incident Notification

Section 1: Client Information

Last Name: ___________________________ First Name: ___________________________
Date of Birth: (YYYY-MM-DD) Age: _______ Gender: _______ ISM ID for Child: _______

Child/Youth Custody Status: ___________________________

Aboriginal Status/Identity

If child is Aboriginal, please select:

□ Aboriginal □ Non-Aboriginal

If not applicable please specify: ___________________________

Section 2: Family Composition

Parent(s) Name: ___________________________

Step Parent(s)/Partner(s) of Parent(s): ___________________________

Current Care Provider (if applicable) and relationship to child: ___________________________

Section 3: CYFS Information

Social Worker assigned to follow up on death/critical incident: ___________________________

Region: ___________________________

Page 1 of 3
Section 4: Details of Death / Critical Incident

Date & Time Child, Youth and Family Services notified:

Name of Social Worker notified of death / critical incident:

Date Notified (YYYY-MM-DD) Time Notified: A.M. P.M.

Date of Death / Critical Incident: (YYYY-MM-DD)

Type of Notification:

☐ Death ☐ Critical Incident

Type of Critical Incident:

If other, please specify:

Description of death or critical incident:

Supplementary Information Attached? ☐ Yes ☐ No

Section 5: Response to Death / Critical Incident

Immediate:

Further follow up, if required:

Please specify the internal/external service providers who have been notified about the death/critical incident:

Please specify the internal/external service providers who will be notified about the death/critical incident:
Section 6: Review

Social Worker completing form: (print name) Date: (YYYY-MM-DD)

Name of Supervisor who reviewed form: (print name) Date: (YYYY-MM-DD)

Name of Zone Manager who reviewed form: (print name) Date: (YYYY-MM-DD)

Final Review:

I, [Name of Regional Director] have reviewed the circumstances and I am satisfied with the plan for further follow-up.

Regional Director's Signature Date: (YYYY-MM-DD)

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

Section 7: ADM Review (to be completed by the ADM - Service Delivery and Regional Operations)

Date Received:
(YYYY-MM-DD) Action Required:

☐ No further action required of regional staff Date Chief Medical Officer Notified: (If applicable) (YYYY-MM-DD)

☐ Further action required of regional staff Date Child & Youth Advocate Notified: (YYYY-MM-DD)

☐ Quality Assurance to complete file summary Date DM Initially Briefed: (YYYY-MM-DD)

Date Minister Initially Briefed: (YYYY-MM-DD)

Explanation of current status and action required of regional staff:

ADM's Signature Date: (YYYY-MM-DD)
Taylor, Jennifer

From: Rodgers, Paula  
Sent: Thursday, February 04, 2016 3:31 PM  
To: Dow, Sara; Tilley, Jean; Healey, Rick M.  
Subject: RE: Speech from the Throne - Sent on behalf of Paula Burt

Sara, this is good as it pertains to the second item. Paula

From: Dow, Sara  
Sent: Thursday, February 04, 2016 1:18 PM  
To: Tilley, Jean; Healey, Rick M.; Rodgers, Paula  
Subject: RE: Speech from the Throne - Sent on behalf of Paula Burt

Hi

Here are a couple of items that may work to submit for Paula Burt's request. Let me know what you think.

Statutory Review of the Children and Youth Care and Protection Act  
In accordance with Section 80 of the Children and Youth Care and Protection Act the Minister shall conduct a review of the act, including public consultations every 5 years. This review will commence by June 30, 2016.

Mandatory Reporting of Critical Incidents and Deaths to the Office of the Child and Youth Advocate (OCYA)  
The mandate letter to Minister Gambin-Walsh directed her to work with the OCYA, and other departments to develop legislation that will make it mandatory to report deaths and critical incidents to the OCYA.

From: Cochrane, Rachelle  
Sent: Thursday, January 28, 2016 11:01 AM  
To: O'Neill, Melony; Tilley, Jean; Healey, Rick M.; Rodgers, Paula; O'Brien, Donna  
Cc: Dow, Sara; Hunt, Deanne  
Subject: FW: Speech from the Throne - Sent on behalf of Paula Burt  
Importance: High

Hi all

Pls see request from centre. Any suggestions here? I was thinking we may want to include mandatory reporting of CIs and Deaths.  
Thanks

From: Heath, Daisy  
Sent: Thursday, January 28, 2016 10:43 AM  
To: Ballard, Donna M; Bown, Charles W.; Brewer, Donna; Brown, Milly; Burt, Paula; Chippett, Jamie; Clarke, Beverley; Cochrane, Rachelle; Companion, Lori Anne; Cooper, Bruce; Dooling, Genevieve (AES); Dutton, Sean; Evans, James W; Gover, Aubrey; Hearn, Judith; Jacobs, Heather; Janes, Colleen G; Lewis, David B.; MacDonald, Ellen; Meade, Brent; O'Rielly, Alastair; Puddester, Leigh; Vivian-Walsh, Janet; Williams, Geoff; Foote, Carla; Ottenheimer, John - NLHC; Ploughman, Mark; Samson, Mike - MMSB; Janes, Jackie  
Cc: Bailey, Bev; Hackett-Myles, Julia J; Hickey, Barbara; Hoddinott, Fanny; Hunt, Deanne; Jarvis, Carolyn B.; Manuel, Sue; O'Keefe, Dorothy; Power, Yvonne A; Nippard, Melissa; Joy, Carla; Hunt, Pam; Williams, Ann Marie; Shea, Connie K.;
SENT ON BEHALF OF PAULA BURT

As in previous years, we are seeking input from Departments/Agencies regarding potential initiatives to be profiled in the 2016 Speech from the Throne. Would you please assess key initiatives that you are planning to pursue in the upcoming fiscal year that you feel appropriate for inclusion. Please include a short comment (sentence of two) describing each initiative and identify those that are budget dependent or require policy approval. With respect to Cabinet papers, please indicate when you would anticipate that they will be submitted.

Your feedback by **February 5th, 2016** would be appreciated.

Thanks,
Paula
Taylor, Jennifer

From: Cochrane, Rachelle
Sent: Friday, February 05, 2016 3:07 PM
To: Burt, Paula
Cc: Tilley, Jean; Hunt, Deanne
Subject: FW: Speech from the Throne - Sent on behalf of Paula Burt

Importance: High

Paula

As per the email from Daisy, attached is possible item for inclusion in the speech from the Throne.

Mandatory Reporting of Critical Incidents and Deaths to the Office of the Child and Youth Advocate (OCYA)
The mandate letter to Minister Gambin-Walsh directed her to work with the OCYA, and other departments to develop legislation that will make it mandatory to report deaths and critical incidents to the OCYA.

Sec. 27(1)(i), Sec. 27(2)(a)

From: Heath, Daisy
Sent: Thursday, January 28, 2016 10:43 AM
To: Ballard, Donna M; Bown, Charles W.; Brewer, Donna; Brown, Milly; Burt, Paula; Chippett, Jamie; Clarke, Beverley; Cochrane, Rachelle; Companion, Lori Anne; Cooper, Bruce; Dooling, Genevieve (AES); Dutton, Sean; Evans, James W; Gover, Aubrey; Hearn, Judith; Jacobs, Heather; Janes, Colleen G; Lewis, David B.; MacDonald, Ellen; Meade, Brent; O'Rielly, Alastair; Puddester, Leigh; Vivian-Walsh, Janet; Williams, Geoff; Foote, Carla; Ottenheimer, John - NLHC; Ploughman, Mark; Samson, Mike - MMSB; Janes, Jackie
Cc: Bailey, Bev; Hackett-Myles, Julia J.; Hickey, Barbara; Hoddinott, Fanny; Hunt, Deanne; Jarvis, Carolyn B.; Manuel, Sue; O'Keefe, Dorothy; Power, Yvonne A; Nippard, Melissa; Joy, Carla; Hunt, Pam; Williams, Ann Marie; Shea, Connie K.; Savory, Pamela; Blackmore, Diane; Pitcher, Madonna; Haynes, Brenda; Power, Elaine; Lefevre, Gloria D.; White, Anne M.; Compton, Sheryl; Carroll, Cathy; Eddy, Tracey; Greening, Gloria - NLHC; Pridie, Janice R; ‘Michelle Dunn’ (mdunn@mmsb.nl.ca); Clarke, Elaine; Mullaley, Julia; Day, Elizabeth
Subject: Speech from the Throne - Sent on behalf of Paula Burt
Importance: High

SENT ON BEHALF OF PAULA BURT

As in previous years, we are seeking input from Departments/Agencies regarding potential initiatives to be profiled in the 2016 Speech from the Throne. Would you please assess key initiatives that you are planning to pursue in the upcoming fiscal year that you feel appropriate for inclusion. Please include a short comment (sentence of two) describing each initiative and identify those that are budget dependent or require policy approval. With respect to Cabinet papers, please indicate when you would anticipate that they will be submitted.

Your feedback by February 5th, 2016 would be appreciated.

Thanks,
Paula
Taylor, Jennifer

From: Evans, Sandra
Sent: Tuesday, March 22, 2016 11:49 AM
To: Tilley, Jean
Subject: RE: Critical Incident Definition

It is -

On another note – just got off the phone with

Sandra

Sandra Evans
Director Quality Assurance
Department of Child, Youth and Family Services
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”

From: Tilley, Jean
Sent: Tuesday, March 22, 2016 11:43 AM
To: Evans, Sandra
Subject: RE: Critical Incident Definition

Is this the same defn that we were using since Fall 2014?

From: Evans, Sandra
Sent: Tuesday, March 22, 2016 11:00 AM
To: Downey, Dana; Elmore Higdon, Juanita; Fry, Wally; Jewer, Rhonda J.; Lambert, Mary Lou; Mcgrath, Patricia; Mullett, Chris; Noseworthy, Beth; Park, Brian; Parsons, Jill; Reid, Robert R (CYFS); Rice, Barry; Winsor, Amanda
Cc: Clemens-Spurrell, Linda; Cull, Barbara L.; Hoddinott, Susan; Whelan, Jackie; O'Brien, Donna; Tilley, Jean; Patey, Denise
Subject: Critical Incident Definition
Importance: High

Folks:

Sec. 29(1)(a)
Let me know if you have any questions. Thank you

Sandra

Sandra Evans
Director Quality Assurance
Department of Child, Youth and Family Services
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)
Taylor, Jennifer

From: Evans, Sandra
Sent: Wednesday, March 23, 2016 9:50 AM
To: Wiseman, Anthony
Cc: Tilley, Jean
Subject: RE: Further Information re: Policies

Tony:

The Auditor positions were created back late 2010 when the other positions for QA were created. They were initially classified as Senior Policy, Planning and Research Analysts. Once I came into the position end January 2013, I starting trying to hire the remaining staff. Given the job description, the caliber of applicants after the first posting, and the location here in GF-W we determined these positions may be difficult to fill so we applied to have them reclassified to HL in Oct 2013. In the summer of 2014 they were reclassified to Social Worker III positions (still in bargaining unit).

To once again follow-up on your policy question

if you have any questions.

Thanks,

Sandra

Sandra Evans
Director Quality Assurance
Department of Child, Youth and Family Services
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You"

From: Wiseman, Anthony
Sent: Tuesday, March 22, 2016 5:09 PM
To: Evans, Sandra
Subject: RE: Further Information re: Policies

Thanks Sandra. With respect to the four vacant auditor positions, can you tell the date(s) those positions were created for the QA Division?

Tony Wiseman
Audit Senior
Office of the Auditor General
Province of Newfoundland and Labrador
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From: Evans, Sandra  
Sent: Tuesday, March 22, 2016 11:54 AM  
To: Wiseman, Anthony  
Subject: Further Information re: Policies

Tony:

I never thought to add this piece. [Redacted]

[Redacted]

Hope this is helpful.

Sandra

Sandra Evans  
Director Quality Assurance  
Department of Child, Youth and Family Services  
5 C Harris Avenue  
Mailing Address:  
Provincial Building  
3 Cromer Avenue  
Grand Falls-Windsor, NL A2A 1W9  
709-292-4525  
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You"

"This message, including any attachments, is for the sole use of the intended recipients and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message."
Jean

This is the letter to Carol signed by the premier regarding the CI/deaths legislation

-----Original Message-----
From: Hunt, Deanne
Sent: Monday, April 04, 2016 3:30 PM
To: Cochrane, Rachelle
Subject: EXE-044942/01 : Response from Premier to Carol Chafe Re: ICOR2016/0741

Rachelle,

The letter to Carol Chafe was signed by the Premier. Please see attached copy.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Child, Youth & Family Services
95 Elizabeth Avenue
P.O. Box 8700
St. John's, NL
A1B 4J6
Tele: (709) 729-0958
Fax: (709) 729-1049
E-Mail: drhunt@gov.nl.ca
March 16, 2016

Ms. Carol A. Chafe
Child and Youth Advocate
Office of the Child and Youth Advocate
193 LeMarchant Road
St. John’s, NL, A1C 2H5

Dear Ms. Chafe:

Thank you for your letter detailing your ongoing commitment and advocacy regarding the mandatory reporting to your office of deaths and critical incidents involving children and youth receiving government services. As indicated in the Speech from the Throne, government recognizes the importance of doing everything we can to protect children and youth, and our commitment to this reporting.

The Department of Child, Youth and Family Services continues to work toward fulfilling the direction outlined in the Minister of Child, Youth and Family Services’ December 2015 mandate letter to work with her colleagues and your office on legislation that would result in reporting to your office. I understand the Minister has met with the Ministers of Health and Community Services, Justice and Public Safety, and Education and Early Childhood Development to discuss this matter.

I certainly appreciate your interest in advancing this work on a priority basis and, I too, share your interest in seeing this completed. As a new government, it is essential that we fully understand the implications of all new policy initiatives, and I am trusting my Ministers to carefully examine all new requirements that could be placed on public services. The Minister has advised that much work has been completed including an understanding of what is a critical incident and the reporting timeframes you are seeking.

We will continue to collaborate with you on this important initiative, and the Minister will continue to consult with you as this moves forward.

Sincerely,

[Signature]

Dwight Ball
Premier
MLA, Humber-Gros Morne

cc: Honourable Sherry Gamlin-Walsh, Minister of Child, Youth and Family Services
Taylor, Jennifer

From: Hunt, Deanne
Sent: Friday, April 08, 2016 4:58 PM
To: Cochrane, Rachelle
Cc: Cotter, Joanne; Tilley, Jean; Healey, Rick M.
Subject: Meeting re: Critical Incidents & Deaths

Rachelle,

I have scheduled the meeting re: Critical Incidents & Deaths for Mon. Apr. 11 @ 10:30 a.m. in our Executive Boardroom.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Child, Youth & Family Services
95 Elizabeth Avenue
P.O. Box 8700
St. John's, NL
A1B 4J6
Tel.: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dvhunt@gov.nl.ca
From: Tilley, Jean
Sent: Monday, April 18, 2016 9:12 AM
To: Hunt, Deanne
Subject: Accepted: Critical Incidents and Deaths
Taylor, Jennifer

From: Tilley, Jean
Sent: Monday, May 16, 2016 8:53 AM
To: Roberts, Denyse
Subject: Fw: Documents for tomorrow’s briefing on critical incident reporting
Attachments: decisionnote.docx; ANNEX A.docx; AnnexBWork Plan.xls; Annex CWork Plan.xls

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cotter, Joanne <JoanneCotter@gov.nl.ca>
Sent: Sunday, May 15, 2016 4:36 PM
To: Cochrane, Rachelle; Tilley, Jean; Healey, Rick M.; O’Brien, Donna; O’Neill, Melony
Subject: Documents for tomorrow’s briefing on critical incident reporting

Hi folks,

In advance of our meeting tomorrow morning at 9a.m., here is a copy of the decision note and related documents.

I will also bring copies to the meeting for everyone and you can take the first few minutes to review the information prior to a discussion.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Decision Note  
Department of Child, Youth and Family Services

Title: Reporting of Critical Incidents (CI) to the Advocate for Children and Youth (ACY) Sec. 29(1)(a)

Issue

Background and Current Status:

- The Office of the ACY is a statutory office of the House of Assembly established in 2002 under the authority of the Child and Youth Advocate Act (CYA Act).
- The ACY represents the rights and interests of children and youth receiving government programs and services and provides services in four areas: individual advocacy, systemic advocacy, reviews and investigations, and education and promotion.
- Since 2011, three reports from the Advocate’s office have recommended the development of a protocol with CYFS for the reporting of CIs and deaths involving children and youth.
- In July 2014, the Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of CIs and deaths from government departments (CYFS, HCS, EECD, JPS) including that the current delay in receiving information from government about child deaths and CIs prevents her from intervening early to prevent future incidents from occurring.
- In November 2014, the House of Assembly passed a motion committing to legislation to respond to the Advocate’s request to change the CYA Act to mandate public body reporting of deaths and CIs.
- The Liberal Platform document, “A Stronger Tomorrow: Our Five Point Plan” (fall 2015) committed to “legislate the mandatory reporting of deaths and critical incidents to the Advocate”.
- In December 2015, the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the House of Assembly regarding this reporting. Government reiterated its support for mandatory reporting of deaths and critical incidents to the Advocate in the March 2016 Speech From The Throne.
- The ACY continues to publicly express concern about lack of progress on this file. In a recent media interview, the ACY advised that under the previous government intensive work took place between January and June 2015 and that little progress has been made since the change in government.
- Since September 2014 CYFS has been reporting deaths in policy to the ACY (reporting an average of ten per year)
- In November 2014, CYFS established a CI definition (updated March 2016) and notification process for the reporting of CIs from regional staff to the ADM of Service Delivery and
Regional Operations (SD&RO). Currently this information is not proactively reported to the Advocate.

**Analysis:**

Sec. 29(1)(a), Sec. 27(2)(b)
Taylor, Jennifer

**Subject:** Critical Incidents and Deaths  
**Location:** CYFS-STJH-RM-BR-95 Eliz (1.0), Executive Boardroom-FL1

**Start:** Mon 5/16/2016 9:00 AM  
**End:** Mon 5/16/2016 10:00 AM  
**Show Time As:** Tentative

**Recurrence:** (none)  
**Meeting Status:** Not yet responded

**Organizer:** Hunt, Deanne  
**Required Attendees:** Cochrane, Rachelle; Cotter, Joanne; O'Brien, Donna; Tilley, Jean; Healey, Rick M.; O'Neill, Melony

**Optional Attendees:** Bragg, Dana; Roberts, Denyse; Singleton, Debbie
Taylor, Jennifer

From: Foote, Sheila
Sent: Wednesday, May 18, 2016 9:48 AM
To: Roberts, Denyse
Cc: Cotter, Joanne; Tilley, Jean; Hunt, Deanne
Subject: RE: RE: Meeting on May 25th, 2016

Hi Denyse,
Carol gave me the following agenda items for next week’s quarterly meeting:

[Redacted]

She may have couple of more items to add. Waiting for further information on them.

Kind regards,
Sheila

From: Roberts, Denyse
Sent: Wednesday, May 11, 2016 10:23 AM
To: Foote, Sheila
Cc: Cotter, Joanne; Tilley, Jean; Hunt, Deanne
Subject: RE: Meeting on May 25th, 2016

Hi Sheila,

Does the Advocate have any agenda items for the upcoming Quarterly Meeting on May 25th at 12 p.m.

Thanks,
Denyse

Denyse Roberts
Administrative Assistant to
Jean Tilley, ADM, Corporate Services
Department of Child, Youth & Family Services
95 Elizabeth Avenue (P.O. Box B700)
St. John’s, NL A1B 4J6
Tel: 709-729-1858 Fax: 709-729-1049
Email: DenyseRoberts@gov.nl.ca
FYI

From: Cochrane, Rachelle  
Sent: Friday, May 20, 2016 3:11 PM  
To: Collins, Megan  
Cc: Dow, Sara; Tilley, Jean; O’Neill, Melony; Hunt, Deanne  
Subject: RE: Information Note

Good afternoon,

I write in response to your email of May 20, 2016, wherein you provided the Department an Information Note entitled “Child Death Review Committee Reports” and requested feedback by end of day on May 24, 2016. The note outlines the findings of two Individual Case reports from the Child Death Review Committee (CDRC) and includes copies of the reports.

The Department has completed a review of the findings of the reports and has verified there are no recommendations made to CYFS within the two reports:

- **Case # 15ME0196**: there are no recommendations made to CYFS with respect to this case. In the report, one recommendation is made to the Eastern Regional Health Authority.

- **Case # 15ME3030**: there are no recommendations made to CYFS with respect to this case. In the report, a total of three recommendations are made to the Department of Justice and Public Safety.

The Department has no further feedback or comment respecting the reports at this time. If you have any questions, please feel free to contact me at any time.

Thank you,

From: Collins, Megan  
Sent: Friday, May 20, 2016 12:37 PM  
To: Barfoot, Scott; Harvey, Michael; Meade, Brent; Puddester, Leigh; Cochrane, Rachelle  
Cc: Ryan, Renee C.; Kelland, Donna; Dow, Sara; Pitcher, Madonna  
Subject: Information Note

Good afternoon,

Cabinet Secretariat is in receipt of an Information note entitled “Child Death Review Committee Reports”.

Please review and provide feedback by end of day Tuesday, May 24.

This will be available via DCP shortly.
Kindest regards,
Megan

Megan Collins, B.A. M.A.
Cabinet Officer
Cabinet Secretariat, Executive Council
Government of Newfoundland and Labrador
Tel: 709.729.5215
Taylor, Jennifer

From: Tilley, Jean
Sent: Tuesday, May 24, 2016 5:03 PM
To: Cotter, Joanne
Subject: CI Death decision note.doc
Attachments: CI Death decision note.doc

I am foolish. Made another change.
Decision/Direction Note
Department of Child, Youth and Family Services

Title: Reporting of Critical Incidents (CI) to the Advocate for Children and Youth (ACY)

Decision/Direction Required: Sec. 29(1)(a)

Background and Current Status:
- The Office of the Child and Youth Advocate is a statutory office of the House of Assembly established in 2002 under the authority of the Child and Youth Advocate Act (CYA Act). The ACY represents the rights and interests of children and youth receiving government programs and services and provides services in four areas: individual advocacy, systemic advocacy, reviews and investigations, and education and promotion.

- Since 2011, three investigative reports from ACY have recommended the development of a protocol with CYFS for the reporting of deaths and CIs involving children and youth.

- In July 2014, the ACY tabled a briefing note in the HOA outlining a rationale for the mandatory reporting of deaths and CIs from government departments (CYFS, HCS, EECD, JPS) including that the current delay in receiving information about child deaths and CIs prevents the office from intervening early to prevent future incidents from occurring.

- In November 2014, the House of Assembly passed a motion committing to legislation to respond to the ACY’s request to change the CYA Act to mandate public body reporting of deaths and CIs. At that time, the Deputy Ministers of the Departments of CYFS, HCS, EECD and JPS were directed to consult with the Advocate to develop clarity on the Advocate’s request.

- The Liberal Platform document, “A Stronger Tomorrow: Our Five Point Plan” (fall 2015) committed to “legislate the mandatory reporting of deaths and critical incidents to the Advocate”.

- In December 2015, the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the House of Assembly regarding this reporting.
• Government reiterated its support for mandatory reporting of deaths and critical incidents to the Advocate in the March 2016 Speech from the Throne.

• Since September 2014 CYFS has been reporting deaths, in policy to the ACY, (9 deaths occurred in 2014-15 and 4 deaths in 2015-16) of children and youth who were either receiving services at the time of his/her death or had received services twelve months preceding the death.

• In recent media interviews (April 2016) the ACY advised that under the previous government intensive work and collaboration occurred between January and June 2015 and that little progress has been made since that time.

Analysis:

• Sec. 27(1)(i), Sec. 27(2)(a)

• Government has publicly stated that departments have prioritized this work and that more time is required to carefully examine the implications of mandatory reporting from a resource perspective.

• Sec. 29(1)(a), Sec. 27(2)(b)

Pages 3 and 4 of this briefing note redacted under Sec. 27(2)(b) and Sec. 29(1)(a)
Sent from my BlackBerry 10 smartphone on the Bell network.

Original Message
From: Tilley, Jean <JeanTilley@gov.nl.ca>
Sent: Tuesday, May 24, 2016 5:05 PM
To: Cochrane, Rachelle
Subject: Emailing: CI Death decision note.doc, Annex A CI Death note.docx

Have a look at this when you get a chance.

Your message is ready to be sent with the following file or link attachments:

CI Death decision note.doc
Annex A CI Death note.docx

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.
I told Rachelle that you did not know about the comments. All good now. They withdrew them.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: McGrath, Dave
Sent: Wednesday, May 25, 2016 6:57 PM
To: Tilley, Jean; Cotter, Joanne
Subject: RE: Information Note

Hi Jean and Joanne,

I’m catching up on some emails. Regarding the below, [Sec. 29(1)(a)]

If you have any questions for me or require anything further, do not hesitate to call me.

From: Cochrane, Rachelle
Sent: Wednesday, May 25, 2016 1:40 PM
To: Tilley, Jean
Cc: Healey, Rick M.; Dow, Sara; McGrath, Dave
Subject: Fw: Information Note

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Meade, Brent <BMeade@gov.nl.ca>
Sent: Wednesday, May 25, 2016 11:57 AM
To: Collins, Megan
Cc: Cochrane, Rachelle; Ryan, Renee C.
Subject: FW: Information Note

Hi Megan [Sec. 29(1)(a)]

If you wish to discuss, you may reach me at 729 3555.

Thanks

Brent
Hi Rachelle

Recognizing there were no recommendations made to CYFS within the two reports, I wanted to ensure you were aware of the following feedback I have received from other departments as it relates to Case#15ME0196 and CYFS:

Sec. 29(1)(a)

I would be happy to discuss further if you wish.

Kindest regards,
Megan

Megan Collins, B.A. M.A.
Cabinet Officer
Cabinet Secretariat, Executive Council
Government of Newfoundland and Labrador
Tel: 709.729.5215

Good afternoon,

I write in response to your email of May 20, 2016, wherein you provided the Department an Information Note entitled “Child Death Review Committee Reports” and requested feedback by end of day on May 24, 2016. The note outlines the findings of two Individual Case reports from the Child Death Review Committee (CDRC) and includes copies of the reports.
The Department has completed a review of the findings of the reports and has verified there are no recommendations made to CYFS within the two reports:

- **Case # 15ME0196**: there are no recommendations made to CYFS with respect to this case. In the report, one recommendation is made to the Eastern Regional Health Authority.

- **Case # 15ME3030**: there are no recommendations made to CYFS with respect to this case. In the report, a total of three recommendations are made to the Department of Justice and Public Safety.

The Department has no further feedback or comment respecting the reports at this time. If you have any questions, please feel free to contact me at any time.

Thank you,

From: Collins, Megan  
Sent: Friday, May 20, 2016 12:37 PM  
To: Barfoot, Scott; Harvey, Michael; Meade, Brent; Puddester, Leigh; Cochrane, Rachelle  
Cc: Ryan, Renee C.; Kelland, Donna; Dow, Sara; Pitcher, Madonna  
Subject: Information Note

Good afternoon,

Cabinet Secretariat is in receipt of an Information note entitled “Child Death Review Committee Reports”.

Please review and provide feedback by end of day Tuesday, May 24.

This will be available via DCP shortly.

Kindest regards,
Megan

Megan Collins, B.A. M.A.  
Cabinet Officer  
Cabinet Secretariat, Executive Council  
Government of Newfoundland and Labrador  
Tel: 709.729.5215
How is the note going?

Sent from my BlackBerry 10 smartphone on the Bell network.

I was thinking about the CI note last night.

Hope today's session is going well.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John's, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Taylor, Jennifer

From: Cochrane, Rachelle
Sent: Friday, May 27, 2016 5:04 PM
To: Tilley, Jean; Cotter, Joanne
Subject: Re: CI note

Sure. I may not read it this weekend. Too much.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Tilley, Jean
Sent: Friday, May 27, 2016 3:24 PM
To: Cochrane, Rachelle; Cotter, Joanne
Subject: Re: CI note

Do you want a copy?

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cochrane, Rachelle
Sent: Friday, May 27, 2016 3:12 PM
To: Tilley, Jean; Cotter, Joanne
Subject: Re: CI note

OK. Thanks

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Tilley, Jean
Sent: Friday, May 27, 2016 3:00 PM
To: Cochrane, Rachelle; Cotter, Joanne
Subject: Re: CI note

I have it to review the weekend.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cochrane, Rachelle
Sent: Friday, May 27, 2016 2:58 PM
To: Cotter, Joanne; Tilley, Jean
Subject: Re: CI note

How is the note going?

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cotter, Joanne
Sent: Friday, May 27, 2016 2:53 PM
To: Cochrane, Rachelle; Tilley, Jean
Subject: CI note
Hope today's session is going well.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John's, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Hi Ladies,

Just a reminder to Betty Day, Bev Clarke, Janet Vivian-Walsh & Heather Jacobs to please provide their comments on the Critical Incidents & Deaths Decision Note to Rachelle Cochrane and Jean Tilley by tomorrow, Tuesday, June 7th.

Thanks,

Deanne

---

Deanne Hunt  
Administrative Assistant  
Office of the Deputy Minister  
Department of Child, Youth & Family Services  
95 Elizabeth Avenue  
P.O. Box 8700  
St. John’s, N.L.  
A1B 4J6  
Tel: (709) 729-0958  
Fax: (709) 729-1049  
E-Mail: dshunt@.gov.nl.ca
Thanks, Karen.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Stone, Karen M.
Sent: Monday, June 6, 2016 5:06 PM
To: Cochrane, Rachelle; Tilley, Jean
Subject: Fw: CYFS decision note on critical incident reporting to Advocate

Hi folks,
Bev has asked that I forward the email below to you. Please let me know if you need anything else.
Thanks for the opportunity to review.
Karen

Sent from my BlackBerry 10 smartphone on the Bell network.
From: Stone, Karen M. <karens@gov.nl.ca>
Sent: Sunday, June 5, 2016 10:17 AM
To: Clarke, Beverley
Subject: CYFS decision note on critical incident reporting to Advocate

Bev,
I’ve reviewed the note.  Sec. 29(1)(a)

CYFS have asked for our comments by Tuesday to Rachelle and her ADM, Jean Tilley.

Karen
Version circulated for comments.
Your message is ready to be sent with the following file or link attachments:

CI Death decision note with Annex.doc

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.
Okay - on my way after I use the washroom 😊

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John's, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

From: Tilley, Jean
Sent: Friday, July 15, 2016 11:41 AM
To: Cotter, Joanne
Subject: Re: CI/Death policy

Ready now.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cotter, Joanne
Sent: Friday, July 15, 2016 11:40 AM
To: Tilley, Jean
Subject: CI/Death policy

Just checking to see if you want me to come to exec mtg to discuss the CI/Death protocol? I don’t want to leave for lunch and you need me! I don’t have to be anywhere so I can wait around. Let me know

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Hi Jean,

Attached please find the revised Cl/Death protocol and related form for review.

Sandra and I are wondering if the current practice of NOT placing File Summaries on the client file will remain status quo. If there is a change in this practice we will need to reflect it in the protocol. Look forward to your feedback! In the meantime, we will work on a pp presentation for roll-out.

Joanne
Critical Incident/Death Notification Form

Section 1: Client Information

Last Name: ___________________________  First Name: ___________________________

Date of Birth: (YYYY-MM-DD) ________  Age: ________  Gender: ________  CRMS ID for Child: ________

Aboriginal Status/Identity

Child/ Youth Custody Status: ___________________________

If child is Aboriginal, please select:  

- Aboriginal
- Non-Aboriginal

If not applicable please specify: ___________________________

Section 2: Family Composition

Parent(s) Name: ___________________________

Step Parent(s)/Partner(s) of Parent(s): ___________________________

Current Care Provider (if applicable) and relationship to child: ___________________________

siblings (if 21 years of age and under):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Date of Birth (YYYY-MM-DD)</th>
<th>Child's Status</th>
<th>Where Not Applicable Specify Child's Status</th>
<th>Was child involved in Critical Incident/Death</th>
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</tbody>
</table>

Section 3: CYFS Information

Social Worker assigned to follow up on death/critical incident: ___________________________

Region: ___________________________

Clinical Program Supervisor for Social Worker: ___________________________

Zone Manager for Social Worker: ___________________________

Current Open Program(s) (Check all that apply & include CRMS ID#)

- Protective Intervention
- Youth Services
- Kinship
- Adoptions
- In-Care
- Community Youth Corrections

Please specify program:  

- Secure Custody
- Open Custody

Specify any programs previously open (include CRMS ID and date of closure for each program): ___________________________
Section 4: Details of Death / Critical Incident

Date & Time: Child, Youth and Family Services notified:

Name of Social Worker notified of death / critical incident:

Date Notified: (YYYY-MM-DD) Time Notified: [ ] A.M. [ ] P.M. Date of Death / Critical Incident: (YYYY-MM-DD)

Type of Notification: Type of Critical Incident:

☐ Death ☐ Critical Incident

If other please specify:

Description of death or critical incident:

Supplementary Information Attached? [ ] Yes [ ] No

Section 5: Response to Death / Critical Incident

Immediate:

Further follow up, if required:

Please specify the internal/external service providers who have been notified about the death/critical incident:

Please specify the internal/external service providers who will be notified about the death/critical incident:

Section 6: Review

Social Worker completing form: (print name) Date: (YYYY-MM-DD)

Name of Supervisor who reviewed form: (print name) Date: (YYYY-MM-DD)

Name of Zone Manager who reviewed form: (print name) Date: (YYYY-MM-DD)

Final Review:

I, [signature], have reviewed the circumstances and I am satisfied with the plan for further follow-up.

Name of Regional Director

Regional Director’s Signature Date: (YYYY-MM-DD)

Form MUST be submitted to the ADM - Service Delivery & Regional Operations, and Director of Quality Assurance.
Section 7: ADM Review (to be completed by the ADM - Service Delivery and Regional Operations)

Date Received:
(YYYY-MM-DD)

Action Required:
☐ No further action required of regional staff
☐ Further action required of regional staff
☐ Quality Assurance to complete file summary

Date Chief Medical Officer Notified: (If applicable) (YYYY-MM-DD)

Date Child & Youth Advocate Notified: (YYYY-MM-DD)

Date DM Initially Briefed: (YYYY-MM-DD)

Explanation of current status and action required of regional staff:

________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________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Critical Incident and Death Protocol

Policy no.: QA-2014-001
Effective Date: March 31, 2014
Date Revised: X, 2016
Policy Cross References:
Legislative References: Adoptions Act, 2013
Children and Youth Care and Protection Act (CYCP Act)
Section 7, Fatalities Investigations Act
Young Persons Offences Act
Youth Criminal Justice Act

PURPOSE:
To outline the process for responding to a critical incident or death of a child/youth who was receiving services from the Department of Child, Youth and Family Services (CYFS) at the time of the critical incident or death or in the preceding twelve months.

POLICY:

1. A critical incident (CI) is an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth such as violence, assault, injury, other serious criminal matters and significant threats of self-injury/harm or suicidal ideation requiring hospitalization beyond the initial assessment and treatment.

2. In response to a CI or death, a social worker shall immediately assess risk and provide support and follow-up to any other child/youth in a family or other environment currently receiving services (i.e. an open program file) from CYFS in accordance with applicable program standards.

3. All procedures relating to responding, notifying, approving and planning for CI’s and deaths shall be followed as outlined in the Procedures section of this protocol.

4. QA shall complete a File review on all child/youth deaths unless the death is due to a natural/medical cause and in all CI’s or death cases where the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM, SD&RO) require a File Summary to be completed.

5. All electronic communication completed in relation to this protocol shall be encrypted or transferred through shared drives per the guideline on Email and Encryption.
6. All public communication by CYFS related to a CI or death of a child/youth shall be managed through the CYFS Director of Communications.

PROCEDURES:

Determining What Constitutes a Critical Incident

1. A social worker shall refer to the CI definition to assess whether an event or circumstance constitutes a CI. Given the complexity of CYFS work, a social worker/supervisor will need to use professional judgment and may also need to consult with a supervisor to make this determination. The following circumstances or events are generally considered to be extraordinary or life threatening and impact the child/youth’s safety or well-being. This list is not exhaustive and meant to be used as a guide only:

a) Suicide attempt, suicidal ideation or self-harming behaviors requiring hospitalization following the initial assessment;
b) Serious injury to a child/youth requiring medical assessment or hospitalization that is accidental (e.g. multiple internal injuries caused by a motor vehicle accident) or suspicious in nature (e.g. abusive head trauma to an infant);
c) A child/youth is abducted;
d) A child/youth is missing and the circumstances of his/her absence (e.g. age and developmental considerations, length of time missing, concern child/youth may be assaulted, injured or involved in serious criminal activity) are extraordinary or life threatening; and,
e) A child/youth is involved in serious criminal matters (e.g. allegedly murdered or seriously injured another person or arson resulting in injury to an individual).

Responding to a Critical Incident or Death

1. A social worker shall immediately notify a supervisor of a CI or death who shall then notify the Zone Manager and the Regional Director.

2. A social worker shall follow all other program specific policies and procedures relevant to the circumstances of the CI or death (e.g. Missing or abducted child or youth policy, screening a referral for child maltreatment, etc.).

3. A social worker shall immediately assess potential risk and provide support and follow up to that child/youth and any other child/youth in a family or other environment who is currently receiving services from CYFS. If a child is not currently receiving services from CYFS, a social worker in consultation with a supervisor, shall also determine if information received constitutes a child maltreatment concern and if so, respond in accordance with the Risk Management Decision-Making Model.

4. The Regional Director shall notify the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM SD&RO) as soon as possible who shall then notify the
Deputy Minister of the CI or death. The Deputy Minister will notify the Minister of all deaths and of CIs, where appropriate.

5. Provincial office staff who are also made aware of a child/youth death by the Chief Medical Examiner’s office shall also notify the ADM SD&RO and QA of the death and enter the date of death in the electronic case file as soon as it is known.

6. The Zone Manager (or designate) shall notify, as soon as possible, a parent of a child/youth in the case of a CI or death of a child/youth in interim care or temporary custody. Notifying parents of children in continuous custody is at the Zone Manager’s discretion.

7. The ADM SD&RO shall notify, by email, the Advocate for Children and Youth of a child/youth’s death within 24 hours of CYFS becoming aware of the death and shall provide basic information such as the child/youth’s age and circumstances surrounding the death.

8. The ADM SD&RO shall notify the Chief Medical Examiner in accordance with Section 7 of the Fatalities Investigations Act, of the death of a child/youth in the custody of a Zone Manager.

9. The social worker initially informed of the CI or death shall complete a Critical Incident/Death Notification form which shall be reviewed by the Clinical Program Supervisor and Zone Manager and submitted to Regional Director for review and signature. The Regional Director shall then forward the form for approval to the ADM SD&RO and provide a copy to the Director, Quality Assurance (QA). This notification process shall occur within 48 hours of the social worker being informed of the CI or death.

10. Upon notification from the region of a CI or death, QA shall open a file to track the CI/deaths and all related follow-up required.

11. A Social Worker shall enter the official date of death in the electronic file as soon as it is known.

12. Critical Incident/Death Notification forms are completed for each child or youth involved in a CI/death unless it involves multiple children from one family who are receiving Protective Intervention services, in which case one form can be completed.

13. The ADM SD&RO, upon reviewing the Critical Incident/Death Notification form, shall determine completeness of the form and may request additional information be provided. Depending on the additional information required, the ADM SD&RO may request regional staff update and resubmit the Critical Incident/Death Notification form. The ADM SD&RO shall approve/sign the Critical Incident/Death Notification Form. Copies of the signed form shall be sent to Regional Director for the client file and to the Director, QA.
14. The ADM SD&RO shall determine if further action is required of regional staff or if a File Summary is required by QA. Any action required of regional staff shall be outlined on the approved Critical Incident/Death Notification Form. The QA Division may assist the ADM SD&RO by monitoring completion of all action required.

15. The ADM SD&RO shall provide a copy of Critical Incident/Death Notification Forms involving a CI or death to the Deputy Minister and other Department officials as appropriate.

16. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification Form to the Advocate for Children and Youth within five days of CYFS being informed of the death of a child or youth.

Completing a File Summary

1. Where a File Summary is required the Zone Manager shall add a note to the electronic file advising that a File Summary is being completed by QA. A note shall be added to the master (paper) file if the case had been closed at the time of the CI or death.

2. Where a File Summary is required the Director, QA shall obtain the master file(s) within five business days and designate a QA Auditor to complete the File Summary using the File Summary Template. The File Summary will be based on a review of services provided in the twelve months preceding the CI or death unless the ADM SD&RO requests a longer review period.

3. Prior to sending the master file(s) to QA, the region shall create a temporary file and copy the last twelve months (or other time frame specified by the ADM SD&RO) of the file.

4. The Director, QA shall send the draft File Summary to the ADM, SD&RO within 30 calendar days of QA receiving the file(s). The ADM SD&RO shall review the draft File Summary and obtain input, where appropriate, from Executive and other department officials. Any feedback shall be provided to QA to finalize the File Summary which is approved by the Director, QA.

Following Up on Key Practice Issues

1. Within 30 days of finalizing the File Summary, QA will arrange a meeting with the Regional Director, Zone Manager, Clinical Program Supervisor and social worker to review any practice issues identified in the File Summary and develop an action plan, where necessary, using the Action Plan Template.

2. Following the meeting, the Zone Manager will add a note to the electronic file or the master file, for closed cases, indicating the File Summary is completed.
3. The original file(s) shall be returned to the appropriate Zone Manager/Clinical Program Supervisor after the File Summary meeting has occurred.

4. Regional staff shall transfer file documentation that has been kept in the temporary file to the original file and the temporary file shall be appropriately destroyed.

Monitoring of Actions Required

1. The QA Division shall monitor implementation of actions required, including contact with persons responsible for actions by expected completion dates and provide updates to the ADM SD &RO when requested.

2. The QA file shall close once the Director, QA determines required action items have been completed and no further monitoring is required.

EXCEPTIONS TO PROTOCOL:

1. *Critical Incident/Death Notification* forms are not required when CYFS staff are notified of a CI or death that has occurred on a closed case due to the limited amount of information typically provided in these circumstances. Regional staff are still required to notify the ADM SD &RO and QA. In these circumstances the ADM SD &RO will only provide the initial notification to the Advocate.

REFERENCE DOCUMENTS:

- Adoptions Policy Manual
- Community Youth Corrections Policy Manual
- Email and Encryption Guideline
- Protection and In Care Policy and Procedures Manual
- Staffed Residential Placement Resources Standards and Procedures Manual

CONTACT INFORMATION:

Director of Quality Assurance
Quality Assurance Division
Department of Child, Youth & Family Services
(709) 292-4525
From: Cotter, Joanne
Sent: Friday, July 22, 2016 2:35 PM
To: Tilley, Jean
Cc: Evans, Sandra
Subject: Revised CI/Death Protocol and related form

Hi Jean,

Attached please find the revised CI/Death protocol and related form for review.

Sandra and I are wondering [REDACTED] Look forward to your feedback! In the meantime, we will work on a pp presentation for roll-out.

Joanne
Sounds good.

Sandra, maybe we can connect tomorrow morning to do some planning?

From: Tilley, Jean
Sent: Wednesday, July 27, 2016 11:01 AM
To: Cotter, Joanne; Evans, Sandra
Subject: RE: CI Death protocol

All good with me.

From: Cotter, Joanne
Sent: Wednesday, July 27, 2016 10:25 AM
To: Evans, Sandra; Tilley, Jean
Subject: CI Death protocol

Jean/Sandra:

Chatted with Barb and [redacted] what are your thoughts?

Sandra,

If we decide to move forward, I can pull together a quick deck tomorrow or next day for your review. We can then send out a memo and begin sessions next week or early the following week. We’ll need to chat about our vacation and who can do what sessions.

Sandra,

Last version is attached. Take one last look! Sending to Chris Osmond by days end as well so they can update the missing/abducted policy. We will also need to include the Action Plan and File Review templates in the training session and post those templates to the intranet.
Folks:

Please disregard if this does not apply to you.

I am pleased to announce that the Child/Youth Death Review Protocol has now been updated to include critical incidents. This combined Critical Incident and Death Protocol includes a combination of the current processes we have been following for reporting a death or critical incident and some new processes to reflect feedback received from regional staff and best practice. The new Protocol comes into effect September 1, 2016.

There will be a number of information sessions via conference call held throughout August to review the new Protocol with Provincial Office staff and appropriate regional management and front-line staff. You only have to attend one session. The session should only take about 30 minutes but we have allotted 1 hour in case of questions. You do not need to sign-up ahead of time. Dial in information is included below.

Joanne Cotter will facilitate the sessions during the week of August 9th -11th and I will facilitate the sessions from August 23-25th. A power point deck will be sent out a day in advance of the first call in each week.

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Sec. 35(1)(g) ACCESS INFORMATION

TELEPHONE KEYPAD FEATURES
*0 Speak to an Operator
*1 Mute/Un-mute your own line
*6 Terminate call when last moderator disconnects (moderator only)

Thank you,

Sandra

Sandra Evans
Director Quality Assurance
Department of Child, Youth and Family Services
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”
A supervisor emailed this morning to determine if CPS's were included in the regional leadership group and the answer is yes. CPS's may join this morning's call, if they are available.

From: Cotter, Joanne  
Sent: Monday, August 08, 2016 2:42 PM  
To: Evans, Sandra; CYFS - Department Wide - All Users  
Subject: RE: New Critical Incident and Death Protocol

Hello everyone,

Please disregard if this does not apply to you.

Further to Sandra’s email, we will use the attached deck to discuss the revised CI/Death protocol during this week’s sessions. The dates and times for each session is included below as well as the dial in information.

First session is tomorrow morning at 10:30 a.m.

Joanne C

From: Evans, Sandra  
Sent: Tuesday, August 02, 2016 3:18 PM  
To: CYFS - Department Wide - All Users  
Subject: New Critical Incident and Death Protocol

Folks:

Please disregard if this does not apply to you.

I am pleased to announce that the Child/Youth Death Review Protocol has now been updated to include critical incidents. This combined Critical Incident and Death Protocol includes a combination of the current processes we have been following for reporting a death or critical incident and some new processes to reflect feedback received from regional staff and best practice. The new Protocol comes into effect September 1, 2016.

There will be a number of information sessions via conference call held throughout August to review the new Protocol with Provincial Office staff and appropriate regional management and front-line staff. You only have to attend one session. The session should only take about 30 minutes but we have allotted 1 hour in case of questions. You do not need to sign-up ahead of time. Dial in information is included below.

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Thank you,

Sandra

Sandra Evans  
Director Quality Assurance  
Department of Child, Youth and Family Services  
5 C Harris Avenue  
Mailing Address:  
Provincial Building  
3 Cromer Avenue  
Grand Falls-Windsor, NL A2A 1W9

709-292-4525  
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”
Ok thanks

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You"

Go ahead with the roll out since there are only minor changes to the current process.

Jean:

Will we proceed with rolling out the info sessions on the new Protocol (three done and three left starting tomorrow).

Thanks.

Sandra

Sec. 29(1)(a)
Never miss an opportunity to tell your child "I Love You"
Hello everyone,

Please disregard if this does not apply to you.

Further to my email below, we will use the attached deck to discuss the revised CI/Death protocol during this week's sessions. The dates and times for the remaining sessions are included below as well as the dial in information.

First session for this week is tomorrow morning at 10:30 a.m. N.L time.

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1V9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You."

From: Evans, Sandra
Sent: Tuesday, August 02, 2016 3:18 PM
To: CYFS - Department Wide - All Users
Subject: New Critical Incident and Death Protocol

Folks:

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Thank you,

Sandra

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Never miss an opportunity to tell your child "I Love You"
Critical Incident and Death Protocol

August 2016

Critical Incident and Death Protocol

- Current Child/Youth Death Review Protocol implemented in March 2014

- Currently no formal protocol for critical incidents – staff required to follow processes in Death Protocol

- The Child/Youth Death Review Protocol has now been updated to include Critical Incidents and renamed the “Critical Incident/Death Protocol”
Critical Incident and Death Protocol

What Remains Unchanged:
- The definition of a critical incident (CI)
- Immediate assessment of risk and support to child/youth
- The notification process from regional staff to ADM and QA
- Related public communications managed through CYFS Director of Communications
- ADM to notify the Advocate and Chief Medical Examiner as required

Critical Incident and Death Protocol

What HAS changed/been clarified:
- Notification form has been revised based on regional feedback/discussions with QA
- CI/Death Notification form has:
  - "fillable" sections
  - CI categories in a drop down box
  - More space to describe family composition
  - Space for custody and Aboriginal status of child/youth
  - Space for programs currently opened and those previously opened
  - Space for internal and external service providers notified/to be notified of CI or death
  - RD and ADM signs – SCWK’er, CPS and ZM names are included but no signature required.
Critical Incident and Death Protocol

What HAS changed/been clarified:

- The social worked initially informed of the CI/death completes the CI/Death Notification form

- The form is completed on the child/youth unless it involves multiple children in a family receiving PIP services

- Staff have 48 hours (currently 24hrs) to complete and send the form to ADM for approval

- The form will NOT be completed for CI/death notifications on closed cases due to limited information available in those circumstances

Critical Incident and Death Protocol

What HAS changed/been clarified:

- Date of death of child/youth shall be entered in CRMS as soon as it becomes known

- Parents of children in interim/temporary custody are notified of CI’s/deaths involving their children; notifying parents of children in continuous custody is at the discretion of the ZM

- QA will complete File Reviews (formally called “File Summary”) on all deaths not related to natural/medical causes and in other cases where required by ADM

- File review will now contain actions required – this will guide development of an action plan with regional staff

- File review and QA file closure approved by QA and not ADM

Newfoundland
Labrador
Critical Incident and Death Protocol

Implementation:

- Updated protocol will be effective September 1, 2016.
- Revised protocol and related forms will be uploaded to the Intranet and send out by email prior to September 1, 2016.
  - CI/Death Notification Form
  - File Review Template
  - Action Plan Template

Questions?
Sandra, is this still a draft policy?

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Evans, Sandra
Sent: Sunday, August 28, 2016 9:06 PM
To: Walsh, Susan
Cc: Tilley, Jean
Subject: Re: CI and Death Protocol

For sure. Will send first thing in the morning.
Sent from my Blackberry

From: Walsh, Susan
Sent: Sunday, August 28, 2016 01:49 PM
To: Evans, Sandra
Cc: Tilley, Jean
Subject: CI and Death Protocol

Hi Sandra,

I have reviewed the draft Critical Incident and Death Protocol. I do have feedback and questions on the draft protocol. Could you email me a draft of it so I could send my comments in track changes?

Thanks, Susan

Susan Walsh
Assistant Deputy Minister
Service Delivery and Regional Operations
Department of Children, Seniors and Social Development
(709) 729-3473
Taylor, Jennifer

From: Walsh, Susan
Sent: Monday, August 29, 2016 12:55 PM
To: Evans, Sandra
Cc: Tilley, Jean
Subject: RE: CI and Death Protocol
Attachments: Critical Incident and Death Protocol feedback.docx

Hi Sandra,

Attached please find my feedback on the draft policy. Upon your review I would be happy to discuss this with you.

Thanks, Susan

Susan Walsh
Assistant Deputy Minister
Service Delivery and Regional Operations
Department of Children, Seniors and Social Development
(709) 729-3473

From: Evans, Sandra
Sent: Monday, August 29, 2016 8:40 AM
To: Walsh, Susan <SWalsh@gov.nl.ca>
Cc: Tilley, Jean <JeanTilley@gov.nl.ca>
Subject: RE: CI and Death Protocol

Susan:

Good morning!

Attached please find the draft CI and Death Protocol. Feel free to call me if you have any questions.

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”

From: Walsh, Susan
Sent: Sunday, August 28, 2016 1:50 PM
To: Evans, Sandra
Cc: Tilley, Jean
Subject: CI and Death Protocol

Hi Sandra,

I have reviewed the draft Critical Incident and Death Protocol. I do have feedback and questions on the draft protocol. Could you email me a draft of it so I could send my comments in track changes?

Thanks, Susan

Susan Walsh
Assistant Deputy Minister
Service Delivery and Regional Operations
Department of Children, Seniors and Social Development
(709) 729-3473
Critical Incident and Death Protocol

Policy no.: QA-2014-001
Effective Date: March 31, 2014
Date Revised: September 1, 2016
Legislative References: Adoptions Act, 2013
Children and Youth Care and Protection Act (CYCP Act)
Section 7, Fatalities Investigations Act
Young Persons Offences Act
Youth Criminal Justice Act

PURPOSE:

To outline the process for responding to a critical incident or death of a child/youth who was receiving services from the Department of Children, Seniors and Social Development (CSSD) at the time of the critical incident or death or in the preceding twelve months.

POLICY:

1. A critical incident (CI) is defined as an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth such as violence, assault, injury, other serious criminal matters and significant threats of self-injury/harm or suicidal ideation requiring hospitalization beyond the initial assessment and treatment.

2. In response to a CI or death, a social worker shall immediately assess the risk and provide support and follow-up to any other child/youth in a family or other environment currently receiving services (i.e. an open program file) from CSSD in accordance with applicable program standards.

3. All procedures relating to responding, notifying, approving and planning for a CI or death shall be followed as outlined in the Procedures section of this protocol.

4. QA shall complete a File Review on all child/youth deaths, unless the death is due to a natural/medical cause, and CI in cases where the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM, SD&RO) requires a File Review to be completed.

5. All electronic communication completed in relation to this protocol shall be encrypted or transferred through shared drives per the guideline on Email and Encryption.
6. All public communication by CSSD related to a CI or death of a child/youth shall be managed through the CSSD Director of Communications.

PROCEDURES:

Determining What Constitutes a Critical Incident

1. A social worker shall refer to the CI definition to assess whether an event or circumstance constitutes a CI. Given the complexity of the work, a social worker will need to use professional judgment and may also need to consult with a supervisor to make this determination. The following circumstances or events are generally considered to be extraordinary or life threatening and impact the child/youth’s safety or well-being. This list is not exhaustive and meant to be used as a guide only:

a) Suicide attempt, suicidal ideation or self-harming behaviors requiring hospitalization following the initial assessment;
b) Serious injury to a child/youth requiring medical assessment or hospitalization that is accidental (e.g. multiple internal injuries caused by a motor vehicle accident) or suspicious in nature (e.g. abusive head trauma to an infant);
c) A child/youth is abducted;
d) A child/youth is missing and the circumstances of his/her absence (e.g. age and developmental considerations, length of time missing, concern child/youth may be assaulted, injured or involved in serious criminal activity) are extraordinary or life threatening; and,
e) A child/youth is involved in a serious criminal matter (e.g. allegedly murdered or seriously injured another person or arson resulting in injury to an individual).

Responding to a Critical Incident or Death

1. A social worker shall immediately notify a supervisor of a CI or death who shall then notify the Zone Manager and the Regional Director of a CI or death.

2. A social worker shall follow all program specific policies and procedures relevant to the circumstances of the CI or death (e.g. missing or abducted child/youth policy, screening a referral for child maltreatment, etc.).

3. A social worker shall immediately assess potential risk and provide support and follow up to the child/youth who is subject to the CI and any other child/youth in a family or other environment who is currently receiving services from CSSD. If a child is not currently receiving services from CSSD, a social worker in consultation with a supervisor, shall also determine if information received constitutes a child maltreatment concern and if so, respond in accordance with the Risk Management Decision-Making Model.

4. The Regional Director shall notify the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM SD&RO) as soon as possible who shall then notify the
Deputy Minister of the CI or death. The Deputy Minister will notify the Minister of all deaths and of CIs, where appropriate.

5. Provincial office staff who are also made aware of a child/youth death by the Chief Medical Examiner's office shall also notify the ADM SD&RO and the Quality Assurance Division (QA) of the death and enter the date of death in the electronic case file as soon as it is known.

6. The Zone Manager (or designate) shall notify, as soon as possible, the parent(s) of a child/youth in the case of a CI or death of a child/youth in interim care or temporary custody. Notifying parents of children in continuous custody is at the Zone Manager's discretion.

7. The ADM SD&RO shall notify, by email, the Advocate for Children and Youth of a child/youth's death within 24 hours of CSSD becoming aware of the death and shall provide basic information such as the child/youth's age and circumstances surrounding the death.

8. The ADM SD&RO shall notify the Chief Medical Examiner in accordance with Section 7 of the Fatalities Investigation Act, of the death of a child/youth in the custody of a Zone Manager.

9. The social worker initially informed of the CI or death shall complete a Critical Incident/Death Notification form which shall be reviewed by the Clinical Program Supervisor and Zone Manager and submitted to the Regional Director for review and signature. The Regional Director shall then forward the form for approval to the ADM SD&RO and provide a copy to the Director, QA. This notification process shall occur within 48 hours of the social worker being informed of the CI or death.

10. Upon notification from the region of a CI or death, QA shall open a file to track the CI or death and all related follow-up required.

11. A social worker shall enter the official date of death in the electronic file as soon as it is known.

12. Critical Incident/Death Notification forms are completed for each child or youth involved in a CI/death unless it involves multiple children from one family who are receiving Protective Intervention services, in which case one form shall be completed.

13. The ADM SD&RO, upon reviewing the Critical Incident/Death Notification form, shall determine completeness of the form and may request additional information be provided. Depending on the additional information required, the ADM SD&RO may request regional staff update and resubmit the Critical Incident/Death Notification form. The ADM SD&RO shall approve/sign the Critical Incident/Death Notification form. Copies of the signed form shall be sent to the Regional Director for the client file and to the Director, QA for the QA file.
14. The ADM SD&RO shall determine if further action is required of regional staff or if a File Review is required by QA. Any action required of regional staff shall be outlined on the approved Critical Incident/Death Notification form. QA may assist the ADM SD&RO by monitoring completion of all action required.

15. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form involving a CI or death to the Deputy Minister and other Department officials, as appropriate.

16. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form to the Advocate for Children and Youth within five days of CSSD being informed of the death of a child or youth.

Completing a File Review

1. Where a File Review is required the Zone Manager shall add a note to the electronic file advising that a File Review is being completed by QA. A note shall be added to the master (paper) file if the case has been closed.

2. Where a File Review is required the Director, QA shall obtain the master file(s) within five business days and designate a QA Auditor to complete it using the File Review Template. The File Review will be based on a review of services provided in the twelve months preceding the CI or death unless the ADM SD&RO requests a longer review period. The File Review shall also outline all findings resulting from the review and any actions required.

3. Prior to sending the master file(s) to QA, the region shall create a temporary file and copy the last twelve months (or other time frame specified by the ADM SD&RO) of the file.

4. The Director, QA shall send the draft File Review to the ADM SD&RO within 30 calendar days of QA receiving the file(s). The ADM SD&RO shall review the draft File Review and obtain input, where appropriate, from Executive and other Department officials. Any feedback shall be provided to QA to finalize the File Review which is approved by the Director, QA and retained in the QA file.

Following Up on Findings-Developing an Action Plan

1. Within 30 days of finalizing the File Review, QA will arrange a meeting with the Regional Director, Zone Manager, Clinical Program Supervisor and social worker to review the findings and required actions identified in the File Review and to develop a plan using the Action Plan Template. The action plan will then be attached to the File Review as an appendix.

2. Following the File Review meeting, the Zone Manager will add a note to the electronic file or the master file, for closed cases, indicating the File Review is completed.
3. The original file(s) shall be returned to the appropriate Zone Manager/Clinical Program Supervisor after the File Review meeting has occurred.

4. Regional staff shall transfer file documentation that has been kept in the temporary file to the original file and the temporary file shall be appropriately destroyed.

**Monitoring of Actions Required**

1. The QA Division shall monitor implementation of actions required, including contact with persons responsible for actions by expected completion dates and provide updates to the ADM SD&RO when requested.

2. The QA file shall close once the Director, QA determines required action items have been completed and no further monitoring is required.

**EXCEPTIONS TO PROTOCOL:**

1. In the case of a closed file, if the critical incident or death of a child/youth occurred within 12 months of the case closing it must still be reported to the ADM and QA. However, a Critical Incident/Death Notification form is not required due to the limited amount of information typically provided in these circumstances. Information on historical CSSD involvement with a child/youth may be requested by the ADM SD&RO on a case by case basis. The social worker will document this request on the master (paper) file only. In these circumstances the ADM SD&RO will only provide the initial notification to the Advocate.

   Where the circumstances surrounding a death or critical incident results in the opening or reopening of a protective intervention file, a discussion with the ADM SD&RO is required to determine if a CI/Death Notification form is required.

**REFERENCE DOCUMENTS:**

- Adoptions Policy Manual
- Community Youth Corrections Policy Manual
- Email and Encryption Guideline
- Protection and In Care Policy and Procedures Manual
- Staffed Residential Placement Resources Standards and Procedures Manual
- Critical Incident/Death Notification Form
- File Review Template
- Action Plan Template
CONTACT INFORMATION:

Director of Quality Assurance
Quality Assurance Division
Department of Children, Seniors and Social Development
(709) 292-4525
Sounds good to me.
Sent from my Blackberry

---

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
Department of Children, Seniors and Social Development
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

---

Sandra is going to discuss it with Susan tomorrow.

---

Quick scan and here is what I see:
Let me know if you need me to join your discussion with Susan on this.

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
Department of Children, Seniors and Social Development
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

From: Tilley, Jean
Sent: Monday, August 29, 2016 3:58 PM
To: Cotter, Joanne
Subject: FW: CI and Death Protocol

From: Walsh, Susan
Sent: Monday, August 29, 2016 12:55 PM
To: Evans, Sandra
Cc: Tilley, Jean
Subject: RE: CI and Death Protocol

Hi Sandra,

Attached please find my feedback on the draft policy. Upon your review I would be happy to discuss this with you.

Thanks, Susan

Susan Walsh
Assistant Deputy Minister
Service Delivery and Regional Operations
Department of Children, Seniors and Social Development
(709) 729-3473

From: Evans, Sandra
Sent: Monday, August 29, 2016 8:40 AM
To: Walsh, Susan <Swalsh@gov.nl.ca>
Cc: Tilley, Jean <JeanTilley@gov.nl.ca>
Subject: RE: CI and Death Protocol

Susan:

Good morning!

Attached please find the draft CI and Death Protocol. Feel free to call me if you have any questions.

Sandra
From: Walsh, Susan  
Sent: Sunday, August 28, 2016 1:50 PM  
To: Evans, Sandra  
Cc: Tilley, Jean  
Subject: CI and Death Protocol

Hi Sandra,

I have reviewed the draft Critical Incident and Death Protocol. I do have feedback and questions on the draft protocol. Could you email me a draft of it so I could send my comments in track changes?

Thanks, Susan

Susan Walsh  
Assistant Deputy Minister  
Service Delivery and Regional Operations  
Department of Children, Seniors and Social Development  
(709) 729-3473
Ok great

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You."

From: Tilley, Jean
Sent: Wednesday, August 31, 2016 1:23 PM
To: Evans, Sandra
Subject: RE: CI/death and missing children protocol

We will call you. everyone is available. should not take long.

From: Evans, Sandra
Sent: Wednesday, August 31, 2016 1:21 PM
To: Tilley, Jean
Subject: RE: CI/death and missing children protocol

Yes no problem

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You."

141
From: Tilley, Jean
Sent: Wednesday, August 31, 2016 12:30 PM
To: Cotter, Joanne; Walsh, Susan; Evans, Sandra
Subject: CI/death and missing children protocol

We need to have a quick discussion on this sometime today if possible because they are both effective tomorrow. There is an issue with ZM's. How is everyone at 1:30 for a quick call?
Taylor, Jennifer

From: Evans, Sandra
Sent: Wednesday, September 07, 2016 11:38 AM
To: Chafe, Carol
Cc: Walsh, Susan
Subject: Critical Incident and Death Protocol
Attachments: Critical Incident and Death Protocol.pdf

Dear Ms. Chafe:

As per your conversation with Susan Walsh, Assistant Deputy Minister, Service Delivery and Regional Operations, attached please find the Critical Incident and Death Protocol.

Regards,

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You"
Critical Incident and Death Protocol

Policy no.: QA-2014-001
Effective Date: March 31, 2014
Date Revised: September 1, 2016
Legislative References:
Adoptions Act, 2013
Children and Youth Care and Protection Act (CYCP Act)
Section 7, Fatalities Investigations Act
Young Persons Offences Act
Youth Criminal Justice Act

PURPOSE:

To outline the process for responding to a critical incident or death of a child/youth who was receiving services from the Department of Children, Seniors and Social Development (CSSD) at the time of the critical incident or death or in the preceding twelve months.

POLICY:

1. A critical incident (CI) is defined as an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth such as violence, assault, injury, other serious criminal matters and significant threats of self-injury/harm or suicidal ideation requiring hospitalization beyond the initial assessment and treatment.

2. In response to a CI or death, a social worker shall immediately assess the risk and provide support and follow-up to any other child/youth in a family or other environment currently receiving services (i.e. an open program file) from CSSD in accordance with applicable program standards.

3. All procedures relating to responding, notifying, approving and planning for a CI or death shall be followed as outlined in the Procedures section of this protocol.

4. QA shall complete a File Review on all child/youth deaths, unless the death is due to a natural/medical cause, and in cases where the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM, SD&RO) requires a File Review to be completed.

5. All electronic communication completed in relation to this protocol shall be encrypted or transferred through shared drives per the guideline on Email and Encryption.
6. All public communication by CSSD related to a CI or death of a child/youth shall be managed through the CSSD Director of Communications.

PROCEDURES:

Determining What Constitutes a Critical Incident

1. A social worker shall refer to the CI definition to assess whether an event or circumstance constitutes a CI. Given the complexity of the work, a social worker will need to use professional judgment and may also need to consult with a supervisor to make this determination. The following circumstances or events are generally considered to be extraordinary or life threatening and impact the child/youth's safety or well-being. This list is not exhaustive and meant to be used as a guide only:

   a) Suicide attempt, suicidal ideation or self-harming behaviors requiring hospitalization following the initial assessment;
   b) Serious injury to a child/youth requiring medical assessment or hospitalization that is accidental (e.g. multiple internal injuries caused by a motor vehicle accident) or suspicious in nature (e.g. abusive head trauma to an infant);
   c) A child/youth is abducted;
   d) A child/youth is missing and the circumstances of his/her absence (e.g. age and developmental considerations, length of time missing, concern child/youth may be assaulted, injured or involved in serious criminal activity) are extraordinary or life threatening; and,
   e) A child/youth is involved in a serious criminal matter (e.g. allegedly murdered or seriously injured another person or arson resulting in injury to an individual).

Responding to a Critical Incident or Death

1. A social worker shall immediately notify a supervisor who shall then notify the Zone Manager and the Regional Director of a CI or death. When this occurs outside of regular business hours, the on call supervisor shall notify the Zone Manager, Regional Director and ADM - SD&RO.

2. A social worker shall follow all other program specific policies and procedures relevant to the circumstances of the CI or death (e.g. missing or abducted child/youth policy, screening a referral for child maltreatment, etc.).

3. A social worker shall immediately assess potential risk and provide support and follow up to the child/youth and any other child/youth in a family or other environment who is currently receiving services from CSSD. If a child is not currently receiving services from CSSD, a social worker in consultation with a supervisor, shall also determine if information received constitutes a child maltreatment concern and if so, respond in accordance with the Risk Management Decision-Making Model.
4. The Regional Director shall notify the ADM SD&RO as soon as possible who shall then notify the Deputy Minister of the CI or death. The Deputy Minister will notify the Minister of all deaths and of CIs where appropriate.

5. Provincial office staff who are also made aware of a child/youth death by the Chief Medical Examiner’s office shall also notify the ADM SD&RO and the Quality Assurance Division (QA) of the death and enter the date of death in the electronic case file as soon as it is known.

6. The Zone Manager (or designate) shall notify, as soon as possible, the parent(s) of a child/youth in the case of a CI or death of a child/youth in interim care or temporary custody. Notifying parents of children in continuous custody is at the Zone Manager’s discretion.

7. The ADM SD&RO shall notify, by email, the Advocate for Children and Youth of a child/youth’s death within 24 hours of CSSD becoming aware of the death and shall provide basic information such as the child/youth’s age and circumstances surrounding the death.

8. The ADM SD&RO shall notify the Chief Medical Examiner in accordance with Section 7 of the Fatalities Investigations Act, of the death of a child/youth in the custody of a Zone Manager.

9. The social worker initially informed of the CI or death shall complete a Critical Incident/Death Notification form which shall be reviewed by the Clinical Program Supervisor and Zone Manager and submitted to the Regional Director for review and signature. The Regional Director shall then forward the form for approval to the ADM SD&RO and provide a copy to the Director, QA. This notification process shall occur within 48 hours of the social worker being informed of the CI or death.

10. Upon notification from the region of a CI or death, QA shall open a file to track the CI or death and all related follow-up required.

11. A social worker shall enter the official date of death in the electronic file as soon as it is known.

12. Critical Incident/Death Notification forms are completed for each child or youth involved in a CI or death unless it involves multiple children from one family who are receiving Protective Intervention services, in which case one form shall be completed.

13. The ADM SD&RO, upon reviewing the Critical Incident/Death Notification form, shall determine completeness of the form and may request additional information be provided. Depending on the additional information required, the ADM SD&RO may request regional staff update and resubmit the Critical Incident/Death Notification form. The ADM SD&RO shall approve/sign the Critical Incident/Death Notification form. Copies of the signed form shall be sent to the Regional Director for the client file and to the Director, QA for the QA file.
14. The ADM SD&RO shall determine if further action is required of regional staff or if a File Review is required by QA. Any action required of regional staff shall be outlined on the approved Critical Incident/Death Notification form. QA will assist the ADM SD&RO by monitoring completion of all action required and provide updates to the ADM SD&RO.

15. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form involving a CI or death to the Deputy Minister and other Department officials, as appropriate.

16. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form to the Advocate for Children and Youth within five days of CSSD being informed of the death of a child or youth.

Completing a File Review

1. Where a File Review is required the Zone Manager shall add a note to the electronic file advising that a File Review is being completed by QA. A note shall be added to the master (paper) file if the case has been closed.

2. Where a File Review is required the Director, QA shall obtain the master file(s) within five business days and designate a QA Auditor to complete it using the File Review Template. The File Review will be based on a review of services provided in the twelve months preceding the CI or death unless the ADM SD&RO requests a longer review period. The File Review shall also outline all findings resulting from the review and any actions required.

3. Prior to sending the master file(s) to QA, the region shall create a temporary file and copy the last twelve months (or other time frame specified by the ADM SD&RO) of the file.

4. The Director, QA shall send the draft File Review to the ADM SD&RO within 30 calendar days of QA receiving the file(s). The ADM SD&RO shall review the draft File Review and obtain input, where appropriate, from Executive and other department officials. Any feedback shall be provided to QA to finalize the File Review which is approved by the Director, QA and retained in the QA file.

Following Up on Findings-Developing an Action Plan

1. Within 30 days of finalizing the File Review, QA will arrange a meeting with the Regional Director, Zone Manager, Clinical Program Supervisor and social worker to review the findings and required actions identified in the File Review and to develop a plan using the Action Plan Template. The action plan will then be attached to the File Review as an appendix.

2. Following the File Review meeting, the Zone Manager will add a note to the electronic file, or the master file for closed cases, indicating the File Review is completed.
3. The original file(s) shall be returned to the appropriate Zone Manager/Clinical Program Supervisor after the File Review meeting has occurred.

4. Regional staff shall transfer file documentation that has been kept in the temporary file to the original file and the temporary file shall be appropriately destroyed.

Monitoring of Actions Required

1. The QA Division shall monitor implementation of actions required, including contact with persons responsible for actions by expected completion dates and provide updates to the ADM SD&RO.

2. The QA file shall close once the Director, QA determines required action items have been completed and no further monitoring is required.

EXCEPTIONS TO PROTOCOL:

1. In the case of a closed file, if the critical incident or death of a child/youth occurred within 12 months of the case closing it must still be reported to the ADM and QA. However, a Critical Incident/Death Notification form is not required due to the limited amount of information typically provided in these circumstances. Information on historical CSSD involvement with a child/youth may be requested by the ADM SD&RO on a case by case basis. The social worker will document this request on the master (paper) file only. In these circumstances the ADM SD&RO will only provide the initial notification to the Advocate for Children and Youth.

Where the circumstances surrounding a death or critical incident results in the opening or reopening of a protective intervention file, a discussion with the ADM SD&RO is required to determine if a CI/Death Notification form is required.

REFERENCE DOCUMENTS:

- Adoptions Policy Manual
- Community Youth Corrections Policy Manual
- Email and Encryption Guideline
- Protection and In Care Policy and Procedures Manual
- Staffed Residential Placement Resources Standards and Procedures Manual
- Critical Incident/Death Notification Form
- File Review Template
- Action Plan Template
CONTACT INFORMATION:

Director of Quality Assurance
Quality Assurance Division
Department of Children, Seniors and Social Development
(709) 292-4525
Hi Jean,

I am forwarding a copy of Kim’s legal opinion on CYA related disclosures (and my summary) to Susan for her files. I recall there was no change in practice required following our review and discussion at the executive meeting. Just want to ensure that was your recollection as well.

Thanks.

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
Department of Children, Seniors and Social Development
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

---

Hi everyone,

Sec. 29(1)(a), Sec. 30(1)(a)
Taylor, Jennifer

From: Tilley, Jean
Sent: Friday, September 16, 2016 4:29 PM
To: Roberts, Denyse
Subject: meeting setup

Please set up a meeting with Kim (Justice), Joanne Cotter, Sandra and Denise Patey on child death protocol. I will provide Kim with info in advance of the meeting. last week sept of early oct is fine.
| Subject: | Child Death Protocol |
| Location: | CYFS-STJH-RM-BR-95 Eliz (12), Boardroom-FL2 |
| Start: | Fri 9/30/2016 2:00 PM |
| End: | Fri 9/30/2016 3:00 PM |
| Show Time As: | Tentative |
| Recurrence: | (none) |
| Meeting Status: | Not yet responded |
| Organizer: | Roberts, Denyse |
| Required Attendees: | McLennan, Kimberley; Cotter, Joanne; Evans, Sandra; Patey, Denise; Tilley, Jean |

**CONFERENCE CALL INFORMATION**

Sec. 35(1)(g)

**TELEPHONE KEYPAD FEATURES**

- *0 Speak to an Operator*
- *1 Mute/Un-mute your own line*
- *6 Terminate call when last moderator disconnects (moderator only)*
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Taylor, Jennifer

From: O'Neall, Melony
Sent: Wednesday, September 28, 2016 2:48 PM
To: GambinWalsh, Sherry; Cooper, Bruce; Tilley, Jean; Cotter, Joanne; Walsh, Susan
Cc: White, Kelly; Bennett, Derek
Subject: Child and Youth Advocate legislation way overdue; must be priority

For immediate release
Sept. 28, 2016

Child and Youth Advocate legislation way overdue; must be priority

The NDP critic for Children, Seniors and Social Development says the province’s Child and Youth Advocate has waited too long for legislation promised first by the former Conservative government, agreed on by the entire House of Assembly, highlighted in last December’s ministerial mandate letters, and promised again in the Speech from the Throne.

St. John’s Centre MHA Gerry Rogers says it is shameful that government is still not providing the advocate with the information she needs, despite her years of formal requests for mandatory reporting legislation.

“When the Liberals were in Opposition, Dwight Ball brought a private member’s motion into the House of Assembly urging the immediate adoption of this legislation. All three parties voted in support of that,” Rogers said.

“The PCs started work, but didn’t get the legislation completed. The Liberals have said it is important, but in the full year they’ve been in office, I have seen no sign that they are actually doing anything to make this legislation happen. They certainly did not introduce it in the spring sitting.”

Rogers says the Child and Youth Advocate’s work helps prevent the repetition of critical incidents or deaths of children or youth, and she must be given accurate and timely information.

“The Advocate says this amendment would give us one of the most progressive legislations in Canada and allow her to further fulfill her mandate as Child and Youth Advocate,” said Rogers.

“Those are two goals we should definitely be striving for. It is inexcusable that government has not yet introduced the legislation.”
For information, contact Jean Graham, ph. 729-2137 (o) or 693-9172 (c).
https://nlnndpcaucus.ca/nr092816CYALegislation

Director of Communications, NDP Caucus
O: 709-729-2137 C/T: 709-693-9172
5th floor, Confederation Building
St. John’s, NL A1B 4J6

Melony O’Neill
Director of Communications
Department of Children, Seniors and Social Development (Children and Youth)
95 Elizabeth Avenue, P.O. Box 8700
St. John’s, NL A1B 4J6
709-729-5148

Newfoundland
Labrador
Children, Seniors and Social Development
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Sure

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Eddy, Tracey
Sent: Wednesday, October 5, 2016 9:36 AM
To: Tilley, Jean
Subject: RE: Meeting with Bruce

How about today around 1:00?

From: Tilley, Jean
Sent: Wednesday, October 5, 2016 9:34 AM
To: Eddy, Tracey
Subject: Re: Meeting with Bruce

No I am off after today until Tuesday.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Eddy, Tracey
Sent: Wednesday, October 5, 2016 9:33 AM
To: Tilley, Jean
Subject: Meeting with Bruce

Hi Jean,

Bruce would like a meeting with you and Kimberley McLellan re: critical incident reporting. Are you available at 10:00 tomorrow?

Thanks,
Tracey

Tracey Eddy
Administrative Assistant to the Deputy Minister
Children, Seniors and Social Development
2nd Floor, West Block
Confederation Building
St. John’s, NL A1B 4J6
traceyeddy@gov.nl.ca
709-729-3556
Justice and Public Safety  
January 14, 2016

Public Advisory: Child Death Review Committee Case Reviews

Under section 13.5 of the Fatalities Investigations Act, the Minister of Justice and Public Safety is required, within 60 days after receiving a report from the Child Death Review Committee (CDRC), to make public those recommendations relating to:

- Relevant protocols, policies and procedures;
- Standards and legislation;
- Linkages and coordination of services; and
- Improvements to services affecting children and pregnant women.

The CDRC forwarded two reports to the Minister of Justice and Public Safety on December 4, 2015. The reports examine the facts and circumstances surrounding two unrelated deaths of youth in Newfoundland and Labrador that occurred in September 2014 and February 2015.

Case 1:
A youth died suddenly while living in residence at Memorial University.

Recommendation:
Memorial University of Newfoundland review policy and establish protocol related to entering residence rooms when there are concerns about the health, safety and well-being of a student.

Case 2:
A youth died of hypothermia.

Recommendations:

1. CYFS to develop a transition program for youth as they leave care (suggest one-year in duration), in which youth are provided with support and mentoring.
2. CYFS to collaborate with the Innu health and social services programs in the development of this program for Innu youth.
This report has been forwarded to the Child and Youth Advocate.

From: Shallow, Michelle  
Sent: Thursday, October 20, 2016 2:29 PM  
To: Griffin, Mark; Hodder, Robert  
Cc: Cotter, Joanne  
Subject: Re: Update on 2 recommendations from CRDC

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Griffin, Mark  
Sent: Thursday, October 20, 2016 6:34 AM  
To: Shallow, Michelle; Hodder, Robert  
Cc: Cotter, Joanne  
Subject: FW: Update on 2 recommendations from CRDC

Hi Michelle and Robert,

I'm wondering if you're aware of the below? Can you let me know? We have to provide an update by October 26th?

Thanks,
Mark

From: Griffin, Mark  
Sent: Thursday, October 20, 2016 11:03 AM  
To: Healey, Rick M.  
Subject: Update on 2 recommendations from CRDC

Hi Rick,

I was wondering if you have an awareness of the following two recommendations from the CRDC and any update on current status?

1. CYFS develop a transition program for youth as they leave care (suggest one year in duration) in which youth are provided with support and mentoring.
2. CYFS collaborate with the Innu Health and Social Services Programs in the development of this program for Innu youth.

Regards,
Mark

Mark Griffin, BA, MSW, RSW  
Manager of Information Services  
Information Management and Protection Division  
Department of Children, Seniors and Social Development  
Government of Newfoundland and Labrador
The Youth Services Program (YSP) assists young people who have been determined to be in need of protective intervention in accordance with the definition of a child in need of protection as outlined in s.10 of the CYCP Act. In addition, the YSP is designed to assist youth during their transition to early adulthood by helping them make connections to supports and services available to them once they leave this program.

The Youth Screening and Assessment Tool is used in the assessment of a youth’s need for services through this program. The program assists youth who are:

- At risk of maltreatment and can no longer reside with their parents;
- At risk of being asked to leave the family home;
- Transitioning to the YSP from the In Care Program; or
- Transitioning home from the In Care Program and requesting support to assist with the transition.

Youth engagement is critical to maximizing a youth’s success. Although youth may enter the program seeking financial support only, it is hoped that every youth will take advantage of other supports available and utilize the Youth Services Plan to set goals for their future health and well-being. To whatever extent possible, the social worker provides the youth with all the information they need to be active participants in service planning and make informed decisions regarding their lives.

To provide coordinated services for youth, collaboration with other services providers, professionals, and informal supports involved with youth should take place. Where youth are in agreement and provide informed consent, regular sharing of information, consultation and/or
case conferencing with these collateral contacts (e.g. other professionals, significant others) and the youth should take place.

Paula

From: Cochrane, Rachelle
Sent: Sunday, January 10, 2016 3:04 PM
To: Rodgers, Paula
Cc: Healey, Rick M.; Hunt, Deanne
Subject: Child Death Review Committee

Paula

Looking for further info on the policy surrounding the youth services agreement, specifically the CDRC is recommending a transition plan/program for youth as they leave care (suggesting one year in duration), in which youth are provided with support and mentoring.

Sec. 29(1)(a)
This is it.

From: Dow, Sara  
Sent: Thursday, October 20, 2016 4:30 PM  
To: Tilley, Jean  
Subject: FW: JPS Note for Review

From: Rodgers, Paula  
Sent: Friday, December 18, 2015 12:48 PM  
To: Cochrane, Rachelle  
Subject: FW: JPS Note for Review

Sec. 29(1)(a)

Rachelle,

Paula

From: Osmond, Christine M  
Sent: Friday, December 18, 2015 12:23 PM  
To: Rodgers, Paula; Healey, Rick M.  
Cc: Maddick, Herb; Osmond, Christine M  
Subject: RE: JPS Note for Review

Hi Paula,
I have reviewed the note and report provided.  

In regards to the recommendation 1,  

Sec. 29(1)(a)

Please let me know if you require any further information.  

Christine
From: Rodgers, Paula  
Sent: Thursday, December 17, 2015 4:28 PM  
To: Healey, Rick M.  
Cc: Osmond, Christine M  
Subject: FW: JPS Note for Review

Rick, see email below. Rachelle asked that I provide comment on the recommendation for CYFS in the next CDRC report. I think Christine should have a look at this and comment. I will send you the report. Paula

From: Cochrane, Rachelle  
Sent: Thursday, December 17, 2015 3:25 PM  
To: Hunt, Deanne  
Cc: Rodgers, Paula  
Subject: FW: JPS Note for Review

Deanne
Can you pls print for Paula and I and KIV for tomorrow at noon

From: Norman, Katie  
Sent: Thursday, December 17, 2015 3:21 PM  
To: Brown, Milly; Dooling, Genevieve (AES); Cochrane, Rachelle  
Cc: Barfoot, Scott; Gardiner, Bob B; Tilley, Jean; Oliver, Patricia; Blackmore, Diane  
Subject: JPS Note for Review

Good Afternoon,

Cabinet Secretariat has received an information note from JPS entitled, “Child Death Review Committee Reports.” Your review of the note is requested as there is material that relates to your respective mandates.

Patricia is in the process of placing this note in DCP for your review. If you have any difficulty accessing, please call her at 6598.

Please advise me by 2 pm tomorrow, Friday, December 18, if your Department has any comments.

Thank you,

Katie

Katie Norman | Cabinet Officer  
Cabinet Secretariat, Executive Council  
Government of Newfoundland and Labrador  
709-729-6527
Here you go.
Title: Mandatory Reporting of Critical Incidents and Deaths to the Office of the Child and Youth Advocate (OCYA).

Key Messages:

- CSSD continues to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.

- I recently met with the Advocate (October 2016) to keep her informed and updated on our government’s progress.

- Since September 2014, my department has been voluntarily reporting all deaths to the Advocate, resulting in the reporting of about 10 deaths per year.

- The Advocate is supportive of this process, but has requested that reporting be legislated as opposed to an agreement with the department.

- Since the onset of the process, work has been done by all relevant departments, as well as the Child and Youth Advocate’s office. Each department continues to work on their individual proposed reporting protocol.

- While we recognize the process has been ongoing for some time, changes to the Advocate’s legislation impact many government departments. Therefore, consultations, input and feedback from all government departments/stakeholders was necessary.

- Since the onset of the process, a considerable amount of work has been done by all the relevant departments, as well as the Child and Youth Advocate’s office (a DM committee was established; a working group was established which included CYA representative; groups met regularly to develop definition of critical incident and understand the parameters of CYA’s request). Each department continues to work on developing their individual proposed reporting protocol.

- The proposed legislation is progressive and would be unprecedented across the country, particularly considering that no other province or territory requires that four departments including Health, Justice, Education, and Child Protection report critical incidents and deaths to the Child and Youth Advocate.

- It is also important to note that the absence of mandatory reporting to the Child and Youth Advocate does not mean that departments and agencies do not have appropriate accountability measures already in place to respond to critical incidents.
and deaths.

- The safety and protection of our vulnerable populations such as children and youth is an important focus for our government. We will continue to work cooperatively with the Child and Youth Advocate and also continue to review all our existing programs and services and focus on addressing any identified issues.

- The Speech from the Throne indicates our government's commitment to advancing this legislation.

Background:

- In recent years, Advocate's reports have recommended the development of a protocol with CSSD for the reporting of CI's and deaths involving children and youth.

- In July 2014 the Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of deaths and CI's including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

- The Advocate has publically stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CSSD.

- In November 2014 the HOA passed a motion committing to legislation to respond to the Advocate's request for mandatory reporting of CI's and deaths to her office.

- In December 2015 the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting. A further commitment was noted in the March 2016 Speech from the Throne.

Current Status:

- The departments of CSSD, JPS, HCS and EECD are completing an in-depth analysis of the Advocate's request to ensure we fully appreciate the implications resulting from mandatory reporting for each department and for the whole of government particularly in the current fiscal climate.
From: Shea, Erin  
Sent: Wednesday, November 09, 2016 1:32 PM  
To: Tilley, Jean  
Cc: O’Neill, Melony  
Subject: FYI - REV: House of Assembly Note Mandatory Reporting November 4 2016.docx

Hi Jean,
Here’s the newest version of the Mandatory Reporting Note. The highlighted part has been added from the binder edits.
Thanks,
E.

House of Assembly Note

Title: Mandatory Reporting of Critical Incidents and Deaths to the Office of the Child and Youth Advocate (OCYA)

Key Messages:

- CSSD continues to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.

- I recently met with the Advocate (October 2016) to keep her informed and updated on our government’s progress, and there is a meeting being scheduled with the Advocate to advance this further in the coming days.

- Since September 2014, my department has been voluntarily reporting all deaths to the Advocate, resulting in the reporting of about 10 deaths per year.

- The Advocate is supportive of this process, but has requested that reporting be legislated as opposed to an agreement with the department.

- Since the onset of the process, work has been done by all relevant departments, as well as the Child and Youth Advocate’s office. Each department continues to work on their individual proposed reporting protocol.
• While we recognize the process has been ongoing for some time, changes to the Advocate’s legislation impact many government departments. Therefore, consultations, input and feedback from all government departments/stakeholders was necessary.

• Since the onset of the process, a considerable amount of work has been done by all the relevant departments, as well as the Child and Youth Advocate’s office (a DM committee was established; a working group was established which included CYA representative; groups met regularly to develop definition of critical incident and understand the parameters of CYA’s request). Each department continues to work on developing their individual proposed reporting protocol.

• The proposed legislation is progressive and would be unprecedented across the country, particularly considering that no other province or territory requires that four departments including Health, Justice, Education, and Child Protection report critical incidents and deaths to the Child and Youth Advocate.

• It is also important to note that the absence of mandatory reporting to the Child and Youth Advocate does not mean that departments and agencies do not have appropriate accountability measures already in place to respond to critical incidents and deaths.

• The safety and protection of our vulnerable populations such as children and youth is an important focus for our government. We will continue to work cooperatively with the Child and Youth Advocate and also continue to review all our existing programs and services and focus on addressing any identified issues.

• The Speech from the Throne indicates our government’s commitment to advancing this legislation.
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- In December 2015 the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting. A further commitment was noted in the March 2016 Speech from the Throne.

Current Status:

- The departments of CSSD, JPS, HCS and EEC and are completing an in-depth analysis of the Advocate's request to ensure we fully appreciate the implications resulting from mandatory reporting for each department and for the whole of government particularly in the current fiscal climate.

Prepared by/Reviewed by: M. Griffin/J. Tilley
Updated as requested

From: Keeping, Zachary  
Sent: Wednesday, November 09, 2016 3:03 PM  
To: Dow, Sara  
Subject: RE:

From: Dow, Sara  
Sent: Wednesday, November 09, 2016 3:01 PM  
To: Keeping, Zachary  
Subject: FW:

From: Tilley, Jean  
Sent: Wednesday, November 09, 2016 2:59 PM  
To: Dow, Sara  
Subject:

(Pilot of new definition for Critical Incidents began Nov 1, 2014; revisions made Feb 18, 2016)
Program Quick Facts

There are five main programs in CYFS:
1) Protective Intervention
2) In Care
3) Youth Services
4) Community Youth Corrections
5) Adoptions

1) Protective Intervention Program (*a.k.a. PIP*) as of June 30th, 2016

<table>
<thead>
<tr>
<th>Children/Youth in PIP</th>
<th>Number</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living at Home (age 0-15)</td>
<td>4901</td>
<td>90%</td>
</tr>
<tr>
<td>Living with Kin (age 0-18)</td>
<td>559</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>5460</td>
<td>100%</td>
</tr>
</tbody>
</table>

2) In Care as of June 30th, 2016

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children (age 0-15)</td>
<td>891</td>
<td>91%</td>
</tr>
<tr>
<td>Youth (age 16 to 21)</td>
<td>91</td>
<td>9%</td>
</tr>
<tr>
<td>Total</td>
<td>982</td>
<td>100%</td>
</tr>
</tbody>
</table>

*32% of all children and youth in care are aboriginal

<table>
<thead>
<tr>
<th>Placement Type</th>
<th>Number</th>
<th>Percentage of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care (Level I or II)</td>
<td>723</td>
<td>74%</td>
</tr>
<tr>
<td>Foster Care (Level III)</td>
<td>19</td>
<td>2%</td>
</tr>
<tr>
<td>Staffed Residential (Level IV)</td>
<td>146</td>
<td>15%</td>
</tr>
<tr>
<td>Out of Province Placement</td>
<td>29</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>65</td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>982</td>
<td>100%</td>
</tr>
</tbody>
</table>
3) Youth Services (i.e., aged 16 to 21 who have signed voluntary agreements) as of **June 30th, 2016**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Youth Corrections</td>
<td>185</td>
</tr>
<tr>
<td>Extrajudicial Sanctions</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>200</td>
</tr>
</tbody>
</table>

4) Community Youth Corrections (i.e., Youth age 12-18 in Conflict with Law) as of **June 30th, 2016**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Services</td>
<td>170</td>
</tr>
<tr>
<td>Supportive Services</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>201</td>
</tr>
</tbody>
</table>

5) Adoptions

**Between July 1st, 2015 and June 30th, 2016:**

<table>
<thead>
<tr>
<th>Adoption Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Adoption</td>
<td>28</td>
</tr>
<tr>
<td>Inter-provincial Adoption</td>
<td>10</td>
</tr>
<tr>
<td>Inter-country Adoption</td>
<td>3</td>
</tr>
<tr>
<td>Direct Placement</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>42</td>
</tr>
</tbody>
</table>

*Of the 28 Domestic Adoptions, 13 children were adopted by their foster parents*

**As of June 30th, 2016:**

<table>
<thead>
<tr>
<th>Adoptive Parents</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved Adoptive Parents</td>
<td>90</td>
</tr>
<tr>
<td>Adoptive Parents matched with Children</td>
<td>23</td>
</tr>
<tr>
<td>Adoptive Parents with children in placements awaiting finalization</td>
<td>12</td>
</tr>
</tbody>
</table>
**Additional Quick Facts**

**Placement Resources as of June 30th, 2016**

557 Foster Homes (Level 1 to 3)  
(Net gain from previous quarter: 21)

**Deaths and Critical Incidents in 2015**

- 34 Critical incidents  
  (Increase from previous year: 14)
- 9 Deaths  
  (Increase from previous year: 5)

*Of the 9 deaths in 2015, 3 deaths were natural, 5 deaths were accidental, and 1 death was suicide.
*Pilot of new definition for Critical Incidents began Nov. 1, 2014; revisions made Feb. 18, 2016

**Human Resources as of November 9th, 2016**

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Positions</th>
<th>Total Filled Positions</th>
<th>Total Vacant Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CSSD Positions</td>
<td>810</td>
<td>688</td>
<td>122</td>
</tr>
</tbody>
</table>

*Some vacant positions due to be abolished*
Taylor, Jennifer

From: Evans, Sandra
Sent: Monday, November 14, 2016 6:14 PM
To: Tilley, Jean
Subject: Re: Work plan

Ok perfect. Will make edits tomorrow, remove draft and send back to you.
Sent from my Blackberry

From: Tilley, Jean
Sent: Monday, November 14, 2016 6:09 PM
To: Evans, Sandra
Subject: RE: Work plan

I am good with it. I would add in policies and procedure and give examples of CI/Deaths, etc that you have done.

From: Evans, Sandra
Sent: Monday, November 14, 2016 9:24 AM
To: Tilley, Jean
Subject: RE: Work plan

Hi Jean:

I have gone through the list you refer to below (sent to AG Sep 28/15) and all the other information I sent the AG. It is all there. I did not include policies and procedures as a specific item as figured that was more of an ongoing item like monitoring your budget, updating your work plan, completing your attendance etc... After the AG released his report I added another activity to the draft that refers to items coming out of the recommendations and one of those is the operational procedures. I also did not list presentations to Executive such as the one scheduled today with DM as they are more ad-hoc and by request. I was not sure if you sent the work plan off to anyone yet so I did mark it draft when I sent it to you and as I just mentioned, added the AG piece Thursday and have made minor edits until I hear back from you on the first draft.

Thanks,

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”

From: Tilley, Jean
Sent: Sunday, November 13, 2016 9:33 PM
To: Evans, Sandra  
Subject: Re: Workplan

Remember the list of things the QA division is responsible for that we gave to Tony the Auditor. Does the workplan cover all of those activities?

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Evans, Sandra  
Sent: Wednesday, November 9, 2016 3:35 PM  
To: Tilley, Jean  
Cc: Roberts, Denyse  
Subject: Workplan

Hi Jean:

Thank you for giving me the extra time to complete this. I am hoping this is what you are looking for. I struggled a little with finding a happy medium between too much and not enough detail! I still have draft on it until I hear back from you. Thanks.

Sandra

Sandra Evans  
Director Quality Assurance  
Department of Children, Seniors and Social Development  
5 C Harris Avenue  
Mailing Address:  
Provincial Building  
3 Cromer Avenue  
Grand Falls-Windsor, NL A2A 1W9  
709-292-4525  
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”
We just went down through the files. Do you want to call me and I can run through them with you?

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
 Provincial Building
 3 Cromer Avenue
 Grand Falls-Windsor, NL A2A 1W9
 709-292-4525
 709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”

From: Tilley, Jean
Sent: Monday, December 05, 2016 11:27 AM
To: Evans, Sandra
Subject: RE: Note for MIN on Child Deaths Dec 2016.docx

Do you know how many of these have been confirmed by CME?

From: Evans, Sandra
Sent: Monday, December 05, 2016 11:14 AM
To: Tilley, Jean
Subject: RE: Note for MIN on Child Deaths Dec 2016.docx

How’s this?

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Never miss an opportunity to tell your child “I Love You”

From: Tilley, Jean  
Sent: Monday, December 05, 2016 11:10 AM  
To: Evans, Sandra  
Subject: Re: Note for MIN on Child Deaths Dec 2016.docx  

Have all these been confirmed by CME except the unknown  

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Evans, Sandra  
Sent: Monday, December 5, 2016 11:06 AM  
To: Tilley, Jean  
Subject: RE: Note for MIN on Child Deaths Dec 2016.docx  

How does this look?

Sandra

Sandra Evans  
Director Quality Assurance  
Department of Children, Seniors and Social Development  
5 C Harris Avenue  
Mailing Address:  
Provincial Building  
3 Cromer Avenue  
Grand Falls-Windsor, NL A2A 1W9  
709-292-4525  
709-292-4541 (Fax)  

Never miss an opportunity to tell your child “I Love You”

From: Tilley, Jean  
Sent: Monday, December 05, 2016 11:03 AM  
To: Evans, Sandra  
Subject: Re: Note for MIN on Child Deaths Dec 2016.docx  

Yes the 8  

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Evans, Sandra  
Sent: Monday, December 5, 2016 11:00 AM  
To: Tilley, Jean  
Subject: RE: Note for MIN on Child Deaths Dec 2016.docx  

Sure. To clarify, do you mean for each of the deaths that have occurred 

Sandra
Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”

From: Tilley, Jean
Sent: Monday, December 05, 2016 11:00 AM
To: Evans, Sandra
Subject: Re: Note for MIN on Child Deaths Dec 2016.docx

Can you add in bullet on case type?

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Tilley, Jean
Sent: Monday, December 5, 2016 10:52 AM
To: Evans, Sandra
Subject: Note for MIN on Child Deaths Dec 2016.docx
Child Death Reporting

- All deaths are reported to the Child and Youth Advocate of a child/youth who was receiving services (PIP, In Care, kinship, youth services, youth corrections) at the time of the death or in the preceding 12 months.

- Once death reported, social worker immediately assesses the risk and provides support and follow-up to any other child/youth in a family.

- Chief Medical Examiner is also notified in accordance with Section 7 of the Fatalities Investigations Act of the death of a child/youth in the custody of a Zone Manager.

- 8 deaths from December 14/2015-December 4/2016

Sec. 40 (1)
Checking on if numbers < 5 should be released.
Child Death Reporting

- All deaths are reported to the Child and Youth Advocate of a child/youth who was receiving services (PIP, In Care, kinship, youth services, youth corrections) at the time of the death or in the preceding 12 months.

- Once a death is reported, social worker immediately assesses the risk and provides support and follow-up to any other child/youth in a family. Also, parents of a child in care are notified and support is offered.

- Chief Medical Examiner is also notified in accordance with Section 7 of the Fatalities Investigations Act of the death of a child/youth in the custody of a Zone Manager.

- Breakdown of 8 deaths by service from Dec 14/2015 to Dec 4/2016:
  - Youth Services: 1
  - Youth Corrections: 1
  - Kinship: 1
  - In Care: 1
  - PIP: 4

- 8 deaths from Dec 14/2015 to Dec 4/2016

[Sec. 40 (1)]
Perfect thanks

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child "I Love You"
From: O'Neill, Melony
Sent: Monday, December 05, 2016 2:52 PM
To: Tilley, Jean
Subject: Child Deaths December 2016.docx
Attachments: Child Deaths December 2016.docx
Child/Youth Deaths

- The death of a child or youth is a tragic and emotional time – whether it is a family member, a friend, or even our dedicated staff who had a vested interest in the lives of these children and youth – and they are all grieving for these losses.

- Since December 2015, there have been 8 children and youth who passed away while receiving services from the department (or were in receipt of services in the 12 months preceding their death).

- Breakdown of 8 deaths by service:
  - Youth Services: 1
  - Youth Corrections: 1
  - Kinship: 1
  - In Care: 1
  - PIP: 4

- In terms of identifying the cause of death, we have a convention of not reporting numbers less than five for privacy reasons, as my colleagues across the House would know.

- We try to balance openness with sensitivity, so I have asked my officials to investigate as to whether this is still an acceptable practice regarding such sensitive information.

- The Chief Medical Examiner (CME) notified; Child Death Review Committee reviews all cases investigated by the CME; Child and Youth Advocate notified

- Advocate previously stated regarding child deaths - "It doesn’t necessarily mean when it does occur that something wrong has occurred."

- A circumstance in which, sadly, a child passes away while receiving services from our department, cannot and should not be automatically equated with wrongdoing or omission.
<table>
<thead>
<tr>
<th><strong>Subject:</strong></th>
<th>Critical Incidents/Death Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location:</strong></td>
<td>Susan's Office</td>
</tr>
<tr>
<td><strong>Start:</strong></td>
<td>Tue 12/20/2016 3:30 PM</td>
</tr>
<tr>
<td><strong>End:</strong></td>
<td>Tue 12/20/2016 4:30 PM</td>
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<td><strong>Show Time As:</strong></td>
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<td><strong>Recurrence:</strong></td>
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<td><strong>Meeting Status:</strong></td>
<td>Not yet responded</td>
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<td><strong>Organizer:</strong></td>
<td>Bragg, Dana</td>
</tr>
<tr>
<td><strong>Required Attendees:</strong></td>
<td>Walsh, Susan; Patey, Denise; Dow, Sara; Handregan, Kellie; Farrell, Lindsay; Clemens-Spurrell, Linda; Cull, Barbara L.; Whelan, Jackie; Tilley, Jean E.</td>
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<td><strong>Importance:</strong></td>
<td>High</td>
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**Conference Call Instructions:**

- Sec. 35(1)(g)

**Telephone Keypad Features:**

- *0 Speak to an Operator
- *1 Mute/Un Mute your own line
- *6 Terminate call when last participant disconnects (moderator only)
FYI

From: Dalton, Krista
Sent: Tuesday, January 24, 2017 10:28 AM
To: GambinWalsh, Sherry; Cooper, Bruce; Walsh, Susan; Healey, Rick M.; Tilley, Jean
Cc: O'Neill, Melony
Subject: FW: NLIS 1 - Public Advisory: Child Death Review Committee Case Review

FYI...

From: Releases, News
Sent: Tuesday, January 24, 2017 10:25 AM
To: Releases, News
Subject: NLIS 1 - Public Advisory: Child Death Review Committee Case Review

NLIS 1
Justice and Public Safety
January 24, 2017

Public Advisory: Child Death Review Committee Case Review

Under section 13.5 of the Fatalities Investigations Act, the Minister of Justice and Public Safety is required, within 60 days after receiving a report from the Child Death Review Committee (CDRC), to make public those recommendations relating to:

- Relevant protocols, policies and procedures;
- Standards and legislation;
- Linkages and coordination of services; and
- Improvements to services affecting children and pregnant women.

The CDRC forwarded a report to the Minister of Justice and Public Safety on December 1, 2016. The report examines the facts and circumstances surrounding the death of a youth as the result of a motor vehicle accident in Newfoundland and Labrador.

Recommendations:
1. The Department of Justice and Public Safety increase penalties for lack of seatbelt usage; and
2. The Departments of Health and Community Services, Justice and Public Safety, Education and Early Childhood Development, and Service NL review and improve current efforts to educate youth about the importance of seatbelt usage.

This report has been forwarded to the Child and Youth Advocate.
Dropped by - call me when you are free to chat about today's mtg.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: Tilley, Jean
Sent: Thursday, February 23, 2017 12:13 PM
To: Cotter, Joanne
Subject: RE: CI/Death note

Sounds good.

From: Cotter, Joanne
Sent: Thursday, February 23, 2017 11:40 AM
To: Tilley, Jean
Subject: CI/Death note

Talked with Krista Walker (Melony not around) about the HOA note- she agreed we wait for outcome of mtg with Advocate to frame up any new key messages. If you can give me a quick update when the meeting is done then I will update the note and send it along.

Sec. 40 (1)

Attending the regional mtg on death/CI policy and forms at 1:30 but that shouldn't take that long.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
Hi Jean

I followed up with Krista as I had not heard from her. She has placed this HOA note and KMs in the Minister and DM binders for HOA.

Sec. 29 (1)(a)

Call me if this doesn’t make sense.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: Dalton, Krista
Sent: Friday, February 24, 2017 3:52 PM
To: Cotter, Joanne
Cc: O’Neill, Melony
Subject: RE: HOA - Mandatory reporting

Hi Joanne,

Here’s the copy that’s in the minister’s binder. If there’s any changes please provide to Melony. She’ll switch out the copies that have been provided.

Thanks,
Krista

From: Cotter, Joanne
Sent: Friday, February 24, 2017 9:38 AM
To: Dalton, Krista
Subject: FW: HOA - Mandatory reporting

Krista,

I had your last name wrong! Previous email bounced back as undeliverable.

Joanne Cotter, MSW, RSW
Hi there,

Her is the updated HOA note on CI/Death reporting. Few minor changes proposed to the KM’s for your review.

The KM in green is updated based on yesterday’s meeting with the Advocate, which was very positive and productive according to Jean.

If you make changes to the KMs can you let me know as I may also change the current status section to the attached BN.

Thanks!

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
CYA Mandatory Reporting of Critical Incidents and Deaths

CSSD continues to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.

In December 2015, a new Advocate for Children and Youth was appointed. I recently met with the new Advocate (February 2017) to update her on our government’s progress and to seek her feedback on this important initiative. Further discussions are planned and we will continue to work collaboratively with the Advocate as we move forward with this initiative.

Since September 2014, my department has been voluntarily reporting all deaths to the Advocate, resulting in the reporting of about 10 deaths per year.

The Advocate is supportive of this process, but has requested that reporting be legislated as opposed to an agreement with the department.

Since the onset of the process, work has been done by all relevant departments, as well as the Child and Youth Advocate’s office. Each department continues to work on their individual proposed reporting protocol.

While we recognize the process has been ongoing for some time, changes to the Advocate’s legislation impact many government departments and the Advocate’s office. Therefore; consultations, input and feedback from all government departments / stakeholders was necessary.
Since the onset of the process, a considerable amount of work has been done by all the relevant departments, as well as the Child and Youth Advocate’s office (a DM committee was established; a working group was established which included CYA representative; groups met regularly to develop definition of critical incident and understand the parameters of CYA’s request). Each department continues to work on developing their individual proposed reporting protocol.

The proposed legislation is progressive and would be unprecedented across the country, particularly considering that no other province or territory requires that four departments including Health, Justice, Education, and Child Protection report critical incidents and deaths to the Child and Youth Advocate.

It is also important to note that the absence of mandatory reporting to the Child and Youth Advocate does not mean that departments and agencies do not have appropriate accountability measures already in place to respond to critical incidents and deaths.

The safety and protection of our vulnerable populations such as children and youth is an important focus for our government. We will continue to work cooperatively with the Child and Youth Advocate and also continue to review all our existing programs and services and focus on addressing any identified issues.

The Speech from the Throne indicates our government’s commitment to advancing this legislation.
CYA Mandatory Reporting of Critical Incidents and Deaths

Background:
- In recent years, Advocate’s reports have recommended the development of a protocol with CSSD for the reporting of CI’s and deaths involving children and youth.

- In July 2014 the former Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of deaths and CI’s including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

- The former Advocate has publically stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CSSD.

- In November 2014 the HOA passed a motion committing to legislation to respond to the Advocate’s request for mandatory reporting of CI’s and deaths to her office.

- In December 2015 the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting. A further commitment was noted in the March 2016 Speech from the Throne.

Current Status:
- The departments of CSSD, JPS, HCS and EECD are completing an in-depth analysis of the Advocate’s request to ensure we fully appreciate the implications resulting from mandatory reporting for each department and for the whole of government particularly in the current fiscal climate.

- In December 2016, Government appointed a new Advocate for Children and Youth. CSSD officials met with the new Advocate on February 23 to update her on Government’s progress and to seek her feedback on this important initiative.

- A meeting between the Advocate and DMs of CSSD, HCS, EECD and JPS is planned for the coming weeks to discuss next steps to move this initiative forward.
This is the latest version of the CYA note. I did not hear back from Jackie yet.

From: Tilley, Jean
Sent: Monday, February 27, 2017 9:01 AM
To: O’Neill, Melony
Subject: FW: CYA Mandatory Reporting (3).docx
Attachments: CYA Mandatory Reporting (3).docx

Jackie, as discussed yesterday, please review the attached key messages which we have prepared for the Minister. Let me know if you have any suggestions or would like any changes.

Have a nice weekend.

Jean
Taylor, Jennifer

From: Tilley, Jean
Sent: Monday, February 27, 2017 9:03 AM
To: Lake-Kavanagh, Jackie
Subject: RE: CYA Mandatory Reporting (3).docx

Thanks. Have a great trip!

From: Lake-Kavanagh, Jackie
Sent: Monday, February 27, 2017 8:24 AM
To: Tilley, Jean
Subject: Re: CYA Mandatory Reporting (3).docx

Jean,
Sorry for delay. This looks good. I am in Labrador this week with pretty full days, but will keep an eye on my BlackBerry as best as possible in case anything related arises.
Jackie

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Tilley, Jean
Sent: Friday, February 24, 2017 4:53 PM
To: Lake-Kavanagh, Jackie
Subject: CYA Mandatory Reporting (3).docx

Jackie, as discussed yesterday, please review the attached key messages which we have prepared for the Minister. Let me know if you have any suggestions or would like any changes.

Have a nice weekend.

Jean
Taylor, Jennifer

From: Tilley, Jean
Sent: Monday, February 27, 2017 9:03 AM
To: O'Neill, Melony
Subject: RE: CYA Mandatory Reporting (3).docx

Heard from Jackie and she is fine with this.

From: Tilley, Jean
Sent: Monday, February 27, 2017 9:01 AM
To: O'Neill, Melony
Subject: FW: CYA Mandatory Reporting (3).docx

This is the latest version of the CYA note. I did not hear back from Jackie yet.

From: Tilley, Jean
Sent: Friday, February 24, 2017 5:24 PM
To: Lake-Kavanagh, Jackie
Subject: CYA Mandatory Reporting (3).docx

Jackie, as discussed yesterday, please review the attached key messages which we have prepared for the Minister. Let me know if you have any suggestions or would like any changes.

Have a nice weekend.

Jean
-----Original Message-----
From: O'Neill, Melony
Sent: Monday, February 27, 2017 8:56 AM
To: Tilley, Jean; Healey, Rick M.; Walsh, Susan
Subject: Notes

Your message is ready to be sent with the following file or link attachments:

Not responsive to request

Not responsive to request

Not responsive to request
Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.
Taylor, Jennifer

From: Tilley, Jean
Sent: Monday, February 27, 2017 10:11 AM
To: O'Neill, Melony
Subject: RE: Updated - CYA Mandatory Reporting

Yes good with this.

From: O'Neill, Melony
Sent: Monday, February 27, 2017 9:57 AM
To: Tilley, Jean
Subject: Updated - CYA Mandatory Reporting

Hi Jean,

Is this okay with you?

Thanks,

Mel
Hi Jean/Linda,

Please see the attached correspondence and note from Bruce.

Thanks,

Deanne

Deanne Hunt  
Administrative Assistant  
Office of the Deputy Minister  
Department of Children, Seniors and Social Development  
Confederation Building, West Block  
P.O. Box 8700  
St. John's, NL  
A1B 4J6  
Tel: (709) 729-6958  
Fax: (709) 729-1649  
E-Mail: dhunt@gov.nl.ca
From: Cooper, Bruce  
Sent: Monday, February 27, 2017 12:13 PM  
To: Hunt, Deanne  
Subject: Fw: Emailing: Child Death Review Committee Case Review.PDF  
Attachments: Child Death Review Committee Case Review.PDF  

Pls print.

Sent from my BlackBerry 10 smartphone on the Bell network.

Original Message
From: Abbott, John <JohnAbbott@gov.nl.ca>
Sent: Monday, February 27, 2017 11:59 AM
To: Cooper, Bruce
Subject: FW: Emailing: Child Death Review Committee Case Review.PDF

Bruce
I am sending for your information. As one of the recommendations of a Child Death review reference a prevention initiative, I thought I'd bring to your attention (i.e. I think it should have referenced your department as opposed to ours??). Also attached is Gerrie Smith's hand-written note to me which is self-explanatory. OK John A

-----Original Message-----
From: Power, Elaine
Sent: Monday, February 27, 2017 11:51 AM
To: Abbott, John
Subject: Emailing: Child Death Review Committee Case Review.PDF

Your message is ready to be sent with the following file or link attachments:

Child Death Review Committee Case Review.PDF

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.
Public Advisory: Child Death Review Committee Case Review

Justice and Public Safety
January 24, 2017

Public Advisory: Child Death Review Committee Case Review

Under section 13.5 of the Fatalities Investigations Act, the Minister of Justice and Public Safety is required, within 60 days after receiving a report from the Child Death Review Committee (CDRC), to make public those recommendations relating to:

- Relevant protocols, policies and procedures;
- Standards and legislation;
- Linkages and coordination of services; and
- Improvements to services affecting children and pregnant women.

The CDRC forwarded a report to the Minister of Justice and Public Safety on December 1, 2016. The report examines the facts and circumstances surrounding the death of a youth as the result of a motor vehicle accident in Newfoundland and Labrador.

Recommendations:

1. The Department of Justice and Public Safety increase penalties for lack of seatbelt usage; and

2. The Departments of Health and Community Services, Justice and Public Safety, Education and Early Childhood Development, and Service NL review and improve current efforts to educate youth about the importance of seatbelt usage.

This report has been forwarded to the Child and Youth Advocate.

- 30 -

Media contact:

Lesley Clarke
Director of Communications (A)
Department of Justice and Public Safety
709-729-6965, 699-2910
LesleyClarke@gov.nl.ca

2017 01 24 10:25 a.m.
John,
I spoke to Jan Tucker at LPS.

Pls let me know if you require anything further.

GERRIE SMITH
Feb 10/17
Sec. 29(1)(a)
Sec. 40(1)
356
Taylor, Jennifer

Current version

From: O'Neill, Melony
Sent: Monday, February 27, 2017 9:57 AM
To: Tilley, Jean
Subject: Updated - CYA Mandatory Reporting

Hi Jean,

Is this okay with you?

Thanks,

Mel
Hi Jean,

When I read down through this information I don’t think there is anything for us to do at this point. I think it is just an FYI.

Linda

Hi Jean/Linda,

Just a reminder about the attached correspondence which Bruce sent to you on Feb. 27th.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John’s, NL
A1B 4J6
Telex: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dwhunt@gov.nl.ca

Hi Jean/Linda,

Please see the attached correspondence and note from Bruce.

Thanks,
Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John’s, N.L.
A1B 4J6
Tel: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dhunt@gov.nl.ca
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
Hi Jean,

Did you have an opportunity to review this?

Thanks,

Mel

Melony O’Neill
Director of Communications
Department of Children, Seniors and Social Development
6th Floor, West Block
St. John’s, NL A1B 4J6
709-729-5148

Newfoundland Labrador
Children, Seniors and Social Development

From: O’Neill, Melony
Sent: Tuesday, March 28, 2017 1:53 PM
To: Tilley, Jean
Subject: CYA Mandatory Reporting.docx

Hi Jean,

The minister asked me to ensure this is the most up-to-date version. Can you have a look?

Thanks,

Mel
CYA Mandatory Reporting of Critical Incidents and Deaths

CSSD continues to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.

In December 2016, a new Advocate for Children and Youth was appointed. I recently met with the new Advocate (February 2017) to discuss this matter and to seek her feedback and develop a shared plan to continue our work. We discussed areas of mutual interest, including how to define a critical incident and timeframes for reporting to the Advocate.

Further discussions are planned and we will continue to work collaboratively with the Advocate as we move forward with this initiative.

I have been, and will continue to meet regularly with the Advocate to discuss areas of mutual interest.

Since September 2014, my department has been voluntarily reporting all deaths to the Advocate, resulting in the reporting of an average of 10 deaths per year. The Advocate is supportive of this process.

It is also important to note that the absence of mandatory reporting to the Child and Youth Advocate does not mean that departments and agencies do not have appropriate accountability measures already in place to respond to critical incidents and deaths.

Since the onset of the process, work has been done by all relevant departments, as well as the Child and Youth Advocate’s
office.

While we recognize the process has been ongoing for some time, changes to the Advocate's legislation impact many government departments and the Advocate's office. Therefore; consultations, input and feedback from all government departments / stakeholders was necessary.

A considerable amount of work has been done by all the relevant departments, as well as the Advocate's Office (a DM committee was established; a working group was established which included a CYA representative to better understand the Advocate's request).

The safety and protection of our vulnerable populations such as children and youth is an important focus for our government. We will continue to work cooperatively with the Child and Youth Advocate and also continue to review all our existing programs and services and focus on addressing any identified issues.

The Speech from the Throne indicates our government's commitment to advancing this legislation.
CYA Mandatory Reporting of Critical Incidents and Deaths

Background:
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• In July 2014 the former Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of deaths and CI’s including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

• The former Advocate has publically stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CSSD.

• In November 2014 the HOA passed a motion committing to legislation to respond to the Advocate’s request for mandatory reporting of CI’s and deaths to her office.

• In December 2015 the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting. A further commitment was noted in the March 2016 Speech from the Throne.

Current Status:
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• In December 2016, Government appointed a new Advocate for Children and Youth. CSSD officials met with the new Advocate on February 23 to update her on Government’s progress and to seek her feedback on this important initiative.

• A meeting between the Advocate and DMs of CSSD, HCS, EECD and JPS is planned for the coming weeks to discuss next steps to move this initiative forward.
Critical Incidents & Deaths Reporting - Next Steps
CSSD-STJH-RM-BR-ConfedWest, Executive Boardroom-FL6

Thu 3/30/2017 11:00 AM
Thu 3/30/2017 12:00 PM
Tentative

(none)

Not yet responded

Hunt, Deanne

Cooper, Bruce; Abbott, John; Jacobs, Heather; Gardiner, Bob B; Tilley, Jean; Lake-Kavanagh, Jackie

Power, Elaine; Eddy, Tracey; Manuel, Sue; Roberts, Denyse; Holt, Suzanne

Meeting will take place in the Executive Boardroom, Department of Children, Seniors and Social Development, 6th Floor, Confederation Building, West Block
Taylor, Jennifer

From: Cotter, Joanne
Sent: Wednesday, April 05, 2017 8:58 AM
To: Tilley, Jean
Subject: RE: Thursday’s meeting with OCYA

k- I’ll put these in an agenda and get Denise to circulate today and advise folks they can also add agenda items

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: Tilley, Jean
Sent: Tuesday, April 04, 2017 4:56 PM
To: Cotter, Joanne
Subject: RE: Thursday’s meeting with OCYA

Sounds good. an agenda would be great.

From: Cotter, Joanne
Sent: Tuesday, April 04, 2017 4:54 PM
To: Tilley, Jean
Subject: Thursday’s meeting with OCYA

Should we pull together an agenda for Thursday’s meeting? From my review, the following requires discussion (not all for Thursday of course)

Sec. 29(1)(a)

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
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<th>Name for CI/Deaths Working Group</th>
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</tr>
<tr>
<td>Start:</td>
<td>Thu 4/6/2017 3:00 PM</td>
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<tr>
<td>Organizer:</td>
<td>Roberts, Denyse</td>
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<tr>
<td>Required Attendees:</td>
<td>Tilley, Jean; Cotter, Joanne; Tucker, Ian J.; Gray, Karen; Kenny, Samantha</td>
</tr>
<tr>
<td>Subject:</td>
<td>Name for CI/Deaths Working Group</td>
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<tr>
<td>Meeting Status:</td>
<td>Not yet responded</td>
</tr>
<tr>
<td>Organizer:</td>
<td>Roberts, Denyse</td>
</tr>
<tr>
<td>Required Attendees:</td>
<td>Tilley, Jean; Cotter, Joanne; Tucker, Ian J.; Gray, Karen; Kenny, Samantha</td>
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</table>
Taylor, Jennifer

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<th>Subject:</th>
<th>Critical Incident Death Reporting</th>
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<tbody>
<tr>
<td>Location:</td>
<td>CSSD-STJH-RM-BR-ConfedWest, Training Room-FL6</td>
</tr>
<tr>
<td>Start:</td>
<td>Wed 4/12/2017 3:00 PM</td>
</tr>
<tr>
<td>End:</td>
<td>Wed 4/12/2017 4:00 PM</td>
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<tr>
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<td>Tentative</td>
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<tr>
<td>Recurrence:</td>
<td>(none)</td>
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<td>Meeting Status:</td>
<td>Not yet responded</td>
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<td>Organizer:</td>
<td>Roberts, Denyse</td>
</tr>
<tr>
<td>Required Attendees:</td>
<td>Tilley, Jean; Cotter, Joanne; Tucker, Ian J.; Kenny, Samantha; Gray, Karen</td>
</tr>
</tbody>
</table>
Taylor, Jennifer

Subject: Critical Incident Death Reporting
Location: CSSD-STJH-RM-BR-ConfedWest, Training Room-FL6
Start: Wed 4/12/2017 3:00 PM
End: Wed 4/12/2017 4:00 PM
Recurrence: (none)
Meeting Status: Accepted
Organizer: Roberts, Denyse
Required Attendees: Tilley, Jean; Cotter, Joanne; Tucker, Ian J.; Kenny, Samantha; Gray, Karen
Taylor, Jennifer

Subject: FW: Mandatory reporting
Location: CSSD

Start: Mon 5/15/2017 3:30 PM
End: Mon 5/15/2017 4:30 PM
Show Time As: Tentative
Recurrence: (none)
Meeting Status: Not yet responded
Organizer: Cotter, Joanne

Meeting will be in the Executive Boardroom, 6th Floor, West Block Confederation Building.

Thanks,
Denyse

-----Original Appointment-----
From: Cotter, Joanne
Sent: Tuesday, May 09, 2017 11:53 AM
To: Cotter, Joanne; Tilley, Jean; Ring, Stephen R.; Gray, Karen; Kenny, Samantha
Subject: Mandatory reporting
When: Monday, May 15, 2017 3:30 PM-4:30 PM (UTC-03:30) Newfoundland.
Where: CSSD

Jean now has a meeting in her calendar for later Tuesday afternoon. Can we do Monday 3:30 -4:30?

Here are outstanding areas for discussion: Sec. 29(1)(a)
Taylor, Jennifer

From: Evans, Sandra
Sent: Wednesday, August 31, 2016 5:32 PM
To: CSSD - Department Wide - All Users
Subject: Critical Incident and Death Protocol and Related Forms

Hi Everyone:

Please disregard if this does not apply to you.

Attached please find the Critical Incident and Death Protocol. The Protocol comes into effect September 1, 2016. Also attached are the following documents:

- Critical Incident/Death Notification Form – this form is used for reporting a death or critical incident and replaces all other forms previously used;
- Guidelines for Completion of the CI/Death Notification Form – this is a handout that can be used to assist in completing the Notification Form;
- File Review Template – this template outlines what is included in a File Review if Quality Assurance (QA) completes a review on a client file;
- Action Plan Template – this is completed by the region if a File Review is conducted by QA on a file and there is follow-up action required of regional staff;

The Protocol and documents will also be posted on the Department Intranet site. If you have any questions, please do not hesitate to contact Kellie Handregan, Social Worker III (Auditor) at 292-4571 or me as per below contact information.

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”
Department of Children, Seniors and Social Development
Quality Assurance File Review Action Plan

File Review (Client Initials): _______
Date of Regional Meeting: _______

File Review Findings Requiring Action:
1. _______

Plan:

<table>
<thead>
<tr>
<th>File Review Findings</th>
<th>Action(s)</th>
<th>Person Assigned to Implement Action</th>
<th>Expected Completion Date</th>
<th>Date Completed</th>
<th>By Whom</th>
</tr>
</thead>
</table>

Signature of Social Worker(s) _______ Date _______
Reviewed/Signature of Supervisor(s) _______ Date _______
Reviewed/Signature of Zone Manager _______ Date _______
Received/Signature of Director QA _______ Date _______

403
Department of Children, Seniors and Social Development
Quality Assurance File Review Template

File Review – Client Name

Introduction
- Description of incident; Include name and age of child/youth, region and location of death

Family Composition
- Immediate family members and DOB (if known)
- Extended family and caregivers

Summary of Placement History (if applicable)

Summary of CYFS Involvement
- Family History (Past 12 months)

Key Practice Issues
- Policy/Procedures
  o Risk management practices or other Program Practices
- Case Management
  o Assessment and Ongoing Intervention
  o Client Contact
  o Documentation
  o Monitoring
  o Services Provided
  o Coordination of Services; Case Conferencing
  o Case Closure Summaries
- Clinical Decision Making
  o Services, Planning and Follow-Up
  o Decisions Made

Analysis of Key Practice Issues
- Analysis links key practice issues discussed to policy.
- File Review Findings Requiring Action
  o Policy Implications
  o Training Implications

Signatures Required
- QA Auditor, Director QA

Appendix A – File Review Action Plan
Critical Incident/Death Notification Form

Section 1: Client Information

Last Name: [ ]  First Name: [ ]  Date of Birth: (YYYY-MM-DD) [ ]  Age: [ ]  Gender: [ ]  CRMS ID for Child: [ ]

Aboriginal Status/Identity

Child/Youth Custody Status: [ ]  If child is Aboriginal, please select: [ ] Aboriginal [ ] Non-Aboriginal

If not applicable please specify: [ ]

Section 2: Family Composition

Parent(s) Name: [ ]

Step Parent(s)/Partner(s) of Parent(s): [ ]

Current Care Provider (if applicable) and relationship to child: [ ]

Sibling(s) (if 21 years of age and under):

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Date of Birth (YYYY-MM-DD)</th>
<th>Child's Status</th>
<th>Where Not Applicable Specify Child's Status</th>
<th>Was child involved in Critical Incident, Death</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Yes [ ] No [ ]</td>
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<td>Yes [ ] No [ ]</td>
</tr>
</tbody>
</table>

Section 3: CSSD Information

Social Worker assigned to follow up on death/critical incident: [ ]

Region: [ ]

Clinical Program Supervisor for Social Worker: [ ]

Zone Manager for Social Worker: [ ]

Current Open Program(s) (Check all that apply & Include CRMS ID#)

- [ ] Protective Intervention [ ] Youth Services
- [ ] Kinship [ ] Adoptions
- [ ] In-Care [ ] Community Youth Corrections

Please specify program: [ ] Secure Custody [ ] Open Custody

Specify any programs previously open (include CRMS ID and date of closure for each program): [ ]
Section 4: Details of Death / Critical Incident

Date & Time Children, Seniors and Social Development notified:

Name of Social Worker notified of death / critical incident:

Date Notified: (YYYY-MM-DD)  Time Notified:  □ A.M.  □ P.M.  Date of Death / Critical Incident: (YYYY-MM-DD)

Type of Notification:

□ Death  □ Critical Incident

If other please specify:

Description of death or critical incident:

Supplementary Information Attached?  □ Yes  □ No

Section 5: Response to Death / Critical Incident

Immediate:

Further follow up, if required:

Please specify the internal/external service providers who have been notified about the death/critical incident:

Please specify the internal/external service providers who will be notified about the death/critical incident:

Section 6: Review

Social Worker completing form: (print name)  Date: (YYYY-MM-DD)

Name of Supervisor who reviewed form: (print name)  Date: (YYYY-MM-DD)

Name of Zone Manager who reviewed form: (print name)  Date: (YYYY-MM-DD)

Final Review:

I, ___________________________ have reviewed the circumstances and I am satisfied with the plan for further follow-up.

Name of Regional Director

Regional Director's Signature  Date: (YYYY-MM-DD)

Form MUST be submitted to the ADM - Service Delivery & Regional Operations, and Director of Quality Assurance.
Section 7: ADM Review (to be completed by the ADM - Service Delivery and Regional Operations)

Date Received: (YYYY-MM-DD)

Action Required:

☐ No further action required of regional staff

☐ Further action required of regional staff

☐ Quality Assurance to complete file summary

Date Chief Medical Officer Notified: (If applicable) (YYYY-MM-DD)

Date Child & Youth Advocate Notified: (YYYY-MM-DD)

Date DM Initially Briefed: (YYYY-MM-DD)

Explanation of current status and action required of regional staff:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

ADM's Signature

________________________________________________________________________

Date: (YYYY-MM-DD)
Critical Incident and Death Protocol

Policy no.: QA-2014-001
Effective Date: March 31, 2014
Date Revised: September 1, 2016
Legislative References: Adoptions Act, 2013
Children and Youth Care and Protection Act (CYCP Act)
Section 7, Fatalities Investigations Act
Young Persons Offences Act
Youth Criminal Justice Act

PURPOSE:

To outline the process for responding to a critical incident or death of a child/youth who was receiving services from the Department of Children, Seniors and Social Development (CSSD) at the time of the critical incident or death or in the preceding twelve months.

POLICY:

1. A critical incident (CI) is defined as an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth such as violence, assault, injury, other serious criminal matters and significant threats of self-injury/harm or suicidal ideation requiring hospitalization beyond the initial assessment and treatment.

2. In response to a CI or death, a social worker shall immediately assess the risk and provide support and follow-up to any other child/youth in a family or other environment currently receiving services (i.e. an open program file) from CSSD in accordance with applicable program standards.

3. All procedures relating to responding, notifying, approving and planning for a CI or death shall be followed as outlined in the Procedures section of this protocol.

4. QA shall complete a File Review on all child/youth deaths, unless the death is due to a natural/medical cause, and in cases where the Assistant Deputy Minister, Service Delivery and Regional Operations (ADM, SD&RO) requires a File Review to be completed.

5. All electronic communication completed in relation to this protocol shall be encrypted or transferred through shared drives per the guideline on Email and Encryption.
6. All public communication by CSSD related to a CI or death of a child/youth shall be managed through the CSSD Director of Communications.

PROCEDURES:

Determining What Constitutes a Critical Incident

1. A social worker shall refer to the CI definition to assess whether an event or circumstance constitutes a CI. Given the complexity of the work, a social worker will need to use professional judgment and may also need to consult with a supervisor to make this determination. The following circumstances or events are generally considered to be extraordinary or life threatening and impact the child/youth’s safety or well-being. This list is not exhaustive and meant to be used as a guide only:
   a) Suicide attempt, suicidal ideation or self-harming behaviors requiring hospitalization following the initial assessment;
   b) Serious injury to a child/youth requiring medical assessment or hospitalization that is accidental (e.g. multiple internal injuries caused by a motor vehicle accident) or suspicious in nature (e.g. abusive head trauma to an infant);
   c) A child/youth is abducted;
   d) A child/youth is missing and the circumstances of his/her absence (e.g. age and developmental considerations, length of time missing, concern child/youth may be assaulted, injured or involved in serious criminal activity) are extraordinary or life threatening; and,
   e) A child/youth is involved in a serious criminal matter (e.g. allegedly murdered or seriously injured another person or arson resulting in injury to an individual).

Responding to a Critical Incident or Death

1. A social worker shall immediately notify a supervisor who shall then notify the Zone Manager and the Regional Director of a CI or death. When this occurs outside of regular business hours, the on call supervisor shall notify the Zone Manager, Regional Director and ADM - SD&RO.

2. A social worker shall follow all other program specific policies and procedures relevant to the circumstances of the CI or death (e.g. missing or abducted child/youth policy, screening a referral for child maltreatment, etc.).

3. A social worker shall immediately assess potential risk and provide support and follow up to the child/youth and any other child/youth in a family or other environment who is currently receiving services from CSSD. If a child is not currently receiving services from CSSD, a social worker in consultation with a supervisor, shall also determine if information received constitutes a child maltreatment concern and if so, respond in accordance with the Risk Management Decision-Making Model.
4. The Regional Director shall notify the ADM SD&RO as soon as possible who shall then notify the Deputy Minister of the CI or death. The Deputy Minister will notify the Minister of all deaths and of CIs where appropriate.

5. Provincial office staff who are also made aware of a child/youth death by the Chief Medical Examiner’s office shall also notify the ADM SD&RO and the Quality Assurance Division (QA) of the death and enter the date of death in the electronic case file as soon as it is known.

6. The Zone Manager (or designate) shall notify, as soon as possible, the parent(s) of a child/youth in the case of a CI or death of a child/youth in interim care or temporary custody. Notifying parents of children in continuous custody is at the Zone Manager’s discretion.

7. The ADM SD&RO shall notify, by email, the Advocate for Children and Youth of a child/youth’s death within 24 hours of CSSD becoming aware of the death and shall provide basic information such as the child/youth’s age and circumstances surrounding the death.

8. The ADM SD&RO shall notify the Chief Medical Examiner in accordance with Section 7 of the Fatalities Investigations Act, of the death of a child/youth in the custody of a Zone Manager.

9. The social worker initially informed of the CI or death shall complete a Critical Incident/Death Notification form which shall be reviewed by the Clinical Program Supervisor and Zone Manager and submitted to the Regional Director for review and signature. The Regional Director shall then forward the form for approval to the ADM SD&RO and provide a copy to the Director, QA. This notification process shall occur within 48 hours of the social worker being informed of the CI or death.

10. Upon notification from the region of a CI or death, QA shall open a file to track the CI or death and all related follow-up required.

11. A social worker shall enter the official date of death in the electronic file as soon as it is known.

12. Critical Incident/Death Notification forms are completed for each child or youth involved in a CI or death unless it involves multiple children from one family who are receiving Protective Intervention services, in which case one form shall be completed.

13. The ADM SD&RO, upon reviewing the Critical Incident/Death Notification form, shall determine completeness of the form and may request additional information be provided. Depending on the additional information required, the ADM SD&RO may request regional staff update and resubmit the Critical Incident/Death Notification form. The ADM SD&RO shall approve/sign the Critical Incident/Death Notification form. Copies of the signed form shall be sent to the Regional Director for the client file and to the Director, QA for the QA file.
14. The ADM SD&RO shall determine if further action is required of regional staff or if a 
File Review is required by QA. Any action required of regional staff shall be outlined on 
the approved Critical Incident/Death Notification form. QA will assist the ADM SD&RO 
by monitoring completion of all action required and provide updates to the ADM 
SD&RO.

15. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form 
involving a CI or death to the Deputy Minister and other Department officials, as 
appropriate.

16. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form 
to the Advocate for Children and Youth within five days of CSSD being informed of the 
death of a child or youth.

Completing a File Review

1. Where a File Review is required the Zone Manager shall add a note to the electronic file 
advising that a File Review is being completed by QA. A note shall be added to the 
master (paper) file if the case has been closed.

2. Where a File Review is required the Director, QA shall obtain the master file(s) within 
five business days and designate a QA Auditor to complete it using the File Review 
Template. The File Review will be based on a review of services provided in the twelve 
months preceding the CI or death unless the ADM SD&RO requests a longer review 
period. The File Review shall also outline all findings resulting from the review and any 
actions required.

3. Prior to sending the master file(s) to QA, the region shall create a temporary file and copy 
the last twelve months (or other time frame specified by the ADM SD&RO) of the file.

4. The Director, QA shall send the draft File Review to the ADM SD&RO within 30 
calendar days of QA receiving the file(s). The ADM SD&RO shall review the draft File 
Review and obtain input, where appropriate, from Executive and other department 
officials. Any feedback shall be provided to QA to finalize the File Review which is 
approved by the Director, QA and retained in the QA file.

Following Up on Findings-Developing an Action Plan

1. Within 30 days of finalizing the File Review, QA will arrange a meeting with the 
Regional Director, Zone Manager, Clinical Program Supervisor and social worker to 
review the findings and required actions identified in the File Review and to develop a 
plan using the Action Plan Template. The action plan will then be attached to the File 
Review as an appendix.

2. Following the File Review meeting, the Zone Manager will add a note to the electronic 
file, or the master file for closed cases, indicating the File Review is completed.
3. The original file(s) shall be returned to the appropriate Zone Manager/Clinical Program Supervisor after the File Review meeting has occurred.

4. Regional staff shall transfer file documentation that has been kept in the temporary file to the original file and the temporary file shall be appropriately destroyed.

Monitoring of Actions Required

1. The QA Division shall monitor implementation of actions required, including contact with persons responsible for actions by expected completion dates and provide updates to the ADM SD&RO.

2. The QA file shall close once the Director, QA determines required action items have been completed and no further monitoring is required.

EXCEPTIONS TO PROTOCOL:

1. In the case of a closed file, if the critical incident or death of a child/youth occurred within 12 months of the case closing it must still be reported to the ADM and QA. However, a Critical Incident/Death Notification form is not required due to the limited amount of information typically provided in these circumstances. Information on historical CSSD involvement with a child/youth may be requested by the ADM SD&RO on a case by case basis. The social worker will document this request on the master (paper) file only. In these circumstances the ADM SD&RO will only provide the initial notification to the Advocate for Children and Youth.

Where the circumstances surrounding a death or critical incident results in the opening or reopening of a protective intervention file, a discussion with the ADM SD&RO is required to determine if a CI/Death Notification form is required.

REFERENCE DOCUMENTS:

- Adoptions Policy Manual
- Community Youth Corrections Policy Manual
- Email and Encryption Guideline
- Protection and In Care Policy and Procedures Manual
- Staffed Residential Placement Resources Standards and Procedures Manual
- Critical Incident/Death Notification Form
- File Review Template
- Action Plan Template
CONTACT INFORMATION:

Director of Quality Assurance
Quality Assurance Division
Department of Children, Seniors and Social Development
(709) 292-4525
CRITICAL INCIDENT/DEATH NOTIFICATION FORM (PRE-ISM):
GUIDELINES FOR COMPLETION

A copy of this form can be found on the Dept. Intranet site (https://cyfs.intranet.psnl.ca/Pages/default.aspx). If you have any questions about the completion of this form, please contact Quality Assurance.

Section 1: Client Information

Input name of child/youth who has deceased or was involved in the critical incident. If multiple children involved from the same family, enter the name of the oldest child and required information in that section for that child. Other children in the family involved will be recorded in Section 2.

Section 2: Family Composition

If more room is needed for siblings, please attach the names as a Word document, providing the required information. If other children in the same family are also being reported as a death or critical incident, this information must be recorded appropriately in the last column of the sibling section, e.g., if three siblings were in a car accident, or two siblings deceased in the same fire.

Section 3: CSSD Information

This section includes the name of the client’s worker and his/her Supervisor and Zone Manager and NOT the person notified of the death/critical incident who completes the form. This is captured in Section 4.

For Current Open Programs, check off all open programs and include CRMS ID #.

For any files closed, indicate what files were open and include date file closed for each program.

Section 4: Details of Death/Critical Incident

This section is completed by the person first notified of the death/critical incident who is then responsible for completing the form.

There is a drop down menu for Type of Critical Incident. If neither category is applicable choose “other” and briefly specify what the Critical Incident is in the space provided. If 2 categories are applicable for the type of Critical Incident choose the one that is more serious. In the Description box, provide a very brief summary of the event/events leading up the death/CI.

Section 5: Response to Death/Critical Incident

Immediate: what was done in response to the notification, such as support was provided to family.

Further Follow-Up Required: what is to be done after the report is complete, e.g., follow-up with family, follow-up with RCMP.
Internal Service providers can include but are not limited to other social workers involved with the client under a different program area or other Dept. employees.

External Services providers can include but are not limited to other health professionals involved with the child/youth external to the Dept. such as medical doctor, counselor, psychiatrist, school, police, child care provider.

Section 6: Review

Social worker, Supervisor and Zone Manager must type in their name in the appropriate box after their work is complete (e.g. Supervisor reviews the form). Once completed, the form is sent to the Regional Director (RD) who reviews and approves with written signature. If the RD is away, this section must be completed by the RD covering. Form sent to ADM SD&RO and Director QA.

Section 7: ADM Review

ADM determines if any action required and indicates dates personnel are notified where appropriate. ADM signs form and sends copy to region and QA.
Bruce, further to our discussion yesterday regarding the process on Critical incidents and Deaths. The revised protocol was circulated today (below and attached). For your information the protocol provides the following direction:

A social worker shall immediately notify a supervisor who shall then notify the Zone Manager and the Regional Director of a CI or death. The Regional Director shall notify the ADM SD&RO as soon as possible who shall then notify the Deputy Minister of the CI or death.

When this occurs outside of regular business hours, the on call supervisor shall notify the Zone Manager, Regional Director and ADM - SD&RO.

The Deputy Minister will notify the Minister of all deaths and of CIs where appropriate.

Sec. 29 (1)(a)

If you would like to discuss please let me know.

Thanks, Susan

Susan Walsh
Assistant Deputy Minister
Service Delivery and Regional Operations
Department of Children, Seniors and Social Development
(709) 729-3473

From: Evans, Sandra
Sent: Wednesday, August 31, 2016 5:32 PM
To: CYFS - Department Wide - All Users <CYFS-AllUsers@gov.nl.ca>
Subject: Critical Incident and Death Protocol and Related Forms

Hi Everyone:

Please disregard if this does not apply to you.

Attached pleased find the Critical Incident and Death Protocol. The Protocol comes into effect September 1, 2016. Also attached are the following documents:

- Critical Incident/Death Notification Form – this form is used for reporting a death or critical incident and replaces all other forms previously used;
- Guidelines for Completion of the CI/Death Notification Form – this is a handout that can be used to assist in completing the Notification Form;
- File Review Template – this template outlines what is included in a File Review if Quality Assurance (QA) completes a review on a client file;
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The Protocol and documents will also be posted on the Department Intranet site. If you have any questions, please do not hesitate to contact Kellie Handregan, Social Worker III (Auditor) at 292-4571 or me as per below contact information.

Sandra

Sandra Evans
Director Quality Assurance
Department of Children, Seniors and Social Development
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”
Critical Incident and Death Protocol

Policy no.: QA-2014-001
Effective Date: March 31, 2014
Date Revised: September 1, 2016
Legislative References: Adoptions Act, 2013
Children and Youth Care and Protection Act (CYCP Act)
Section 7, Fatalities Investigations Act
Young Persons Offences Act
Youth Criminal Justice Act

PURPOSE:
To outline the process for responding to a critical incident or death of a child/youth who was receiving services from the Department of Children, Seniors and Social Development (CSSD) at the time of the critical incident or death or in the preceding twelve months.

POLICY:

1. A critical incident (CI) is defined as an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth such as violence, assault, injury, other serious criminal matters and significant threats of self-injury/harm or suicidal ideation requiring hospitalization beyond the initial assessment and treatment.

2. In response to a CI or death, a social worker shall immediately assess the risk and provide support and follow-up to any other child/youth in a family or other environment currently receiving services (i.e. an open program file) from CSSD in accordance with applicable program standards.

3. All procedures relating to responding, notifying, approving and planning for a CI or death shall be followed as outlined in the Procedures section of this protocol.

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PROCEDURES:

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1. A social worker shall refer to the CI definition to assess whether an event or circumstance constitutes a CI. Given the complexity of the work, a social worker will need to use professional judgment and may also need to consult with a supervisor to make this determination. The following circumstances or events are generally considered to be extraordinary or life threatening and impact the child/youth’s safety or well-being. This list is not exhaustive and meant to be used as a guide only:

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   c) A child/youth is abducted;
   d) A child/youth is missing and the circumstances of his/her absence (e.g. age and developmental considerations, length of time missing, concern child/youth may be assaulted, injured or involved in serious criminal activity) are extraordinary or life threatening; and,
   e) A child/youth is involved in a serious criminal matter (e.g. allegedly murdered or seriously injured another person or arson resulting in injury to an individual).

Responding to a Critical Incident or Death

1. A social worker shall immediately notify a supervisor who shall then notify the Zone Manager and the Regional Director of a CI or death. When this occurs outside of regular business hours, the on call supervisor shall notify the Zone Manager, Regional Director and ADM - SD&RO.

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3. A social worker shall immediately assess potential risk and provide support and follow up to the child/youth and any other child/youth in a family or other environment who is currently receiving services from CSSD. If a child is not currently receiving services from CSSD, a social worker in consultation with a supervisor, shall also determine if information received constitutes a child maltreatment concern and if so, respond in accordance with the Risk Management Decision-Making Model.
4. The Regional Director shall notify the ADM SD&RO as soon as possible who shall then notify the Deputy Minister of the CI or death. The Deputy Minister will notify the Minister of all deaths and of CIs where appropriate.

5. Provincial office staff who are also made aware of a child/youth death by the Chief Medical Examiner’s office shall also notify the ADM SD&RO and the Quality Assurance Division (QA) of the death and enter the date of death in the electronic case file as soon as it is known.

6. The Zone Manager (or designate) shall notify, as soon as possible, the parent(s) of a child/youth in the case of a CI or death of a child/youth in interim care or temporary custody. Notifying parents of children in continuous custody is at the Zone Manager’s discretion.

7. The ADM SD&RO shall notify, by email, the Advocate for Children and Youth of a child/youth’s death within 24 hours of CSSD becoming aware of the death and shall provide basic information such as the child/youth’s age and circumstances surrounding the death.

8. The ADM SD&RO shall notify the Chief Medical Examiner in accordance with Section 7 of the Fatalities Investigations Act, of the death of a child/youth in the custody of a Zone Manager.

9. The social worker initially informed of the CI or death shall complete a Critical Incident/Death Notification form which shall be reviewed by the Clinical Program Supervisor and Zone Manager and submitted to the Regional Director for review and signature. The Regional Director shall then forward the form for approval to the ADM SD&RO and provide a copy to the Director, QA. This notification process shall occur within 48 hours of the social worker being informed of the CI or death.

10. Upon notification from the region of a CI or death, QA shall open a file to track the CI or death and all related follow-up required.

11. A social worker shall enter the official date of death in the electronic file as soon as it is known.

12. Critical Incident/Death Notification forms are completed for each child or youth involved in a CI or death unless it involves multiple children from one family who are receiving Protective Intervention services, in which case one form shall be completed.

13. The ADM SD&RO, upon reviewing the Critical Incident/Death Notification form, shall determine completeness of the form and may request additional information be provided. Depending on the additional information required, the ADM SD&RO may request regional staff update and resubmit the Critical Incident/Death Notification form. The ADM SD&RO shall approve/sign the Critical Incident/Death Notification form. Copies of the signed form shall be sent to the Regional Director for the client file and to the Director, QA for the QA file.
14. The ADM SD&RO shall determine if further action is required of regional staff or if a File Review is required by QA. Any action required of regional staff shall be outlined on the approved Critical Incident/Death Notification form. QA will assist the ADM SD&RO by monitoring completion of all action required and provide updates to the ADM SD&RO.

15. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form involving a CI or death to the Deputy Minister and other Department officials, as appropriate.

16. The ADM SD&RO shall provide a copy of the Critical Incident/Death Notification form to the Advocate for Children and Youth within five days of CSSD being informed of the death of a child or youth.

Completing a File Review

1. Where a File Review is required the Zone Manager shall add a note to the electronic file advising that a File Review is being completed by QA. A note shall be added to the master (paper) file if the case has been closed.

2. Where a File Review is required the Director, QA shall obtain the master file(s) within five business days and designate a QA Auditor to complete it using the File Review Template. The File Review will be based on a review of services provided in the twelve months preceding the CI or death unless the ADM SD&RO requests a longer review period. The File Review shall also outline all findings resulting from the review and any actions required.

3. Prior to sending the master file(s) to QA, the region shall create a temporary file and copy the last twelve months (or other time frame specified by the ADM SD&RO) of the file.

4. The Director, QA shall send the draft File Review to the ADM SD&RO within 30 calendar days of QA receiving the file(s). The ADM SD&RO shall review the draft File Review and obtain input, where appropriate, from Executive and other department officials. Any feedback shall be provided to QA to finalize the File Review which is approved by the Director, QA and retained in the QA file.

Following Up on Findings-Developing an Action Plan

1. Within 30 days of finalizing the File Review, QA will arrange a meeting with the Regional Director, Zone Manager, Clinical Program Supervisor and social worker to review the findings and required actions identified in the File Review and to develop a plan using the Action Plan Template. The action plan will then be attached to the File Review as an appendix.

2. Following the File Review meeting, the Zone Manager will add a note to the electronic file, or the master file for closed cases, indicating the File Review is completed.
3. The original file(s) shall be returned to the appropriate Zone Manager/Clinical Program Supervisor after the File Review meeting has occurred.

4. Regional staff shall transfer file documentation that has been kept in the temporary file to the original file and the temporary file shall be appropriately destroyed.

Monitoring of Actions Required

1. The QA Division shall monitor implementation of actions required, including contact with persons responsible for actions by expected completion dates and provide updates to the ADM SD&RO.

2. The QA file shall close once the Director, QA determines required action items have been completed and no further monitoring is required.

EXCEPTIONS TO PROTOCOL:

1. In the case of a closed file, if the critical incident or death of a child/youth occurred within 12 months of the case closing it must still be reported to the ADM and QA. However, a Critical Incident/Death Notification form is not required due to the limited amount of information typically provided in these circumstances. Information on historical CSSD involvement with a child/youth may be requested by the ADM SD&RO on a case by case basis. The social worker will document this request on the master (paper) file only. In these circumstances the ADM SD&RO will only provide the initial notification to the Advocate for Children and Youth.

Where the circumstances surrounding a death or critical incident results in the opening or reopening of a protective intervention file, a discussion with the ADM SD&RO is required to determine if a CI/Death Notification form is required.

REFERENCE DOCUMENTS:

- Adoptions Policy Manual
- Community Youth Corrections Policy Manual
- Email and Encryption Guideline
- Protection and In Care Policy and Procedures Manual
- Staffed Residential Placement Resources Standards and Procedures Manual
- Critical Incident/Death Notification Form
- File Review Template
- Action Plan Template
CONTACT INFORMATION:

Director of Quality Assurance
Quality Assurance Division
Department of Children, Seniors and Social Development
(709) 292-4525
From: Cotter, Joanne
Sent: Monday, September 12, 2016 4:20 PM
To: CSSD - Department Wide - All Users
Subject: Policy revisions-Protection and In Care Policy and Procedures Manual
Attachments:
3.14 A Child or Youth Absent Without Permission Sept 12 2016.pdf; 3.15 Child or Youth Missing or Abducted September 12 2016.pdf; Glossary of Terms Sept 12 2016.pdf; Missing or Abducted Child or Youth Located Report (Sept 2, 2016).pdf; Missing or Abducted Child or Youth Report (Sept 2, 2016).pdf; Memo to staff regarding Child or Youth Absent Without Permission & Missi...pdf

Hello everyone

Please see attached a memo regarding revisions to the Protection and In Care Policy and Procedures Manual (June 2011), two revised policies (3.14 A Child or Youth Absent Without Permission & 3.15 A Child or Youth Missing or Abducted) a revised glossary, and two new forms (Missing or Abducted Child or Youth Report Form & Missing or Abducted Child or Youth Located Report Form) that will replace the current Missing or Abducted Child or Youth Report form.

These two policies have been revised as a result of changes to the Departmental notification process when a child or youth is missing and procedures have been added regarding children and youth who are located but refusing to return to their placement. The policies have also been updated to reflect the new Critical Incident and Death Protocol and the Provincial Territorial Protocol of Children, Youth and Families Moving Between Provinces and Territories.

The forms have also been updated to reflect the new notification process and it is important to note these forms will now be submitted to the Zone Manager instead of the Manager for Service Delivery and Regional Operations.

Staff are required to review these revised polices and to update any hard copies in their Protection and In Care Policy and Procedures Manual. The new forms will be effective immediately and staff are advised to delete any hard copy or electronic versions of the previous form. The policy manual will be updated on the CSSD Intranet and the Departmental website and the new forms will also be placed on the CYFS Intranet.

Two teleconference sessions will also be offered for staff who would like to discuss any of the changes to these two policies. Staff will be advised shortly of the date and time of these two sessions.

Please refer any questions you may have to your Supervisor and/or Zone Manager who will seek clarification, where necessary, from provincial office.

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
Department of Children, Seniors and Social Development
95 Elizabeth Avenue
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709-729-3527 (P) 709-729-6382 (F)
PLANNING: A CHILD OR YOUTH ABSENT WITHOUT PERMISSION

Policy no.: 3.14
Effective Date: March 2007
Date Revised: June 30, 2011; September 12, 2016
Policy Cross References: Planning: A Child or Youth Missing or Abducted; Youth Services Agreement; Placement Resources: Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories; Critical Incident and Death Protocol (QA-2014-001)
Legislative References:

PURPOSE: To outline the process for responding when a child or youth in the care or custody of a manager is absent without permission. The policy also applies to youth who are residing in a placement through a Youth Services Agreement.

POLICY:

1. A child or youth is determined to be absent without permission if they break curfew, leave their placement without permission, or do not return to their placement at the expected time. If they are absent without permission for more than five hours and cannot be located or are absent for less than five hours and there are risk factors the social worker determines are likely to impact the child or youth's immediate safety, they are considered missing.

2. Where information is received that a child or youth is absent without permission, the social worker shall first ensure the absence does not actually meet the definition of a missing or abducted child/youth. Where it is determined that the child/youth is actually missing or abducted, the Planning: A Child or Youth Missing or Abducted policy shall be followed.

3. Where a child or youth is determined to be absent without permission (absent), a social worker shall immediately:
   a) collaborate with the child or youth’s placement resource (e.g., foster parent or residential staff person) and determine what steps are to be taken to help locate and/or return the child or youth to their placement;
   b) consult with a supervisor to share all information known about the child or youth; and
   c) ensure any needed support is provided to the child or youth following their return.
PROCEDURES:

1. Social workers are usually informed by a placement resource (e.g., foster parent, residential staff person) that a child or youth is absent without permission. A placement resource is expected to immediately inform a social worker when a child or youth is absent without permission.

2. A social worker shall **immediately** consult with a supervisor and share all known information about the absent child or youth in order to make timely and effective decisions.

3. When a social worker determines that a child or youth is absent, they shall contact the placement resource to:
   a) discuss all information known about the child or youth;
   b) determine what steps may be taken to locate and return the child or youth to their placement; and
   c) determine who will be responsible for each step.

   **Notwithstanding the role of the placement resource in responding to a child or youth's absence, a social worker shall ensure that all agreed upon steps are undertaken.**

4. Actions taken to locate an absent child or youth may include conducting a search of the neighborhood or contacting friends and family for information. The placement resource and the social worker shall **immediately** share new information with each other, as new information may result in the social worker upgrading the child or youth’s status to missing or abducted.

5. Where a child or youth is absent without permission and has not returned to their placement during regular office hours, the social worker shall advise the placement resource to contact the on call social worker if the child or youth does not return within the five hour timeframe or immediately if the placement resource has new information that may indicate the child or youth is missing or abducted.

6. When a child or youth who is absent has been located but refuses to return to their placement, the social worker, in consultation with the supervisor, and where available, members of the in care planning team, shall develop a case specific response plan based on the needs of the child or youth. The social worker shall attempt to contact the child or youth on a daily basis and try to engage and support the child or youth, including, encouraging them to return to their placement. Where appropriate, other members of the in care planning team may assist the social worker in engaging the child or youth. The social worker shall document the response plan in the child or youth’s file.

7. If it is assessed that the child or youth is staying in an environment that may place them at risk, the social worker, in consultation with the supervisor, shall consider requesting the assistance of the police in returning the child or youth to their placement. Where the
assistance of the police is requested, the social worker shall document the response of the police to this request in the child or youth’s file.

8. The social worker, in consultation with the supervisor, shall review the need for additional requests for police assistance if circumstances change and/or new information is received regarding the safety and well-being of a child or youth.

9. The social worker shall advise a placement resource that when an absent child or youth returns, the placement resource shall immediately contact a social worker. The social worker shall discuss the following with the placement resource:
   a) the child or youth’s demeanor since his/her return;
   b) the circumstances surrounding the child or youth’s absence;
   c) whether a social worker or placement resource (e.g., foster parent, residential staff person) should follow up with the child or youth to discuss the absence;
   d) what factors may increase or decrease the likelihood of future absent episodes; and
   e) determine what steps may be taken to prevent future absent episodes.

When an absent child or youth returns, a social worker shall immediately notify the supervisor and any other parties who had been notified of the absence and/or contacted for information.

Out of Province Placements

10. The social worker from this province will provide the social worker in the receiving Province or Territory and the placement resource with a copy of the CSSD policy for children and youth who are absent without permission, as well as, the policy regarding missing and abducted children and youth, and respond to any questions they may have.

EXCEPTIONS TO POLICY: None

RELEVANT DOCUMENTS:

- Provincial/Territorial Protocol for Children, Youth and Families Moving Between Provinces and Territories (April 1, 2016), Appendix B
PLANNING: A CHILD OR YOUTH MISSING OR ABDUCTED

Policy no.: 3.15  
Effective Date: June 30, 2011  
Date Revised: December 1, 2011; September 12, 2016  
Policy Cross References: Planning: A Child or Youth Absent Without Permission; Youth Services Agreements; Placement Resources: Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories; Critical Incident and Death Protocol (QA-2014-001)  
Legislative References:  

PURPOSE: To outline the process for responding when a child or youth in the care or custody of a manager is missing or abducted. The policy also applies to youth who are residing in a placement through a Youth Services Agreement.

POLICY:

1. A child or youth is determined to be missing if he or she has been absent without permission for more than five hours and cannot be located or is absent for less than five hours and there are risk factors the social worker determines are likely to impact the child or youth’s immediate safety, as outlined in the glossary under the definition of a missing child/youth.

2. Where a child or youth is missing, a social worker shall:
   a) immediately notify a supervisor who shall immediately notify the manager;
   b) immediately notify all appropriate parties including: police; placement resource (e.g., foster parent(s), residential staff person(s)); parent(s); and where necessary, the on call social worker;
   c) ensure efforts are undertaken to locate and return the child or youth to their placement; and
   d) ensure support is provided to the child or youth, the placement resource, and parent(s) following the child or youth’s return.

3. Where a child or youth has been abducted, a social worker shall:
   a) immediately notify the police;
   b) immediately notify a supervisor who shall immediately notify the manager and regional director (RD). The RD shall notify the Assistant Deputy Minister of Service Delivery and Regional Operations (ADM-SDRO) as soon as possible. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO;
   c) ensure all other appropriate parties are notified immediately including: placement resource, parent(s), and the on call social worker;
d) ensure efforts are undertaken to locate and return the child or youth to their placement; and

e) ensure support is provided to the child or youth, placement resource and parent(s) following the child or youth's return.

4. When a media release or Amber Alert is issued or when a child or youth is missing and it is assessed to be a critical incident, the social worker shall immediately notify the supervisor who shall notify the manager and RD. The RD shall notify the ADM-SDRO as soon as possible. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO. A critical incident is defined as: an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth, such as: violence, assault, injury, other serious criminal matters, significant threats of self-injury/harm, or suicidal ideation requiring hospitalization beyond the initial assessment.

5. Where a child or youth is missing or has been abducted and a media release or Amber Alert is planned, a social worker shall advise the police that information regarding the child or youth's involvement with CSSD shall not be publicly released.

PROCEDURES:

Child or Youth Missing

Consultation with a Supervisor

1. A social worker shall immediately consult with a supervisor when informed that a child or youth is missing, share all known information with the supervisor, and advise the supervisor of what efforts are being made to locate the child or youth. Updates shall be provided to a supervisor on a daily basis, at minimum, during the child or youth’s absence.

2. The social worker shall complete the Missing or Abducted Child or Youth Report and submit it to the supervisor as part of the internal notification process.

3. Where the social worker, in consultation with the supervisor, assesses the child or youth’s missing episode to be a critical incident, the Critical Incident and Death Protocol (QA-2014-001) shall also be followed.

Working with the Placement Resource

4. In most situations, social workers are informed by the placement resource when a child or youth is missing. If a social worker is advised by another source, they shall contact the placement resource to:
   a) inform them of the situation;
   b) discuss all relevant information known about the child or youth and their last known whereabouts;
   c) determine what steps to take to locate the child or youth; and
d) identify who shall complete each step.

For example, a foster parent or residential staff person may contact the police to file the missing persons report and/or update other parties regarding the child or youth’s status. However, the social worker is responsible for ensuring the agreed upon steps, as noted above, are undertaken.

Police

5. A social worker shall ensure the police are immediately contacted and a missing persons report filed when a child or youth is missing. The following information shall be provided to the police:
   a) child or youth’s full name, date of birth, language and ethnicity;
   b) child or youth’s cell phone number, if applicable;
   c) name, address and phone number of the placement resource;
   d) CSSD social worker’s name and phone number;
   e) child or youth’s home community, if different from the placement community;
   f) physical description of the child or youth, including: height, weight, hair style and color, eye color, unique body markings and clothing worn when last seen;
   g) whether articles of clothing or personal items are missing from the child or youth’s room;
   h) a picture of the child or youth (digital picture is preferred);
   i) any known risk factors unique to the child or youth, including: physical, mental health, or medical issues;
   j) child or youth’s state of mind at the time of absence, if known;
   k) when the child or youth was last seen, by whom, and if the child or youth left with someone;
   l) known associates and frequented locations;
   m) names and contact information for family, significant others and friends;
   n) contact information for person(s) who are to be notified if the child or youth is located;
   o) where to transport the child or youth once located, if the police are willing to do so;
   p) any other information requested by the police; and
   q) any other information assessed by the social worker as being relevant.

Media Releases

6. Media releases regarding missing persons are conducted by the police on a case-by-case basis. A manager’s approval is required prior to a social worker making a request for a media release. At times, differences of opinion may arise between CSSD and the police about issuing a media release. Further discussions between the CSSD manager and the police may be required to resolve the matter. In the event that this situation occurs outside of regular business hours, the on call supervisor shall determine if further discussion is required with the police and follow up with the police where necessary.

7. The police may advise a social worker that they plan to issue a media release even if
CSSD has not made such a request. A manager shall immediately be notified in these situations to determine if further discussion with the police is required. In the event that this situation occurs outside of regular business hours, the on call supervisor shall determine if further discussion is required with the police and follow up with the police where necessary.

8. When a media release is being issued, a manager shall ensure the RD and the ADM-SDRO, are notified as soon as possible. When this occurs outside of regular business hours the on call supervisor shall notify the manager, RD and ADM-SDRO.

9. Where a child or youth is missing and a media release is planned, a social worker shall advise the police that information regarding the child or youth’s involvement with CSSD shall not be publicly released.

Parents

10. A social worker shall ensure the parent(s) is immediately notified when a child or youth is missing and is in: interim care, interim custody, temporary custody, or in care under a Protective Care Agreement.

11. When notifying the parent(s), the social worker shall:
   a) provide information about the circumstances surrounding the child or youth’s missing episode and the actions taken to locate the child or youth;
   b) update the parent(s) on a daily basis, at minimum, until the child or youth is located and seek information from the parent(s) that may assist in locating the child or youth; and
   c) ask the parent(s) to immediately provide any new information regarding the child or youth’s status to CSSD.

12. The social worker shall inform the parent(s) of the plan to make a request for a media release prior to making this request when a child or youth is in: interim care, interim custody, temporary custody, or in care under a Protective Care Agreement. The social worker shall also advise the parent(s) when the police decide to issue a media release and CSSD has not made such a request.

13. The decision to contact the parent(s) of a child or youth, who is in voluntary custody, or continuous custody, or of a youth residing in a placement through a Youth Services Agreement, will be made in consultation with a supervisor. The decision will be based on the parent’s relationship with the child or youth and whether they may have information that will assist in locating the child or youth.

Responsibilities of the Supervisor and Manager

14. The supervisor shall notify the manager by email when a child or youth is missing, including, during evenings, weekends, and statutory holidays.

15. Where a child or youth is missing and it is determined to be a critical incident, the
supervisor shall immediately notify the manager and RD. The RD shall then notify the ADM-SDRO as soon as possible. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO. A critical incident is defined as: an extraordinary or life threatening incident that directly impacts the safety and well-being of a child/youth, such as: violence, assault, injury, other serious criminal matters, significant threats of self-injury/harm, or suicidal ideation requiring hospitalization beyond the initial assessment.

16. When a child or youth is missing and it is determined to be a critical incident, the supervisor and manager shall also refer to and follow the Critical Incident and Death Protocol policy (QA-2014-001).

17. Where the manager notified is not the manager who has care/custody of the child or youth (e.g. child or youth is placed outside their home zone), the manager notified shall ensure the manager who has care/custody is notified, the next business day, or as soon as possible thereafter.

Monitoring Actions to Locate and/or Return a Missing Child or Youth

18. A social worker shall consult with a supervisor on a daily basis, at minimum, to review the actions taken to locate a child or youth. Daily contact with all parties who have participated in response efforts shall also occur.

19. When a child or youth who was missing has been located but refuses to return to their placement, the social worker, in consultation with the supervisor, and where available, members of the in care planning team, shall develop a case specific response plan based on the needs of the child or youth. The social worker shall attempt to contact the child or youth on a daily basis and try to engage and support the child or youth, including, encouraging them to return to their placement. Where appropriate, other members of the in care planning team may assist the social worker in engaging the child or youth. The social worker shall document the response plan in the child or youth’s file.

20. If it is assessed that the child or youth is staying in an environment that may place them at risk, the social worker, in consultation with the supervisor, shall consider requesting the assistance of the police in returning the child or youth to their placement. Where the assistance of the police is requested, the social worker shall document the response of the police to this request in the child or youth’s file.

21. The social worker, in consultation with the supervisor, shall review the need for additional requests for police assistance if circumstances change and/or new information is received regarding the safety and well-being of a child or youth.

Sharing Information between On-call and Day Staff Regarding a Missing Child or Youth

22. The sharing of information between a child or youth’s social worker and the on-call social worker is crucial. This will help ensure that the staff involved in decisions about
a missing child or youth have pertinent and up to date information.

23. The child or youth’s social worker shall inform the on-call social worker each day that a child or youth is missing using the *On Call Notification Form*.

24. Any follow up provided by the on-call social worker regarding a missing child or youth, including new notifications received during the on-call shift, shall be documented in the case notes and forwarded to the child or youth’s social worker *at the beginning of the next working day*. Managers shall ensure processes are in place in their respective zones to facilitate the sharing of information between on-call and day staff.

**Return of a Child or Youth who had been Missing**

25. Once a missing child or youth has been located, a social worker shall *immediately* notify the placement resource, supervisor, manager (by email), and the child or youth’s parent(s) and police, where required. Where the ADM-SDRO had been notified of the missing child or youth, the manager, shall notify the RD, who shall notify the ADM-SDRO that the child or youth has been located. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO. Where a child or youth is in continuous custody or a youth is residing in a placement through a Youth Services Agreement, their parent(s) should be notified only if they had been informed that the child or youth was missing. The foster parent(s) or residential staff person(s) may also assist the social worker in notifying appropriate parties: *however, it is the social worker’s responsibility to ensure all appropriate parties have been notified.*

26. When the child or youth is located, the social worker shall complete the *Missing or Abducted Child or Youth Located Report* and submit it to the supervisor who shall submit it to the manager as part of the internal notification process.

27. Once a child or youth has returned to a placement, a social worker shall contact the child or youth *within 24 hours* to provide support. In situations where the child or youth’s immediate safety was, or is, identified as a concern, a meeting shall occur with the child or youth as soon as possible and *within 24 hours*. At minimum, the social worker shall:
   a) assess and attend to the child or youth’s urgent needs and promptly arrange additional support, if needed (e.g., medical attention, crisis counselling, interview with the police if the child or youth has been the victim of a crime);
   b) discuss with the child or youth what happened during the time they were missing;
   c) determine if additional supports are needed in the short term; and
   d) assess how future missing episodes may be prevented.

28. A social worker shall also discuss the missing episode with the child or youth’s placement resource to:
   a) discuss the circumstances regarding the child or youth’s missing episode;
   b) obtain information about the child or youth’s demeanor since their return;
   c) discuss what factors may increase or decrease the likelihood of future missing episodes; and
   d) determine what steps may be taken to prevent future missing episodes.
29. Support shall also be provided to the placement resource (e.g., foster parent, residential staff person) who may have been negatively impacted by the child or youth's missing episode.

30. A social worker should also discuss the child or youth's missing episode with the parent(s) and provide support, where appropriate. Support may also be extended to siblings, other family members, and others who have a significant relationship with the child or youth.

31. In situations where a child or youth is repeatedly missing, a social worker shall arrange a case conference with: the placement resource; the child/youth, where age and developmentally appropriate; the parent(s), depending on the child/youth's care/custody status and level of involvement; and other professionals involved with the child/youth, as appropriate. The purpose of the case conference is to:
   
   a) identify reasons why the child/youth repeatedly goes missing;
   b) identify, if possible, where the child/youth goes, with whom, and what they do while missing;
   c) determine if additional supports are required to assist the child or youth, such as a referral to counselling or other community supports;
   d) develop a safety plan with the child or youth to reduce the likelihood of harm should a future missing episode occur; and
   e) develop and document a plan to prevent or reduce missing episodes. The social worker shall ensure the placement provider has a copy of the plan and that the plan is monitored and updated as necessary, based on the child/youth's needs and whether the plan is reducing/eliminating missing episodes.

Child or Youth Abducted

Police

32. Where a child or youth has been abducted, a social worker shall ensure the police are immediately contacted and a report is filed indicating that a child or youth has been abducted. The following information shall be provided to the police:

   a) all known information regarding the circumstances surrounding the child or youth's abduction;
   b) child or youth's full name, date of birth, language and ethnicity;
   c) child or youth's cell phone number, if applicable;
   d) name, address and phone number of the placement resource;
   e) CSSD social worker's name and phone number;
   f) child or youth's home community, if different from the placement community;
   g) physical description of the child or youth, including: height, weight, hair style and color, eye color, unique body markings, and clothing worn when last seen;
   h) whether articles of clothing or personal items are missing from the child or youth's room;
   i) a picture of the child or youth (digital picture is preferred);
j) any known risk factors unique to the child or youth, including: physical, mental health, or medical issues;
k) child or youth’s state of mind at the time of the abduction, if known;
l) when the child or youth was last seen, by whom, and if the child or youth left with someone;
m) known associates and frequented locations;
n) names and contact information for family, significant others and friends;
o) contact information for person(s) who are to be notified if the child or youth is located;
p) where to transport the child or youth once located;
q) any other information requested by the police; and
r) any other information assessed by the social worker as being relevant.

Consultation with a Supervisor

33. The social worker shall immediately consult with a supervisor when informed that a child or youth has been abducted. The supervisor shall immediately notify the manager, and RD of the abduction and the RD shall notify the ADM-SDRO as soon as possible. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO. The social worker shall provide updates to the supervisor on a daily basis, at minimum, including what efforts are being made to locate the child or youth.

34. The social worker shall complete the Missing or Abducted Child or Youth Report and submit it to the supervisor as part of the internal notification process.

35. A child or youth abduction is considered a critical incident and the social worker, in consultation with the supervisor, shall also ensure the Critical Incident and Death Protocol (QA-2014-001) is followed.

36. Where the manager notified is not the manager who has care/custody of the child or youth (e.g. child or youth is placed outside their home zone), the manager notified shall ensure the manager who has care/custody is notified, the next business day, or as soon as possible thereafter.

Working with the Placement Resource

37. The social worker shall immediately contact the placement resource to ensure they are aware that a child or youth has been abducted and:
   a) provide information about the circumstances surrounding the child or youth’s abduction;
   b) discuss all relevant information known about the child or youth and their last known whereabouts and request that they notify the social worker and police immediately if they become aware of any new information that may assist in the search for the child or youth;
   c) discuss their role in working with the social worker and the police to locate the child or youth; and
   d) update them on a daily basis, at minimum, until the child or youth is located.
Parents

38. A social worker shall ensure the parent(s) is immediately notified when a child or youth has been abducted and is in: interim care, interim custody, temporary custody, or in care under a Protective Care Agreement.

39. When notifying the parent(s), the social worker shall:
   a) provide information about the circumstances surrounding the child or youth’s abduction and the actions taken to locate the child or youth;
   b) seek any information the parent(s) may have that could assist the police and request that they notify the social worker or the police immediately if they have any new information; and
   c) update the parent(s) on a daily basis, at minimum, until the child or youth is located.

40. The decision to contact the parent(s) of a child or youth who is in voluntary custody or continuous custody, or of a youth residing in a placement through a Youth Services Agreement, will be made in consultation with a supervisor. The decision will be based on the parent’s relationship with the child or youth and whether they may have information that will assist in locating the child or youth.

Amber Alerts

41. Amber Alerts can only be released by the police. If a child or youth has been abducted, the police may decide to issue an Amber Alert to provide the public with immediate and up-to-date information about the child or youth through widespread media broadcasts soliciting the public’s help in the safe and swift return of the child or youth.

42. A social worker shall immediately consult with a supervisor and manager if the police are planning to issue an Amber Alert. The police require the written permission of a parent before an Amber Alert can be issued. In the event that this situation occurs outside of regular business hours, the social worker shall consult with the on call supervisor.


44. When a decision has been made by the police to issue an Amber Alert the social worker shall immediately notify the supervisor who shall notify the manager and RD. The RD shall notify the ADM-SDRO as soon as possible. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO.

Sharing Information between On-call and Day Staff Regarding an Abducted Child or Youth

45. The sharing of information between the child or youth’s social worker and the on-call social worker is crucial. This will help ensure that the staff involved in decisions
about an abducted child or youth have pertinent and up to date information.

46. The child or youth’s social worker shall inform the on-call social worker each day that a child or youth is abducted using the On Call Notification Form.

47. Any follow up provided by the on-call social worker regarding an abducted child or youth, including new notifications received during the on-call shift, shall be documented in the case notes and forwarded to the child or youth’s social worker at the beginning of the next working day. Managers shall ensure processes are in place in their respective zones to facilitate the sharing of information between on-call and day staff.

Return of a Child or Youth who had been Abducted

48. Once an abducted child or youth has been located, a social worker shall immediately notify the; placement resource, supervisor, manager (by email), and the child or youth’s parent(s) and police where required. The manager shall notify the RD, who shall ensure the ADM-SDRO is notified of the child or youth’s return. When this occurs outside of regular business hours, the on call supervisor shall notify the manager, RD and ADM-SDRO. Where a child or youth is in voluntary custody, continuous custody, or is youth residing in a placement under a Youth Services Agreement, their parent(s) should be notified only if they had been informed that the child or youth had been abducted. A foster parent(s) or residential staff person(s) may assist the social worker in notifying appropriate parties; however, it is the social worker’s responsibility to ensure all appropriate parties have been notified.

49. When the child or youth is located, the social worker shall complete the Missing or Abducted Child or Youth Located Report and submit it to the supervisor who shall submit it to the manager as part of the internal notification process.

50. The social worker shall discuss with the police any required follow up, including if the police will need to interview the child or youth and if there are any safety measures that should be implemented to prevent future abductions.

51. Once a child or youth has returned to a placement, a social worker shall contact the child or youth within 24 hours to provide support. In situations where the child or youth’s immediate safety was, or is, identified as a concern, a meeting shall occur with the child or youth as soon as possible and within 24 hours. At minimum, the social worker shall:
   a) assess and attend to the child or youth’s urgent needs and promptly arrange additional support, if needed (e.g., medical attention, crisis counselling, interview with the police);
   b) discuss with the child or youth what happened during the time they were abducted; and
   c) determine if additional supports are needed in the short term.

52. A social worker shall also discuss the abduction with the child or youth’s placement resource to:
   a) discuss the circumstances surrounding the child or youth’s abduction;
b) obtain information about the child or youth’s demeanor since their return;
c) determine what steps may be taken to reduce the likelihood of a future abduction;
and
d) develop a plan with the placement resource to ensure necessary support is provided
to the child or youth.

53. Support shall also be provided to the placement resource (e.g., foster parent, residential
staff) who may have been negatively impacted by the child or youth’s abduction.

54. A social worker should also discuss the child or youth’s abduction with the parent(s) and
provide support, where appropriate. Support may also be extended to siblings, other
family members, or others who have a significant relationship with the child or youth.

Out of Province Placements

55. In accordance with the Provincial/Territorial Protocol for Children, Youth and Families
Moving Between Provinces/Territories (PT Protocol), a receiving Province or Territory (PT)
will report any significant events, including when a child or youth is abducted or missing, to
the originating PT immediately or as soon as reasonably possible.

56. The process for a receiving PT notifying this province when a child or youth is abducted or
missing shall be outlined in the Case Planning and Management section of the
Interprovincial Placement Agreement (IPPA). The social worker shall:
a) provide a copy of CSSD policy for children and youth who are absent without
permission, as well as, the policy for missing and abducted children and youth, to
the designated social worker in the receiving PT and the placement resource where
the child or youth resides; and
b) discuss expectations regarding how the placement resource (e.g. foster home,
residential treatment program) and the receiving PT will respond when a child or
youth from this province is missing or has been abducted.

EXCEPTIONS TO POLICY: None

RELEVANT DOCUMENTS:

- Missing or Abducted Child or Youth Report Form
- Missing or Abducted Child or Youth Located Report Form
- On-Call Notification Form
- Provincial/Territorial Protocol for Children, Youth and Families Moving Between
Provinces/Territories (April 2016), Appendix B
- Interprovincial Placement Agreement Form
GLOSSARY OF TERMS

Abducted Child/Youth: a child or youth who has been led away, in secret or by force, from their residence, school or community.

Bridging Provision: allows for an existing supervision or temporary custody order, granted pursuant to Subsection 32(2) of the CYCP Act, to remain in effect until an application for a subsequent order is heard in court and an order is granted. For the Bridging Provision to come into effect, the application for a subsequent order must be filed with the court before the expiration of the existing order.

Care: the physical daily care and nurturing of a child/youth (Subsection 2(1)(b) of the CYCP Act).

Carers: Individuals recruited and assessed by a Service Provider and approved by CYFS to provide a safe and stable family-based home environment for children/youth in care.

Child: a person actually or apparently under the age of 16 years (Subsection 2(1)(c) of the CYCP Act).

Child Maltreatment: the non-accidental infliction of injury or harm to a child by a parent, or the injury or harm of a child by another person and the parent does not protect the child. Child maltreatment includes the physical, sexual or emotional abuse of a child.

Child Protection Referral: Information received under Section 11 of the CYCP Act that a child is, or may be, in need of protective intervention.

Child/Youth Absent Without Permission: a child or youth who breaks curfew, leaves their placement without permission, or does not return to their placement at the expected time.

Client Disclosure File: a file created separate from the client file to maintain all correspondence and work completed regarding a request for information from a CYFS record.

Client File: an electronic or hard copy of all client documentation and interventions.
Cohabitating Youth: two people who are residing together in a conjugal relationship outside of marriage, and the relationship fits one or more of the following criteria:
a) the two people share economic interdependence;
b) there are parental connections between the two people based on evidence of shared dependents and the sharing of parental roles; or
c) the societal perception of the two people is that they present themselves as a couple in the community.

Collateral Source or Contact: A person, professional or agency that is connected to the child/youth or family that may have information about the alleged maltreatment and/or about the family in general. The information can assist in clarifying and collaborating information about significant events or issues which have been provided by parents and children.

Continuous Custody: a custodial arrangement in which a manager becomes the sole custodian of the child/youth and has the right to make all decisions regarding the child/youth including medical decisions. The manager or a social worker may consent to the provision of medical treatment for the child/youth, and the manager may consent to the adoption of the child/youth under the Adoption Act.

Court: the Supreme Court of Newfoundland and Labrador Trial Division (Family) or the Provincial Court.

Critical Incident a critical incident (CI) is an incident of extraordinary or life threatening nature that directly impacts the safety and well-being of a child/youth such as violence, assault, injury and other serious criminal matters. A CI includes significant threats of self-injury, self-harm or suicidal ideation requiring hospitalization beyond the initial assessment and treatment.

Custody: the rights and responsibilities of a parent with respect to a child/youth (Subsection 2(1)(e) of CYCP Act).

Day: every day (except Saturdays, Sundays, and government holidays recognized by field services) unless the time period specified is six (6) days or more in which case “days” means calendar days.

Educational or Rehabilitation Program: includes a post-secondary certificate, diploma or degree program, a high school equivalency program, or pre-employment program;
employment, life skills or career development program; mental health and addictions treatment program, day program for youth with developmental disabilities or a physical rehabilitation program prescribed by the youth’s physician.

**Emergency Placement Homes (EPH)**

are staffed living arrangements that offer 24 hour emergency care to children and youth for a specified period to either assess a child or youth’s placement needs, and/or to transition a child or youth to a longer term placement.

**Excepted Information:**

information contained in a client record that is protected from release and includes referral sources, information that is subject to solicitor-client privilege, information pertaining to an adoption of a child (Adoption Act), information under the Youth Criminal Justice Act, information that may interfere with a criminal investigation and/or third party information.

**Facsimile:**

a record produced by electronic means, or a written record of a telephone conversation made by both parties to the conversation while it is in progress, and which the parties have confirmed as to its accuracy by reading their record of the conversation to one another at the end of the conversation (as per Subsection 22(3) of the CYCP Act).

**Family Based Care Pilot Program:**

A Pilot Program of CYFS whereby a Service Provider uses a family-based carer model to provide long-term or short-term placements for children and/or youth in care, where it has been determined to be an extraordinary circumstance and these children/youth cannot be placed in an existing placement resource.

**Foster Parent:**

a person with whom a child/youth (who is in the care or custody of a manager) is placed for care with the approval of a manager and who, by agreement with a manager, has assumed responsibility for the care of the child/youth. A foster parent includes a family member or a person significant to the child/youth but does not include the parent of the child/youth (Subsection 2(1)(h) of the CYCP Act).

**Government Record:**

records created or received by a public body in the conduct of its affairs and include a cabinet record, transitory record or abandoned record (Subsection 2(b.1) of the Management of Information Act).
Group Homes: are staffed residential settings that provide group care for children and youth who have complex social, emotional, behavioural and developmental needs and as a result require a level of residential service that cannot be provided through a less structured, family based setting.

Equivalency Program: include Adult Basic Education (ABE) programming, General Education Development (GED) preparation programs and literacy programs to prepare for ABE or GED program enrollment.

In Care Planning Team: a team of individuals involved in planning for the child/youth in care. The team must include the social worker for the child/youth and the social worker for the child/youth’s parent(s); the child/youth (where developmentally appropriate); the parent(s) of the child or youth (if they are actively involved), foster parent(s) or residential staff person; and may also include other professionals working with the child/youth including extended family, significant others or other community partners.

In Care Progress Report (IPR): a comprehensive written report developed for each child/youth in care/custody by the social worker in consultation with the child/youth’s planning team. The IPR will document the child/youth’s progress on a number of developmental dimensions, outline the supports and services the child/youth requires, identify who will be responsible for linking the child/youth to identified supports and services, and monitor the goals and outcomes for the child/youth. The IPR will also monitor and document the implementation of the child/youth’s contact with their parent(s), siblings, extended family, significant others, their community and culture as outlined in the Plan for the Child filed with the Court.

Income: includes earned and unearned income:

a) Earned income - money paid to a youth in exchange for labor;

b) Unearned income - money received by a youth that is not in exchange for labour, such as parental support (court or non-court ordered) paid directly to a youth, employment insurance benefits, pension income or stipends paid to youth to attend training.
Information: personal information obtained under the CYCP Act or a predecessor Act that is held in government records by, or is in the custody of or under the control of the Department, and includes information that is written, photographed, recorded or stored in any manner.

Individualized Living Arrangements (ILAs) are staffed living arrangements specific to children and youth who have extraordinary social, emotional, behavioral, development and medical needs. Children and youth with these needs cannot be appropriately matched with a foster home or group home.

Interim Approval: a one-time temporary approval of a regular foster home. The full regular foster parent PRIDE approval process must be completed within the time frames specified in the Regular Foster Home Approval Process policy.

Interim Care: a care arrangement for a child who is removed under Section 20 of the CYCP Act. The manager has interim care of the child until the child is returned, under Section 45, to the parent from whom the child was removed, or until a judge makes an order at a Presentation Hearing under Section 31. While the manager has interim care of the child the manager, or a social worker, may authorize a qualified health practitioner to examine the child and consent to necessary health care for the child where the parent cannot be contacted if, in the opinion of a qualified health practitioner, health care should be provided without delay (as per Section 24 of the CYCP Act).

Interim Custody: an order issued by the court at a Presentation Hearing or in accordance with Subsection 31(1)(c) of the CYCP Act where the child is placed in or remains in the custody of a manager until the conclusion of the Protective Intervention Hearing.

Interim Services: residential and supportive services offered to meet the youth’s basic needs (food, clothing, shelter, and physical safety) until assessment of the youth’s need for protective intervention is completed.

Investigation Plan: the plan for conducting the protection investigation. It minimally identifies the social worker assigned to the investigation; identifies who will conduct the interviews; when and where the interviews will be conducted; what collaterals may be relevant and required to complete the investigation; and whether police involvement will be required.
Judge: a judge of the court.

Kinship Care Agreement: a written agreement that enables a parent to voluntarily transfer the care of his/her child to an approved kinship caregiver unless custody is already transferred pursuant to s.32(2)(b) of the CYCP Act; and enables a social worker to place a child in a kinship living arrangement with an approved caregiver.

Kinship Caregiver: members of the extended family or a significant other approved to care for a child or youth under a Kinship Service Program.

Kinship Services: a program available to provide supportive and financial services to approved kinship caregivers who are willing and capable of providing care to a child who is in need of protective intervention and requires an out of home living arrangement.

Level 1: the first level of the continuum of care which includes kinship homes, interim approved regular foster homes, and approved relative/significant other foster homes that have not completed PRIDE Pre-service sessions.

Level 2: the second level of the continuum of care, which consists of approved relative/significant other and regular foster homes that have completed PRIDE Pre-service sessions.

Level 3: the third level of the continuum of care, which consists of approved specialized foster homes.

Level 4: the forth level of the continuum of care which consists of staffed residential placements resources including Emergency Placement Homes, Group Homes, and Individualized Living Arrangements.

Live-in-Model verses Rotational Staff Model: in Level 4, a Group Home, EPH or ILA may be staffed using a Live-in Model which means that children and/or youth are cared for by an in-house “parent”, who is supported by rotating staff or a Rotational Staff Model which means that children and/or youth are cared for by a rotational staff complement 24 hours per day.

Manager: a person appointed by the Minister of the Department of Child, Youth and Family Services who exercises the powers and performs the duties that are conferred or imposed upon them by the CYCP Act.

Missing Child/Youth: a child or youth who is absent without permission and
cannot be located for more five (5) hours, or has been absent without permission for less than five (5) hours and:
a) is under 12 years of age;
b) has a disability (i.e. physical, intellectual, cognitive);
c) has a recent and repeated history of drug/alcohol/solvent use;
d) has suspected or known mental health issues;
e) has a diagnosed mental illness;
f) has a recent history of suicide attempts or suicidal ideation;
g) has a recent history self-harming behaviors;
h) there are severe weather conditions (i.e. blizzard);
i) has a medical condition that requires monitoring (i.e. diabetes and insulin dependent);
j) is suspected of or is associating with individuals who pose an immediate safety threat to the child/youth (i.e. violent offenders, pimps); and
k) any other risk factor that the social worker determines is likely to impact the child or youth's immediate safety.

Missing Youth: a youth who has signed a Youth Services Agreement and is living independently in the community is considered missing when:
a) an individual contacts CYFS to report they have not seen or heard from a youth for a specified period of time and the lack of contact is out of character for the youth;
b) the youth did not arrive for a scheduled CYFS appointment and, concerned for the youth's safety and well-being, the youth's social worker designates the youth as missing; or
c) the police contact CYFS to report that a missing persons report has been filed on the youth.

Necessary Health Care: health care that is recommended by a qualified health practitioner. The treatment is such that, in the opinion of the qualified health practitioner, it should be provided without delay.

Necessary Medical Treatment: medical treatment that is recommended by a qualified health practitioner. The treatment is such that, in the opinion of the qualified health practitioner, treatment should be provided without delay.

Net Pay: the remaining earnings after deductions from gross earnings are made.

Non-Custodial Parent: a parent of a child/youth who does not have custody but
regularly exercises right of access.

**Non-Offending Parent:** the parent not alleged to be involved in the maltreatment of the child.

**Ongoing Protective Intervention Services:** Services and interventions provided by CYFS to children (and their families) determined to be in need of protective intervention due to a risk of future maltreatment.

**Order Set Aside:** where a youth’s written request to have an order of continuous custody set aside has been approved, the order is no longer in effect and a manager no longer has legal responsibility for the youth. Where an order is set aside the manager does not have a legal right to make decisions or consent to medical treatment on the youth’s behalf.

**Out of Province Placement:** An approved placement for a child or youth in care in a residential program located in a province/territory outside of Newfoundland and Labrador. These placements provide specialized care and/or treatment for children and youth. This specialized care may be provided in a residential group home setting and/or a foster home setting overseen by a treatment agency.

**Parent of a Child/Youth:** includes:

a) the custodial mother;
b) the custodial father;
c) a custodial step-parent;
d) a non-custodial parent who regularly exercises, or attempts to exercise, right of access to the child/youth;
e) a person to whom custody of a child/youth has been granted by a written agreement or by a court order; or
f) a person who is responsible for the child or youth’s care and with whom the child or youth resides, except a foster parent

**Party:** the person(s) named in the Application as an applicant or respondent in a court proceeding.

**Peace Officer:** a member of the Royal Newfoundland Constabulary or a member of the Royal Canadian Mounted Police, and includes a person approved by the Attorney General to perform the duties of a peace officer (Section 2(n) of the CYCP Act).
Personal Service: the person who is being served should personally receive the documents.

Placement: an approved foster home, group home, EPH, ILA or an out-of-province residential treatment program in which a child or youth is residing.

Placement Card: a template containing specific information about a child or youth that is given to a foster parent or a residential care provider at the time of placement.

Plan for the Child: the plan for the child(ren) (in accordance with Section 29 of the CYCP Act) that is filed with the court after a social worker has filed an Application for Protective Intervention Hearing requesting a supervision or custody order. The Plan for the Child outlines prior involvement with the child(ren) and family, the child protection concerns, and the recommended services and interventions to address these concerns. In cases where the child(ren) has been removed and is in Care, the Plan for the Child outlines the efforts planned to maintain the child(ren)’s contact with the parent, family or other person significant to the child(ren) and a description of the arrangements made or being made to recognize the importance of the child(ren)’s identity and cultural and community connections.

Preliminary Approval: a short term, expedited approval of a relative/significant other foster home which enables a child/youth to be quickly and safely placed with a familiar person(s). The full approval process must be completed within the time frames specified in the Relative/Significant Other Foster Home Approval policy.

Presentation Hearing: an initial hearing held informally before a judge to consider the circumstances surrounding the child(ren)’s removal, and to determine whether there is sufficient evidence to proceed to the Protective Intervention Hearing. The court shall determine what interim order is appropriate until a more comprehensive hearing is held to determine whether the child(ren) are in need of protective intervention. The Presentation Hearing is an important prelude to the Protective Intervention Hearing but may result in the judge making a final order (in accordance with Section 32 of the CYCP Act), thus removing the necessity for a Protective Intervention Hearing.

PRIDE: Parent Resources for Information Development and Education. A standardized competency-based model for recruiting, preparing, and assessing foster and adoptive parents. It also
refers to ongoing training components for approved foster families.

Proceeding: any appearance in court resulting from a court application.

Protective Intervention Hearing: a hearing held after a Presentation Hearing if the matter has not been resolved at the Presentation Hearing. At the Protective Intervention Hearing, the judge will hear evidence, determine whether a child is in need of protective intervention and give a final order (in accordance with Subsection 32(2) of the CYCP Act) with respect to the application before the court.

Protection Investigation: the process of responding to a complaint of alleged child maltreatment to assess the immediate risk to the child, and to determine the child’s need for protective intervention. It involves interviewing and observing the child in need of protective intervention and interviewing their siblings, parents and collateral sources; gathering information through the agency’s records and through checks with the police, school, medical records, and any other means necessary. Depending on the allegation, the investigation may require joint interviews with the police.

Protective Care Agreement: a written agreement that allows a parent(s) to transfer care and supervision of a child to a manager of CYFS. A Protective Care Agreement does not transfer custody of the child to a manager.

Provincial/Territorial Protocol on Children, Youth and Families Moving Between Provinces and Territories: a framework for the provision of consistent, quality services to children and families moving between provinces and territories.

Public Body: a department created under the Executive Council Act, or a branch of the executive government of the province; a corporation, the ownership of which, or a majority of shares of which, is vested in the Crown; a corporation, commission, board or body, the majority of the members of which, or the majority of members of the board of directors of which, are appointed by an Act, the Lieutenant-Governor in Council or a
minister, a local public body, or the House of Assembly and statutory offices, as defined in the House of Assembly Accountability, Integrity and Administration Act (Subsection 2(p) of ATIPPA).

**Qualified Health Practitioner:**
a physician, nurse, nurse practitioner, licensed practical nurse, dentist or dental hygienist.

**Reasonable Grounds:** for child protection purposes, some reasonable and reliable information upon which the social worker determines that a child may be in need of protective intervention.

**Record:** a correspondence, memorandum, form, paper, parchment, manuscript, map, plan, drawing, painting, print, photograph, magnetic tape, computer disc, microform, electronically produced document and other documentary material regardless of physical form or characteristic (Subsection 2(f) of MI Act). Transitory records are not included.

**Referral Source:** any individual who reports concerns of alleged abuse or maltreatment of a child to CYFS under Section 11 of the CYCP Act. The referral source may be a self-identified person or a person who wishes to remain anonymous.

**Relative/Significant Other Foster Parent:** a family member or person significant to the child/youth with whom a child/youth (who is in the care or custody of a manager) is placed for care with the approval of a manager and who, by agreement with a manager, has assumed responsibility for the care of the child/youth.

**Relevant Information:** all information pertinent to CYCP court proceedings including information generated by CYFS, statements by experts and other prospective witnesses, and all other evidence required to present the manager’s application that is not protected by law from production to third parties.

**Removal:** a legal procedure whereby a child/youth, believed to be in need of protective intervention, has been removed from his/her parent’s care and placed in the interim care of a manager until a judge makes an order at the Presentation Hearing.

**Repudiate:** to refuse to accept or support; to have nothing to do with; to renounce; to reject.
Residential Placement: an approved board, lodging and associated supervisory, shelter or group care for a child/youth who is in the care or custody of a manager (Subsection 2(1)(q) of the CYCP Act).

Residential Services: includes monthly financial and supportive services provided to youth in need of protective intervention who are living outside the parental home and who have signed a Youth Services Agreement.

Residing Independently In the Community: a youth who is residing outside the parental home in an apartment, board, lodging or bedsitting arrangement and has signed a Youth Services Agreement with CYFS.

Screening and Prioritization Guidelines: a guide to assist a social worker’s professional assessment of information when screening and assigning a response priority to child protection referrals.

Screening Decision: a decision made by a social worker and supervisor whether or not to conduct a protection investigation of a referral of alleged child maltreatment.

Service Agreement a signed contract between CYFS and a Service Provider which defines the Services to be provided by the Service Provider and the terms and conditions under which these services are to be provided.

Severing: the process of reviewing the client file and removing information that is excepted from release in disclosure.

Social Worker: a person registered under the Social Workers Association Act and employed by the Department of Child, Youth and Family Services.

Solicitor-Client Privilege: confidential information/advice intended only for the client. This may include letters, emails, memos, faxes or contact notes that relate to legal opinions, legal strategy, and/or litigation.

Subsequent Order: an order granted when an application is filed with the court for another order under Subsection 32(2) of the CYCP Act.

Substituted Service: a type of service, other than personal service, permitted by the Rules of the Supreme Court, 1986 or the rules of the Provincial Court.
Summer Employment: income earned between the months of June and August as outlined in the Youth with Income policy.

Supervision Order: an order issued by the court at a Presentation Hearing in accordance with Subsection 31(2)(b)(c) or (d) of the CYCP Act, or at a Protective Intervention Hearing in accordance with Subsection 32(2)(a) or (b) of the CYCP Act.

Supportive Services: services provided to youth who have signed a Youth Services Agreement. Supportive services may include social work support such as facilitating referrals to community agencies, crisis intervention, and case management services. Emergency funding for items or services that cannot be obtained from another source may also be provided.

Telewarrant: a time limited written order issued by a judge that gives a social worker the authority to enter premises, by force, where necessary to remove a child. A telewarrant is sought when a social worker cannot appear in person before a judge. By obtaining a telewarrant a social worker is receiving a judge’s sanction to remove the child. A telewarrant also provides the authority for the police to become involved in assisting with the removal.

Temporary Custody: a custodial relationship in which the manager has custody of a child for a period specified by a court order and the manager or a social worker has the right to make all decisions regarding the child with the exception of medical consent. The manager or a social worker may consent to necessary medical treatment for the child as recommended by a qualified health practitioner, where the child's parent is unavailable or refuses to consent to the treatment.

Temporary Custody Order: an order issued by the court at a Presentation Hearing or Protective Intervention Hearing in accordance with Subsection 32(b) or (c) CYCP Act.

Third Party: in relation to a request for access to a record or for personal information, third party refers to a person, group of persons or organization other than the person who made the request or a public body (Subsection 2(t) of ATIPPA).

Timely Manner: reasonable amount of time so as to allow the solicitor(s) representing the parent(s), or the parents representing themselves if they are not represented by legal counsel, to review
the disclosure and be able to prepare for the court proceeding.

Transitory Record: a government record of temporary usefulness in any format or medium having no ongoing value beyond an immediate and minor transaction or the preparation of a subsequent record (Section 2(h) of MI Act). Transitory records include jot notes and draft documents.

Warrant: is a time limited written order issued by a judge that gives a social worker the authority to enter a premises, by force, where necessary to remove a child. By obtaining a warrant, a social worker is receiving a judge’s sanction to remove the child. A warrant also provides the authority for the police to become involved in assisting with the removal.

Youth: a person who is 16 years of age or over but under 18 years of age.

Youth Screening and Assessment Tool (YSAT): a tool used by the social worker to complete an initial screening (intake) and assessment of a youth’s need for protective intervention.
# Missing or Abducted
Child or Youth Located Report

Please complete per child/youth and submit to the Zone Manager, when a child or youth who has been abducted or has been missing, is located.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth (YYYY-MM-DD)</th>
<th>Care/Custody Status</th>
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<table>
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<tr>
<th>Missing From (Placement Type)</th>
<th>Zone</th>
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<tr>
<th>Time Reported Missing (e.g. 3:30 PM)</th>
<th>Date Missing (YYYY-MM-DD)</th>
<th>Time Returned (e.g. 3:30 PM)</th>
<th>Date Returned (YYYY-MM-DD)</th>
</tr>
</thead>
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</table>

Total Days Missing

Notifications: (select all that apply)

- Parent
- Zone Manager
- Police
- Provincial Office
- Media
- Regional Director
- Other (please specify)

Name of Social Worker

Date (YYYY-MM-DD)
Missing or Abducted Child or Youth Report

Please complete per child/youth and submit to the Zone Manager, when a child or youth has been abducted or is missing.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth (YYYY-MM-DD)</th>
<th>Care/Custody Status</th>
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</table>

Notifications: (select all that apply)

- Parent
- Zone Manager
- Police
- Provincial Office
- Media
- Regional Director
- Other (please specify)

Name of Social Worker

Date (YYYY-MM-DD)
MEMO

TO: All CSSD staff
FROM: Joanne Cotter, Provincial Director (Acting)
DATE: September 12, 2016
RE: Revisions to the Protection and In Care Policy and Procedures Manual (June 2011)

I am pleased to advise that the Protection and In Care Policy and Procedures Manual (June 2011) has been updated effective September 12, 2016 to reflect revisions to the following:

- Policy 3.14 A Child or Youth Absent Without Permission
- Policy 3.15 A Child or Youth Missing or Abducted
- Glossary of Terms

These two policies have been revised to: reflect changes to Departmental notification processes; add procedures regarding children and youth who refuse to return to their placements; and include the new Critical Incident and Death Protocol and Provincial Territorial Protocol of Children, Youth and Families Moving Between Provinces and Territories.

In addition to the policies, the Missing or Abducted Child or Youth Report form previously submitted to the Manager of Service Delivery and Regional Operations has been replaced by the following forms, which will now be submitted to the Zone Manager:

- Missing or Abducted Child or Youth Report Form
- Missing or Abducted Child or Youth Located Report Form

Staff are required to review these revised policies and update hard copies in their Protection and In Care Policy and Procedures Manuals. The new forms will be effective immediately and staff are advised to delete any hard copy or electronic versions of the previous form. The manual will be updated on the Department’s Intranet and website and the new forms will be placed on the Intranet.

Two teleconference sessions will also be offered for staff who would like to discuss any of the changes to these two policies. Staff will be advised shortly of the date and time for these two sessions.

If you have any questions, please discuss with your supervisors and zone managers.

Sincerely,

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
### Taylor, Jennifer

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Regroup re: Next Steps for Advancing Critical Incidents and Death Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Executive Boardroom, CCSD, 2nd Floor, West Block</td>
</tr>
<tr>
<td>Start:</td>
<td>Fri 9/30/2016 1:30 PM</td>
</tr>
<tr>
<td>End:</td>
<td>Fri 9/30/2016 2:00 PM</td>
</tr>
<tr>
<td>Recurrence:</td>
<td>(none)</td>
</tr>
<tr>
<td>Meeting Status:</td>
<td>Accepted</td>
</tr>
<tr>
<td>Organizer:</td>
<td>Eddy, Tracey</td>
</tr>
<tr>
<td>Required Attendees:</td>
<td>Abbott, John; Vivian-Walsh, Janet; Jacobs, Heather; Cooper, Bruce; Day, Elizabeth; Manuel, Sue; Blackmore, Diane; Hunt, Deanne</td>
</tr>
</tbody>
</table>
Good Morning All,
I want to flag a number of high priority issues that are important for us to be on top of this week as there are deadlines approaching:

Happy Monday!
Bruce
Please see the second of four transcripts from Carol Chafe on Issues and Answers:

ONGOING INVESTIGATIONS: "Ms. Chafe" talks about the ongoing investigations into child's deaths and what will happen to them once she steps down. She discusses some of the issues she identified first when she went into the position and how they have been resolved. ["Heather Gillis", Guest Panelist]

Program:                NTV - Issues & Answers
Aired:                  2016/11/20 12:06:00pm
Duration:               00:05:00
Reporter:               Lynn Burry
Ref Id:                 E8u-7P6-20

LYNN BURRY: Heather?

HEATHER GILLIS: A big part of your job is doing investigations into child deaths and other critical incidents. What's going to happen with the investigations that are ongoing now, once you depart?

CAROL CHAFE: Well, I'm currently...myself and my staff...are conducting six current investigations, and I just called four new ones. So, there's 10 active investigations, and there's a lot of work gone into those particular ones now...the ones that we've called in the past couple of years or so, and, you know, I can't describe the intensive work that goes into these. Every document is reviewed, every policy is compared, and then, you know, I interview people as necessary, which can be anywhere from two people to 30 people, per investigation. So, there's a lot of time and dedication invested by myself and by my staff, and, but, you know, its a process we've well-tuned over the past six years, and we're getting it out really as fast as possible, but I would say 'fast' is not the key...its the quality of it. I'm proud to say that we have a good process, and the six that we currently have are various levels...I have one now...its completed, and its near ready to get printed...the report...and then I will release it. There's another that's in its final draft, and another that I'm just going over the first draft, and the other three are in document review. So, they're all very active, and the four new
ones...I've just received all documents, and we're going to start that process, so my hope is that whoever takes over my position will certainly pick that up and carry it forward, and let the good work that's been done move forward, and get the results out, most importantly, so government knows the changes they have to make so it doesn't happen again; the situations that occurred.

LYNN BURRY: One of the complaints that has been made in the past is that there are gaps in the system, and that's sometimes why problems have arisen; that children haven't been treated or followed up on the way they should be. Can you give us your assessment at this time of things that have happened in the past, when you came into the job, what you saw as the problems, and why things were going wrong?

CAROL CHAFE: Well, I can honestly say that the things I identified when I first went there are still happening today. I'd like to say...and I can confidently say...that they have lessened in...well, to my knowledge, in the frequency of it...but, you know, every report that we do, and every investigation, and for that matter, every individual case we get involved in on a daily basis, we tend to see the typical deficiencies, which are: lack of proper assessment, lack of proper follow up, lack of any documentation or proper documentation, not following policy, lack of communication and collaboration between professionals. So, while progress has been made, that's still evident today, and, I mean, obviously, as you know, in the AG report today, he himself looked at other files in more detail...a larger number at a time...and he's come up with the same types of items, of deficiency.

LYNN BURRY: So, why is that happening? Is it that there are not enough resources, or people aren't trained properly?

CAROL CHAFE: Well, a lot of it, I would say, yes, is the resources and workload for the staff, and as well, training and education, and policies and procedures. But, I can certainly say, and I credit the Department, now called Child...Children, Seniors, and Social Development...with the fact that a lot of good work has happened, you know. They have reviewed resources; some areas have had better structured resources. All are being trained and educated, and polices have been revised and rewritten, and a large part of that was from reports that came from our office, and current ones I'm doing; they've been very cooperative. And, you know, I continue to say that when I released the status of my recommendation reports for the past last year...and I'm working on this year's for release in the future too...that, you know, they are cooperating now, and they're doing a lot of that, but now, lately, in the past few reports, I'll also make the comment that now, you know, its change on paper, but we have to start seeing a change at the front line. So, that's where the focus has got to be: the culture and thinking of everyone at the front line has to gel with what we're saying in policy and procedure. Not to just go and get educated in your sessions, but go and act on it, and, you know, even in most recent ones where I interviewed staff from the department...and the workload is less than it was...they're still not doing a lot of the things that need to be done. So, there's a lot more work to be done there.
NL News Now
Email: production@nlnewsnow.ca
Tel: 709-726-6397
Web: www.nlnewsnow.ca
Thanks!

Sent from my BlackBerry 10 smartphone on the Bell network.

FYI Bruce.
There are other transcripts ordered from Ms. Chafe’s interview. We will send them along once they are received.
SB

From: NLIS, NLIS
Sent: Monday, November 21, 2016 9:49 AM
To: Foote, Carla; Cannizzaro, Michelle
Cc: O’Neill, Melony; Shea, Erin; Barfoot, Scott; Hayes-Butt, Paula
Subject: FW: NLNewsNow Transcript - ONGOING INVESTIGATIONS: "Ms. Chafe" talks about the ongoing

ONGOING INVESTIGATIONS: "Ms. Chafe" talks about the ongoing investigations into child's deaths and what will happen to them once she steps down. She discusses some of the issues she identified first when she went into the position and how they have been resolved. ["Heather Gillis", Guest Panelist]

Program: NTV - Issues & Answers
Aired: 2016/11/20 12:06:00pm
Duration: 00:05:00
Reporter: Lynn Burry
Ref Id: E8u-7P6-20

Please find attached the requested transcript.

NL News Now
Email: production@nlnewsnow.ca
Tel: 709-726-6397
Web: www.nlnewsnow.ca
HEATHER GILLIS: As many people know, you will be leaving in the middle of December, and moving on; you haven't reapplied for your job, but, for the person who steps up and takes it next: what kind of advice do you have for them going forward, for children and youth in the province?

CAROL CHAFE: Well, firstly, I would say focus on the children and youth. This position is so crucial; I mean, people fought for this to be created years ago, this office and this position, and especially over the most recent years, its been so productive and so good for what we can do for the children and youth. So, its crucial that the person in there is focused on that; focused on the mandate of the office. Its not a role you go into for yourself, or to promote yourself or anything else. It has to be all about the children and youth. The second thing is, I would say, there are a lot of good processes we have set up, and I have excellent staff there: Please, you know, work with them and listen to them. Move forward what we've done, by all means, you know...you have your own ideas, but don't just wipe out what's been done. Have a good clear eye and look at it all, and just move the momentum forward and don't give up, because every little bit of progress helps in moving it forward.

LYNN BURRY: And your advice to the government, when it comes to assisting the work of your office?
CAROL CHAFE: Oh, well, as always, under the legislation, cooperate and provide us with the information we want, but please pass the legislation for mandatory reporting for the office, because, as I said, I wasn't pursuing that for me, myself, but for the position and the office, and that's so crucial for all the children and youth, that that legislation for mandatory reporting of critical incidents and deaths occur, because then, at least, we're knowing about everything, and we can try and help every child, instead of just one.

LYNN BURRY: And, of course, the comment you made just a moment ago that if there are cutbacks to come in government spending, it should not be in...

CAROL CHAFE: No, it's not an area to even consider, it really isn't, because it's obvious that it needs the resources, and it needs more attention.

LYNN BURRY: Ms. Chafe, I know you're retiring from this position. You've had a career now as Child and Youth Advocate; you had a long career in the health care sector as well, and this may not be the last we've heard of Carol Chafe.

CAROL CHAFE: That's not my plan right now. I'll take a little break, but I'm certainly ready to take on another challenge.

LYNN BURRY: Well, good luck to you in the future.

CAROL CHAFE: Thank you very much.
Can we get the info on when the CYA’s position was posted online; when it was removed and where we are with the process - IAC?

Thank you,
Minister

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Shea, Erin  
Sent: Monday, November 21, 2016 4:24 PM  
To: Bennett, Derek; Cooper, Bruce; GambinWalsh, Sherry; Healey, Rick M.; Tilley, Jean; Walsh, Susan; White, Kelly  
Cc: O’Neill, Melony; Shea, Erin  
Subject: QP for Monday, Nov 21

Please see the following unedited version of the QP from today. Attached is the full period and below are the excerpts relevant to the department; the specific questions from Opposition and Third Party have been highlighted:

**MR. SPEAKER:** The hon. Member for Fortune Bay – Cape La Hune.

**MS. PERRY:** Thank you, Mr. Speaker.

Did the minister of child, youth and family services have any concerns about government collapsing the once stand-alone Department of CYFS?

**MR. SPEAKER:** The hon. the Minister of Children, Seniors and Social Development.

**MS. GAMBIN-WALSH:** Not at all, Mr. Speaker.

We have put two very good teams together. Child protection is a critical and challenging area of service delivery and the two teams together are doing a great job.

**SOME HON. MEMBERS:** Hear, hear!

**MR. SPEAKER:** The Member for Fortune Bay – Cape La Hune.

**MS. PERRY:** The Child and Youth Advocate, Carol Chafe, in an interview this weekend said that she was pleased with the progress being made by the former administration. Little to nothing has been done by the current government over the last 12 months.

I ask the minister: Can she tell us what’s been done with mandatory reporting legislation?

**MR. SPEAKER:** The hon. Minister of Children, Seniors and Social Development.

**MS. GAMBIN-WALSH:** Thank you, Mr. Speaker.

Yes, Mr. Speaker, I, myself, met with the Child and Youth Advocate just last month and my team is meeting next month. The department’s involved with the critical incident reporting, reporting of deaths and critical incidents – are working independently on their own issues and their own statements.

Thank you.

**SOME HON. MEMBERS:** Hear, hear!

**MR. SPEAKER:** The Member for Fortune Bay – Cape La Hune.

**MS. PERRY:** Last year, Mr. Speaker, that legislation was just about ready to bring into government. It was nearly a year now –

**SOME HON. MEMBERS:** Oh, oh!
MR. SPEAKER: Order, please!
The Member for Fortune Bay – Cape La Hune.
MS. PERRY: Thank you so much, Mr. Speaker.
It was tabled in our last days of government, so why have you been delaying it for over a year?
MR. SPEAKER: The hon. the Minister of Children, Seniors and Social Development.
MS. GAMBIN-WALSH: Mr. Speaker, I’m not sure how they knew it was going to be their last days in
government and I’m not sure why they didn’t put it through; however, we are working to put it through and we
will deliver on our promise.
SOME HON. MEMBERS: Hear, hear!
MR. SPEAKER: The hon. the Member for Fortune Bay – Cape La Hune.
MS. PERRY: We certainly didn’t know that would happen. That’s how history turned out. If we were there it
would have been done by now, Mr. Speaker.
SOME HON. MEMBERS: Hear, hear!
MS. PERRY: I ask the minister of child, youth and family services with respect to children that are in the care
of the Newfoundland government, what measures has her government put in place to ensure these children are
receiving the proper vaccinations?
MR. SPEAKER: The hon. the Minister of Health and Community Services.
MR. HAGGIE: Mr. Speaker, there is a universal vaccination program for, I think, somewhere between 11 and 14 conditions which rolls out and is available to every child in the province free of charge.

SOME HON. MEMBERS: Hear, hear!

MR. SPEAKER: The hon. the Member for Fortune Bay – Cape La Hune.

MS. PERRY: Mr. Speaker, it doesn’t give me a comfort level that they’re looking after the children in their care.

When will all the children in the care of government receive their vaccinations?

MR. SPEAKER: The hon. the Minister of Health and Community Services.

MR. HAGGIE: Mr. Speaker, thank you for the question. If the Member opposite has any evidence that they are not receiving them, I would be delighted to hear it.

........

MR. SPEAKER: The hon. the Member for the District of St. John’s Centre.

MS. ROGERS: Mr. Speaker, Carol Chafe, the Child and Youth Advocate is stepping down after six years of intensive and courageous work on behalf of the children and youth of our province. Her last day is December 15, less than a month away.

I ask the minister, Mr. Speaker: How long has she known the advocate was stepping down, what has she done to start the process to find a new replacement, how long will it take the Independent Appointments Commission to find her replacement?

MR. SPEAKER: The hon. the Minister of Children, Seniors and Social Development.

MS. GAMBIN-WALSH: Mr. Speaker, I found out like everyone else when Carol was stepping down, through the media release. The appointments, it will go through the Independent Appointments Commission.

I would like to take this opportunity to thank Carol. Her work has been phenomenal and she is dedicated to her job.

SOME HON. MEMBERS: Hear, hear!

MR. SPEAKER: The hon. the Member for St. John’s Centre.

MS. ROGERS: Mr. Speaker, this is a crucial role in our province. I ask the minister: What is planning do to to fill the vacant position of Child and Youth Advocate until a new advocate is found?

MR. SPEAKER: The hon. the Minister of Children, Seniors and Social Development.

MS. GAMBIN-WALSH: Mr. Speaker, I believe Carol will stay in the role until December 15. It will go through the Independent Appointments Commission.

SOME HON. MEMBERS: Hear, hear!

MR. SPEAKER: The hon. the Member for St. John’s Centre.

MS. ROGERS: Mr. Speaker, December 15 is just a few weeks away. What is she going to do to to bridge that gap?

MR. SPEAKER: The hon. the Minister of Children, Seniors and Social Development.

MS. GAMBIN-WALSH: Mr. Speaker, we knew this position was up for review and we have already put it up on the website and advertised for the position.

SOME HON. MEMBERS: Hear, hear!

MR. SPEAKER: The hon. the Member for St. John’s Centre.

MS. ROGERS: Thank you, Mr. Speaker.

Well it’s going to take longer than a few weeks I dare say.

Mr. Speaker, I ask the minister what is she going to do to address the crisis issues the Auditor General raised in his report regarding the documentation and assessment issues in child protection cases?

MR. SPEAKER: The hon. the Minister of Children, Seniors and Social Development.

MS. GAMBIN-WALSH: Mr. Speaker, child protection is a critical and challenging area of service delivery. Every day our social workers go to work making difficult decisions about the safety and protection of our children. Our department has put in place a quality committee. We accept all 27 recommendations of the Auditor General. We have met with the School of Social Work so we can fast track a program on documenting.

Thank you, Mr. Speaker.

SOME HON. MEMBERS: Hear, hear!
MR. SPEAKER: The hon. the Member for St. John’s Centre for a very quick question.
MS. ROGERS: Again, Mr. Speaker, I ask the minister where is the crucial long-awaited legislation of mandatory reporting of deaths and critical incidents of children and youth to the Child and Youth Advocate. When can we see that?
MR. SPEAKER: The hon. the Minister of Children, Seniors and Social Development, for a quick response.
MS. GAMBIN-WALSH: Mr. Speaker, the work is ongoing and as I said earlier each department is working on their individual proposed reporting protocol.
SOME HON. MEMBERS: Hear, hear!
Thank you for your response.

Your response in the house yesterday as reported in Hansard is incomplete information.

"The People" need complete information with regard to all deaths in care/custody of GNL.

Please publish same ASAP...etc

Sent from my iPhone

> On Dec 8, 2016, at 11:29 AM, "GaminWalsh, Sherry" <SherryGaminWalsh@gov.nl.ca> wrote:
> Sec. 40 (1)
> the information is on the government website and I answered this question in the HOA. You should realize that some children who have passed away are medically compromised.
> Sec. 40 (1)
> Minister Gamin - Walsh
> Sec. 40 (1)
> Sent from my BlackBerry 10 smartphone on the Bell network.
> Original Message
> From: Sec. 40 (1)
> Sent: Thursday, December 8, 2016 10:13 AM
> To: Premier; ; GaminWalsh, Sherry
> Cc: Sec. 40 (1)
> Subject: How many children have died in care of GNL ?...
> Sec. 40 (1)
> "The People" need to know how many children have died in care of GNL.
> "The People" have a right to complete public information regarding the deaths of children in care of GNL.
>
> Please publish this public information...ASAP...etc
>
> Sent from my iPhone
>
> "This email and any attached files are intended for the sole use of the primary and copied addressee(s) and may contain privileged and/or confidential information. Any distribution, use or copying by any means of this information is strictly prohibited. If you received this email in error, please delete it immediately and notify the sender."
See below.

We do not currently report critical incidents publicly, but we will report rounded numbers as part of open government once we have the data for this calendar year.

Sara,
I am accurate in saying 1. we currently do not publicly report Critical Incidents and 2. this is something we are looking at as part of open govt?
Bruce
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atipoffice@gov.nl.ca.
Hi Mark,

I spoke to Bruce about the e-mail search. Friday, February 24th is a good day for your to come by to conduct a search of his e-mail.

Thank you.

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John's, NL
A1B 4J6
Tel: (709) 729-6958
Fax: (709) 729-1449
E-Mail: dhunt@gov.nl.ca

Hi Deputy Minister,

I'm out of the office after today until Friday. I'm wondering if you have time on Friday, February 24 or Monday, February 27, for me to complete the search? The response is due on March 7th, and cab sec requires five days to review any relevant documentation before release.

Regards,
Mark

Mark...I am happy for you to search my computer. I am not going away on Mon and Tuesday now. Let's find a time. B
From: Griffin, Mark
Sent: Friday, February 10, 2017 11:50 AM
To: Cooper, Bruce <BruceCooper@gov.nl.ca>
Subject: ATIPP E-mail Search

Deputy Minister,

We have a number of ATIPP requests that require a search of your e-mail (responsive records for critical incidents and deaths, [Redacted]. Sara mentioned you were out of the office next week. Would you prefer I complete the search by sitting at your computer or through the multi-mailbox tool? If you would prefer I use the multi-mailbox tool, can you send me an e-mail granting me permission to search your e-mail so that I can include on the request to OCIO?

Regards,
Mark

Mark Griffin, BA, MSW, RSW
Social Worker III
Quality Assurance
Department of Children, Seniors and Social Development
Government of Newfoundland and Labrador
6th Floor, West Block
Confederation Building
P.O. Box 8700
St. John's, NL A1B 4J6
Phone: (709) 729-5172, Fax: (709) 729-6382
E-mail: markgriffin@gov.nl.ca
Potential copyright material

If you wish to obtain a copy please contact the ATIPP Office at (709) 729-7072 or atippoffice@gov.nl.ca.
I have printed and placed in your urgent file folder.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Child, Youth & Family Services
95 Elizabeth Avenue
P.O. Box 8700
St. John’s, NL
A1B 4J6
Tele: (709) 729-0958
Fax: (709) 729-1049
E-Mail: drhunt@gov.nl.ca
-----Original Message-----
From: Cooper, Bruce
Sent: Monday, February 27, 2017 12:13 PM
To: Hunt, Deanne
Subject: Fw: Emailing: Child Death Review Committee Case Review.PDF

Pls print.

Sent from my BlackBerry 10 smartphone on the Bell network.

Original Message
From: Abbott, John <JohnAbbott@gov.nl.ca>
Sent: Monday, February 27, 2017 11:59 AM
To: Cooper, Bruce
Subject: FW: Emailing: Child Death Review Committee Case Review.PDF

Bruce
I am sending for your information. As one of the recommendations of a Child Death review reference a prevention initiative, I thought I’d bring to your attention (i.e. I think it should have referenced your department as opposed to ours??). Also attached is Gerrie Smith's hand-written note to me which is self-explanatory. OK John A

-----Original Message-----
From: Power, Elaine
Sent: Monday, February 27, 2017 11:51 AM

519
To: Abbott, John
Subject: Emailing: Child Death Review Committee Case Review.PDF

Your message is ready to be sent with the following file or link attachments:

Child Death Review Committee Case Review.PDF

Note: To protect against computer viruses, e-mail programs may prevent sending or receiving certain types of file attachments. Check your e-mail security settings to determine how attachments are handled.
Hi Jean/Linda,

Please see the attached correspondence and note from Bruce.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John’s, NL
A1B 4J6
Tel: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dhunt@gov.nl.ca
Hi Jean/Linda,

Just a reminder about the attached correspondence which Bruce sent to you on Feb. 27th.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John's, NL
A1B 4J6
Tel: (709) 729-6958
Fax: (709) 729-1049
E-Mail: dhunt@gov.nl.ca

From: Hunt, Deanne
Sent: Monday, February 27, 2017 2:41 PM
To: Tilley, Jean; Carter, Linda
Cc: Roberts, Denyse; Whitten, Corina; Cooper, Bruce
Subject: Child Death Review Committee Case Review

Hi Jean/Linda,

Please see the attached correspondence and note from Bruce.

Thanks,

Deanne
Tele: (709) 729-6958
Fax: (709) 729-4049
E-Mail: dshunt@gov.nt.ca
Taylor, Jennifer

<table>
<thead>
<tr>
<th>Subject:</th>
<th>KIV - E-Mail to Jean/Linda re: Child Death Review Committee</th>
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<tr>
<td>Start:</td>
<td>Fri 3/3/2017 8:30 AM</td>
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<tr>
<td>End:</td>
<td>Fri 3/3/2017 9:00 AM</td>
</tr>
<tr>
<td>Recurrence:</td>
<td>(none)</td>
</tr>
<tr>
<td>Organizer:</td>
<td>Cooper, Bruce</td>
</tr>
</tbody>
</table>
Our government will continue to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.
From: Hunt, Deanne
Sent: Wednesday, March 29, 2017 2:33 PM
To: Cooper, Bruce
Subject: RE: Critical Incidents and Deaths Meeting - March 30

Bruce,

Ian Tucker will be attending on behalf of Heather Jacobs.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John’s, N.L.
A1B 4J6
Tel.: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dhunt@gov.nl.ca

From: Hunt, Deanne
Sent: Wednesday, March 29, 2017 9:31 AM
To: Cooper, Bruce
Subject: Critical Incidents and Deaths Meeting - March 30

Bruce,

Tracey Eddy called to say that Heather Jacobs is unable to attend tomorrow’s meeting at 11:00 a.m. re: Critical Incidents and Deaths due to meeting commitments involving her Minister. Tracey will check with Minister to see if she can send someone else on her behalf.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John’s, N.L.
A1B 4J6
Tel.: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dxhunt@gov.nl.ca
### Taylor, Jennifer

**Subject:** Critical Incidents & Deaths Reporting - Next Steps  
**Location:** CSSD-STJH-RM-BR-ConfedWest, Executive Boardroom-FL6  

**Start:** Thu 3/30/2017 11:00 AM  
**End:** Thu 3/30/2017 12:00 PM  
**Show Time As:** Tentative  

**Recurrence:** (none)  
**Meeting Status:** Not yet responded  

**Organizer:** Hunt, Deanne  
**Required Attendees:** Cooper, Bruce; Abbott, John; Jacobs, Heather; Gardiner, Bob B; Tilley, Jean; Lake-Kavanagh, Jackie  
**Optional Attendees:** Power, Elaine; Eddy, Tracey; Manuel, Sue; Roberts, Denyse; Holt, Suzanne  

Meeting will take place in the Executive Boardroom, Department of Children, Seniors and Social Development, 6th Floor, Confederation Building, West Block
Taylor, Jennifer

Subject: Critical Incidents & Deaths Reporting - Next Steps
Location: CSSD-STJH-RM-BR-ConfedWest, Executive Boardroom-FL6

Start: Thu 3/30/2017 11:00 AM
End: Thu 3/30/2017 12:00 PM

Recurrence: (none)
Meeting Status: Accepted

Organizer: Hunt, Deanne
Required Attendees: Cooper, Bruce; Abbott, John; Jacobs, Heather; Gardiner, Bob B; Tilley, Jean; Lake-Kavanagh, Jackie
Optional Attendees: Power, Elaine; Eddy, Tracey; Manuel, Sue; Roberts, Denyse; Holt, Suzanne

NOTE: Heather Jacobs unable to attend – Ian Tucker attending on her behalf

Meeting will take place in the Executive Boardroom, Department of Children, Seniors and Social Development, 6th Floor, Confederation Building, West Block
Hi Melony,

Do you need this brought into the boardroom?

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Children, Seniors and Social Development
Confederation Building, West Block
P.O. Box 8700
St. John's, NL
A1B 4J6
Tel: (709) 729-6958
Fax: (709) 729-1049
E-Mail: dhunt@gov.nl.ca

From: O'Neill, Melony
Sent: Monday, November 21, 2016 11:39 AM
To: Hunt, Deanne; O'Rielly, Madonna
Subject: Fw: NLNewsNow Transcript - ADVISE FOR REPLACEMENT: "Carol Chafe" talks about what advi

Can one of you ladies kindly print this for the minister?

Thanks,

Mel

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Barfoot, Scott <ScottBarfoot@gov.nl.ca>
Sent: Monday, November 21, 2016 11:36 AM
To: Cooper, Bruce; O'Neill, Melony
Subject: FW: NLNewsNow Transcript - ADVISE FOR REPLACEMENT: "Carol Chafe" talks about what advi

From: NLIS, NLIS
Sent: Monday, November 21, 2016 11:25 AM
To: Shea, Erin; O'Neill, Melony
ADVISE FOR REPLACEMENT: "Carol Chafe" talks about what advise she would give whoever ends up in the position of Child and Youth Advocate about it being all about the children and youth. She urges government to cooperate with the office because it is so crucial that there be mandatory reporting. ["Heather Gillis", Guest Panelist]

Program: NTV - Issues & Answers
Aired: 2016/11/20 12:25:00pm
Duration: 00:04:00
Reporter: Lynn Burry
Ref Id: n6X-3v6-20

Please find attached the requested transcript.

NL News Now
Email: production@nlnewsnow.ca
Tel: 709-726-6397
Web: www.nlnewsnow.ca
Here's another one for printing.

Sent from my BlackBerry 10 smartphone on the Bell network.

From: NLIS, NLIS <nlis@gov.nl.ca>
Sent: Monday, November 21, 2016 11:43 AM
To: Shea, Erin; O'Neill, Melony
Cc: Foote, Carla; Cannizzaro, Michelle; Barfoot, Scott
Subject: FW: NLNewsNow Transcript - MANDATORY REPORTING: Child and Youth Advocate "Carol Chafe"

MANDATORY REPORTING: Child and Youth Advocate "Carol Chafe" discusses the need for mandatory reporting of child deaths and critical incidents. ["Heather Gillis", Guest Panelist]

Program: NTV - Issues & Answers
Aired: 2016/11/20 12:15:00pm
Duration: 00:06:00
Reporter: Lynn Burry
Ref Id: Z6S-3c7-20

Please find attached the requested transcript.

NL News Now
Email: production@nlnewsnow.ca
Tel: 709-726-6397
Web: www.nlnewsnow.ca
MANDATORY REPORTING: Child and Youth Advocate "Carol Chafe" discusses the need for mandatory reporting of child deaths and critical incidents. ["Heather Gillis", Guest Panelist]

Program: NTV - Issues & Answers
Aired: 2016/11/20 12:15:00pm
Duration: 00:06:00
Reporter: Lynn Burry
Ref Id: Z6S-3c7-20

LYNN BURRY: Welcome back everyone and our special guest on this week's program is Carol Chafe who is the province's Child and Youth Advocate who announced to the public earlier this week that she was going to step down from her position and finishes up the middle of December. Our next question comes from Heather Gillis.

HEATHER GILLIS: With mandatory reporting of child deaths and critical incidents still not there, how would this help you advocate for children and youth in the province.

CAROL CHAFE: Well ah you know, as I've said many times in terms of seeking that I only become aware of cases through various avenues and whether that is that the client calls us themselves, a family member, a professional, I hear it in the media from your stories; I'm not getting notified automatically by Departments when critical incidents occur or deaths. Since I've been seeking this, now it's five years since I first brought this issue up and that was initially when making recommendations directly to CYFS in particular I mean my office has a mandate for other government departments but the key one is CYFS but, and you know that wasn't getting responded to so then I formally a couple of years ago did put in that I wanted a change in legislation and you know the process I've gone through for that. We are finally making really good progress. In 2014 near the end of year, the PC government at the time agreed, they brought it right to the House and it was all agreed to that they would move forward. From January to June of 2015 we had a lot of good work, we had a good working committee of those departments and my office. A lot of work done and we were this close and the House closed in June but there was still an intent and a promise that you know hopefully it would pass in the fall and we would have this up and running January 2016. Then there was a new election and really here we are today and honestly I have inquired on a regular basis every opportunity I'm out on an issue I raise, I keep getting assured it's still a priority you know and I appreciate that but I have not seen one effort of movement moving forth. Having said that there is a meeting supposed to come up soon next week that I will be back at the table for the first time in over a year to talk with those departments on it.

LYNN BURRY: Do you worry with the fact that we are going through difficult economic times, that there will be a trickle down effect when it comes to having social workers and people on the ground who are able to detect child abuse the way that they should be. I'm just wondering about cutbacks, do you see that having an effect or not?
CAROL CHAFE: If there were cutbacks it would most definitely have an effect, a very negative effect. I would like to think that no government would ever cut down the crucial services that can further put those children and youth at risk.

---------------------------------------------------------------

NL News Now
Email: production@nlnewsnow.ca
Tel: 709-726-6397
Web: www.nlnewsnow.ca
HEATHER GILLIS: As many people know, you will be leaving in the middle of December, and moving on; you haven’t reapplied for your job, but, for the person who steps up and takes it next: what kind of advice do you have for them going forward, for children and youth in the province?

CAROL CHAFE: Well, firstly, I would say focus on the children and youth. This position is so crucial; I mean, people fought for this to be created years ago, this office and this position, and especially over the most recent years, its been so productive and so good for what we can do for the children and youth. So, its crucial that the person in there is focused on that; focused on the mandate of the office. Its not a role you go into for yourself, or to promote yourself or anything else. It has to be all about the children and youth. The second thing is, I would say, there are a lot of good processes we have set up, and I have excellent staff there: Please, you know, work with them and listen to them. Move forward what we’ve done, by all means, you know...you have your own ideas, but don’t just wipe out what’s been done. Have a good clear eye and look at it all, and just move the momentum forward and don’t give up, because every little bit of progress helps in moving it forward.

LYNN BURRY: And your advice to the government, when it comes to assisting the work of your office?

CAROL CHAFE: Oh, well, as always, under the legislation, cooperate and provide us with the information we want, but please pass the legislation for mandatory reporting for the office, because, as I said, I wasn’t pursuing that for me, myself, but for the position and the office, and that’s so crucial for all the children and youth, that that legislation for mandatory reporting of critical incidents and deaths occur, because then, at least, we’re knowing about everything, and we can try and help every child, instead of just one.

LYNN BURRY: And, of course, the comment you made just a moment ago that if there are cutbacks to come in government spending, it should not be in...

CAROL CHAFE: No, its not an area to even consider, it really isn’t, because its obvious that it needs the resources, and it needs more attention.
LYNN BURRY: Ms. Chafe, I know you're retiring from this position. You've had a career now as Child and Youth Advocate; you had a long career in the health care sector as well, and this may not be the last we've heard of Carol Chafe.

CAROL CHAFE: That's not my plan right now. I'll take a little break, but I'm certainly ready to take on another challenge.

LYNN BURRY: Well, good luck to you in the future.

CAROL CHAFE: Thank you very much.

-------------------------------------------------------------------------------------------------------------------------------------------

NL News Now
Email: production@nlnewsnow.ca
Tel: 709-726-6397
Web: www.nlnewsnow.ca
Taylor, Jennifer

Subject: Ministerial Meeting with CYFS/EECS/HSC/JPS re: Critical Incidents
Location: SWSD Executive Boardroom, 2nd Floor, West Block

Start: Mon 1/18/2016 1:00 PM
End: Mon 1/18/2016 2:00 PM

Recurrence: (none)

Meeting Status: Accepted

Organizer: Barnes, Joanne

Required Attendees: Gambin-Walsh, Sherry; Haggie, John; Kirby, Dale; Parsons, Andrew; Cooper, Bruce; Cochrane, Rachelle; Vivian-Walsh, Janet; Jacobs, Heather; Bennett, Derek

Optional Attendees: Cormey, Janet; Hunt, Deanne; Stewart, Rhonda; Power, Colleen (HCS); O’Rielly, Madonna; Jarvis, Carolyn B.; Power, Elaine; Manuel, Sue
Taylor, Jennifer

From: Barnes, Joanne
Sent: Friday, January 08, 2016 9:47 AM
To: Cormey, Janet; Stewart, Rhonda; Power, Colleen (HCS)
Cc: O’Rielly, Madonna
Subject: FW: potential meeting Monday January 18 with Ministers of Education, Justice, Health and CYFS

Good morning ladies,

Sec. 29(1)(a)

I’ve been asked to set up a meeting with our Ministers for January 18 in the afternoon.

Please advise of your Minister’s availability for January 18th at 2pm. The meeting will be held in SWSD Executive Boardroom, 2nd Floor, West Block. I will send out a meeting invitation after I hear back from you.

Thanks

Joanne

From: Cochrane, Rachelle
Sent: Thursday, January 07, 2016 4:57 PM
To: Barnes, Joanne
Subject: Fw: potential meeting Monday January 18 with Ministers of Education, Justice and Health

OK. Tomorrow can you schedule this for early afternoon on 18th

Sent from my BlackBerry 10 smartphone on the Bell network.

From: GambinWalsh, Sherry <SherryGambinWalsh@gov.nl.ca>
Sent: Thursday, January 7, 2016 4:55 PM
To: Cochrane, Rachelle
Subject: Re: potential meeting Monday January 18 with Ministers of Education, Justice and Health

Yes. I am busy at an event that morning so give me time to get back from the event.

Minister

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cochrane, Rachelle
Sent: Thursday, January 7, 2016 3:54 PM
To: GambinWalsh, Sherry
Subject: potential meeting Monday January 18 with Ministers of Education, Justice and Health

Minister
Public Advisory: Child Death Review Committee Case Review

Under section 13.5 of the Fatalities Investigations Act, the Minister of Justice and Public Safety is required, within 60 days after receiving a report from the Child Death Review Committee (CDRC), to make public those recommendations relating to:

- Relevant protocols, policies and procedures;
- Standards and legislation;
- Linkages and coordination of services; and
- Improvements to services affecting children and pregnant women.

The CDRC forwarded a report to the Minister of Justice and Public Safety on March 2, 2017. The report examines the facts and circumstances surrounding the death of an infant from Sudden Infant Death Syndrome (SIDS) in 2016. This report resulted in the following recommendation:

- Labrador-Grenfell Health continue to engage in discussion with officials in Innu health and social service programs to discuss culturally-appropriate response to preventing SIDS deaths in Innu communities.

This report has been forwarded to the Child and Youth Advocate.

- 30 -

Media contact
Lesley Clarke
Justice and Public Safety
709-729-6985, 699-2910
LesleyClarke@gov.nl.ca

2017 04 28 12:35 p.m.
<table>
<thead>
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<th><strong>Subject:</strong></th>
<th>Ministerial Meeting with CYFS/EECS/HSC/JPS re: Critical Incidents</th>
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<tr>
<td><strong>Location:</strong></td>
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<tr>
<td><strong>Start:</strong></td>
<td>Mon 1/18/2016 1:00 PM</td>
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<tr>
<td><strong>End:</strong></td>
<td>Mon 1/18/2016 2:00 PM</td>
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<td><strong>Organizer:</strong></td>
<td>Barnes, Joanne</td>
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<td><strong>Required Attendees:</strong></td>
<td>GambinWalsh, Sherry; Haggie, John; Kirby, Dale; Parsons, Andrew; Cooper, Bruce; Cochrane, Rachelle; Vivian-Walsh, Janet; Jacobs, Heather; Bennett, Derek</td>
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<td><strong>Optional Attendees:</strong></td>
<td>Cormey, Janet; Hunt, Deanne; Stewart, Rhonda; Power, Colleen (HCS); O'Rielly, Madonna; Jarvis, Carolyn B.; Power, Elaine; Manuel, Sue</td>
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<td><strong>Taylor, Jennifer</strong></td>
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<td><strong>Subject:</strong></td>
<td>Meeting with Minister Kirby re: Critical Incidents</td>
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<tr>
<td><strong>Location:</strong></td>
<td>Dept of EECD Executive Boardroom, 3rd Floor, West Block</td>
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<td><strong>Start:</strong></td>
<td>Tue 1/12/2016 10:30 AM</td>
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<td><strong>Meeting Status:</strong></td>
<td>Meeting organizer</td>
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<td><strong>Organizer:</strong></td>
<td>GambinWalsh, Sherry</td>
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<tr>
<td><strong>Required Attendees:</strong></td>
<td>Cochrane, Rachelle; Bennett, Derek</td>
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</table>
Provincial Corropondance
Cotter, Joanne

From: Cotter, Joanne  
Sent: Thursday, December 10, 2015 12:08 PM  
To: Rodgers, Paula  
Subject: original draft of BN  
Attachments: TransitionBNonCI.doc.doc

Joanne Cotter, MSW, RSW  
Senior Policy Analyst  
Department of Child, Youth & Family Services  
95 Elizabeth Avenue  
PO Box 8700 St. John’s, NL A1B 4J6  
709-729-1675 (P)  709-729-6382 (F)
Following the CME’s investigation, the Child Death Review Committee (CDRC) completes a review of the death and provides a report to the Minister of JPS. The Advocate is required under the FI Act to receive a copy of CDRC report.

As previously indicated, since fall 2014 and by agreed policy between CYFS and the Advocate’s office, CYFS reports child deaths to the Advocate through the ADM of regional service delivery. Basic information (birthdate, brief summary) is provided within 24 hours of CYFS becoming aware of the death, followed by more detailed information within 5 days (name, history of service involvement, circumstances surrounding death, action plan) using a standardized form, attached as Annex C. This process is working well and the Advocate has indicated she would like to see a similar process implemented in other reporting departments.
From: Rogers, Paula
Sent: Tuesday, January 19, 2016 10:50 AM
To: Tucker, Ian J.
Subject: RE: Follow up from meeting

Thanks, Ian. Paula

From: Tucker, Ian J.
Sent: Tuesday, January 19, 2016 10:50 AM
To: Rodgers, Paula
Cc: Ring, Stephen R.
Subject: RE: Follow up from meeting

Hi Paula - Steve and I are going to touch base with Dr. Avis hopefully this morning.

Ian Tucker
Solicitor – Civil Division
Department of Justice and Public Safety
Government of Newfoundland and Labrador
4th Floor, East Block
Confederation Building
P.O. Box 8700
St. John’s, NL A1B 4J6
Phone: 729-4411
Good morning Ian. I am following up from yesterday’s meeting. Thank you for your input at it.

Paula Rodgers MSW RSW
Executive Director
Child, Youth and Family Services
95 Elizabeth Ave (P.O.Box 8700)
St. John’s, NL A1B 4J6
Tel: (709) 729-7213  Fax: 709-729-1699
Email: PaulaRodgers@gov.nl.ca
Paula,

Here are two options to discuss with Karen provided HCS confirms this is still an outstanding issue.
From: Tucker, Ian J.
Sent: Thursday, January 21, 2016 9:14 AM
To: Rodgers, Paula
Subject: FW: Deaths

FYI

Ian Tucker
Solicitor – Civil Division
Department of Justice and Public Safety
Government of Newfoundland and Labrador
4th Floor, East Block
Confederation Building
P.O. Box 8700
St. John’s, NL A1B 4J6
Phone: 729-4411

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From: Ring, Stephen R.
Sent: Monday, January 18, 2016 12:05 PM
To: Tucker, Ian J.
Subject: FW: Deaths

From: Ring, Stephen R.
Sent: Thursday, May 14, 2015 1:38 PM
To: Cotter, Joanne
Subject: Fw: Deaths

FYI...

Sent from my BlackBerry 10 smartphone.

From: Mullaly, Ken <kmullaly@gov.nl.ca>
Sent: Wednesday, May 13, 2015 9:34 AM
To: Ring, Stephen R.
Subject: Deaths

Hi Steve

Here are the numbers for deaths under the age of 19 years for the last five years. If you have any questions please let me know.

Thanks Ken
<table>
<thead>
<tr>
<th>YEAR</th>
<th>TOTAL # UNDER 19yrs</th>
</tr>
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<tbody>
<tr>
<td>2014</td>
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<td>2011</td>
<td>50</td>
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<tr>
<td>2010</td>
<td>59</td>
</tr>
</tbody>
</table>

Ken Mullaly  
Registrar  
Vital Statistics Division  
Service Newfoundland and Labrador  
kmullaly@gov.nl.ca  
t: 709 729.3311 | f: 709.729.1402

**************************************************************************
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Rodgers, Paula

From: Tucker, Ian J.
Sent: Thursday, January 21, 2016 9:14 AM
To: Rodgers, Paula
Subject: FW: # of deaths of children (under 19 years of age)

Importance: High

FYI

Ian Tucker
Solicitor – Civil Division
Department of Justice and Public Safety
Government of Newfoundland and Labrador
4th Floor, East Block
Confederation Building
P.O. Box 8700
St. John’s, NL A1B 4J6
Phone: 729-4411

This e-mail is confidential and solicitor-client privileged. Any unauthorized copying, distribution or disclosure is prohibited. Disclosure to anyone other than the recipient does not constitute a waiver of privilege. If you have received this e-mail in error, please notify me immediately and delete all versions of same.

From: Ring, Stephen R.
Sent: Monday, January 18, 2016 12:03 PM
To: Tucker, Ian J.
Subject: FW: # of deaths of children (under 19 years of age)
Importance: High

From: Ring, Stephen R.
Sent: Tuesday, June 16, 2015 10:00 AM
To: Cotter, Joanne; Rodgers, Paula
Subject: FW: # of deaths of children (under 19 years of age)
Importance: High

FYI...Thanks.

Steve

From: Examiner, Chief Medical
Sent: Tuesday, June 16, 2015 9:49 AM
To: Ring, Stephen R.
Subject: # of deaths of children (under 19 years of age)
Importance: High

Good morning Steve:
Please see the list below for the # of deaths of children (under 19 years of age) that were reported to the Chief Medical Examiner’s Office for the following years:

2010 = 29  
2011 = 22  
2012 = 12  
2013 = 20  
2014 = 10  

Thank you,

Wendy Taylor  
Administrative Officer I  
Office of the Chief Medical Examiner  
Health Sciences Centre  
300 Prince Philip Drive  
St. John’s NL A1B 3V6  
Tel: (709) 777-6402  
Fax: (709) 777-6975  
E-mail: oeme@gov.nl.ca
Hi Deanne,

Here is the revised Premier’s letter.

Thanks

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

Hi Joanne,

Here is the letter.

Thanks,

Deanne

Deanne Hunt
Administrative Assistant
Office of the Deputy Minister
Department of Child, Youth & Family Services
95 Elizabeth Avenue
P.O. Box 8700
St. John’s, NL
A1B 4J6
Tel: (709) 729-0958
Fax: (709) 729-1049
E-Mail: dhunt@gov.nl.ca
March 10, 2016

Ms. Carol A. Chafe  
Child and Youth Advocate  
Office of the Child and Youth Advocate  
193 LeMarchant Road  
St. John’s, NL, A1C 2H5

Dear Ms. Chafe:

Thank you for your letter detailing your ongoing commitment and advocacy regarding the mandatory reporting to your office of deaths and critical incidents involving children and youth receiving government services. As indicated in the Speech from the Throne, government recognizes the importance of doing everything we can to protect children and youth, and we will be moving forward with this initiative.

The Department of Child, Youth and Family Services continues to work toward fulfilling the direction outlined in the Minister’s December 2015 mandate letter which is to work with colleagues in other government departments and your office to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate. The Minister of Child, Youth and Family Services has met with the Ministers of Health and Community Services, Justice and Public Safety, and Education and Early Childhood Development to discuss this matter.

I have directed the Departments to prioritize this work, but it is essential that we take the time necessary to carefully examine the implications of mandatory reporting and in particular an understanding of the impacts, if any, for front line workers. I understand much work has been completed including an understanding of what is a critical incident, an understanding of the timeframes you are seeking for reporting to the office, and the kind of information departments have been requested to report to your office.

We will continue to collaborate with you on this important initiative and the Minister of Child, Youth and Family Services will continue to provide regular updates to your office on government’s progress.

Sincerely,

DWIGHT BALL  
Premier  
MHA, Humber-Gros Morne

cc: Sherry Gambin-Walsh, Minister, Child, Youth and Family Services
Information Note
Department of Child, Youth and Family Services

Title: Amendments to the Child and Youth Advocate Act and the Fatalities Investigations Act.

Issue: To provide an update on the work undertaken to draft legislative amendments for the mandatory reporting to the Child and Youth Advocate of death and critical incidents (CI’s) involving children and youth

Background and Current Status:
- In recent years, the Child and Youth Advocate’s (CYA) reports (Joey’s Story, Turning a Blind Eye and Out of Focus) recommended the development of a protocol with the Department of Child, Youth and Family Services (CYFS) for the reporting of deaths and critical incidents. In June 2014, the Advocate tabled a briefing note in the House of Assembly (HOA) outlining her rationale for receiving reports of all deaths and CI’s from departments providing services to children and youth. The rationale includes delays in receiving reports will delay investigations and ultimately the CYA’s role in preventing future incidents. In addition, the CYA advises that having reporting in legislation as compared to agreements with departments and agencies will better assist her in fulfilling an advocacy role.

- In November 2014, The HOA passed an all-party motion committing to introduce legislation to address the CYA’s request for legislative change to the Child and Youth Advocate Act (CYA Act) for the mandatory reporting of deaths and critical incidents involving children and youth receiving government services. Subsequently, the deputy ministers of CYFS, Early Education and Childhood Development (EECD), Health and Community Services (HCS) and Justice and Public Safety (JPS) were directed to consult with the Advocate on the definition of a critical incident as well as to draft legislation responding to the Advocate’s request. The Minister of CYFS was also directed in his December 8, 2013, Mandate letter to consult with the Advocate in the preparation of draft legislation and introduce the legislation in the HOA.

- Currently, there is no legislative requirement for departments, public bodies or agencies to report critical incidents involving children or youth to the CYA. With respect to child deaths, the CYA does receive reports of the Child Death Review Committee (CDRC) from the Minister of Justice, as per s. 13.4 of the Fatalities Investigations Act (FI Act). The CYA advised this reporting is insufficient as 1) the reports are not completed on all child deaths and 2) reporting to the CYA is not timely as the CDRC review only commences once the Chief Medical Examiner’s review is complete. Since fall 2014 and by agreed policy between CYFS and the Advocate’s office, CYFS also reports child deaths to the Advocate.

Sec. 27(1)(i), Sec. 27(2)(a)
Hi Sara,

I completed the key results section of the table below as per our request.

Feel free to make any changes you feel are necessary. When you read my comments keep this in mind to decide if the wording is correct:

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

From: Dow, Sara
Sent: Thursday, April 07, 2016 9:28 AM
To: Cotter, Joanne
Subject: RE: Reporting for DM Contract

This is for the 15-16 fiscal year so it would just be what was the progress and status as of March 31, 2016

From: Cotter, Joanne
Sent: Thursday, April 07, 2016 9:25 AM
To: Dow, Sara
Subject: RE: Reporting for DM Contract

I Sara,

Is this for the 15-16 fiscal year?

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

From: Dow, Sara
Sent: Thursday, March 31, 2016 4:05 PM
To: Cotter, Joanne; McGrath, Dave
Cc: Tilley, Jean
Subject: Reporting for DM Contract
Hi all,

We have to report on the DM contract for the end of April. I’ve included the table below which is in the DM contract which references the OCYA. Would you mind updating this for me for April, 10th? I’m available should you have any questions.

**Priority 1:** Develop and introduce legislation regarding the request of the Office of the Child and Youth Advocate for departments and agencies of government of deaths and critical incidents involving children and youth.

<table>
<thead>
<tr>
<th>Reporting Component</th>
<th>Key Results (year-end)</th>
<th>Comments (Include explanation of any variances)</th>
<th>Evaluation Clerk of Performance Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicators used to demonstrate activity</strong></td>
<td></td>
<td></td>
<td>Sec. 27(1)(i), Sec. 27(2)(a)</td>
</tr>
<tr>
<td>Worked with the OCYA, and the Departments of Justice and Public Safety (JPS), Education and Early Childhood Development (EECD) and Health and Community Services (HCS)</td>
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<td></td>
<td></td>
<td>With the formation of a new Liberal Government in December 2015, the minister of CYFS was directed in the departmental mandate letter</td>
<td></td>
</tr>
</tbody>
</table>
to develop legislation for consideration by the House of Assembly regarding this reporting.

Sec. 27(1)(i), Sec. 27(2)(a)

Sec. 27(1)(i), Sec. 27(2)(a)

Sec. 27(1)(i), Sec. 27(2)(b)

Sara Dow
Director, Policy and Strategic Planning
Department of Child, Youth and Family Services
Government of Newfoundland and Labrador
95 Elizabeth Ave, PO Box 8700
Hi folks,

In advance of our meeting tomorrow morning at 9a.m., here is a copy of the decision note and related documents.

I will also bring copies to the meeting for everyone and you can take the first few minutes to review the information prior to a discussion.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Decision Note
Department of Child, Youth and Family Services

Title: Reporting of Critical Incidents (CI) to the Advocate for Children and Youth (ACY)

Issue: [Blackout]

Background and Current Status:
- The Office of the ACY is a statutory office of the House of Assembly established in 2002 under the authority of the Child and Youth Advocate Act (CYA Act).
- The ACY represents the rights and interests of children and youth receiving government programs and services and provides services in four areas: individual advocacy, systemic advocacy, reviews and investigations, and education and promotion.
- Since 2011, three reports from the Advocate’s office have recommended the development of a protocol with CYFS for the reporting of CIs and deaths involving children and youth.
- In July 2014, the Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of CIs and deaths from government departments (CYFS, HCS, EECD, JPS) including that the current delay in receiving information from government about child deaths and CIs prevents her from intervening early to prevent future incidents from occurring.
- In November 2014, the House of Assembly passed a motion committing to legislation to respond to the Advocate’s request to change the CYA Act to mandate public body reporting of deaths and CIs.
- The Liberal Platform document, “A Stronger Tomorrow: Our Five Point Plan” (fall 2015) committed to “legislate the mandatory reporting of deaths and critical incidents to the Advocate”.
- In December 2015, the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the House of Assembly regarding this reporting. Government reiterated its support for mandatory reporting of deaths and critical incidents to the Advocate in the March 2016 Speech From The Throne.
- The ACY continues to publicly express concern about lack of progress on this file. In a recent media interview, the ACY advised that under the previous government intensive work took place between January and June 2015 and that little progress has been made since the change in government.
- Since September 2014 CYFS has been reporting deaths in policy to the ACY (reporting an average of ten per year)
- In November 2014, CYFS established a CI definition (updated March 2016) and notification process for the reporting of CIs from regional staff to the ADM of Service Delivery and
Regional Operations (SD&RO). Currently this information is not proactively reported to the Advocate.

Analysis:

Sec. 29(1)(a), Sec. 27(2)(b)
Hi folks, good news. Don’t worry about the estimating. I don’t need any data from you now. I misunderstood the plan for tracking data.

Joanne Cotter, MSW, RSW  
Senior Policy Analyst  
Department of Child, Youth & Family Services  
95 Elizabeth Avenue  
PO Box 8700 St. John’s, NL A1B 4J6  
709-729-1675 (P) 709-729-6382 (F)

From: Clemens-Spurrell, Linda  
Sent: Monday, May 16, 2016 3:36 PM  
To: Cull, Barbara L.; Whelan, Jackie; Cotter, Joanne; Hoddinott, Susan  
Cc: O’Brien, Donna  
Subject: RE: Critical Incident Notifications

I can’t share details because I have no idea what it was, I am thinking it might have been a file from 2010-2011.

From: Cull, Barbara L.  
Sent: Monday, May 16, 2016 2:39 PM  
To: Whelan, Jackie; Cotter, Joanne; Clemens-Spurrell, Linda; Hoddinott, Susan  
Cc: O’Brien, Donna  
Subject: RE: Critical Incident Notifications

From: Whelan, Jackie  
Sent: Monday, May 16, 2016 2:23 PM  
To: Cull, Barbara L.; Cotter, Joanne; Clemens-Spurrell, Linda; Hoddinott, Susan  
Cc: O’Brien, Donna  
Subject: RE: Critical Incident Notifications
Can we discuss!

From: Cull, Barbara L.
Sent: Monday, May 16, 2016 1:34 PM
To: Cotter, Joanne; Clemens-Spurrell, Linda; Whelan, Jackie; Hoddinott, Susan
Cc: O’Brien, Donna
Subject: RE: Critical Incident Notifications

Hi folks,

We need your help on something in relation to the critical incident file. In order to help you understand what we need I need to give you a quick back grounder:

Background:
You may recall that there has been some discussion over the past year or so about reporting critical incidents to the Advocate. A decision from Government about legislative reporting by government departments (CYFS, Health, Justice and Education) has not yet been made. If you have further questions about this process you can discuss this with Donna or give me a call.
I am happy to chat with you individually or collectively to provide additional clarity, if needed (729-1675). Please get back to me with a regional response by end of day Wednesday (May 18) it would be greatly appreciated. I apologize for the short turnaround time; we just made a decision on this at an executive meeting this morning.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
Updated note

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John's, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Decision/Direction Note
Department of Child, Youth and Family Services

Title: Reporting of Critical Incidents (CI) to the Advocate for Children and Youth (ACY)

Decision/Direction Required: Sec. 29(1)(a)

Background and Current Status:
- The Office of the Child and Youth Advocate is a statutory office of the House of Assembly established in 2002 under the authority of the Child and Youth Advocate Act (CYA Act). The ACY represents the rights and interests of children and youth receiving government programs and services and provides services in four areas: individual advocacy, systemic advocacy, reviews and investigations, and education and promotion.

- Since 2011, three investigative reports from ACY have recommended the development of a protocol with CYFS for the reporting of CIs and deaths involving children and youth.

- In July 2014, the ACY tabled a briefing note in the HOA outlining a rationale for the mandatory reporting of CIs and deaths from government departments (CYFS, HCS, EECD, JPS) including that the current delay in receiving information about child deaths and CIs prevents the office from intervening early to prevent future incidents from occurring.

- In November 2014, the House of Assembly passed a motion committing to legislation to respond to the ACY’s request to change the CYA Act to mandate public body reporting of deaths and CIs. At that time, the Deputy Ministers of the Departments of CYFS, HCS, EECD and JPS were directed to consult the Advocate to develop clarity on the Advocate’s request.

- The Liberal Platform document, “A Stronger Tomorrow: Our Five Point Plan” (fall 2015) committed to “legislate the mandatory reporting of deaths and critical incidents to the Advocate”.

- In December 2015, the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the House of Assembly regarding this reporting. Government reiterated its support for mandatory reporting of deaths and critical incidents to the Advocate in the March 2016 Speech From The Throne.
• Since September 2014 CYFS has been reporting deaths in policy to the ACY (reporting an average of ten per year).

• In November 2014, CYFS established a CI definition (updated March 2016) and notification process for internal tracking and reporting of CIs from regional staff to the ADM of Service Delivery and Regional Operations.

• In recent media interviews (April 2016) the ACY advised that under the previous government intensive work and collaboration occurred between January and June 2015 and that little progress has been made since that time.

**Analysis:**

Sec. 27(1)(i), Sec. 27(2)(a)

• Government has publicly stated that departments have prioritized this work and that more time is required to carefully examine the implications of mandatory reporting from a resource perspective. It is anticipated that ACY will continue to request updates from CYFS on this file and will continue to publicly express concern regarding Government’s progress on the file.

Sec. 29(1)(a), Sec. 27 (2)(b)

Please note pages 3 and 4 of this briefing note redacted under Sec. 27(2)(b) and 29(1)(a)
Cotter, Joanne

From: Cotter, Joanne
Sent: Tuesday, May 24, 2016 3:36 PM
To: Tilley, Jean
Subject: revised note
Attachments: premier'sdecisionnote.doc; ANNEX A premiersnotedocx.docx

Here you go

Decision Note document duplicate of pages 302-305. These pages have been removed (pp. 309-312)

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Okay. Thanks

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

---

**From:** Cochrane, Rachelle  
**Sent:** Tuesday, May 24, 2016 12:47 PM  
**To:** Hunt, Deanne; Cotter, Joanne  
**Cc:** Barnes, Joanne  
**Subject:** Re: Meeting File for Minister

Joanne

All we need is the Agenda and the 2 letters from Carol Deanne has. I will bring the file with me when I come over.

Sent from my BlackBerry 10 smartphone on the Bell network.

---

**From:** Hunt, Deanne  
**Sent:** Tuesday, May 24, 2016 12:25 PM  
**To:** Cotter, Joanne  
**Cc:** Barnes, Joanne; Cochrane, Rachelle  
**Subject:** Meeting File for Minister

Hi Joanne,

Rachelle asked me to e-mail you to ask who is preparing the file for the Minister for tomorrow’s meeting on critical incidents & deaths?

Thanks,

Deanne

Deanne Hunt  
Administrative Assistant  
Office of the Deputy Minister  
Department of Child, Youth & Family Services  
95 Elizabeth Avenue  
P.O. Box 8700
Hi Rachelle,

The note has been updated following Jean’s review over the weekend. Here is the revised draft.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Decision/Direction Note
Department of Child, Youth and Family Services

Title: Reporting of Critical Incidents (CI) to the Advocate for Children and Youth (ACY)

Decision/Direction Required: Sec. 29(1)(a)

Background and Current Status:
• The Office of the Child and Youth Advocate is a statutory office of the House of Assembly established in 2002 under the authority of the Child and Youth Advocate Act (CYA Act). Since 2011, three investigative reports from ACY have recommended the development of a protocol with CYFS for the mandatory reporting of deaths and CIs involving children/youth.
• In 2014, CBC requested and received historical information (from 2009 to 2014) on the number of deaths and critical incidents involving CYFS children/youth which had not been provided to the Advocate. Since that time, the Advocate has placed considerable attention on departments regularly providing this information to her office.
• In July 2014, the ACY tabled a briefing note in the HOA outlining a rationale for the mandatory reporting of deaths and CIs from government departments (CYFS, HCS, EECD, JPS) including current delays in receiving information about child deaths and CIs prevents the office from intervening early to prevent future incidents from occurring.
• Since September 2014 CYFS has been reporting deaths of children/youth receiving services at the time of the death or in the twelve months preceding their death.
• In November 2014, the House of Assembly passed a motion committing to legislation to mandate reporting; the Deputy Ministers of CYFS, HCS, EECD and JPS were directed by then Premier Davis to consult with the Advocate and develop legislation for mandatory reporting to respond to the Advocate’s request.
• The fall 2015 Liberal Platform document further committed to legislate mandatory reporting with the Minister of CYFS directed in her mandate letter to give effect to this reporting. A further commitment to mandatory reporting was noted in the March 2016 Speech from the Throne.
• In recent media interviews and meetings, the ACY advised of the previous government’s intensive work and collaboration involving CYFS, EECD, JPS and HCS between January and June 2015 noting there has been little progress since that time. This work was directed by then Premier Davis.

Analysis: Sec. 27(1)(i), Sec. 27(2)(a)
• In light of the commitment in the Liberal Red Book, the Minister’s mandate letter and the Speech from the Throne, the Advocate is becoming increasingly vocal with the lack of action by Government. In a meeting with the CYFS Minister on May 25th, she advised she will now consider regularly writing departments requesting they report deaths and Cls to her. On May 27, 2016, she again wrote Premier Ball requesting action on this file.

• The Advocate’s work is largely focused on the most vulnerable population, the majority who are involved with CYFS and collaboration between these two offices is critical. In June 2016, CYFS is anticipating a fairly negative report from the Auditor General with the extent of front-line compliance with child protection policies which will again raise public concern for the safety of vulnerable children.

• In light of the public commitments made regarding reporting and the importance of a collaborative relationship between the two offices.
Sec. 29(1)(a), Sec. 27(2)(b)

Prepared/approved by: R. Cochrane/J. Tilley/J.Cotter
Ministerial approval:

May X, 2016
From: Cotter, Joanne
Sent: Tuesday, May 31, 2016 1:01 PM
To: Cochrane, Rachelle
Subject: CI note
Attachments: CI Death decision noterevised.doc

This briefing note is duplicate to the Briefing note starting page 316, and therefore has been redacted as duplicate (pages 321-323)

Here is the note in case you wanted to review while I’m gone to lunch. Password to follow.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Cotter, Joanne

From: Cotter, Joanne
Sent: Wednesday, June 01, 2016 2:23 PM
To: Tilley, Jean
Subject: latest draft
Attachments: ANNEX A.final.docx; CI Death decision noterevised.doc

Annex A document duplicate of page 313 and therefore page 324 has been removed.
Decision Note document not included as it is duplicate of note starting page 316.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John's, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)
Deanne Hunt  
Administrative Assistant  
Office of the Deputy Minister  
Department of Child, Youth & Family Services  
95 Elizabeth Avenue  
P.O. Box 8700  
St. John’s, NL  
A1B 4J6  
Tel: (709) 729-0958  
Fax: (709) 729-1049  
E-Mail: dhunt@gov.nl.ca
Sandra

Sandra Evans
Director Quality Assurance
Department of Child, Youth and Family Services
5 C Harris Avenue
Mailing Address:
Provincial Building
3 Cromer Avenue
Grand Falls-Windsor, NL A2A 1W9
709-292-4525
709-292-4541 (Fax)

Never miss an opportunity to tell your child “I Love You”
## Child/Youth Critical Incidents* by Year and Category

### 2009-May 31, 2016

<table>
<thead>
<tr>
<th></th>
<th>Attempted Suicide/ Suicide Ideation</th>
<th>Serious Injury or Incident Requiring Medical Assessment or Hospitalization</th>
<th>Missing Child/ Youth</th>
<th>Engaged in Self-Harm, High Risk or Life Threatening Behaviors</th>
<th>Committed Serious Criminal Offenses</th>
<th>Suspicious Injuries</th>
<th>High CYFS Involvement/ CYFS Concerns</th>
<th>Aggressive Behavior/Act of Violence Towards Person or Property</th>
<th>Allegations of/ Assaulted by Parent, Care Giver or Other</th>
<th>Public Case/Media Attention</th>
<th>Other</th>
<th>Total</th>
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<td>6</td>
<td>5</td>
<td>2</td>
<td>93</td>
</tr>
</tbody>
</table>

*Prior to Nov 1, 2014: No standard definition for critical incidents

Nov 1, 2014: Definition of Critical Incidents: For active cases involving children and youth receiving CYFS services (in care, protective intervention, kinship, youth services and youth corrections). An incident of an extraordinary or life threatening nature which directly impacts the safety and well-being of a child such as violence, assault, injury and other serious criminal matters.

Feb 18, 2016: Definition clarified to include significant threats of self-injury, self-harm or suicide ideation that require hospitalization beyond initial assessment and treatment.
From: Dow, Sara
Sent: Monday, July 04, 2016 10:15 AM
To: Cotter, Joanne
Cc: Tilley, Jean
Subject: Re: Update on Commitments

I'm just in a ATIPP meeting, I'll pop over when I'm back

Sent from my BlackBerry 10 smartphone on the Bell network.

From: Cotter, Joanne
Sent: Monday, July 4, 2016 9:56 AM
To: Dow, Sara
Cc: Tilley, Jean
Subject: RE: Update on Commitments

Hi Sara,

Had a review. Status is “commenced/in progress”. Let’s chat about completion date and any other information you may need.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John’s, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

From: Dow, Sara
Sent: Thursday, June 30, 2016 4:11 PM
To: Cotter, Joanne
Cc: Tilley, Jean
Subject: Update on Commitments

Hi Joanne

We’ve been asked to give a status update on our commitments. Here are some instructions regarding the completion of the spreadsheet: Sec. 29(1)(a)

If something is commenced/in-progress, please identify an anticipated completion date.

The Commitments have not been consolidated, so there is some duplication.

So you really only have one update!
If you want I can sit with you on Monday and we can go through it.

<table>
<thead>
<tr>
<th>Commitment</th>
<th>Date</th>
<th>Source of Commitment</th>
<th>Department/Agency Responsible</th>
<th>Supporting Department/Agency</th>
<th>Policy Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>I expect you to work with your colleagues and the Child and Youth Advocate to develop legislation for the House of Assembly that will make it mandatory to report deaths and critical incidents to the Advocate.</td>
<td>#######</td>
<td>Mandate Letter</td>
<td>CYFS</td>
<td></td>
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<tr>
<td>Legislate mandatory reporting of deaths and critical incidents to the Child and Youth Advocate</td>
<td>#######</td>
<td>Election Platform</td>
<td>CYFS</td>
<td>JPS</td>
<td>Child and You Advocate</td>
</tr>
<tr>
<td>In November 2014, the House of Assembly passed a motion committing to legislation to respond to the Child and Youth Advocate’s request to change the Child and Youth Advocate Act to mandate public body reporting of deaths and critical incidents. My Government recognizes the importance of doing everything we can to protect children and youth and will be moving forward with this initiative.</td>
<td>3/8/2016</td>
<td>Speech from the Throne</td>
<td>CYFS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sara Dow**  
Director, Policy and Strategic Planning  
Department of Child, Youth and Family Services  
Government of Newfoundland and Labrador  
95 Elizabeth Ave, PO Box 8700  
St. John’s NL, A1B 4J6  
ph: 709-729-7529  
fax: 709-729-1853
Thanks Chris.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Child, Youth & Family Services
95 Elizabeth Avenue
PO Box 8700 St. John's, NL A1B 4J6
709-729-1675 (P) 709-729-6382 (F)

Hi
I have given my edits and comments to Mabel and she will review as well.

Christine Osmond MSW, RSW
Provincial Director
Department of Child, Youth and Family Services
P.O.Box 8700 St. John's, NL
A1B 4J6
(709)729-3527(Ph), (709)729-1853(Fax)
christineosmond@gov.nl.ca
Cotter, Joanne

From: Cochrane, Rachelle
Sent: Tuesday, July 26, 2016 4:42 PM
To: Cotter, Joanne
Cc: Tilley, Jean
Subject: FW: Number of Occurrences for 2014 -2015

Let's chat tomorrow

From: Tubrett, Denise
Sent: Monday, June 22, 2015 2:47 PM
To: Cochrane, Rachelle
Cc: Cooper, Bruce
Subject: FW: Number of Occurrences for 2014 -2015

Rachelle, see below as requested. Any questions let me know. Denise

Denise Tubrett, CGA, MBA
Assistant Deputy Minister
Regional Services
Department of Health and Community Services
t. 709.729.0620
e. dtubrett@gov.nl.ca

From: Durfy-Sheppard, Denise
Sent: Monday, June 22, 2015 2:36 PM
To: Tubrett, Denise
Cc: Stone, Karen M.
Subject: Number of Occurrences for 2014 -2015

Denise
Information as per your request.

From April 1, 2014 – March 31, 2015, there were [redacted] occurrences reported and finally approved when this report was run on June 22, 2015.

According to the Severity Scale definitions used within the Clinical Safety Reporting System (CSRS), moderate - serious events are considered to be Levels 4, 5 & 6.
Level 4 severity indicates an initial or prolonged hospitalization.
Level 5 severity indicates that there was permanent harm to the client.
Level 6 indicates that the client died.

Patient Safety Act, Section 10(3)

For the time period April 1, 2014 – March 31, 2015 there were [redacted] Level 4, 5 and 6 occurrences reported. The definitions used in CSRS are purposely broad and a decision was made not to distinguish between preventable and non-preventable occurrences or adverse events.

Thanks
Denise

Denise Durfy Sheppard
Office of Adverse Health Events
Department of Health and Community Services
Confederation Building
Yes thanks for reminder.

Sent from my BlackBerry 10 smartphone on the Bell network.

Hi all

Just a reminder, could you let me know if you have responsive documents to this ATIPP request by Tuesday morning?

Hi all —

I have an update on the request and it is now refined as follows:

“All information sent to and from the Minister or the Minister’s EA in relation to mandatory reporting of critical incidents and/or deaths to the CYA from January 2016 to January 2017.”

So in your search this would only be emails, paper records, electronic records on shared drive that you sent to the Minister or the Minister sent to you. Also the end day would be January 10, 2017, as that is the date we received the request.

I’m available to discuss.
Yesterday we received the ATIPP requests noted below. As you all have involvement with the CYA file, the request CSSD 2-2017 will require you all to conduct an exhaustive search of your records. All records mean everything electronic and paper.

We are currently going back to the applicant to try and refine the parameters, but I wanted to give you all a heads up in the interim.

From: Taylor, Jennifer
Sent: Tuesday, January 10, 2017 4:33 PM
To: Cooper, Bruce; O’Rielly, Madonna; Hunt, Deanne; White, Kelly; O’Neill, Melony; Tilley, Jean; Walsh, Susan; Healey, Rick M.; Roberts, Denyse; Bragg, Dana; Ryan, Renee C.; Miller Pitt, Janet
Cc: Dow, Sara
Subject: New ATIPP requests (CSSD 1-2017 to CSSD 4-2017)
Importance: High

Good afternoon all,

CSSD 2-2017: All records with relation to or mention mandatory reporting (critical incidents or deaths) to the Child Youth Advocate from January 2016 - January 2017
[not responsive to application]

If you could please confirm if you – or any of your staff – might have records responsive to either of these requests, and let either me or Sara Dow know as soon as possible, it would be greatly appreciated.

Thank you!

Jennifer Taylor
Policy and Program Specialist/ ATIPP Coordinator (CIPP/C)
Department of Children, Seniors and Social Development
Phone: (709) 729-6370
Fax: (709) 729-0870
Email: jennifertaylor@gov.nl.ca
Hi Sara,

I have conducted an email search and have not sent or received correspondence to the minister on Critical incidents or deaths in the timeframe specified.

As I vacated the position in August 2017 I am connecting with Mark on electronic and paper records of materials that may have been prepared for minister briefings while I held the position (January – August 2016) to ensure he has covered this piece off. I will email you again regarding this piece.

Thanks

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
In Care and Adoptions
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-3527 (P) 709-729-6382 (F)

Hi all

Just a reminder, could you let me know if you have responsive documents to this ATIPP request by Tuesday morning?

Hi all

I have an update on the request and it is now refined as follows:

“All information sent to and from the Minister or the Minister’s EA in relation to mandatory reporting of critical incidents and/ or deaths to the CYA from January 2016 to January 2017.”
So in your search this would only be emails, paper records, electronic records on shared drive that you sent to the Minister or the Minister sent to you. Also the end day would be January 10, 2017, as that is the date we received the request.

I'm available to discuss.

From: Dow, Sara  
Sent: Wednesday, January 11, 2017 11:32 AM  
To: Shallow, Michelle; Cotter, Joanne; Griffin, Mark; McGrath, Dave; Roberts, Denyse; Handregan, Kellie; Oliver, Jodi  
Cc: Taylor, Jennifer; Hodder, Robert; Tilley, Jean  
Subject: FW: New ATIPP requests (CSSD 1-2017 to CSSD 4-2017)  
Importance: High

Good Morning

Yesterday we received the ATIPP requests noted below. As you all have involvement with the CYA file, the request CSSD 2-2017 will require you all to conduct an exhaustive search of your records. All records mean everything electronic and paper.

We are currently going back to the applicant to try and refine the parameters, but I wanted to give you all a heads up in the interim.

From: Taylor, Jennifer  
Sent: Tuesday, January 10, 2017 4:33 PM  
To: Cooper, Bruce; O’Rielly, Madonna; Hunt, Deanne; White, Kelly; O’Neill, Melony; Tilley, Jean; Walsh, Susan; Healey, Rick M.; Roberts, Denyse; Bragg, Dana; Ryan, Renee C.; Miller Pitt, Janet  
Cc: Dow, Sara  
Subject: New ATIPP requests (CSSD 1-2017 to CSSD 4-2017)  
Importance: High

Good afternoon all,

CSSD 2-2017: All records with relation to or mention mandatory reporting (critical incidents or deaths) to the Child Youth Advocate from January 2016 - January 2017

Not responsive to application

If you could please confirm if you – or any of your staff – might have records responsive to either of these requests, and let either me or Sara Dow know as soon as possible, it would be greatly appreciated.

Thank you!

Jennifer Taylor  
Policy and Program Specialist/ ATIPP Coordinator (CIIP/C)  
Department of Children, Seniors and Social Development  
Phone: (709) 729-6370  
Fax: (709) 729-0870
Email: jennifertaylor@gov.nl.ca
I have no idea why I don’t have a coopt of the PP presentation – I would have created it unless Paul finalized it. Still looking.

I have this note that was created for the minister – it may not be final but I guess it should be included anyway. Check to see if a different version as provided to Sara.

Joanne Cotter, MSW, RSW
Provincial Director (Acting)
In Care and Adoptions
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-3527 (P) 709-729-6382 (F)
Ministerial Information Note

Title: Mandatory Reporting of Critical Incidents and Deaths to the Advocate for Children and Youth (ACY).

Issue: Update on the process to legislate reporting of critical incidents (CI) and deaths to the Advocate for Children and Youth.

Key Messages:

- Child, Youth and Family Services take all recommendations of the Advocate for Children and Youth very seriously and are committed to implementing all requests and recommendations. Through various investigations and reviews the Advocate has made 104 recommendations to Child, Youth and Family Services. Of the 104 recommendations, 89 have been fully implemented and work continues on the remaining 15 recommendations.

- Child, Youth and Family Services continues to work toward fulfilling the direction outlined in the Minister’s December 2015 mandate letter which is to work with colleagues in other government departments and the Advocate for Children and Youth to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate.

- What is being requested is not only reporting for children and youth receiving services from the Department of Child, Youth and Family Services but also reporting of critical incidents and deaths of children and youth receiving services from the Departments of Health and Community Services, Justice and Public Safety and Education and Early Childhood Development. This means there are many parties involved such as private and public schools, child care agencies, hospitals, police, and correction services. As a new government we want to take the time required to fully understand and appreciate the implications resulting from mandatory reporting for these parties and for the government as a whole. It is important that we get this right for the children and youth in our province. Sec. 29 (1)(a)
Background:

- The Advocate’s office is a statutory office of the House of Assembly established in 2002 under the authority of the *Child and Youth Advocate Act (CYA Act)*.

- The Advocate represents the rights and interests of children and youth receiving government services and provides advocacy in four main capacities: individual advocacy, systemic advocacy, reviews and investigations and education and promotion.

- In 2008, the *CYA Act* was amended to substantially broaden the powers of the ACY to review and investigate **all** matters involving children and youth regardless if a complaint regarding a child or youth is made to the office.

- Specific powers added included the power to call and subpoena witnesses, the power to review all documentation regarding services provided to the children or youth, the power to review departmental policies and procedures and recommend changes and the ability to recommend whether government programs or services are meeting the needs of children and youth. These changes have resulted in the Advocate having one of the broadest mandates in Canada (similar to SK).

- Since 2011, three reports from the Advocate’s office have recommended the development of a protocol with CYFS for the reporting of CI’s and deaths involving children and youth.

- In July 2014, the Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of CI’s and deaths including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

- The Advocate has publicly stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CYFS.

- In November 2014, the HOA passed a motion committing to legislation to respond to the Advocate’s request for the mandatory reporting of CI’s and deaths to her office. In addition to CYFS and with the Advocate’s support, the Advocate’s request includes reporting by EECD, JPS and HCS and their bodies.
• In December 2015, the Minister of CYFS was directed in a departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting.

Current Status: Sec. 29(1)(a)

• Next Steps:
  • Continue to work with the departments and when ready, CYFS will update the Advocate on government’s progress.

Potential Questions:

1. Are all departments committed to the reporting?

   • As per the Advocate’s request, mandatory reporting is being considered for the Departments of Child, Youth and Family Services, Health and Community Services, Justice and Public Safety and Education and Early Childhood Development and their bodies. This includes parties such as the child care sector, private and aboriginal schools, regional health authorities, police and corrections services and the Advocate supports this approach.

   • CYFS is committed to continuing the work of reporting deaths and critical incidents to the Advocate.

   • If further questioned on whether all department’s support mandatory reporting add:

        • Each respective department is in the best position to comment on their support for mandatory reporting to the Advocate. Given Child, Youth and Family Service’s involvement with vulnerable children, the department is committed to continuing the work of reporting deaths and critical incidents to the Advocate.
3. Given the current fiscal restraints government is facing, are there budget implications for those departments to report deaths and critical incidents to the Advocate?

- There are no direct financial costs associated with reporting as existing departmental resources will be used, however it is anticipated that additional resources will be required to respond to requests for information from the Advocate following the department’s notification of deaths and critical incidents to the Advocate’s office. Between January and December 2015, CYFS responded to 45 written requests for information from the Advocate and frontline workers in CYFS also provided regular and ongoing updates on case specific case matters to the Advocate.

Prepared by: J. Cotter/P. Rodgers
Approved by: R. Cochrane
March 3, 2016
I can't say specifically when they were asked, but there were questions as to whether work was still being done on the matter.

Mel

Melony O'Neill
Director of Communications
Department of Children, Seniors and Social Development
6th Floor, West Block
St. John's, NL A1B 4J6
709-729-5148

Newfoundland Labrador

Children, Seniors and Social Development

Hi Melony,

I am updating the HOA note on mandatory reporting of deaths and CI's. Do you know if any questions were asked on this matter in the last HOA session?

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

Joanne, can you have a look and update if necessary?
From: O'Neill, Melony
Sent: Monday, February 20, 2017 3:50 PM
To: Tilley, Jean
Subject: Note

Here you go 😊

Mel

Melony O'Neill
Director of Communications
Department of Children, Seniors and Social Development
6th Floor, West Block
St. John's, NL A1B 4J6
709-729-5148

Newfoundland
Labrador

Children, Seniors and Social Development
Krista,

I had your last name wrong! Previous email bounced back as undeliverable.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: Cotter, Joanne
Sent: Friday, February 24, 2017 9:36 AM
To: O'Neill, Melony; Walker, Krista
Subject: HOA - Mandatory reporting

Hi there,

Her is the updated HOA note on CI/Death reporting. Few minor changes proposed to the KM's for your review.

If you make changes to the KMs can you let me know as I may also change the current status section to the attached BN.

Thanks!

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
Title: Mandatory Reporting of Critical Incidents and Deaths to the Office of the Child and Youth Advocate (OCYA)

Key Messages:

- CSSD continues to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.

- Since September 2014, my department has been voluntarily reporting all deaths to the Advocate, resulting in the reporting of about 10 deaths per year.

- The Advocate is supportive of this process, but has requested that reporting be legislated as opposed to an agreement with the department.

- Since the onset of the process, work has been done by all relevant departments, as well as the Child and Youth Advocate’s office. Each department continues to work on their individual proposed reporting protocol.

- While we recognize the process has been ongoing for some time, changes to the Advocate’s legislation impact many government departments. Therefore, consultations, input and feedback from all government departments/stakeholders was necessary.

- Since the onset of the process, a considerable amount of work has been done by all the relevant departments, as well as the Child and Youth Advocate’s office (a DM committee was established; a working group
was established which included CYA representative; groups met regularly to develop definition of critical incident and understand the parameters of CYA's request). Each department continues to work on developing their individual proposed reporting protocol.

- The proposed legislation is progressive and would be unprecedented across the country, particularly considering that no other province or territory requires that four departments including Health, Justice, Education, and Child Protection report critical incidents and deaths to the Child and Youth Advocate.

- It is also important to note that the absence of mandatory reporting to the Child and Youth Advocate does not mean that departments and agencies do not have appropriate accountability measures already in place to respond to critical incidents and deaths.

- The safety and protection of our vulnerable populations such as children and youth is an important focus for our government. We will continue to work cooperatively with the Child and Youth Advocate and also continue to review all our existing programs and services and focus on addressing any identified issues.

- The Speech from the Throne indicates our government's commitment to advancing this legislation.
Background:

- In recent years, Advocate’s reports have recommended the development of a protocol with CSSD for the reporting of CI’s and deaths involving children and youth.

- In July 2014 the former Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of deaths and CI’s including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

- The former Advocate has publically stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CSSD.

- In November 2014 the HOA passed a motion committing to legislation to respond to the Advocate’s request for mandatory reporting of CI’s and deaths to her office.

- In December 2015 the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting. A further commitment was noted in the March 2016 Speech from the Throne.

Current Status:

- The departments of CSSD, JPS, HCS and EECD are completing an in-depth analysis of the Advocate’s request to ensure we fully appreciate the implications resulting from mandatory reporting for each department and for the whole of government particularly in the current fiscal climate.

- In December 2016, Government appointed a new Advocate for Children and Youth. CSSD officials met with the new Advocate on February 23 to update her on Government’s progress and to seek her feedback on this important initiative.

- A meeting between the Advocate and DMs of CSSD, HCS, EECD and JPS is planned for the coming weeks to discuss next steps to move this initiative forward.

Prepared by/ Reviewed by: J. Cotter/J. Tilley
Hi Jean,

Here are a few discussion points for the meeting. You may choose to only use some of the bullet points under each discussion point but I think this captures the main issues.

Let me know if you have any questions.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
Krista Dalton is reviewing the KMs now for finalization. Once they are reviewed she will let me know if changes we remade as I may need to tweak the corresponding BN. So, will I just send along to you facilitate sharing of KMs with ACY?

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
Hi Sara,

I was talking with Jean today about this matter. I'll chat with you about his when you return to the office and fill you in on our discussion.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
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709-729-5172 (P) 709-729-6382 (F)
Hi Jean

I followed up with Krista as I had not heard from her. She has placed this HOA note and KMs in the Minister and DM binders for HOA. Wanted to bring that to your attention in case you review and want changes made.

Sec. 29 (1)(a)

Call me if this doesn’t make sense.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
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PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: Dalton, Krista
Sent: Friday, February 24, 2017 3:52 PM
To: Cotter, Joanne
Cc: O’Neill, Melony
Subject: RE: HOA - Mandatory reporting

Hi Joanne,

Here’s the copy that’s in the minister’s binder. If there’s any changes please provide to Melony. She’ll switch out the copies that have been provided.

Thanks,

Krista

From: Cotter, Joanne
Sent: Friday, February 24, 2017 9:38 AM
To: Dalton, Krista
Subject: FW: HOA - Mandatory reporting

Krista,

I had your last name wrong! Previous email bounced back as undeliverable.

Joanne Cotter, MSW, RSW
Hi there,

Her is the updated HOA note on CI/Death reporting. Few minor changes proposed to the KM’s for your review.

If you make changes to the KM’s can you let me know as I may also change the current status section to the attached BN.

Thanks!

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709-729-5172 (P) 709-729-6382 (F)
CYA Mandatory Reporting of Critical Incidents and Deaths

CSSD continues to work toward fulfilling the direction outlined in the December 2015 mandate letter to work with colleagues and the Advocate to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate for consideration in the House of Assembly.

In December 2015, a new Advocate for Children and Youth was appointed. I recently met with the new Advocate (February 2017) to update her on our government’s progress and to seek her feedback on this important initiative. Further discussions are planned and we will continue to work collaboratively with the Advocate as we move forward with this initiative.

Since September 2014, my department has been voluntarily reporting all deaths to the Advocate, resulting in the reporting of about 10 deaths per year.

The Advocate is supportive of this process, but has requested that reporting be legislated as opposed to an agreement with the department.

Since the onset of the process, work has been done by all relevant departments, as well as the Child and Youth Advocate’s office. Each department continues to work on their individual proposed reporting protocol.

While we recognize the process has been ongoing for some time, changes to the Advocate’s legislation impact many government departments and the Advocate’s office. Therefore, consultations, input and feedback from all government departments / stakeholders was necessary.
Since the onset of the process, a considerable amount of work has been done by all the relevant departments, as well as the Child and Youth Advocate's office (a DM committee was established; a working group was established which included CYA representative; groups met regularly to develop definition of critical incident and understand the parameters of CYA's request). Each department continues to work on developing their individual proposed reporting protocol.

The proposed legislation is progressive and would be unprecedented across the country, particularly considering that no other province or territory requires that four departments including Health, Justice, Education, and Child Protection report critical incidents and deaths to the Child and Youth Advocate.

It is also important to note that the absence of mandatory reporting to the Child and Youth Advocate does not mean that departments and agencies do not have appropriate accountability measures already in place to respond to critical incidents and deaths.

The safety and protection of our vulnerable populations such as children and youth is an important focus for our government. We will continue to work cooperatively with the Child and Youth Advocate and also continue to review all our existing programs and services and focus on addressing any identified issues.

The Speech from the Throne indicates our government’s commitment to advancing this legislation.
CYA Mandatory Reporting of Critical Incidents and Deaths

Background:

- In recent years, Advocate’s reports have recommended the development of a protocol with CSSD for the reporting of CI’s and deaths involving children and youth.

- In July 2014 the former Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of deaths and CI’s including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

- The former Advocate has publically stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CSSD.

- In November 2014 the HOA passed a motion committing to legislation to respond to the Advocate’s request for mandatory reporting of CI’s and deaths to her office.

- In December 2015 the Minister of CYFS was directed in the departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting. A further commitment was noted in the March 2016 Speech from the Throne.

Current Status:

- The departments of CSSD, JPS, HCS and EEC are completing an in-depth analysis of the Advocate’s request to ensure we fully appreciate the implications resulting from mandatory reporting for each department and for the whole of government particularly in the current fiscal climate.

- In December 2016, Government appointed a new Advocate for Children and Youth. CSSD officials met with the new Advocate on February 23 to update her on Government’s progress and to seek her feedback on this important initiative.

- A meeting between the Advocate and DMs of CSSD, HCS, EEC and JPS is planned for the coming weeks to discuss next steps to move this initiative forward.
From: Cotter, Joanne
Sent: Friday, February 24, 2017 5:06 PM
To: Tilley, Jean
Attachments: CYA Mandatory Reporting.docx
Attachment (pages 387-388) redacted under Sec. 29(1)(a)

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
Will do – send me ON’s as well.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: O'Brien, Deanne
Sent: Monday, February 27, 2017 9:07 AM
To: Cotter, Joanne
Subject: RE: mandatory reporting info

Yes please send along.

From: Cotter, Joanne
Sent: Friday, February 24, 2017 4:29 PM
To: O'Brien, Deanne
Subject: mandatory reporting info

Materials as discussed. Do you have BC and SK’s policies? I can send it to you

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
k- I’ll put these in an agenda and get Denise to circulate today and advise folks they can also add agenda items

Joanne Cotter, MSW, RSW  
Senior Policy Analyst  
Department of Children, Seniors and Social Development  
6th Floor, West Block  
Confederation Building  
PO Box 8700 St. John’s, NL A1B 4J6  
709-729-5172 (P)  709-729-6382 (F)

From: Tilley, Jean  
Sent: Tuesday, April 04, 2017 4:56 PM  
To: Cotter, Joanne  
Subject: RE: Thursday’s meeting with OCYA

Sounds good. an agenda would be great.

From: Cotter, Joanne  
Sent: Tuesday, April 04, 2017 4:54 PM  
To: Tilley, Jean  
Subject: Thursday’s meeting with OCYA

Should we pull together an agenda for Thursday’s meeting? From my review, the following requires discussion (not all for Thursday of course)
Hi Ian,

Can you hang around for a few minutes tomorrow after the mtg with the OCYA?

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John’s, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
That's great – if you could tentatively hold while we hear from Steve that would be great.

Karen, left you a v/m- give me a call tomorrow if you're free.

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)

From: Kenny, Samantha
Sent: Monday, May 08, 2017 4:18 PM
To: Cotter, Joanne
Subject: RE: Meeting - Mandatory reporting

HI Joanne,

Hope you had a nice vacation! 😊
I'm good for the 16th in the afternoon. Samantha

From: Cotter, Joanne
Sent: Monday, May 08, 2017 4:13 PM
To: Gray, Karen; Kenny, Samantha; Ring, Stephen R.
Subject: Meeting - Mandatory reporting

Hi folks,

Sec. 40 (1)

So checking in to see if we could meet next Tuesday (16th) - late afternoon?

Let me know – thanks

Joanne Cotter, MSW, RSW
Senior Policy Analyst
Department of Children, Seniors and Social Development
6th Floor, West Block
Confederation Building
PO Box 8700 St. John's, NL A1B 4J6
709-729-5172 (P) 709-729-6382 (F)
Ministerial Information Note

Title: Mandatory Reporting of Critical Incidents and Deaths to the Advocate for Children and Youth (ACY).

Issue: Update on the process to legislate reporting of critical incidents (CI) and deaths to the Advocate for Children and Youth.

Key Messages:

- Child, Youth and Family Services take all recommendations of the Advocate for Children and Youth very seriously and are committed to implementing all requests and recommendations. Through various investigations and reviews the Advocate has made 104 recommendations to Child, Youth and Family Services. Of the 104 recommendations, 89 have been fully implemented and work continues on the remaining 15 recommendations.

- Child, Youth and Family Services continues to work toward fulfilling the direction outlined in the Minister’s December 2015 mandate letter which is to work with colleagues in other government departments and the Advocate for Children and Youth to develop legislation on mandatory reporting of critical incidents and deaths to the Advocate.
Background:

- The Advocate’s office is a statutory office of the House of Assembly established in 2002 under the authority of the Child and Youth Advocate Act (CYA Act).

- The Advocate represents the rights and interests of children and youth receiving government services and provides advocacy in four main capacities: individual advocacy, systemic advocacy, reviews and investigations and education and promotion.

- In 2008, the CYA Act was amended to substantially broaden the powers of the ACY to review and investigate all matters involving children and youth regardless if a complaint regarding a child or youth is made to the office.

- Specific powers added included the power to call and subpoena witnesses, the power to review all documentation regarding services provided to the children or youth, the power to review departmental policies and procedures and recommend changes and the ability to recommend whether government programs or services are meeting the needs of children and youth. These changes have resulted in the Advocate having one of the broadest mandates in Canada (similar to SK).

- Since 2011, three reports from the Advocate’s office have recommended the development of a protocol with CYFS for the reporting of CI’s and deaths involving children and youth.

- In July 2014, the Advocate tabled a briefing note in the HOA outlining her rationale for the mandatory reporting of CI’s and deaths including that the current delay in receiving information from government about child deaths prevents her from intervening early to advocate or investigate matters and to prevent future incidents from occurring.

- The Advocate has publicly stated the need for legislative change after she became aware through the media (who were advised through an ATIPPA request) of the deaths of 26 children previously involved with CYFS.

- In November 2014, the HOA passed a motion committing to legislation to respond to the Advocate’s request for the mandatory reporting of CI’s and deaths to her office. In addition to CYFS and with the Advocate’s support, the Advocate’s request includes reporting by EECD, JPS and HCS and their bodies.
• In December 2015, the Minister of CYFS was directed in a departmental mandate letter to develop legislation for consideration by the HOA regarding this reporting.

Current Status:

Sec. 29(1)(a)

Next Steps:

Sec. 29(1)(a)

• Continue to work with the departments and when ready, CYFS will update the Advocate on government’s progress.

Potential Questions:

1. Are all departments committed to the reporting?

• As per the Advocate’s request, mandatory reporting is being considered for the Departments of Child, Youth and Family Services, Health and Community Services, Justice and Public Safety and Education and Early Childhood Development and their bodies. This includes parties such as the child care sector, private and aboriginal schools, regional health authorities, police and corrections services and the Advocate supports this approach.

• CYFS is committed to continuing the work of reporting deaths and critical incidents to the Advocate.

• If further questioned on whether all department’s support mandatory reporting add:

• Each respective department is in the best position to comment on their support for mandatory reporting to the Advocate. Given Child, Youth and Family Service’s involvement with vulnerable children, the department is committed to continuing the work of reporting deaths and critical incidents to the Advocate.
3. **Given the current fiscal restraints government is facing, are there budget implications for those departments** to report deaths and critical incidents to the Advocate?

- There are no direct financial costs associated with reporting as existing departmental resources will be used, however it is anticipated that additional resources will be required to respond to requests for information from the Advocate following the department’s notification of deaths and critical incidents to the Advocate’s office. Between January and December 2015, CYFS responded to 45 written requests for information from the Advocate and frontline workers in CYFS also provided regular and ongoing updates on case specific case matters to the Advocate.

Prepared by:  J. Cotter/P. Rodgers  
Approved by:  R. Cochrane  
March 3, 2016
Taylor, Jennifer

From: McGrath, Dave  
Sent: Thursday, June 01, 2017 1:32 PM  
To: Taylor, Jennifer  
Subject: FW: Death/Critical Incidents  

From: Cotter, Joanne  
Sent: Wednesday, December 16, 2015 10:28 AM  
To: Rodgers, Paula; Maddick, Herb; Jewer, Rhonda J; Cull, Barbara L.; Evans, Sandra; Handregan, Kellie; McGrath, Dave; Tilley, Jean  
Subject: RE: Death/Critical Incidents

hi, apparently there's an issue with the cu form. I have reattached. hopefully it will work this time.

From: Cotter, Joanne  
Sent: Tuesday, December 15, 2015 5:13 PM  
To: Rodgers, Paula; Maddick, Herb; Jewer, Rhonda J; Cull, Barbara L.; Evans, Sandra; Handregan, Kellie; McGrath, Dave; Tilley, Jean  
Subject: Death/Critical Incidents

Hi everyone,

Attached please find the updated policy direction document, which will form the basis for policy revisions, and a revised CI/Death form based on our last meeting.

Meeting minutes will be sent out tomorrow for review in advance of Thursday's meeting. Please review the document and the form and advise me of any changes on Thursday. Thanks JC
Newfoundland Labrador
Child, Youth and Family Services

Section 1: Client Information

- Last Name:
- First Name:
- Date of Birth: (YYYY-MM-DD)
- Age:
- Gender:
- CRMS ID for Child:

Aboriginal Status/Identity
- Child/Custody Status:
- If child is Aboriginal, please select:
  - Aboriginal
  - Non-Aboriginal
If not applicable please specify:

Section 2: Family Composition

- Parent(s) Name:
- Step Parent(s)/Partner(s) of Parent(s):
- Current Care Provider (if applicable) and relationship to child:

siblings (if 21 years of age and under):

- Name:
- Age
- Date of Birth (YYYY-MM-DD)
- Child's Status
- Where Not Applicable Specify Child's Status

Section 3: CYFS Information

Social Worker assigned to follow up on death / critical incident:
- Region:
- Clinical Program Supervisor for Social Worker:
- Zone Manager for Social Worker:

Current Open Program(s) (Check all that apply & include CRMS ID#)
- Protective Intervention
- Kinship
- In-Care
- No Open Program
- Youth Services
- Adoptions
- Community Youth Corrections

Please specify program:
- Secure Custody
- Open Custody

If no open programs, please explain: (include dates programs closed)
Section 4: Details of Death / Critical Incident

Date & Time Child, Youth and Family Services notified:

Name of Social Worker notified of death / critical incident:

Date Notified: (YYYY-MM-DD) Time Notified: ☐ A.M. ☐ P.M. Date of Death / Critical Incident: (YYYY-MM-DD)

Type of Notification: ☐ Death ☐ Critical Incident

Type of Critical Incident:

Description of death or critical incident:

Supplementary Attachment? ☐ Yes ☐ No

Section 5: Response to Death / Critical Incident

Immediate:

Further follow up, if required:

Please specify the internal/external service providers who have been notified about the death/critical incident:

Please specify the internal/external service providers who will be notified about the death/critical incident:

Section 6: Review

Social Worker completing form: (print name) Date: (YYYY-MM-DD)

Name of Supervisor (print name) Date: (YYYY-MM-DD)

Name of Zone Manager (print name) Date: (YYYY-MM-DD)

Final Review:

I, __________________________ have reviewed the circumstances and I am satisfied with the plan for further follow-up.

Name of Regional Director

Regional Director's Signature Date: (YYYY-MM-DD)

Form MUST be submitted to the ADM - Service Delivery & Regional Operations, and Director of Quality Assurance.
Section 7: ADM Review (to be completed by the ADM - Service Delivery and Regional Operations)

Date Received:
(YYYY-MM-DD)

Action Required:
☐ No further action required of regional staff
☐ Further action required of regional staff
☐ Quality Assurance to complete file summary

Date Chief Medical Officer Notified: (If applicable) (YYYY-MM-DD)

Date Child & Youth Advocate Notified: (YYYY-MM-DD)

Date DM Initially Briefed: (YYYY-MM-DD)

Date Minister Initially Briefed: (YYYY-MM-DD)

Explanation of current status and action required of regional staff:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

ADM’s Signature

Date: (YYYY-MM-DD)
June 24, 2016

Ms. Carol A. Chafe
Advocate for Children and Youth
Office of the Child and Youth Advocate
193 LeMarchant Road
St. John’s, NL A1C 2H5

Dear Ms. Chafe:

Thank you for your recent letter of May 27, 2016 detailing your continued commitment regarding the mandatory reporting to your office of deaths and critical incidents involving children and youth receiving government services.

I appreciate your interest in moving this matter forward and I trust my Ministers are continually to carefully examine the proposed legislative changes.

We will continue to collaborate with you on this matter, and the Minister of Child, Youth and Family Services will continue to consult with you as this work moves forward.

Sincerely,

[Signature]

DWIGHT BALL
Premier
MHA, Humber-Gros Morne

cc: Sherry Gambin-Walsh, Minister, Child, Youth and Family Services
Deanne

Pls log and copy to Jean and Joanne Cotter

Sent from my BlackBerry 10 smartphone on the Bell network.

Good afternoon everyone,

Today the Premier received a letter from the CY Advocate regarding legislative changes.

I am forwarding a copy of the letter to those people and departments referenced in the attached letter.

Thank you and have a great weekend.

Kind regards,

Joy

Joy Buckle
Senior Advisor – Social Policy and ATIPP Coordinator
Office of the Premier
Government of Newfoundland and Labrador
Tel (709) 729-4304
May 27, 2016

The Honourable Dwight Ball  
Premier of Newfoundland and Labrador  
Office of the Premier  
East Block, Confederation Building  
P.O. Box 8700  
St. John’s, NL A1B 4J6

Re: Amendment to Child and Youth Advocate Act

Dear Premier Ball:

Thank you for your quick response to my letter of March 4, 2016 and your continuing commitment to move this very important initiative forward as you also clearly stated in the Speech from the Throne, March 8, 2016. Further to my letter of March 4, 2016 and your reply of March 16, 2016, it is once again necessary to bring my continuing concerns to your attention. For your convenience I have attached my letter and summaries sent to you on March 4, 2016.

At this time, I would like to advise you that in my Quarterly Meeting with Minister Sherry Gambin-Walsh and Ms. Rachelle Cochrane, Deputy Minister, Child, Youth and Family Services on May 25, 2016 I requested an update on the status of progress on the amendments that I am seeking. Unfortunately, the update I received was very disappointing and concerning in that no progress has been made and I was not reassured that it would happen. To date, I have not been contacted by any of the four key departments: Departments of Child, Youth and Family Services, Justice and Public Safety, Education and Early Childhood Development and Health and Community Services to meet and work with them to progress the changes to this very important legislation. It was clearly directed in your Mandate Letter to Minister Gambin-Walsh of December 14, 2015 which stated "I expect you to work with your colleagues and the Child and Youth Advocate to develop legislation for the House of Assembly that will make it mandatory to report deaths and critical incidents to the Advocate."

Premier, once again I cannot stress how important it is that these legislative changes are made in order for me to fulfill the mandate of the Child and Youth Advocate to ensure that the rights of all children and youth are upheld and their voices are heard.
I have just completed an intensive review of a total of forty-three (43) deaths and forty-three (43) critical incidents involving children and youth from 2009 – 2014 who receive services from Child, Youth and Family Services. These were provided to me after I requested information once I became aware of the ATIPPA request by the media in 2014. This intensive review certainly reinforces for me the need to be notified in a timely manner so that I can advocate and as necessary, investigate on behalf of our children and youth to prevent further tragedies.

I am currently conducting six (6) investigations involving two (2) deaths and four (4) critical incidents and will soon be calling a further four (4) investigations, involving one (1) death, and three (3) critical incidents. This also reinforces for me that I need to be aware of these in a much timelier manner. It is not right that I can only do what needs to be done for the children and youth that I “happen to become aware of” through various avenues.

Respectfully, I once again request that these legislative changes be a priority of your government and that it move forward now so that we can all ensure that, as stated in the Speech from the Throne March 8, 2016, “the importance of doing everything we can to protect children and youth” happens. As I have previously advised you in my letter of March 4, 2016 most of the work for these legislative changes including the agreed upon definition of what a critical incident is and the required reporting timeframes were already completed through intensive work and collaboration between the four key departments and my office from January to June 2015. This is very important work that can easily be built upon in a very short time, but thus far no request to do so has occurred.

I would like to take this opportunity to commend the Department of Child, Youth and Family Services for continuing to provide me with notification of deaths as per the verbal agreement in 2014. However this must also be expanded to include critical incidents. As well it is imperative that the other government departments do the same. My mandate is for all children and youth receiving all government services not just the Department of Child, Youth and Family Services. As well while a verbal agreement is something, it is not what is needed to ensure it always happens for all children and youth today and in the years to come.

I look forward to continuing the discussion and collaboration to ensure that we do everything to prevent future deaths and critical incidents for every child and youth in our province. As always, I am available to discuss this matter at your convenience.

Yours truly,

Carol A. Chafe
Advocate for Children and Youth

Enclosures
March 16, 2016

Ms. Carol A. Chafe  
Child and Youth Advocate  
Office of the Child and Youth Advocate  
193 LeMarchant Road  
St. John’s, NL, A1C 2H5

Dear Ms. Chafe:

Thank you for your letter detailing your ongoing commitment and advocacy regarding the mandatory reporting to your office of deaths and critical incidents involving children and youth receiving government services. As indicated in the Speech from the Throne, government recognizes the importance of doing everything we can to protect children and youth, and our commitment to this reporting.

The Department of Child, Youth and Family Services continues to work toward fulfilling the direction outlined in the Minister of Child, Youth and Family Services’ December 2015 mandate letter to work with her colleagues and your office on legislation that would result in reporting to your office. I understand the Minister has met with the Ministers of Health and Community Services, Justice and Public Safety, and Education and Early Childhood Development to discuss this matter.

I certainly appreciate your interest in advancing this work on a priority basis and, I too, share your interest in seeing this completed. As a new government, it is essential that we fully understand the implications of all new policy initiatives, and I am trusting my Ministers to carefully examine all new requirements that could be placed on public services. The Minister has advised that much work has been completed including an understanding of what is a critical incident and the reporting timeframes you are seeking.

We will continue to collaborate with you on this important initiative, and the Minister will continue to consult with you as this moves forward.

Sincerely,

[Signature]

DWIGHT BALL  
Premier  
MHA, Humber-Gros Morne

cc: Honourable Sherry Gambin-Walsh, Minister of Child, Youth and Family Services
The Honourable Dwight Ball  
Premier of Newfoundland and Labrador  
Office of the Premier  
East Block, Confederation Building  
P.O. Box 8700  
St. John's, NL A1B 4J6  

RE: Amendment to Child and Youth Advocate Act  

Dear Premier Ball:  

As you are aware, I am seeking an amendment to the Child and Youth Advocate Act that will include mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident or when a death of a child or youth occurs. As the representative for children and youth in Newfoundland and Labrador, it is paramount that I have the information I need in order to ensure that the rights and interests of every child and youth are protected and advanced. Mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs will allow me, as the Advocate for Children and Youth, to fulfill my mandate.  

After conducting three separate investigations in August 2011, July 2012 and September 2012, I made the same recommendation to the Department of Child, Youth and Family Services in each investigative report to develop protocol with my office to ensure immediate reporting of any critical incidents or sentinel events occurring with children and youth throughout the province. I did not receive an adequate nor an appropriate response or action on this recommendation. Therefore, in accordance with the Child and Youth Advocate Act Section 24, on September 8, 2014 I sent a letter to the Honourable Thomas Marshall, Premier requesting that he bring this report of non-compliance forward to Cabinet. In response to my request, the Premier advised he discussed this issue with the Honourable Paul Davis, Premier Designate as part of transition discussions.  

On July 31, 2014 I sent a letter to the Honourable Ross Wiseman, Speaker of the House of Assembly and outlined my request for amendment to the Act, and provided a Briefing Note and Backgrounder. On October 3, 2014, I also sent this request and documents to the
Honourable Paul Davis, Premier. As a result, since the fall of 2014 I completed a presentation to Cabinet as well as to the Deputy Ministers' working committee established to review my request.

From February to June of 2015, my office collaborated on the working committee chaired by the Department of Child, Youth and Family Services with representation from the Department of Justice and Public Safety, the Department of Health and Community Services and the Department of Education and Early Childhood Development. The mandate of the working committee was to define critical incidents and prepare a Cabinet Submission to propose these legislative changes. Much hard work and collaboration occurred by this committee and the departments involved, however the House of Assembly closed on June 23, 2015 before the Cabinet Submission was tabled. At that time, there were two outstanding issues we were working to resolve in the Submission, regarding the inclusion of regulated child care and aboriginal schools. Premier Paul Davis publically stated that he was considering having the House of Assembly sit in the Fall of 2015 before the provincial election to pursue legislative changes to the Child and Youth Advocate Act; this did not occur.

I was pleased and encouraged to read in your mandate letter dated December 14, 2015 to the Honourable Sherry Gambin-Walsh, Minister of Child, Youth and Family Services that you expect the Minister "...to work with your colleagues and the Child and Youth Advocate to develop legislation for the House of Assembly that will make it mandatory to report deaths and critical incidents to the Advocate." Further, when I met with the Minister on January 6, 2016, I was advised that she planned to meet with the ministers of the Department of Justice and Public Safety, the Department of Health and Community Services and the Department of Education and Early Childhood Development. I was also advised by the Minister that she would follow up within two weeks. On February 15, 2016, I contacted the Deputy Minister of Child, Youth and Family Services regarding this issue and was told there was no update.

On February 29, 2016, I met with Minister Gambin-Walsh and executives from the Department of Child, Youth and Family Services for a scheduled quarterly meeting. I was surprised and concerned to learn in this meeting that while meetings have occurred between the Ministers of the departments involved, nothing has been done to date to address the two outstanding issues.

In August 2016, it will be five years since I first put forth the recommendation for a protocol to ensure immediate reporting of critical incidents to my office by the Department of Child, Youth and Family Services. In June 2016, it will two years since I publically stated I would seek legislative change regarding mandatory reporting by government departments and agencies to the Child and Youth Advocate when a child or youth receiving services dies or is involved in a critical incident. Currently, it has been over one year since my office collaborated on the working committee chaired by the Department of Child, Youth and Family Services with representation from the Department of Justice and Public Safety, the Department of Health and Community Services and the Department of Education and Early Childhood Development.
It is critical that these legislative changes are made in order for me to fulfill the mandate of the Child and Youth Advocate and ensure that the rights of all children and youth are upheld and their voices are heard. When a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs, the Child and Youth Advocate Act grants me the legislative authority to conduct an independent investigation and provide advocacy services. Unfortunately however, I only become aware of some of these through other avenues such as media, family members or contacts to my office. With this amendment, it will be mandatory that government departments and agencies, in particular, the Department of Child, Youth and Family Services, the Department of Justice and Public Safety, the Department of Health and Community Services and, the Department of Education and Early Childhood Development notify me of these unfortunate events. Ultimately this will allow my staff and I to provide more comprehensive and timely advocacy services. This amendment means that I will be notified when there is a death or a critical incident involving every child or youth receiving government services such as in schools, hospitals, foster homes or a youth detention centre. Immediate notification will allow me as the Advocate to mobilize quickly to investigate, produce recommendations and prevent further harm. It will also enable immediate provision of an advocacy role to ensure all children and youth involved receive supports and services.

Any further delays in implementing this very important amendment continues to jeopardize the rights and interests of every child and youth in Newfoundland and Labrador. Their rights must be protected and advanced, and their voices heard. I ask that you make the children and youth of this province a priority of your government.

The proposed legislative changes are progressive both provincially and nationally and will result in a positive change for the rights and interests for all children and youth in Newfoundland and Labrador. Enclosed for your information are the Briefing Note and Backgrounder that were sent to Premier Paul Davis on October 3, 2014. As the House of Assembly is set to open on March 8, 2016, I look forward to working with the Provincial Government of Newfoundland and Labrador to move forward with the amendment to the Child and Youth Advocate Act. I am available to discuss this matter at your convenience.

Yours truly,

Carol A. Chafe
Advocate for Children and Youth

Enclosures
House of Assembly Management Commission
Briefing Note

Title: Amendment to the Child and Youth Advocate Act

Issue: Amendment to the Child and Youth Advocate Act to include mandatory reporting of critical incidents or death of a child or youth to the Advocate by any Government Department or Agency providing services to the child or youth

Background and Analysis:

The Office of the Child and Youth Advocate (OCYA) is a Statutory Office of the House of Assembly. The office was established under the authority of the Child and Youth Advocate Act and opened in 2002. The OCYA represents the rights, interests and viewpoints of children and youth who are entitled to services and programs provided by the Provincial Government. The OCYA provides advocacy services to children and youth in four (4) main capacities: Individual Advocacy, Systemic Advocacy, Reviews and Investigations, and Education and Promotion.

The Advocate is seeking legislative changes to require government departments and agencies to notify the Advocate when a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs. This immediate notification will allow the Advocate to mobilize quickly to investigate, produce recommendations and prevent further harm. It is imperative that the Advocate receive timely information in the event of a critical incident or death of a child or youth.

Currently there is no requirement under the legislation for any government department or agency to provide notification to the Advocate when a critical incident or death of a child or youth occurs. This causes delays in the Advocate becoming involved in a case and results in the Advocate being unable to immediately provide an advocacy role to ensure that the children and youth involved receive supports and services. Delays in receiving information also affect the timeline in which investigations are completed and recommendations are put forth. The longer the investigation and recommendations are delayed the greater the risk of another child or youth being harmed. Mandatory reporting of critical incidents and deaths to the Advocate would enable the Advocate to respond to situations in a more timely manner.

Not learning of events as they occur prevents the Advocate from advocating on behalf of children and youth, from being proactive and from having the opportunity to engage with service providers to ensure services are provided to the child or youth to address the issue. There are times when the Advocate becomes aware of these incidents by “chance”; through the media; a parent or youth calling; or, a concerned citizen or anonymous person contacting the office. A formal process is needed.

The requested change in legislation would require government departments and agencies to report critical incidents and deaths to the Advocate. The Advocate’s current legislation is strong and envied by many of the Advocate’s counterparts across the country as it, mandates that once the Advocate asks for documents or information it has to be provided.

A legislative scan of Child and Youth Advocate Acts from across Canada was completed. The scan revealed that in the legislation of British Columbia and Alberta there are specific requirements for the reporting of critical injuries and sentinel events. British Columbia’s legislation states that once a public body, responsible for providing services to children, youth and their families becomes aware of a critical
injury or death they must provide information respecting the injury or death to the Representative. Once this information has been received the Representative has the authority to conduct a review. Alberta’s legislation states that when a child is seriously injured or dies while receiving a service, the public body responsible for the service shall report the incident to the Advocate as soon as practicable.

The Advocate is requesting a change in legislation to keep children safe and to better protect children and youth who are in care or are receiving government services. If the Advocate is aware that something has happened with a child or youth she can immediately investigate, make recommendations and prevent similar incidents from reoccurring.

Analysis:

Legal Consultation:
N/A

Internal Consultation(s):
N/A

External Consultation(s):
N/A

Comparison to Government Policy:
N/A

Financial Impact:
N/A

Legislative Impact:
Amendments will be required to the Child and Youth Advocate Act to require mandatory reporting when a critical incident or death of a child or youth occurs.

Options:
1. Approve the proposed amendments to the Child and Youth Advocate Act.
2. Not approve the proposed amendments to the Child and Youth Advocate Act.

Status:
The current legislation applies.

Action Required:
Approval for the proposed amendments to the Child and Youth Advocate Act.

Drafted by: Heather Lannon
Approved by: Carol A. Chafe

Date: July 31, 2014
Backgrounder: Amendment to the Child and Youth Advocate Act.

October 3, 2014

Advocate for Children and Youth Mandate

The mandate of the Advocate for Children and Youth (ACY) is to ensure that the rights and interests of children and youth are protected and advanced and that their views are heard and considered. In my role as the Advocate, an important part of this mandate involves providing information about the availability, effectiveness, responsiveness and relevance of services to children and youth.

When a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs, the Child and Youth Advocate Act grants me the legislative authority to conduct an independent investigation. The goal of any investigation I undertake is to mitigate the likelihood of similar circumstances reoccurring for other children and youth in Newfoundland and Labrador.

While the Child and Youth Advocate Act permits my office to provide advocacy services and conduct investigations, it does not specify mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident or when a death of a child or youth occurs. Unfortunately, the absence of notification presents a barrier to ensuring my mandate is met; without timely information regarding critical incidents and deaths, potential advocacy services and investigations are delayed or not provided. Subsequently, any recommendations pertaining to such investigations are delayed, resulting in the continuation of risks to children and youth.

Recent Media Attention

In recent weeks, I have been asked on multiple occasions to speak to 35 deaths of children and youth since the formation of the Department of Child, Youth and Family Services in 2009. Of these 35 deaths, I was only aware of six before the additional 27 came to my attention through the media and subsequently two notifications since August by the Department of Child, Youth and Family Services. In fact, the six that I was aware of had previously come to my attention through the media. Whenever I become aware of a death or critical incident of a child or youth...
Backgrounder: Amendment to the Child and Youth Advocate Act.

October 3, 2014

receiving government services, regardless of the source, I immediately seek out additional information from the department or agency involved and assess whether or not my office has an advocacy role for that child or youth and any other children and youth involved.

Seeking Legislative Changes for All Departments/Agencies

Since becoming the Advocate for Children and Youth, I have determined this informal process to be problematic as it does not allow for a timely and comprehensive assessment of all issues emerging for children and youth. As the Advocate for Children and Youth, I should be given all the information needed in order to fulfill my mandate of providing advocacy for all the children and youth in this province.

I wish to clarify that the groundwork for seeking legislative change to the Child and Youth Advocate Act commenced prior to the recent media reports. In addition, it should be acknowledged that the legislative changes I will be seeking to the Child and Youth Advocate Act regarding notification will not be limited to the notification of deaths of children and youth receiving services from the Department of Child, Youth and Family Services. It is imperative that I am notified in a timely manner following the death of a child or youth but also equally imperative in the event that a child or youth is involved in a critical incident. Further, not only is this applicable to Child, Youth and Family Services, but to all provincial government departments and agencies that serve children and youth.

Child Death Review Committee and Chief Medical Examiner

I also wish to address the mandates of the Chief Medical Examiner and the newly appointed Child Death Review Committee and highlight the difference of my role. The Child Death Review Committee has the legislated mandate to complete a multi-disciplinary review of all child deaths reported to the Office of the Chief Medical Examiner under the Fatalities Investigations Act. The Child Death Review Committee aims to help to prevent deaths and to improve the health and safety of children which will have a positive impact on the overall health and safety of children and youth in this province. The review process involves a paper review that is forwarded to the Minister of Justice.

There are a number of key points that set the mandate of the Advocate for Children and Youth apart from the Child Death Review Committee. When the death of a child or youth receiving government services occurs, I may call an investigation under the Child and Youth Advocate Act. Rather than investigate the cause of death, my office analyzes whether or not the services
Backgrounder: Amendment to the Child and Youth Advocate Act.

October 3, 2014

provided to a child or a youth up to his or her death met his or her needs and if his or her right to services was upheld. For example, one current investigation involves a four-month-old baby who died while receiving government services. The cause of death was head trauma of which a parent has been criminally charged. While the Chief Medical Examiner and Child Death Review Committee would look at the physical cause of death, my office will analyze all government services provided up until the baby’s death and examine whether or not these services met this baby’s needs and if this baby’s rights were upheld.

Further, my office operates from a rights-based perspective, referencing the United Nations Convention on the Rights of the Child (UNCRC) which ensures the protection and advancement of children’s rights are embedded within the recommendations made. In addition, the process for investigations is not limited to a paper file review and often involves a comprehensive review of documents, policies and legislation of multiple departments and agencies; interviews with professionals and family members; analysis of facts; development of recommendations to government and agencies; and a written report that may be distributed publicly. As well, a comprehensive follow-up process on recommendations with the applicable departments and agencies commences following the completion of an investigation.

Another key difference, that sets my mandate apart from the Child Death Review Committee and Chief Medical Examiner is that my investigative scope is not limited to child deaths. Investigating and providing immediate advocacy services in response to critical incidents involving children and youth receiving government services is unique to the Advocate for Children and Youth. The investigative report Sixteen, released last year, investigated services provided to a youth who was convicted of offences in relation to a tragic fire. Currently, one of the investigations being completed involves a critical incident of a traumatic removal of children from a family of new Canadians. Another current investigation involves severe sexual and physical abuse of several children over a 13 year timeframe while they received government services. In addition to investigations, every day individual advocacy staff at the Advocate for Children and Youth respond to situations requiring advocacy services. In order to investigate and immediately respond to critical incidents, I must be aware of them when they occur.

Importance of Legislation Change

I cannot stress enough, the importance that it be a legislated duty for departments and agencies to report to the Advocate when a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs. I am pleased with the
Backgrounder: Amendment to the Child and Youth Advocate Act.

October 3, 2014

verbal agreement from the Minister of Child, Youth and Family Services that all deaths will be reported to me when the Minister becomes aware. However, the ability to fulfill my mandate cannot be dependent on a particular minister’s choice or decision to notify me. In addition, this verbal agreement does not include critical incidents and does not apply to all government departments and agencies. As the representative for children and youth in Newfoundland and Labrador, it is paramount that I have the information I need in order to ensure that the rights and interests of every child and youth are protected and advanced.

Carol A. Chafe
Advocate for Children and Youth
June 22, 2016

Ms. Carol A. Chafe
Advocate for Children and Youth
Office of the Child and Youth Advocate
193 LeMarchant Road
St. John’s, NL, A1C 2H5

Dear Ms. Chafe:

Thank you for your letter detailing your continued commitment regarding the mandatory reporting to your office of deaths and critical incidents involving children and youth receiving government services. A review of the materials provided with this letter indicates the proposed legislative changes are progressive in nature and will further strengthen the existing broad legislative mandate which envied by many of your national colleagues.

I appreciate your interest in moving this matter forward and I trust my Ministers are carefully examining the implications of this policy initiative. It is important we take the time necessary to review processes currently in place in government departments to respond to deaths and critical incidents to avoid unnecessary duplication of accountability processes. This is especially important given the province’s current fiscal situation.

We will continue to collaborate with you on this matter and the Minister of Child, Youth and Family Services will continue to consult with you as this work moves forward.

Sincerely,

DWIGHT BALL
Premier
MHA, Humber-Gros Morne

cc: Sherry Gambin-Walsh, Minister, Child, Youth and Family Services
March 16, 2016

Ms. Carol A. Chafe
Child and Youth Advocate
Office of the Child and Youth Advocate
193 LeMarchant Road
St. John’s, NL, A1C 2H5

Dear Ms. Chafe:

Thank you for your letter detailing your ongoing commitment and advocacy regarding the mandatory reporting to your office of deaths and critical incidents involving children and youth receiving government services. As indicated in the Speech from the Throne, government recognizes the importance of doing everything we can to protect children and youth, and our commitment to this reporting.

The Department of Child, Youth and Family Services continues to work toward fulfilling the direction outlined in the Minister of Child, Youth and Family Services’ December 2015 mandate letter to work with her colleagues and your office on legislation that would result in reporting to your office. I understand the Minister has met with the Ministers of Health and Community Services, Justice and Public Safety, and Education and Early Childhood Development to discuss this matter.

I certainly appreciate your interest in advancing this work on a priority basis and, I too, share your interest in seeing this completed. As a new government, it is essential that we fully understand the implications of all new policy initiatives, and I am trusting my Ministers to carefully examine all new requirements that could be placed on public services. The Minister has advised that much work has been completed including an understanding of what is a critical incident and the reporting timeframes you are seeking.

We will continue to collaborate with you on this important initiative, and the Minister will continue to consult with you as this moves forward.

Sincerely,

Dwight Ball
Premier
MHA, Humber-Gros Morne

cc: Honourable Sherry Gambin-Walsh, Minister of Child, Youth and Family Services
Hi Joanne,

Attached, for the attention of your Minister, is a letter to Premier Ball dated March 4, 4016, from Carol Chafe, Advocate for Children and Youth.

We are requesting a draft response from your department for the Premier's signature. Please forward draft to premier@gov.nl.ca account.

Thank you,
Kala

------< HP TRIM Record Information >------

Record Number: ICOR2016/0741
Title : Letter dated March 4, 2016 to Premier Ball from Carol A Chafe, Advocate for Children and Youth regarding amendments to the Child and Youth Advocate Act to include mandatory notification when critical incident or death occurs

530
March 4, 2016

CONFIDENTIAL

The Honourable Dwight Ball
Premier of Newfoundland and Labrador
Office of the Premier
East Block, Confederation Building
P.O. Box 8700
St. John's, NL A1B 4J6

RE: Amendment to Child and Youth Advocate Act

Dear Premier Ball:

As you are aware, I am seeking an amendment to the Child and Youth Advocate Act that will include mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident or when a death of a child or youth occurs. As the representative for children and youth in Newfoundland and Labrador, it is paramount that I have the information I need in order to ensure that the rights and interests of every child and youth are protected and advanced. Mandatory notification from government departments and agencies when a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs will allow me, as the Advocate for Children and Youth, to fulfill my mandate.

After conducting three separate investigations in August 2011, July 2012 and September 2012, I made the same recommendation to the Department of Child, Youth and Family Services in each investigative report to develop protocol with my office to ensure immediate reporting of any critical incidents or sentinel events occurring with children and youth throughout the province. I did not receive an adequate nor an appropriate response or action on this recommendation. Therefore, in accordance with the Child and Youth Advocate Act Section 24, on September 8, 2014 I sent a letter to the Honourable Thomas Marshall, Premier requesting that he bring this report of non-compliance forward to Cabinet. In response to my request, the Premier advised he discussed this issue with the Honourable Paul Davis, Premier Designate as part of transition discussions.

On July 31, 2014 I sent a letter to the Honourable Ross Wiseman, Speaker of the House of Assembly and outlined my request for amendment to the Act, and provided a Briefing Note and Backgrounder. On October 3, 2014, I also sent this request and documents to the

1931 Macdonald Road, St. John's, NL A1B 2A5
Tel: 709-726-5888 • Toll Free: 1-866-233-5888 • FAX: 709-726-5888 • Email: info@cyadvocate.nlb.ca • Website: www.childandyouthadvocate.nlb.ca

531
Honourable Paul Davis, Premier. As a result, since the fall of 2014 I completed a presentation to Cabinet as well as to the Deputy Ministers' working committee established to review my request.

From February to June of 2015, my office collaborated on the working committee chaired by the Department of Child, Youth and Family Services with representation from the Department of Justice and Public Safety, the Department of Health and Community Services and the Department of Education and Early Childhood Development. The mandate of the working committee was to define critical incidents and prepare a Cabinet Submission to propose these legislative changes. Much hard work and collaboration occurred by this committee and the departments involved, however the House of Assembly closed on June 23, 2015 before the Cabinet Submission was tabled. At that time, there were two outstanding issues we were working to resolve in the Submission, regarding the inclusion of regulated child care and aboriginal schools. Premier Paul Davis publically stated that he was considering having the House of Assembly sit in the Fall of 2015 before the provincial election to pursue legislative changes to the Child and Youth Advocate Act; this did not occur.

I was pleased and encouraged to read in your mandate letter dated December 14, 2015 to the Honourable Sherry Gambin-Walsh, Minister of Child, Youth and Family Services that you expect the Minister “...to work with your colleagues and the Child and Youth Advocate to develop legislation for the House of Assembly that will make it mandatory to report deaths and critical incidents to the Advocate.” Further, when I met with the Minister on January 6, 2016, I was advised that she planned to meet with the ministers of the Department of Justice and Public Safety, the Department of Health and Community Services and the Department of Education and Early Childhood Development. I was also advised by the Minister that she would follow up within two weeks. On February 15, 2016, I contacted the Deputy Minister of Child, Youth and Family Services regarding this issue and was told there was no update.

On February 29, 2016, I met with Minister Gambin-Walsh and executives from the Department of Child, Youth and Family Services for a scheduled quarterly meeting. I was surprised and concerned to learn in this meeting that while meetings have occurred between the Ministers of the departments involved, nothing has been done to date to address the two outstanding issues.

In August 2016, it will be five years since I first put forth the recommendation for a protocol to ensure immediate reporting of critical incidents to my office by the Department of Child, Youth and Family Services. In June 2016, it will two years since I publically stated I would seek legislative change regarding mandatory reporting by government departments and agencies to the Child and Youth Advocate when a child or youth receiving services dies or is involved in a critical incident. Currently, it has been over one year since my office collaborated on the working committee chaired by the Department of Child, Youth and Family Services with representation from the Department of Justice and Public Safety, the Department of Health and Community Services and the Department of Education and Early Childhood Development.
It is critical that these legislative changes are made in order for me to fulfill the mandate of the Child and Youth Advocate and ensure that the rights of all children and youth are upheld and their voices are heard. When a child or youth receiving services is involved in a critical incident or when the death of a child or youth occurs, the Child and Youth Advocate Act grants me the legislative authority to conduct an independent investigation and provide advocacy services. Unfortunately however, I only become aware of some of these through other avenues such as media, family members or contacts to my office. With this amendment, it will be mandatory that government departments and agencies, in particular, the Department of Child, Youth and Family Services, the Department of Justice and Public Safety, the Department of Health and Community Services and, the Department of Education and Early Childhood Development notify me of these unfortunate events. Ultimately this will allow my staff and I to provide more comprehensive and timely advocacy services. This amendment means that I will be notified when there is a death or a critical incident involving every child or youth receiving government services such as in schools, hospitals, foster homes or a youth detention centre. Immediate notification will allow me as the Advocate to mobilize quickly to investigate, produce recommendations and prevent further harm. It will also enable immediate provision of an advocacy role to ensure all children and youth involved receive supports and services.

Any further delays in implementing this very important amendment continues to jeopardize the rights and interests of every child and youth in Newfoundland and Labrador. Their rights must be protected and advanced, and their voices heard. I ask that you make the children and youth of this province a priority of your government.

The proposed legislative changes are progressive both provincially and nationally and will result in a positive change for the rights and interests for all children and youth in Newfoundland and Labrador. Enclosed for your information are the Briefing Note and Backgrounder that were sent to Premier Paul Davis on October 3, 2014. As the House of Assembly is set to open on March 8, 2016, I look forward to working with the Provincial Government of Newfoundland and Labrador to move forward with the amendment to the Child and Youth Advocate Act. I am available to discuss this matter at your convenience.

Yours truly,

Carol A. Chafe
Advocate for Children and Youth

Enclosures
# Annex C

## Newfoundland Labrador

Child, Youth and Family Services

### Death Notification

#### Client Information
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<thead>
<tr>
<th>Client</th>
<th>Age</th>
<th>Date of Death (YYYY-MM-DD)</th>
<th>Type File</th>
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#### Family Composition
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<thead>
<tr>
<th>Name</th>
<th>Relationship to Client</th>
<th>Age (if 18 and under)</th>
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#### CYFS Information
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<tr>
<th>Region</th>
<th>Office</th>
<th>Clinical Program Supervisor</th>
<th>Zone Manager</th>
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#### Date and Time Information
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<th>Received by Person Completing Form</th>
<th>Date (YYYY-MM-DD)</th>
<th>Time</th>
<th>a.m.</th>
<th>p.m.</th>
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</thead>
</table>

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

Response to event/action taken:
- Immediate
Have required notifications external to CYFS been completed? (e.g., Police, parent(s)) if so, to whom?

**Signatures**

Form Completed by (Print Name)

<table>
<thead>
<tr>
<th>Signature of Social Worker</th>
<th>Date (YYY-MM-DD)</th>
<th>Signature of Supervisor</th>
<th>Date (YYY-MM-DD)</th>
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<table>
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<tr>
<th>Signature of Zone Manager</th>
<th>Date (YYY-MM-DD)</th>
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I, ________________________, have reviewed the circumstances and I am satisfied with the immediate actions being taken and follow-up for the next 48 hours.

Signature of Regional Director Date (YYY-MM-DD)

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

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

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<thead>
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<th>Date Received (YYY-MM-DD)</th>
<th>Action Required</th>
<th>Recommend further action</th>
<th>Recommend full review</th>
<th>Minister and DM Briefed</th>
<th>Date of Briefing</th>
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<td>No additional report or follow-up action required</td>
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<td>Incomplete information/action-in-process noted by region</td>
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<td></td>
<td>Notification of Chief Medical Officer if child is in custody</td>
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<td>Notification of the Child Youth Advocate</td>
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Explanation of current status and additional action:

Signature of ADM Date (YYY-MM-DD)