BEHIND CLOSED DOORS

A STORY OF NEGLECT

Défenseur des enfants et des jeunes du Nouveau-Brunswick

New Brunswick Child&Youth Advocate

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FOREWORD

Pursuant to my authority, as set out in the *Child, Youth and Senior Advocate Act (CYSAA)*, I am providing this investigative review and report concerning a serious case of child neglect of five young children whose parents were charged with failing to provide the necessaries of life, in contravention of Section 215(2)(a)(ii) of the *Criminal Code of Canada*. Both mother and father were sentenced to a period of two years imprisonment and the children were placed in foster care.

It should be stressed that while this is a public report, it does contain detailed information about these children and those who cared for them. Although we have taken great care to protect the privacy of the children and their caretakers, we cannot guarantee that interested parties will not be able to identify them or others charged to care for them. The identities of the children and those others who care for them or provided services were anonymized.

Nevertheless, I would request that readers and interested parties, including the media, respect their privacy and not focus on identifying individuals and locations involved in the matter.

This investigation and report was not prepared in an attempt to find fault or to assign blame, but rather it is written as a testament to what happened and ultimately to indicate failing or gaps in a very complex child welfare system in New Brunswick.

Many hours have been dedicated to this effort by my staff in an effort to record the tragic disintegration of this particular family. In hopes of providing a pathway to identifying the gaps in the system, recommendations are offered in an effort to move the system and its administrators in a positive direction to bring about changes for the benefit of all children living behind closed doors.

When children are receiving child protection services, there is an expectation that they will be safe and protected. I trust that this report and the recommendations which emerge from it will improve the safety of all vulnerable children under the protection of our child welfare system.

Finally, I hope and trust that the young children who are the subject of this review, investigation and report will not be further traumatized when they are finally able to read and appreciate these findings and recommendations.

Norman J. Bossé, Q.C.
Child, Youth and Senior Advocate
Province of New Brunswick

"Sometimes the strongest among us are the ones who love beyond all faults, who smile through silent pain, cry behind closed doors and fight battles nobody knows about." Author Unknown

EXECUTIVE SUMMARY

Nathan, Meghan, Adam, Jacob and Hannah are siblings whose family has been followed by the Department of Social Development since May of 2013 through Family Enhancement Services and Child Protection. On May 17, 2016, all five children were taken into care by the Department following the eviction from their home. When Sheriff's officers arrived at the premises that day, they discovered the family living in squalor with human and animal excrement on many surfaces, broken furniture in various rooms, drug paraphernalia within the children's reach and an absence of food. Upon further investigation, it was discovered that school-aged Nathan and Meghan had missed more than half of their academic year. Furthermore, the condition of the children's health was very grave as several had rotting teeth and all were malnourished. None of the siblings had health insurance as their Medicare coverage had expired two years prior.

In April of 2018, parents Melissa and Rick, were sentenced to two years in prison for failing to provide the necessaries of life to their five children thereby endangering their lives.

In early 2018, the Office of the New Brunswick Child and Youth Advocate gave notice to the Department of Social Development of an investigative review of the Department's involvement with the family. Through this investigation, the following questions arose regarding the services provided to the children:

1. Were risk factors adequately identified and addressed?
2. a) Did Family Enhancement Services effectively address the negative consequences of chronic neglect the children were exposed to?
   b) After the file transfer to Child Protection Services, was there continuity of care with an increased use of authority for the children who were victims of severe and chronic neglect?
3. Did the Department meet its own Practice Standards to protect the children?
4. Evasion of appointments – Was every possible effort made by the social workers to see the children?

To address these issues and improve upon the level of care and support provided to New Brunswick's children, the Office of the Child and Youth Advocate makes the following four recommendations:

Recommendation 1:

That the Department of Social Development and other government departments involved in services to vulnerable children in early years, including the departments of Health, Justice and Office of the Attorney General, Public Safety and Education and Early Childhood Development work together, in consultation with the Advocate's Office, to develop an approach to Integrated Service Delivery (ISD) in early childhood services. This new approach must engage all appropriate stakeholders in public health, in early childhood care settings, and in other public and private settings to provide wrap-around supports to children in early childhood and work collaboratively in preventing, identifying and addressing all cases and forms of child neglect and harm to children.

Recommendation 2:

That the Department of Social Development address chronic neglect seriously and adequately to protect children by:

- ensuring that the Structured Decision Making® (SDM®) pathway assignment of either Family Enhancement Services (FES) or Child Protection (CP) is appropriate for the needs of the family and that the family's history with the Department of Social Development is considered in relation to the pathway assignment.
- ensuring that transition to Child Protection from Family Enhancement Services results in an increased use of authority.

Recommendation 3:

That the Department of Social Development:

- undertake a review of workloads to ensure that social workers have the time necessary to manage their caseloads effectively.
- have mechanisms in place to ensure that Child Protection workers receive all core training before taking on a caseload.
- develop a quality assurance policy to require regional offices to forward cases in which practice standards are known to have been unmet to the Department for review and recommendation by clinical reviewers.
- make statistics from the Clinical Auditing Team available to the public.

Recommendation 4:

That the Department of Social Development take immediate steps to ensure that all Child Protection and Family Enhancement Services social workers understand the legislative authority allowing them to enter any premises to remove a child whose security or development may reasonably be believed to be in danger. Additionally, and equally importantly, that the Department of Social Development review its governing legislation, the *Family Services Act*, to ensure that the Act's provisions are in accordance with the findings of the Supreme Court of Canada in the case of K.L.W.; the wording in the Act should not require an unduly high threshold in regard to the need to ascertain the serious and imminent danger to the security or development of the child before entering premises.

BEHIND CLOSED DOORS – A STORY OF NEGLECT

On May 17, 2016, what was intended to be a routine eviction in Saint John, turned into something far more shocking than anyone could have foreseen or imagined. Four Sheriff's officers arrived at a house to execute an eviction that day. As they entered, a pungent and overwhelming stench of human and animal waste pervaded the air around them. Soon after, the severity of the situation became even more apparent from the scene that lay before their eyes. It alarmed the officers so much so that they immediately contacted Child Protection and the Police Force for assistance.

Likely most alarming, was the human and animal excrement that was widespread throughout the house... on the floors, walls, furniture, and even the ceiling. In the bathroom, feces covered the counter, bathtub and toilet. No toilet paper could be found. On some walls, children had smeared feces and stamped their tiny handprints everywhere. Nothing was untouched by this waste; it was also caked on several teddy bears lying in a pile in front of the toilet.

A visual scan of the house revealed that much destruction had come to pass under this roof. Broken furniture was found in most rooms and many of the walls were punctured with holes the sizes of big and little fists. On the floors, finding an unobstructed path proved challenging as in addition to the feces, dirty clothes were strewn everywhere, unhinged doors lay about, fleas were spotted in different areas, and puddles of purple paint covered many areas.

In the kitchen, the only food consisted of a rotting turnip, a single cabbage, three boxes of Kraft Dinner, a package of Lipton's Sidekicks and several condiments. Cigarette butts covered the windowsills and a bong along with two pipes was observed.

Amidst this squalor, were five young children, some hiding and all in various states of undress and filth. They were accompanied by their young mother, Melissa, who was paralyzed by the shock of being discovered. A dog and two cats were also present. Nathan (8 ½), Meghan (6), Adam (3 ½), Jacob (2) and Hannah (6 months) were thin, pale, small in stature, and did not speak. Some children had sores around their eyes and all had feces encrusted on their faces and bodies. Nathan eventually came out from his hiding spot behind the couch. His hair was shaved into a mohawk and dyed with red paint made to look like blood. He wore no pants, but had on a Ninja Turtle shell and began running around uncontrollably, swinging his nunchucks. These were constructed of what appeared to be pieces of an old shower rod with jagged edges. Later, Nathan would disclose that he wore this costume to, "protect my family from the bad guys who are after us." At one point, Nathan attempted to jump out a window but was caught by an officer who grabbed his arm in time. The baby, Hannah, appeared very lethargic and slow to respond. Although six months old, her size and development were later described by one of the police officers as more like that of a one-month-old.

The two Child Protection social workers on the scene phoned to consult with their supervisor and the decision was made to bring the family to the Department of Social Development. At this point, Melissa was becoming increasingly distraught over having to leave behind her dog and was focused more on her two older children, Nathan and Meghan, with little comfort given to the remaining three in the midst of all this chaos. She tried, without success, to contact the children's father, Rick. When it came time to place everyone in vehicles, a police officer discovered that Hannah's car seat had a broken strap, necessitating a call for another social worker to bring a functional one. In the commotion that surrounded him, two-year-old Jacob cried as he did not want to leave. He finally relented when his older brother, Nathan, got in the car first. And when a social worker picked Jacob up to place him in his seat, he wrapped his arms around her neck for a long time and snuggled in close.

On the drive to the Social Development office, Nathan was visibly distressed, causing him to stutter so badly it was impossible for him to speak a full sentence. He told the social workers that he and his siblings hadn't eaten that day and that most days they go without food. At the Department, the social workers and their supervisor assessed the children's physical state and determined that in addition to suffering from malnourishment, the siblings also had teeth that were severely rotting. Nathan illustrated this by squeezing pus from an abscess in his gums. Review of the family's file revealed that the children's Medicare coverage had been expired for the last two years and that Hannah was never registered. Another deep concern noted was that Nathan and Meghan had missed more than half of their school year, and when they did attend, they were sent to and from in taxis, unsupervised. These issues, along with the deplorable state of the home, the presence of drug paraphernalia and absence of food, resulted in the Child Protection supervisor informing Melissa that her children would be taken into Protective Care that day and placed in two separate foster homes.

A History of Involvement with the Department

Six months prior to this tragic day, a Child Protection file was opened on this family. Quite reasonably, one might be puzzled at how the family's situation could have deteriorated to this degree if they were regularly meeting with a social worker assigned to protect the children and help prevent such a tragedy in the first place. Unfortunately, probably what isn't surprising, is that this was not the Department's first involvement with Melissa. Perhaps learning about her history with Social Development will help to make sense of the situation they found themselves in, on that fateful day the parents were exposed.

As a teenager, Melissa lived with her mother, Linda, and brother, Jake, two years her senior. Her parents had separated, but her father still maintained contact. In school, Melissa struggled academically, a problem that was further exacerbated by high absenteeism. Linda's parenting style was very passive, and it was obvious that in her household, her two children made all the decisions. Because of this, the choice to attend school each day was left up to Melissa and Jake, and on many days, they chose not to. This truancy was addressed by the school social worker, but no significant improvement was ever noted. Coincidentally, almost one decade later, this very same social worker would become Melissa's Family Enhancement Services (FES) social worker through the Department of Social Development, offering parenting guidance and support to Melissa in her role as a mother. Melissa's parenting style would mirror that of her mother's, resulting in recurrent loss of control of her very active children who were said to "run the house". But Melissa's earliest experience with the

Department came at age fourteen, when a Child Protection file opened on the report that a family member allegedly attempted to sexually molest her.

A few years later, now in a relationship with Rick, Melissa became pregnant and delivered her oldest child, Nathan, about one month before her 17th birthday. Being a pregnant teenager, Melissa was followed closely by a Public Health Nurse to support her in having a healthy pregnancy. About one month before Nathan was born, this nurse phoned to make a referral to Child Protection as Melissa was not following through with her appointments and was using marijuana. The call was recorded as a general information call and did not warrant an investigation. The day after Nathan's birth, another Public Health Nurse made a referral to the Department, concerned about the young age of his parents who continued to use marijuana, and their inability to care for a newborn. Because hospital staff did not indicate any concerns with Nathan's care and because Public Health would be supporting the family, the information provided did not warrant investigation and was screened out.

A Family on the Move

(May 2013-Aug 2013)

Despite several other referrals made to the Department from different sources, a file did not officially open for the family until five-year-old Nathan disclosed to his kindergarten teacher that his father gave his mother a black eye. The teacher, along with a vice-principal, phoned the Department to relay this information alongside other concerns, including Nathan smelling of marijuana and his frequent absences. School staff described Nathan as a sickly and pale child with a hesitant voice who often spoke in a babyish tone and who never smiled. His appearance was often unkempt and his clothes ill fitting. The school would regularly supplement Nathan's lunch with extra food and provide nutritious snacks to curb his hunger. During the winter months, Nathan was frequently given warm clothes to wear as those from home were inadequate in the colder weather. Most notably, Nathan was a boy who was exhausted much of the time. On many occasions, his teacher would catch him sleeping while sitting cross-legged on the floor during morning circle. Often, he would be sent to the nurse's office to nap and would need to be awakened for lunch. Nathan's explanation for this fatigue was that he regularly stayed up all night watching scary movies on television. Other troubling observations from school staff were Nathan's underdeveloped social skills and his teeth that appeared to be rotting. His parents were extremely difficult to reach to discuss these matters as they never returned calls, communicated via his agenda book, nor attended parent-teacher interviews.

Fortunately, the referral about Melissa's black eye met the criteria to open a file under Family Enhancement Services, a collaborative approach under the Child Protection program aimed at engaging the family in restoring and maintaining the child's security and development. As mentioned previously, the FES social worker assigned to work with Melissa was her former school social worker, Jodi, and as such, was familiar with the challenges faced by Melissa as a youth. Jodi worked with Melissa and her three children, Nathan, Meghan and Adam for a period of just over one month before they were evicted because of disagreements with the landlord. During this time, Jodi referred Nathan to Early Intervention, a program to support families with children at risk of having developmental delays. The assigned worker, however, mentioned having difficulty reaching Melissa to begin the

appointments. Jodi also tried, unsuccessfully, to secure a New Brunswick Housing (N.B. Housing) home for the family, as Melissa was in constant conflict with her neighbours. During the short period of Jodi's involvement, Social Development received several referrals from neighbours to alert them about the poor supervision of the children outside of the home, including three-year-old Meghan toddling onto busy roads. Like the school, however, Jodi also had trouble meeting with Melissa, who was often not at home for their scheduled visits or would have countless excuses such as having the dates confused. Jodi would later acknowledge that perhaps she should have doubted Melissa's truthfulness, that, "She was getting away with telling stories; she knew what to say." In hindsight, Jodi realized that she should have seen the family more often, but she was often caught up in the paperwork that accompanied her everyday work. Jodi's supervisor reported at times having to urge Jodi to go out to see the family.

No one was home when Jodi arrived at the house for a scheduled visit in late August of 2013. Later, Melissa left a voicemail message saying that they had been evicted. Several weeks afterwards, the landlord wrote to Income Assistance to complain of the condition that Melissa left the house in with dirty diapers everywhere, colouring on the walls, and a clogged toilet. He also shared that he was concerned for the safety of the children. This information was passed on to Jodi by the Income Assistance worker.

(Sept 2013-Jan 2014)

The family's move required a case transfer from Jodi to Leslie, who worked as an FES social worker in a different region. The two women visited the family in their new home approximately one month after the eviction from the previous house, but already, there was a detectable odour of feces which Melissa blamed on the dog. During this visit, a range of issues was discussed such as: the family's isolation in this smaller village, Melissa not having a driver's license, there being little family support with Melissa's mother farther away and Rick living in Saint John for work. Although closer now to Rick's family, Melissa expressed that she did not find his mother to be very helpful. The matter of the children's rotting teeth was also addressed and Melissa agreed to make the necessary dental appointments.

After consulting with her supervisor, Leslie added several items to the family's case plan including: guidance with budgeting, transportation to various appointments and hiring a parent-aide to help once per week with setting routines. At the following home visit, approximately one and a half months later, Leslie and a social work student smelled marijuana which Melissa denied using. At this point, Nathan had been seen once by the Early Intervention worker, and a referral for speech therapy was in place for him at school. Still outstanding, though, were the children's dental appointments. During this visit, Melissa informed Leslie that they had secured an N.B. Housing unit and were moving back to their previous town in January. In the following month, Nathan's school made two referrals to the Department as he was consistently sleeping in class, and had disclosed that sometimes he and his three-year-old sister, Meghan, were left at home, alone. Leslie addressed these concerns with Melissa who denied leaving her children unsupervised. The recently assigned parent-aide was only able to see the family once, during her introductory visit with Leslie, as Melissa cancelled the following visits.

In early January 2014, Leslie spoke with Jodi, the family's former social worker, to notify her of the family's upcoming return. Jodi had been seconded to a different position and therefore Amanda, another social worker on the team, would be assigned to work with them. Leslie visited the family shortly after they settled into their

new home whereupon she discovered that Melissa, now approximately eight months pregnant with her fourth child, had not seen her doctor in the last two months. About one week later, Leslie visited the family once again, this time to transfer the case to Amanda.

(January 2014-May 2014)

In the four months that Amanda worked with the family, the number of children grew from three to four, with the addition of Jacob in February. One month prior to Jacob's arrival, concerns were raised to Amanda from Melissa's income assistance worker about Melissa smelling of marijuana at her last appointment, and not yet having a crib for the baby who was due very soon. At a home visit to address these issues, Melissa confessed to Amanda that she was smoking pot and had done so with her previous three pregnancies. According to Melissa, her family doctor was aware of this. A few weeks later, Nathan (6 ½) showed up at school with a burn mark on his hand. When questioned about this, he described to his resource teacher how he played with both a knife and lighter while his parents slept, and inadvertently burned himself. This teacher later phoned Amanda to inform her about this new injury. Another report from the school came from a guidance counsellor who spoke with Amanda after Nathan relayed an incident where a television fell on him, requiring a follow-up x-ray. Amanda later clarified with Melissa that this accident happened a few years ago, however, she did not speak separately with Nathan to confirm this. Despite receiving several reports relating to the lack of supervision of the children, the parent-aide service that was added to the family's case plan by Leslie did not continue under Amanda's involvement. In fact, no additional supports for the family were put in place during this period.

According to Amanda, the time between Jacob's birth and her decision to close the FES file at the end of May 2014 was a period when the family seemed to function relatively well despite Melissa's challenging new role as a mother of four who was generally on her own. Several factors contributed to Amanda's decision to close just three months following Jacob's birth, including Melissa having more family in this town, living in an N.B. Housing home which made the family more "visible" in the community, and having access to public transportation. Amanda also noted that the relationship between Melissa and Rick was relatively stable with no recent conflict and that Rick helped with the parenting on his weekends home. When questioned about the children's deteriorating dental health, Melissa confirmed that they had seen a dentist. Although aware that Melissa was smoking pot, Amanda offered the following justification, "Melissa stated it (pot) does not impact the way she cares for the children." While it was Amanda's decision to end the Department's involvement with the family, it was her supervisor who gave the final approval to do so.

(May 2015)

After Amanda's involvement with the family ended in June 2014, a file did not reopen with the Department until May 2015, one year later. During this year, different neighbours raised concerns to the Department about the children playing alone outside and the family's home smelling strongly of marijuana. The Department began the process of assessing these concerns but then decided to discontinue as the referrals were deemed to be malicious due to disagreement between neighbours. Another referral not justifying an investigation by the Department was from a school guidance counsellor after being told by Nathan (7 ½) that his mother hits him and that he is always tired. Nathan was never interviewed at school by a Social Development social worker to discuss this.

Eventually, the Department decided to investigate a referral from the school's vice-principal who called to report that Nathan's hand hurt from being pulled out of bed by his father. Around this time, Nathan began missing many days of school. The family's first FES social worker, Jodi, had returned to her original position from her secondment and was re-assigned to work with the family. During her time on the file, five new referrals came in from Melissa's neighbours about the children playing unsupervised outside, near busy roads and late at night. In addition, another parent had reported seeing Nathan outside trying to poke other children with butter knives, although this incident did not warrant the Department's investigation. On an unannounced visit at the end of May, Jodi discovered that the house appeared empty as the family had moved after being evicted from their N.B. Housing home. The family owed over $2000 in rent and had caused $6000 in damages to the property. Photos shared by N.B. Housing depicted much of the house in ruins with dog excrement throughout. Jodi, who recently learned that Melissa was pregnant with her fifth child, expressed deep concern for the children during an FES case transfer meeting with Leslie, who would again be working on the file because of the family's move to a house within her region.

(June 2015-Sept 2015)

In early June, both Jodi and Leslie visited the family in their new home. Melissa was alone with the four children as Rick only came home every other weekend. During this visit, the social workers made several disturbing observations. Jacob, now fifteen months old, spent the entire visit gated in his bedroom with no interaction from Melissa. In addition, Nathan (almost 8) and Meghan (5) were not yet registered for the upcoming school year, and none of the children had been seen by a dentist, contradicting what Melissa had told Amanda a year prior. Leslie noted that the household appeared to be in a constant state of mayhem, a noticeable contrast from her previous involvement one and a half years ago. While determining what services and supports to put in place, Leslie discovered that Early Intervention involvement had ended that January because Melissa was never home. This individual shared with Leslie that she was concerned about all the children so Leslie put in another referral for Early Intervention once she received Melissa's consent. During her carriage of the file, Leslie was notified of two new referrals. The first coming from the RCMP regarding complaints from neighbours that Nathan was intimidating children outside with a tent pole, and the second from a parent in the community who regularly spotted Nathan and Meghan playing at the ball diamond for hours, unsupervised. Due to these new referrals, Leslie presented Melissa with three choices at the following home visit: a parent-aide, Family Group Conference, or Permanency Planning Committee. At the following home visit to discuss the three options, Leslie found marijuana cigarette butts within the children's reach. When she spoke about the risks of the children having access to these, Melissa informed her that the family was moving to Saint John.

(October 2015-May 2016)

In early October, Leslie travelled to Saint John to transfer the file to Tom, an FES social worker, in a meeting with both Melissa and Rick in their new home. The next meeting was cancelled by Melissa and rescheduled for late October. Emily, another FES social worker newly assigned to the case, arrived at the house for this visit. After knocking for several minutes, no one answered the door, prompting Emily to leave Melissa a note to call her. Two days later, Emily met with Melissa and her children in their home for the first time. In a short period, she observed that the family struggled in several areas. Overall, the house was in a state of chaos with the

children running about, beyond Melissa's control. The younger ones wore only diapers and were visibly filthy. Prior to this visit, Nathan's school made a referral about his fighting with classmates who teased him because he smelled of urine. Melissa agreed to work with Emily to make a case plan, identifying goals that supported the family's various needs. At Emily's subsequent visit one week later to sign this plan, the situation she witnessed presented many grave concerns and several safety hazards. Before her eyes, Emily saw one child almost fall out of a window as it was open and did not have a screen. Fortunately, she caught him in time. While surveying the rest of the house, Emily remarked at how unclean it was and came across holes in walls, dangerous roofing tools within the children's reach, cigarette butts everywhere and beds without sheets. All the children were very dirty and in need of a bath. Melissa placed Adam (3) in the bathtub, but then left him unattended, seemingly unaware of the risk this posed. Later, Emily discovered that Melissa could deliver her baby at any point, but had no obvious preparations for a newborn, including a crib.

The next day, Emily consulted with her supervisor, Kevin, about the alarming circumstances surrounding the family and they decided to hire a family support worker (FSW) to work with Melissa on proper supervision, setting routines, and providing a safe environment for her young children. That same day, Emily and Kevin made an unannounced visit to the family home. This angered Melissa, who was obviously annoyed at the surprise visit. Emily and Kevin discussed transferring the file to Child Protection because of all the concerns presented and Melissa's unwillingness to cooperate with the case plan. In the end, Melissa finally agreed to have an FSW in her home. Later that day, Emily contacted the hospital to alert them of Melissa's impending delivery and requested that they notify the Department when she was admitted.

When Family Support Worker (FSW) Elaine arrived for her first visit with the family the following weekend, no one was home prompting her to call the Department's After-Hours Emergency Social Services (AHESS) who directed her to try again tomorrow. The following day, Elaine went to the family home again, but still no one was home. AHESS advised that she try later that evening. Melissa and the children were at home when Deborah, another FSW, went to the home that evening. During this visit, Deborah watched as Melissa placed two of her children in the bathtub and closed the door, leaving them unsupervised. When she told Melissa this was unsafe, Melissa flew into a rage and yelled, causing Deborah to leave. After speaking with her supervisor who told her to stay and help with the nighttime routine until the children were in bed, Deborah returned to the house. Melissa was again verbally hostile, so she left for the final time. After that, Janet, a different FSW, went to the house and encountered the same issues with Melissa who aggressively yelled at her, too. Janet left the house and spoke with her supervisor who then told AHESS that she would not have her support workers subjected to Melissa's belligerent behaviour.

On November 10th, the family's file officially transferred from Family Enhancement Services (FES) to Child Protection (CP). On this same day, Melissa was admitted to the hospital to deliver Hannah, her fifth child. Hannah was born prematurely at 35 weeks' gestation and had significant feeding issues. As such, she was kept in the Neonatal Intensive Care Unit (NICU) for two weeks to support her healthy development and ensure she was feeding and breathing properly. As requested, the Department was notified of her birth. Because Emily was away on vacation, the family's file was tasked to FES social worker, Robin, to oversee during Emily's absence. At Robin's first home visit one week following Hannah's birth, she noted that the children were quite soiled with dirt and grime all over their bodies. Melissa prepared them for a bath but neglected to clean Jacob after removing

his full diaper which resulted in feces floating in the bathtub. Robin demonstrated to Melissa how to clean the tub before bathing the children in it and needed to remind Melissa not to leave her children unsupervised in the bath.

On Robin's subsequent visit with the family, she was accompanied by Sharon, the social worker who would work with the family through the Child Protection program. On this visit to transfer the file, the challenges the family continually faced were quite apparent as the children were unclean, the state of the house was crumbling, and Melissa seemed overwhelmed and unable to manage her children who were all over the place and had taken over. Although Sharon would be the family's assigned CP social worker for approximately four months, this visit would be one of only four during her involvement. Her fourth and final visit would be the one where she transferred the file to another social worker, Alex, a new social worker on the team.

The school is concerned

During Sharon's time on the file, numerous problems concerning the family were reported to the Department from a variety of sources, the majority coming from Nathan and Meghan's school. A number of issues gave the staff at the school cause for worry. Nathan's teacher described him as an angry student, often disengaged with his head down and eyes closed, seemingly "coached not to talk to teachers." He usually had dark circles under his eyes from staying awake all night to watch horror movies. Nathan was always famished, and this hunger sometimes drove him to take crusts from other students' sandwiches and even uneaten food from the garbage. Nonetheless, he remained vigilant about not wanting "social services to know I'm getting food from school." Like Nathan's previous school, this new school provided Nathan (8) and Meghan (5 ½) with food for lunches and snacks, and outfitted the two children for winter. One day, Nathan asked if he could take home a hat and mittens for a younger sibling. Often, both children appeared unclean with dirt caked on their hands and dressed every day in the same clothes that one staff noted, "smelled lightly like an outhouse." Meghan's teacher had to place her homework bag separately from the rest as it had a strong odour of cat urine.

Nathan did not develop any friendships during his school year in part because he was there so seldom. Absenteeism was a huge challenge for the school, with both Nathan and Meghan missing over half of the year and consequently not passing their grades. When they did attend, the children would come and go by taxi, unsupervised. The school bus stop was within sight of the family home, but Nathan said that his mother wouldn't wake up to walk them. Often, the taxis would come unequipped to safely drive the children home, compelling the teachers to request that they return with booster seats. Meghan's dismissal time was one hour earlier than Nathan's and she would habitually fall asleep in the office while waiting for him. Teachers considered it a red flag that Melissa began forgetting to arrange for taxis to pick up the children as early in the school year as September. She was also very challenging to reach to let her know when the taxi had not arrived for the children. In fact, the principal only saw Melissa twice, once when she came for registration and once when she complained about social worker, Emily, visiting the children at school.

One teacher noted that Nathan and Meghan both seemed to arrive at school in a state of "confusion and shock." Each day, Meghan took about one hour to warm up before talking. In this first hour, she always seemed cold, her body visibly shaking. By January, Nathan still wasn't familiar with the location of classroom supplies, routines, students' names nor that of his teacher. Over the course of the year, school staff would make many disturbing observations about the children. As well, through various remarks made by Nathan and Meghan, the staff would learn alarming details about their lives. Unintentionally, the siblings divulged that they ate only once daily, bills weren't paid, Melissa could not afford taxis, and that drugs were purchased and used at home. Because of the family's financial stress, Nathan told an educational assistant (EA) that he worked at the garage beside his house, earning $100 per week to clean. He also detailed a time when Melissa slept all weekend, leaving him to drink seven beers because there was little else in the fridge. On many occasions, the school made referrals to Social Development, however, as remarked by one individual, "We had a sense that Social Development didn't care; they never told us what they did with the information we sent and we don't trust that they did anything." The school principal, with twenty years of experience in the field of education, stated, "They were definitely a red flag family, in my top two families of concern over the years."

Others were concerned, too

In addition to issues raised by the school, a constable of the local police department in the town the family had moved from notified Social Development of a complaint from Melissa's previous landlord who claimed the family had left the house in a horrific state with feces found throughout. The family's doctor office also phoned Sharon twice to inform her that Melissa had missed Hannah's one-month, two-month, and four-month Well-Baby appointments. On the second call, a detailed voicemail was left saying that Hannah's medical care with this doctor would cease if Melissa continued to miss more appointments. As well, Sharon was contacted by Melissa's income assistance worker who told her that the family was facing eviction and the landlord was concerned for the children's safety. This worker was alarmed by Melissa wearing slippers to her last appointment in February, and that she regularly spent $450 per month on taxis to send the children to and from school.

No one is seeing the children

For a variety of reasons, Sharon faced many obstacles in seeing the family and as a result, did not meet the Department's contact standards. The Risk Assessment done on the family placed them at a High Risk, requiring Sharon to have three face-to-face contacts per month with Melissa and her children. The contact standards also dictate that for a high-risk family, the social worker must make three collateral contacts each month. Not including the two visits where the case was transferred from Robin to Sharon, and then from Sharon to Alex, Sharon was only successful in seeing the family twice in seven tries. Whether the visits were scheduled or unannounced seemed to make no difference. The outcome was the same each time with Sharon knocking on Melissa's door to no avail. When no one answered, Sharon would leave Melissa a note asking her to phone to reschedule their appointment. On one of Sharon's attempts to visit, she could hear Rick inside the house with the children, however, Melissa had left a note for her saying that she was visiting her ill mother and Rick did not wish to meet with Sharon without her (Melissa). Sharon did not insist on going forward with the visit regardless.

A range of factors prevented Sharon from meeting with the family, however, many related to her workload. At the time, her team, normally consisting of four social workers and one supervisor, was reduced by half. Her caseload included nine families of multiple children with very complex and high needs, and one with an out of control teenager whom she said took up "a lion's share" of her time. Looking back, Sharon's supervisor, Lauren, reflected that Melissa's file could have benefitted from more attention, but the reality was they gave it the time they were able to, as they were in "putting out fires mode with the other families." Melissa always seemed to have an excuse for missing their scheduled visits. Moreover, she was not receptive to CP services, so none were put in place. When later asked about meeting Departmental contact standards, Sharon acknowledged, "Other work priorities make it almost impossible to meet this standard." In fact, Sharon admitted she was so busy that her file notes were neither complete nor up to date.

To redistribute the team's workload, the family's file transferred to newly hired CP social worker, Alex, four months after Sharon received it from FES. Unbeknownst to Alex, his first visit with the family alongside Sharon in late March 2016 would be only one of two encounters with them. The second of the two would fall on the day the family was evicted from their home on May 17, 2016. Like Sharon, Alex experienced significant challenges in seeing the family despite many endeavours to do so. In the almost two months that Alex managed this file, he tried but failed to see the family a total of eleven times, with eight unsuccessful unannounced visits and three unsuccessful announced visits. Melissa would constantly cancel their scheduled visits and 'forget' the rescheduled ones, or offer an excuse about having confused the dates. Her landlord who worked at the garage next door, rarely saw the family leave the house so it was likely that Melissa managed to evade Alex's attempts at contact simply by not answering the door. All through Alex's involvement, referrals were made to the Department regarding the safety and welfare of the children. The first was a call from a City Police Officer because Nathan was found lingering alone outside a restaurant in the city and subsequently returned home. Shortly after that, Meghan's teacher phoned Alex directly to let him know that both Meghan and Nathan had missed about half of their school year, that they were often tardy, took taxis to and from school and that they would not pass their grades. She also discovered a burn on Meghan's cheek from playing with a hot spatula. Next came a referral from Medicare to alert Alex about the children's health insurance coverage having been expired for the past two years with no response from Melissa when Medicare tried to contact her. When Alex failed to see the family at home, he tried to visit the children at school, without success as they were never there.

About two weeks before the family's eviction, Melissa contacted the Department to tell them she was being evicted in three days. She also contacted her previous social workers, Jodi and Leslie, asking desperately if they knew of NB Housing availability in their respective districts. In a panic, she told them that she did not have money for rent, bills, or taxis and that Rick wasn't living with or supporting them. She also confessed that she had no place to go with her five children after eviction. Both social workers contacted Alex to apprise him of Melissa's upsetting situation. After receiving this news, Alex spoke with Melissa and planned for her to phone her landlord requesting to stay at the house longer. He then consulted with his supervisor and decided to refer Melissa to Fresh Start SJ Services for women facing eviction. He also planned to hire a human services counsellor to help Melissa find a place to live. On this same day, Alex visited the home, but again there was no answer.

In the two weeks leading up to the family's eviction, several more referrals came into the Department including one from the school saying that the kids had not been there since mid-April, and one from the Police Force about two of Melissa's children playing on her roof, throwing items from it. The Police also notified Alex about Melissa's upcoming court date for charges stemming from shoplifting at Walmart. At this point, he decided to schedule a Permanency Planning Committee meeting for May 24th, unaware that the family's eviction would fall one week before this date. On May 17, 2016, the Sheriff's Department phoned Social Development to inform them that Melissa and her five children were being evicted on this day and that they had no place to go.

The Aftermath

After the traumatizing event of being removed from their parents' care, what immediately followed for each of the children is in itself a sad story. The experience served to polarize the siblings, pinning the oldest two against the youngest three. Obviously distraught beyond the point of consolation, Nathan (8 ½) and Meghan (6) began accusing Adam (3 ½) and Jacob (2) of smearing their feces all over the house thus causing the separation from their parents. Nathan also held himself responsible for disclosing incriminating information to the school and social workers and blamed Meghan for saying too much. In contrast, CP worker Mary, who worked with the family post-apprehension recalled that Adam, Jacob and Hannah seemed indifferent to leaving Melissa.

Due to the deplorable state the children were found in upon apprehension, they required immediate medical attention in hospital to determine the status of their health, and what was needed to start the road to recovery and wellness. The children were all malnourished, with rotting teeth, developmental delays, and were behind in their vaccinations. Hannah had a very rigid torso that one social worker believed to result from being left in the same position for long periods of time. At six months old, she had significant difficulty holding her head up. The family's doctor performed medical examinations on each of the children. In remembering those initial appointments, she remarked, "It shocked me with their absolute fear of being here, of being examined, of interacting with others. It was a family that really marked me in my early years of experience."

Foster Care

The siblings were separated into two different foster homes, with Nathan and Meghan together, and Adam, Jacob and Hannah in another home. Nathan (8) really struggled with being in foster care. Betty, his first foster mother, remembered him as having "an empty look in his eyes." She also felt he was deliberately trying to sabotage his placement, as he was destructive with most everything he touched. Starting at a new school wasn't easy for Nathan, either. On his first day, he immediately regretted allowing his parents to shave his hair into a mohawk, and embarrassed, refused to remove his hood.

At times, Nathan would be in good spirits, but this conviviality would abruptly end whenever Melissa called. On the phone, he avoided telling his mother anything positive about Betty's house, instead lying about never having enough to eat, all the while glaring at his foster mother. As soon as he ended the call, his good mood resumed. Betty felt that Nathan behaved this way to spare Melissa's feelings, knowing that they would have taken a hit when her children were removed from her care.

That first night in foster care, Meghan, devastated by the day's earlier events, cried herself to sleep while Betty rubbed her back. For the first two months, she never left Nathan's side, even waiting outside the bathroom door for him. Unlike Nathan, however, Meghan eventually made good progress in adjusting to their new reality with more and more of her cheerful disposition revealing itself every day. Unfortunately, this progress would not continue.

Several episodes of very concerning behaviour by Nathan caused Betty to end his placement prematurely, something she had never done in her eighteen years of fostering. After he tried to hang himself with a scarf from a bunk bed, she was constantly worried that one day she'd discover him lifeless, causing her many sleepless nights. Also during this time, Nathan repeatedly banged his head against a wall, hoping to give himself a coma so that he could sleep away the time before returning to his mother's care. Betty recalls telling social worker Mary, "He needs help, he really needs help, he scares me." Two months after being placed in Betty's care, Nathan was moved to the Observation Unit in the Centre for Youth Care, where Mary explained, "They worked with him on how to be a child." Nathan made excellent strides in his new placement, however, in his absence, Meghan's progress regressed and she became angry and bitter, mourning for Nathan. Betty described her as "Lost... grieving all over again." Fortunately, after his discharge from the Observation Unit, Nathan and Meghan were reunited, but at a different foster home now.

An interview with Evelyn, a foster parent who cared for the three youngest siblings, shed light on how Adam, Jacob and Hannah coped with the change. Rather worrisome, was her recollection of the children cowering and hiding themselves for the first while. They also rarely asked about their parents.

Every day for the first month, Hannah would scream throughout the night, suffering from persistent night terrors. These eventually ceased, but Evelyn remembers thinking that at their peak, she wasn't sure she could continue having this infant in her care. They also discovered that Hannah had an extreme fear of dogs, even in stuffed animal form. Like the night terrors, this phobia also resolved with time and Hannah blossomed into an affectionate and social little girl who eventually caught up with her developmental milestones.

Four-year-old Adam was described by Evelyn as "a poster child for why you foster." No one could understand him and he was extremely aggressive, particularly at daycare. It took considerable convincing, but in the end, Melissa and Rick agreed to medicate Adam for ADHD. Shortly after starting medication, Evelyn described him as "a little sponge who loved learning." With medication, structure and routine firmly in place, Adam's aggression diminished over time, resulting in a marked improvement in his behaviour. Another distinctive change happened at the dinner table. When Evelyn first took the children into her care, Adam would stand in the kitchen, "vibrating" while waiting for food and then subsequently gorge on everything, his hunger insatiable. With time, he learned to slow down and focus his attention on other fun things, rather than on when his next meal would be.

Jacob, two-years-old at the time, had some very significant behaviours. Evelyn remembered him as being lethargic and regularly "zoning out", which was also corroborated by Mary who described him as, "going vacant." Like his brother, Adam, Jacob could be quite aggressive. He rarely spoke, and when he did, made poor eye contact. Often, Jacob could be found crouching in tight spaces and would involve himself in risky play without fear of hurting himself. At times he would laugh inappropriately in different situations. These unusual behaviours led to an assessment for autism. He was not diagnosed as autistic and interestingly, all of these behaviours resolved over time.

The Visits

After the children were taken into care, part of the case plan included supervised visits with both parents, Melissa and Rick. The written observations made by Family Support Workers (FSW) hired to supervise these visits uncovered a vast array of troubling circumstances, with no progress made on the parents' part to improve their chances of getting their children back.

Who's watching the children?

Frequently, the accompanying FSW had to alert Melissa of safety hazards the children were exposed to such as: Jacob running with box cutters, Hannah stuffing small toys in her mouth or eating cat food, Jacob and Adam fighting around hot oil on the stove, Hannah grabbing electrical wires, Jacob carrying a bag of cigarette butts, and all the kids rowdily jumping on the furniture. When warned of these risks, Melissa generally did not respond, and it was left to the FSW to remove the kids from danger. Quite often, Melissa would shut the youngest three children in the living room, choosing instead to focus her attention on Nathan and Meghan. There were many reports of several of the children almost choking on food or other objects, with Melissa completely oblivious. Several factors contributed to her negligence towards the children, the most significant being that Melissa spent a substantial amount of time on her phone, therefore missing much of what was happening around her.

More than safety risks went unnoticed with Melissa. Hannah was regularly left unsupervised in her highchair for long periods of time, usually until prompted by an FSW to be removed. In the beginning, she would reach out for Melissa, but after being ignored too many times, began seeking affection only from the FSWs. Very sadly, Hannah took her first steps in front of her mother who did not notice as she was texting at the time.

The Siblings Are Not Treated Equally

During these visits, it was obvious that Melissa and Rick only wanted to visit with Nathan and Meghan, and that having Adam, Jacob and Hannah present was an inconvenience. Melissa would frequently have one or both older children on her lap who pushed the younger siblings off if they too, tried to cuddle. When Melissa stood up, Meghan made a habit of clinging to her legs, rendering her immobile and unable to pay attention to the others. Anticipating an upcoming unsupervised visit on Christmas, Meghan excitedly told an FSW that, "Mom will lock Jacob and Adam in the bedroom like she always does, then she will lie in bed all day with Nathan and me." To try to get Melissa's attention, Adam and Jacob resorted to constant and violent fighting, often with closed fists. Quite often, they would direct their frustration and aggression on the cat. There were also occasions when these two were unfairly disciplined by Melissa. At one point, Nathan kicked Adam in the face, but it was Adam who was put in a time-out while Nathan was consoled by Melissa after the FSW reprimanded him for his actions. Another time, Meghan picked up Hannah and dropped her on the floor, causing her baby sister to bump her head. Instead of soothing Hannah who was left to cry, Melissa chose to cuddle with Meghan. In fact, Melissa seldom comforted her kids when they injured themselves, likely because she was on her phone. At the end of the visits, Adam, Jacob and Hannah generally received one quick kiss from their parents, while Nathan and Meghan were smothered with hugs and kisses and promised that they would get special toys and treats on the following visit.

Are These Visits a Priority?

The children's visits with their parents were not exempt from Melissa's pattern of frequent cancellations; her most common excuse was cancelling due to illness. Nathan shared once, "It hurts my belly when Mom makes promises." Instead of a coveted opportunity to spend quality time with their children, both Rick and Melissa gave the impression that the visits were a hassle. They never planned any activities, rarely took the children to the playground even when they pleaded to go, and mostly spent the visits on their phones, taking smoke breaks or sleeping. Most of the time, Melissa occupied the children with a tablet or her phone, always giving it first to Nathan who liked to play shooting games. Screen-time limits were never set; it was usually the battery life that determined how long the devices were used. Melissa's lack of discipline and follow-through with her children added to the disorder of these visits, with the children completely beyond control and Melissa entirely indifferent. Sometimes, however, the children's total disregard exasperated Melissa who would respond by lashing out and screaming. Of course, this did little to improve the turmoil.

What are they eating?

Melissa and Rick were responsible for feeding the children at each visit, however, all guidance from FSWs and social workers on appropriate and nutritious food options was deliberately ignored. No matter what time of day, the children were given unlimited quantities of unhealthy items including pop, chips, candies, chocolate and ice cream. One FSW remembers having to quickly intervene when Hannah had stuffed her mouth with a marshmallow, almost choking. Sometimes, these foods replaced regular meals or else sated their hunger so that they did not eat what Melissa cooked. Frequently, Melissa and Rick opted for fast food in lieu of cooking, a bucket of fried chicken being the favourite. The consequences of this diet usually manifested in severe diarrhea, something that the foster parents soon correlated with the visits. On one occasion, Adam suffered so acutely from a stomach ache that hospitalization was required. Accompanied by an FSW, Melissa took him to the hospital as the case plan outlined that she attend all appointments with the children. While waiting with her son in the emergency room, Melissa voiced that the foster mother should have come instead. And when Adam cried because of the pain, Melissa offered him little comfort.

The Pattern Continues

It wasn't long before the state of Melissa's home took a downward spiral. Once again, the familiar smell of cat urine permeated the surroundings. After the visits, the children's feet were blackened from treading across the sullied floors. One visit had to be moved to a local park as the house was infested with fleas, with the situation unimproved at the following visit. Because the children were permitted to run freely about the house while eating, the floors were littered with food scraps, many of which were found and consumed by Hannah. Very matter-of-fact, Nathan once articulated, "Landlords are always mean to Mom so we move a lot."

The Final Decision

Following the apprehension of all five siblings in May 2016 and the ensuing six-month custody order, the Minister of Social Development was granted two further six-month custody order extensions (November 2016, May 2017). During this eighteen-month period, Melissa and Rick failed to make any progress in their case plan with: continued inability to manage all five children and meet their medical, physical and emotional needs; sporadic engagement during scheduled visits; and poor supervision of the children putting their safety at risk and demanding increased supervision and support from FSWs. After the children were taken into care, both parents tested positive for cocaine and marijuana and refused to seek treatment. Melissa was also criminally charged with probation violation and two counts of theft. For these reasons, the Minister began the process of applying for guardianship in November 2017. This application was adjourned, however, to allow for a Family Group Conference to take place in January 2018. It was at this meeting that Rick's mother and stepfather agreed to care for all five children in their home, with support from extended family members. In March 2018, the grandparents were granted full custody on consent of the Department of Social Development.

The following month, Melissa and Rick were sentenced to two years in prison for failing to provide necessaries of life to their five children. The Provincial Court judge wrote in his decision, "What should have been a den of safety and retreat for those children became only walls surrounded by filth and waste." To explain her absence while incarcerated, Melissa told Nathan and Meghan that she needed to go to the hospital for a long time. After learning of the truth, they became hysterical and sobbed to the point of vomiting. Nathan, who always hoped to return to his mother's care and regularly questioned his social worker on how many more items his mother had to "check off" before this could happen, once again had his heart broken.

Discussion and Recommendations

After reading about the family's unfortunate story in the previous narrative, it becomes obvious that several issues were present throughout the course of Social Development's involvement. Was this situation an outlier, an exception to the reality faced by other lower socio-economic families in New Brunswick struggling with similar issues? Or could it be parallel to that of many other families served by the Department? In fact, when the file transferred to Child Protection in Saint John, it was considered one of the more benign cases when compared with others on the team's caseload. Retrospectively deemed as, "one of the worst cases," by Emily, the family's previous FES social worker, once transferred to CP, the severity of the circumstances surrounding the family paled when weighed against that of other families who were constantly in a state of crisis. Putting it mildly, this is an unsettling reality. When asked in a recent interview about the severity of neglect the children experienced, Lauren, the CP supervisor mentioned, "You always think about the community standard, for example, is Nathan the only kid whose clothes smell like urine?" Another social worker implied that the acceptable standard of living sought when working with clients is substantially lower than that of an average middle-class family, "They had the bare minimum to be considered acceptable; little food, but there was food; dirty beds, but there were beds." In accordance with the Advocate's mandate to protect and promote the rights and interests of all New Brunswick children, we must ask whether such standards are in keeping with the Province's obligations under the *UN Convention on the Rights of the Child*.

From a Children's Rights Perspective

The United Nations Convention on the Rights of the Child (UNCRC) is a human rights treaty that defines the basic standards that must be maintained for children and youth in all realms of life – in school, in institutions, at home, at work, and in communities. The rights in the Convention are listed in numbered 'Articles'; for example, Article 27 - the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. All countries which have ratified the treaty, including Canada, have a legal obligation to apply it. By upholding their rights, children are given the best chance to develop to their highest abilities.

UN human rights treaties like the UNCRC are used to help interpret our supreme law, the *Canadian Charter of Rights and Freedoms*. These standards are useful in measuring whether our laws, programs and policies for children and young people are adequate and whether they are being properly applied. The Advocate has a legislated mandate to ensure that the rights of all New Brunswick children are fully respected at all times. This family's story is an example of serious infringements of the children's rights extending from birth to the day they were taken into protective care.

To offer a rights-based analysis illustrating how the children were denied their UNCRC rights, a Children's Rights Impact Assessment (CRIA) was completed using the information gathered from the family's file with Social Development. The CRIA revealed a multitude of child rights violations as set out in the Convention, as the children's best interests were often overlooked by their parents as well as by the Department of Social Development. The rights impacted the most were the right to appropriate assistance and care from parents and the State (Article 18), the right to be protected from neglect (Article 19), the right to health (Article 24), the right to an adequate standard of living (Article 27) and the right to education (Articles 28 and 29). These rights violations inform analysis of whether the strictures of the *Family Services Act* were adhered to by the Department of Social Development. Section 31(1) of New Brunswick's *Family Services Act* (Appendix D) lists twelve criteria where the security or development of a child may be in danger. It is very troubling that ten out of these twelve criteria applied to this family's case.

One thing that this case makes very clear is how interdependent all the rights of children are. Children cannot develop mentally and physically without an adequately nurturing environment. They cannot learn, or be ready to learn, if they are not properly fed, clothed and cared for. Children who are not given nurturing and loving affection from a young age will not engage in play and they may not thrive as other children do. This will in turn also affect their success in school, how they interact with others, and so many other aspects of their lives. Children who do not develop healthy behaviours in terms of nutrition, physical activity, rest and leisure during childhood will be much more likely to face chronic health challenges early in life.

In the Advocate's view, protecting children's rights is the best approach we can use in addressing cases of neglect like this one. A child rights based approach sets out a minimum standard of care that everyone can be held to. It is not necessarily the best or the highest standard, it can almost always be improved upon, but it is a global standard for children. Using a child rights based approach helps bring people on board with solutions. It is not about finding fault or laying blame. It is about making sure we all work together towards every child's best interests.

In August of 2017, prior to our notice of investigation in this matter, the Advocate had already sent a formal notice of investigation to the following government Departments: Social Development; Education and Early Childhood; Health; and Justice and Public Safety. This notice was pursuant to the Advocate's intention to undertake a systemic review into the Province's system of child welfare. That investigation is underway and a series of reports will be published in 2019 outlining our findings and recommendations on how to improve the system overall. Matters not specifically addressed here will be captured in the subsequent reports and recommendations stemming from the Child Welfare Review. The current report, Behind Closed Doors, is focused on the story of one family, but it raises questions and concerns about the system as a whole. We trust that the Department will consider the issues and recommendations in this report to ensure that the failings for this family are not repeated for others. This report will focus upon the main rights violations in terms of the child's right to appropriate assistance and care, to be protected from neglect, to an adequate standard of living and the rights to education and health. The report's finding and recommendations will be framed around the following four issues:

Issues

1. Were risk factors adequately identified and addressed?
2. a) Did Family Enhancement Services effectively address the negative consequences of chronic neglect the children were exposed to?

   b) After the transfer to Child Protection Services, was there continuity of care with an increased use of authority for the children who were victims of severe and chronic neglect?
3. Did the Department meet its own Practice Standards to protect the children?
4. Evasion of appointments – Was every possible effort made by the social workers to see the children?

Is Anybody Listening?

Issue 1: Were risk factors adequately identified and addressed?

From the time between Melissa's pregnancy with her first child to the day the family was evicted from their home and the children placed in care, the Department received a total of twenty-six referrals about the children's safety. These do not include the numerous phone calls and emails directly to the social workers from a range of individuals including education and health professionals who were worried about the family.

The schools were the main source of information on the welfare of the children. Even though staff could only comment directly on Nathan and Meghan, observations of these two enabled them to infer that the condition of the three younger siblings was likely in peril as well. Adam, Jacob and Hannah did not attend daycare, and Melissa rarely left the home. As a result, the youngest and most vulnerable members of the family were virtually invisible in the community. Anecdotal evidence derived from others involved is of paramount importance to the social worker in assessing how the family is functioning. Accordingly, the Department's contact standards mandate that for families assessed at a high risk for future harm, the social worker must make a minimum of three collateral contacts per month. These could include, for example, a phone call to the school or to the family

doctor who has recently seen the children. The school dutifully reported all concerns to either the Department or directly to the assigned social worker. However, matters considered troubling to educators, such as high absenteeism, inadequate lunches or warm clothes, and poor hygiene, would often not meet the criteria needed to elicit a response from the Department. This frustrated the school staff who felt these issues were symptoms of a greater problem but were regularly told, "There is nothing we can do." Others shared that there was never any follow-up from the social worker. Or that if the social worker did come to see the children at school, teachers were not informed nor asked for their input. One principal asserted, "It's definitely a link that can be strengthened."

Another individual who felt left in the dark was the family's primary health care provider. As part of the postnatal follow-up, she was tasked to perform Hannah's Well-Baby appointments during her first year and remembers having significant difficulty in getting Melissa to attend these exams, with appointments missed frequently. When they finally arrived for the one-month check-up, irritation was noted on the baby's body, likely caused by a lack of hygiene. In hindsight, the doctor remarked on how unusual it was to have to review how to properly bathe a baby with a mother of five children. There was never any contact from the Department to notify the family doctor that this family was followed by Child Protection or to ask for her professional feedback. After Melissa failed to attend several appointments, the doctor's office assistant phoned the Department to see if a social worker was involved who could help with transportation, and this is how it was discovered Child Protection was implicated. When discussing the topic of how to improve communication between social workers and medical professionals, the family's doctor noted, "If there is a social worker involved, have them identify themselves as part of the care team. To have a liaison person at Social Development to say that 'things are going well, or things are not going well'... would be helpful." Family doctors are kept in the loop with the care team in terms of other health professionals, but there is a disconnect with Child Protection. Is there a rationale for not informing family doctors or other medical professionals about Protection cases, and if so, does this exist primarily to protect parents rather than focusing on protecting children?

In September 2017, the Integrated Service Delivery (ISD) model was launched in New Brunswick schools province-wide. In this model, professionals from the government departments of Education and Early Childhood Development, Social Development, Health and Public Safety, work together as a multidisciplinary team sharing information and collaborating to provide services and support that directly benefit the child. This diversion from earlier approaches that emphasized confidentiality and avoided information-sharing between departments, was created with the goal of streamlining access to services for children and families. In interviews with two schools that Nathan and Meghan attended, education staff were asked if they thought the outcome for these same children would be different today, with ISD in place. Quite notably, only one out of seven interviewed believed that ISD would have made any difference, with several commenting that they were not familiar enough with the process, and still others doubting ISD's effectiveness, citing challenges including parental consent and, "Lots of red tape." These responses demonstrate the need for more education on the ISD approach and a better-defined process. One thing that is certain is that if ISD had been in place it could only have possibly benefited the oldest two children who were in school. The youngest three remained at home in conditions of chronic neglect with no one watching or listening. And these were the same conditions to which the oldest two returned every night on the days when they were at school.

From a child rights perspective, these children were deprived of their right to a decent standard of living (Article 27), but the deprivation described of frequently arriving at school without appropriate winter clothing, of wearing clothes that smelled of urine, infants with chafed skin from poor hygiene and bathing practices, stories of empty fridges and children drinking beer, goes beyond a concern with poverty and documents the situation of chronic neglect in which the children were living. This was certainly a violation of the children's right to be protected "from all forms of ... neglect or negligent treatment" (Article 19(1)). However, it was also a violation of the children's right and their parents' right to "appropriate assistance ... in the performance of their child-rearing responsibilities" and their "right to benefit from child care services" (Article 18) and to benefit as well from "social programmes to provide necessary support for the child and for those who have the care of the child" (Article 19). Equally as telling as the squalor in which the children lived, was the apparent lack of engagement in other recreative or pro-social activities, impacting on the children's quality of life and their right to play (Article 31).

In sentencing the parents to two years of prison for the neglect of their parental obligations under the *Criminal Code of Canada*, the judge observed that we have all failed these children. We seem to have more expectations of the already very challenged families themselves than we have regarding the professionals involved, and the system. The parents do not bear the blame alone. The system also failed to do what was right and protect these children from damaging chronic neglect. Unfortunately, our review of the case, and several other similar cases that have arisen this year within the caseload of the Advocate's office alone, confirm that this is not an isolated case. Many parents, often single mothers with many young children, find themselves in similar circumstances.

The lack of universal programs to support young parents, infants and children from birth to age five is leaving many New Brunswick children at risk of neglect and abuse. We need child protection services to be more vigilant in cases of chronic neglect, but we also need more eyes on and better collaboration and integration of efforts across all systems to tackle these issues together.

The neurological sciences are providing further proof every day of the profound impact that neglect can have in early years. Every case of early childhood neglect that is prevented can literally turn a life around and potentially save social welfare systems hundreds of thousand of dollars in future expenditures over the child's life span. A recent study by Child Trends in the US demonstrates how early head start (EHS) programs can prevent future child maltreatment.[1] The study looked at child maltreatment records over a period of 16 years and examined the progress of children who had benefited from EHS programs versus children in a control group who had not. The study found that children in the EHS group had better cognitive development, engaged better in play and were less likely to become involved with the child welfare system later in life.

[1]*Green, B.L., Ayoub, C., Dym Bartlett, J., Furrer, C., Chazen Cohen, R., Buttita, K., Von Ende, A., Koepp, A., Regalbuto, E. & Sanders, M. (2018). How Early Head Start Prevents Child Maltreatment. Retrieved from http://www.childtrends.org/publications/how-early-head-start-prevents-child-maltreatment*

European nations at the top of UNICEF's leader board of child welfare, such as Germany, the Netherlands, and Scandinavian countries all invest much more than New Brunswick does in early childhood programs and services. Is it any surprise that their economies have been outperforming ours for years? The Conference Board of Canada is calling on Canadian governments to do more and invest more heavily in early childhood programs and this is the directive that New Brunswick needs to take.

Findings: In summary, we find that the parents' failure to provide the basic necessities of life to their children in this case was compounded by the failure of government to work effectively together to support the children and their parents with valuable social programs and supports, and constituted a violation of the children's right to an adequate standard of living, a violation of their right to be protected from all forms of neglect and negligent treatment, and a violation of their right to prenatal care oriented towards the child's best interests. Specifically, we find that the Province of New Brunswick must do more to protect children in early years from the risks of chronic neglect and abuse. There needs to be an immediate shift in management decision-making with respect to the sharing of information. The current restrictions that prevent front-line staff from sharing information should be reviewed to consider the best interest of the child.

More universal programs of support that identify, report and address cases of neglect, and interdepartmental collaboration to ensure that children in early years benefit fully from wrap-around models of care are all part of the solution.

Recommendation 1: That the Department of Social Development and other government departments involved in services to vulnerable children in early years, including the departments of Health, Justice and Office of the Attorney General, Public Safety and Education and Early Childhood Development work together, in consultation with the Advocate's Office, to develop an approach to Integrated Service Delivery (ISD) in early childhood services. This new approach must engage all appropriate stakeholders in public health, in early childhood services, and in other public and private settings to provide wrap-around supports to children in early childhood and work collaboratively in preventing, identifying and addressing all cases and forms of child neglect and harm to children.

Adequate Protection?

Issue 2: A) Did Family Enhancement Services effectively address the negative consequences of chronic neglect the children were exposed to?

B) After the transfer to Child Protection Services, was there continuity of care with an increased use of authority for the children who were victims of severe and chronic neglect?

In 2011, the Department of Social Development's Child Protection (CP) Program was modified to include Family Enhancement Services (FES), a collaborative approach to New Brunswick's child welfare practice. At the same time, the Structured Decision Making® (SDM®)[2] model was implemented in the Department's process for intake, screening and assessment of referrals. Referrals concerning the safety of a child are received at the Centralized Intake office in Moncton where trained social workers follow standardized assessment forms (SDM® Intake Assessment) to determine if there are elements of protection indicating that a child's security or development may be at risk. Screening criteria on the Intake Assessment recommends assignment to either a CP or an FES social worker in the region the referral originated. This is known as the Multiple Response Pathway. Both CP and FES are considered child protective services serving to restore and maintain the child's security and development, and to support the family through the development of a case plan. Both are mandated services under the *Family Services Act*[3] with Child Protection having a greater use of its legal authority and remedies. To differentiate between the two pathways, FES follows more of a collaborative process intended to engage the family and enhance family functioning.

In interviews with the social workers, they were asked about their reactions to learning of the condition the family was found in on the day they were evicted. Many expressed shock and disbelief that the situation could have declined to such a degree of ruin. They recalled that Melissa's housekeeping was never perfect, with the house often cluttered and untidy, but never to the extent that it was found in on May 17, 2016, with feces widespread. When asked about her impression of Melissa, Lauren, the CP supervisor made the following comment, "She was young, new to the big city, guarded, needed support but wouldn't accept it...a pretty typical neglect case."

[2] *https://www.nccdglobal.org/assessment/sdm-structured-decision-making-systems/child-welfare*
[3] *http://laws.gnb.ca/en/showpdf/cs/F-2.2.pdf*

In truth, this was a severe case of neglect. All the factors that plagued the family from Melissa's youth to her role as a mother of five contributed to the chronic neglect her children were exposed to. These factors included: poverty, history of eviction, lack of supervision, overwhelmed and young mother of five, little to no family or social support, domestic violence, lack of transportation, educational neglect, medical neglect, evasion, and drug use. After consultation with her supervisor, Emily, the family's FES worker in Saint John, made the decision to transfer the file to CP. Until that point, the Department's involvement had been exclusively through FES. Evidently, this path that emphasizes collaboration with the parents did not serve in the best interests of the children.

Several social workers voiced that cases of neglect are generally served by FES. One offered, "Neglect almost always screens in as FES." "Neither myself nor my supervisor thought to transfer to CP; neglect is rarely CP, always FES," said another. But does FES effectively address the detrimental effects that chronic neglect can have on children? Are these effects well-known? Chronic neglect receives less focus in research when compared to other forms of child maltreatment. With physical or sexual abuse, the consequences are obvious, and for that reason CP social workers are responsible for implementing necessary safety plans and interventions required to keep children safe. With chronic neglect, the after-effects, though perhaps not immediately obvious, are nonetheless very damaging to a child's development. The accumulation of harm over time is what impairs the cognitive and social development of children.[4] Moreover, the younger the child and more extensive the neglect, the greater the consequences on the child.[5] A study examining the relationship between neglect in childhood and the manifestation of trauma-related symptoms in the preschool years demonstrated that children who experienced neglect showed more symptoms of post-traumatic stress and dissociation than non-neglected children. In addition, expressive communication between mothers and children suffered.[6] Furthermore, chronic neglect experienced in infancy and early childhood negatively impacts brain development, thereby affecting memory, planning and decision-making.[7] As a result, cognitive delays and learning difficulties are likely to arise.[8]

The decision of which pathway to take, FES vs. CP, is made at Centralized Intake, however, regional social workers working with the families do not always agree with this assignment. One argued, "You should always start with CP, then change to FES if needed." When this same social worker recalled a visit where Jacob remained gated in his room, the rest of the children wreaked havoc in the house, no one had seen the dentist, and the older children had not yet been registered for school, she said very frankly, "You tell me, is that not CP?" It is premature to assign a case to either the FES or CP pathway at Centralized Intake before the regional social worker can do an in-depth assessment or investigation.

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[4]Logan-Greene, P., & Semanchin Jones, A. (2017). Predicting chronic neglect: Understanding risk and protective factors for CPS-involved families. Child and Family Social Work, 23(2), 264-272. doi: 10.1111/12414
[5]Perry, B. D. (2000). The Neurodevelopmental costs of adverse childhood events. Retrieved from http://www.juconicomparte.org/recursos/Neuroarcheology%20of%20childhood%20maltreatment_zmH8.pdf
[6]Milot, T., St-Laurent, D., Ethier, L.S., Provost, M.A. (2011). Trauma-Related Symptoms in Neglected Preschoolers and Affective Quality of Mother-Child Communication. Child Maltreatment, 15(4), 293-304. Retrieved from http://cmx.sagepub.com/content/15/4/293.short
[7]Perry, B. D. (2002). Childhood experience and the expression of genetic potential: What childhood neglect tells us about nature and nurture. Brain and Mind, 3(1), 79-100. doi:10.1023/A:1016557824657
[8]Wilkerson, D., Johnson, G. & Johnson, R. (2009). Children of neglect with attachment and time perception deficits: Strategies and interventions. Education, 129(2), 343.

One phone call is insufficient to ascertain how a family is going to respond to allegations of abuse or neglect, or whether they will cooperate with the case plan. Interestingly, social workers from different regional offices concur that there is a discrepancy between regions as to what cases should be assigned to FES vs. CP. Many agreed that they would benefit from more training on neglect and its effects on children.

There is a common misconception among families served by the Department and even some social workers that FES is voluntary, which is not true. Some families view FES as more of a diluted form of CP and therefore do not take it as seriously. Analogously, chronic neglect is mistakenly regarded by many as less damaging than other forms of maltreatment. This seemed to ring true in Melissa's case. All along she managed to appease her FES social workers by offering excuses for missing appointments, lying about having the children seen by a dentist, claiming she didn't smoke pot and using other strategies that kept her consequence-free. One social worker summed it up in the following, "FES is all about collaborating, so I would always believe Mom rather than not." Meanwhile, Nathan, Meghan, Adam, Jacob and Hannah suffered as no progress was ever made in the case plan. Perhaps the outcome would have been different if the file was served by Child Protection sooner. One rationale given for not considering protective care in cases of chronic neglect was, "Psychological abuse and neglect are harder to prove to a judge (as compared to physical abuse)." Most of the social workers interviewed conceded that the child welfare system did not work until the children were taken into protective care. According to one worker, "Once the kids came into care, the system worked, not before." The children were failed by the system that exists to protect them.

Findings: Once the Department of Social Development intervened with the family in July 2013 through FES, it took almost two and a half years before it was determined that the severity of their situation warranted more intensive support through CP. During this period, FES social workers struggled to collaborate with the parents who remained uncooperative. Meanwhile, the effects of chronic neglect caused developmental harm to each child, damage that became more pronounced with the progression of time. Family Enhancement Services failed to recognize the consequences of chronic neglect on the children, and address this damage by ensuring relevant supports to the family to protect the children. However, when the family's file eventually transferred to Child Protection Services in Saint John, instead of more Departmental involvement, there was a significant decrease in the level of intervention and care provided when the children needed it most.

Recommendation 2: That the Department of Social Development address chronic neglect seriously and adequately to protect children by:

- ensuring that the SDM® pathway assignment of either Family Enhancement Services or Child Protection is appropriate for the needs of the family and that the family's history with the Department of Social Development is considered in relation to the pathway assignment.
- ensuring that transition to Child Protection from Family Enhancement Services results in an increased use of authority.

Quality Control

Issue 3: Did the Department Meet Its Own Practice Standards to Protect the Children?

One recurring issue that was brought to light throughout the course of this investigation was that the social workers were extremely busy managing their caseloads. Discussions with the individuals who worked with the family from different regions of the province all expressed how demanding their jobs can be. In the beginning, there was a delay in opening an FES file for the family with social worker, Jodi, explaining that the necessary paperwork that accompanies her job kept her from seeing the family. "I was always doing assessments; there was no time to open a case, or meet the criteria of visits with the family due to assessments or intakes I'd receive," she explained. Amanda, the second social worker in that same region, also agreed that a lot of time is spent doing assessments and that in her caseload, "There was usually some crisis to attend to." In a very telling interview, Sharon, the family's first CP social worker in Saint John, voiced, "I had to leave Child Protection because it's too emotionally taxing; I had nothing left to give. One case can take everything out of you."

Simply put, the role of a CP social worker is not easy. Supervisor, Lauren, described it well in the following statement, "Social workers have to engage with Mom, but also police her and protect her children from her." She also felt that on average, it takes three years to feel competent as a CP social worker, however, many don't last that long. Charged with keeping children safe, these individuals are often confronted with very hostile parents when intervening in situations involving abuse or neglect. At times, their jobs are further complicated with parents experiencing addictions, or when circumstances are severe enough to warrant the removal of children from their homes. CP social workers often find it stressful and emotionally draining when appearing in court and building a case for taking protective care of a child. When asked about his experience in court, Alex offered the following, "The court system pendulum has swung in the best interest of parents, not children." Another complaint voiced was that protective care hearings are continually adjourned with these delays resulting in increased caseloads. Because CP social workers are witness to the daily struggles and empathize with high-risk families leading tumultuous lives, they are susceptible to compassion fatigue and can become emotionally exhausted from absorbing the problems of those they support. Burnout is common with high rates of turnover. For many new graduates, CP work is their introduction to the field of social work, with relatively few remaining in these roles because of the adversities described above. Some have expressed frustration with being unable to make a difference in the lives of their clients. Those entering the field of social work are caring individuals who want to help others. If working conditions are such that they spend more time in their offices doing paperwork and managing their high caseloads than seeing their clients, it is no wonder that many would feel disheartened and burn out.

With the inherent difficulties unique to CP, effective and comprehensive training in preparation for work in the field is paramount. The training at the Department of Social Development consists of a series of five core modules covering the fundamentals, as well as specialized training on the Structured Decision Making® system, solution-focused practice, intimate partner violence and investigative interviewing. The modules known as the Core 100 Series are offered two to three times per year, as required by the number of new social workers, and it is preferred that employees follow them in a specific order. Accordingly, new social workers often find themselves working with clients and carrying a caseload before having completed the training. This becomes problematic when, for example, a social worker must attend court but has not yet been trained in the court module. Fortunately, many new employees learn the job via shadowing of an experienced worker on the team. When asked about how training could be improved, a shared response was that a "refresher" on the Core Series would be helpful, as well as supplementary training in the areas of domestic violence, sexual abuse, neglect and addictions. Social workers did not feel that they were prepared to deal with this subject matter prior to encountering it on the job. Several individuals felt that although they viewed the training as valuable, they were too busy upon returning to work that they had no time to effectively apply what they had learned.

Review of this family's file with FES and CP revealed a substantial number of instances where obligations to the family were not fulfilled. Child Protection and FES social workers in New Brunswick must adhere to a set of Practice Standards as outlined in the Multiple Response Standards in Child Protection and Family Enhancement Services (2011) (Appendix C). These standards inform the work carried out by the social worker and provide a baseline for evaluating performance and assessing the Department's overall accountability in child welfare practices. The methodology followed in this review involved examining the eleven Standards against FES and CP interventions leading up to the day of eviction and taking protective care of the children. In doing so, numerous examples were identified where the Department's service fell short (see Table 1). The children did not receive the support from the Department that they were entitled to, the exception being after the family moved to Saint John and was followed by FES. During this time, the family was seen on a regular basis including seeing Nathan at school, assessments were completed, a case plan developed, collateral contacts were made, a family support worker was provided, and the social workers consulted with their supervisor as needed.

Table 1: Practice Standard Violations

Multiple Response Standards in Child Protection and Family Enhancement	Violation
Standard 1 Assessment of a Report	• Only 1 record of an intake completed despite 7 referrals received while the family was under CP services
Standard 5 Child Protection services	• Delay in the social worker seeing the family after transfer of the file from FES (the file transferred to CP on Nov 10, 2015, but the CP social worker did not see the family until Dec 2, 2015) • No evidence of safety or risk assessments performed, even after the birth of Hannah • No evidence of a case plan or concurrent plan developed (a legislated requirement); no mention of using the FES case plan • A lack of services provided to the family, apart from driving Melissa to two of Hannah's doctor's appointments and a plan to hire a human services counsellor to help Melissa look for an apartment • Failure of social workers to meet contact standard of 3 in-person contacts per month for a high-risk family; no contacts with Rick between Nov 10, 2015-May 17, 2016 that would meet the requirements of the contact standards • Inadequate number of collateral contacts made by social workers • Nathan was not interviewed separately after the Department received referrals regarding the children's safety; younger siblings were not seen by social worker • Permanency Planning Committee meeting was not scheduled until six months after the file transferred to CP with a limited number of in-person contacts made during that time
Standard 6 Family Enhancement Services	• Failure to continue service of parent aide when the family moved in Jan 2014 • Nathan was not interviewed separately after the Department received referrals regarding the children's safety; younger siblings were not seen by social worker • no contacts with Rick between May 22, 2015-Nov 10, 2015 that would meet the requirements of the contact standards • Inadequate number of collateral contacts made except for when the family was served by FES from Oct-Dec 2015

Multiple Response Standards in Child Protection and Family Enhancement	Violation
Standard 8 Case Closure	• No data indicating that the family's service providers or extended family were notified of FES case closure in May 2014
Standard 9 Conducting the Safety Assessment	• Safety Assessments not completed after the births of Jacob or Hannah, the fourth and fifth children
Standard 10 Clinical Supervision and Case Consultation	• Insufficient recorded consultations with supervisors throughout the file excluding when the family was served by FES from Oct-Dec 2015

Findings: A large majority of Practice Standard violations occurred while the family's file was served by CP, illustrating that after transferring from FES in Saint John, the family received significantly less support and intervention. Heavy workloads contributed to the two CP social workers' inability to comply with their basic work requirements. Ultimately, this contributed to the devastation of the family home and the dire circumstances that surrounded the children. Those who enter the field of social work do so because of a desire to help others. Clearly, none of the social workers involved with this family intended to allow the system to fail them. Several voiced that their heavy workloads were a huge barrier in meeting the Department's defined Practice Standards. The Standards should not be lowered, as they exist to protect children. Therefore, it is imperative that social workers are equipped with everything they need to meet these Standards and fulfil their commitment to keeping children safe.

Recommendation 3: That the Department of Social Development:

- undertake a review of workloads to ensure that social workers have the time necessary to manage their caseloads effectively.
- have mechanisms in place to ensure that Child Protection workers receive all core training before taking on a caseload.
- develop a quality assurance policy to require regional offices to forward cases in which practice standards are known to have been unmet to the Department for review and recommendation by clinical reviewers.
- make statistics from the Clinical Auditing Team available to the public.

Getting Past the Door

Issue 4: Evasion of appointments – Was every possible effort made by the social workers to see the children?

One of the greatest hurdles that all service providers experienced with Melissa was her keen ability to avoid all attempts at contact. Social workers, teachers, principals, landlords, parent-aides, Early Intervention workers, to name a few, were all unable to reach Melissa at some point. To accomplish this feat, Melissa employed a host of evasion tactics, including offering excuses such as confusing the date of an appointment or having a conflicting engagement, cancelling appointments, not showing up for appointments, and not answering her phone or the door.

This history of elusive behaviour resulted in the downfall of the family. During the six-week period that the CP social workers in Saint John were unable to see the family because Melissa never answered her door, the conditions of the home deteriorated exponentially to something that was completely unrecognizable compared to what they had seen on their last visit.

In interviews, the social workers were asked what strategies could be used to see the children when parents refuse access to the house or make it very difficult for the worker to have direct contact. Responses included: seeing the children at school, holding the social assistance cheque, leaving notes at the door, making unannounced visits, and calling the police if it was felt that the children were at immediate risk. Numerous obstacles were also noted, including:

- "The system doesn't give social workers a lot of teeth for when they need to get into a home."
- "Getting into the home is a very common barrier, no matter what province."
- "We need more authority to get into the house."
- "It's an unclear process with no clear direction. Access is the biggest challenge."
- "We feel our hands are tied; there are lots of limitations re: what we can do; lots of room for improvement."

According to the *Family Services Act*, when access to a child is impeded or denied during an investigation, the social worker can:

- consult with Supervisor about alternative action or intervention
- apply to the Court of Queen's Bench – Family Division for an Order authorizing an investigation under subsection 31(2.2) of the *Family Services Act*
- request police assistance when necessary in carrying out an Order authorizing an investigation; in resolving issues of disagreement between Social Development and the police concerning the use of police resources, consult the Procedure for Requesting Police Assistance to Assist with Enforcement of the *Family Services Act* in the Electronic Library
- enter and search without an order and by force if necessary when there are reasonable and probable grounds to believe that the security or development of the child would be seriously and imminently in danger as a result of the time required to obtain an order of the court. Refer to section 31 (2.4) of the *Family Services Act*

- seek a Warrant when access to documents relating to the investigation are denied, subsection 31 (2.6) of the *Family Services Act*, the Social Worker may request information from the agency involved, under subsection 31 (2.7), if the parents refuse to cooperate or make an ex parte application to the court to produce those records or documents, subsection 31 (2.6), if the agency refuses to cooperate

Although the above are measures of last resort, social workers could have employed them to have access to the children and their environment. Although not the preferred practice, the Department has the legislative power to enter a family's home to assess the children's situation. The caregiver's permission is not required to see children in the context of child protection.

Upon further review of the *Family Services Act*, (supra), it is to be noted that the Act is replete with references to the "best interest of the child". In the Preamble to this legislation, we note the following statement-

> "WHEREAS the best interest and safety of the child must always prevail when there is a conflict between risk to the child and preservation of the family unit" [...]

We would agree that the determination of "the best interest of the child" is not always a simple or objective process. Nevertheless, social workers responsible for the protection and care of vulnerable children must use the tools available to them pursuant to the Act to protect these children and determine what is in their "best interest". The definition of the 'best interests' principle in section 1 of the Act includes the following:

> "best interests of the child" means the best interests of the child under the circumstances taking into consideration
>
> (a) the mental, emotional and physical health of the child and his need for appropriate care or treatment, or both [...]

In the Supreme Court of Canada decision of Winnipeg Child and Family Services v. K.L.W.,[9] the Court ruled on whether a valid entry and removal of a child without a warrant or court order in a non-emergency or emergency was a breach of the parent's liberty and security rights pursuant to Section 7 of the *Canadian Charter of Rights and Freedoms*.

Justice L'Heureux-Dubé, writing for the majority of the Court, cited a decision from the Alberta Court of Appeal on the issue of children's rights versus parent's rights, since this issue is most always a point of contention in deciding what is in the child's best interest. She notes as follows:

> Ultimately, however, as the Alberta Court of Appeal recently observed in T. v. Alberta (Director of Child Welfare) 2000 ABCA 182 (Can LII), 188 D.L.R. (4th) 603, at para.14, child protection legislation 'is about protecting children from harm; it is a child welfare statute and not a parents' right statute'.[10]

It is without dispute that the New Brunswick *Family Services Act* is precisely that: child protection legislation.

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[9] *[2000] 2 SCR 519, 2000 SSC 48 (Can LII) [K.L.W.]*
[10] *Ibid, at para. 80.*

The Supreme Court cited a decision of Lord Nicholls[11] concerning the challenging task facing child protection workers:

> I am very conscious of the difficulties confronting social workers and others in obtaining hard evidence, which will stand up when challenged in court, of the maltreatment meted out to children behind closed doors. Cruelty and physical abuse are notoriously difficult to prove. The task of social workers is usually anxious and often thankless. They are criticised for not having acted in response to warning signs which are obvious enough when seen in the clear light of hindsight. Or they are criticised for making applications based on serious allegations which, in the event, are not established in court. Sometimes, whatever they do, they cannot do right.[12]

It must not be concluded that Lord Nicholls' description of the challenges facing social workers is an excuse for not being proactive or a reason not to heed warning signs for fear that whatever action taken could be wrong. Rather, it is an admonition to all who work to protect children that their frustrations with the system should not act as an impediment preventing them from acting, in difficult situations, to protect vulnerable children and acting in their best interest.

Justice L'Heureux-Dubé in K.L.W. ruled that, whether in emergency or non-emergency situations, social workers have the right to enter premises and apprehend children who are in danger. L'Heureux-Dubé conducted an extensive search of many of the social welfare statutes of the Provinces including New Brunswick's and unequivocally found that statutes that permit entry without a warrant or a court order are legal and do not violate privacy rights so long as the legislation has provisions for post-apprehension review by the Court. In fact, sections 51 and 53 of New Brunswick's *Family Services Act* do include these post-apprehension review requirements.

What then is the stumbling block that would prevent social workers from entering premises without warrants or orders? Given the comments and statements we received from many of the social workers and supervisors who were interviewed, it seems probable that there exists a misunderstanding or ignorance of the legislative provisions that allow for intervention or apprehension measures to be used in circumstances such as in this case. Undoubtedly, the Supreme Court of Canada in K.L.W. clarified any misconception regarding the issue of apprehending without prior judicial authorization. To reinforce this principle, we would refer to the following passages of the Court's ruling on this issue:

> **...if this Court were to find that prior judicial authorization of apprehension is required in so-called "non-emergency" situations, the risk inherent in the process of obtaining such authorization would fall primarily on the child. This risk can result from delays related to the need to gather proof of reasonable and probable grounds that the child is in need of protection, whether in the form of an affidavit or of testimony and documentary evidence. While the delays associated with prior ex parte authorization are not as significant as those associated with a prior hearing, they would still leave children at risk of serious, or even life-threatening, harm for at least a number of hours, or even days. A child should never be placed in such jeopardy.[13]**

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[11] *In re H. (Minors) (Sexual Abuse: Standard of Proof), [1996] A.C. 563 (H.L.), at p. 592.*
[12] *In re H, [1996] A.C. 563 (H.L.) quoted in Winnipeg Child and Family Services v. K.L.W. [2000] 2 SCR 519, 2000 SSC 48 (Can LII), at para. 100.*
[13] *K.L.W., at para.109.*

> **It is also clear that a wrongful apprehension does not give rise to the same risk of serious, and potentially even fatal, harm to a child, as would an inability on the part of the state to intervene promptly when a child is at risk of serious harm. (pg. 61, para.111).**

Given the facts in the present case, would it have been reasonable for the social workers to have attempted to enter the premises when it was evident that the mother was not in control of her five children and avoided many opportunities to have the social workers visit her children who were receiving CP services? Considering the provisions of the *Family Services Act* which allows for a search of the premises and the removal of a child (Section 33(2)) and the post-apprehension procedures that would have the Court review the actions of the state (Sections 51 & 53), and further considering the decision of the Supreme Court of Canada in K.L.W., it would be reasonable to answer that question in the affirmative.

Findings: During the six months the family was served by Child Protection, both social workers failed to meet the Department's Contact Standards of three face-to-face contacts per month for a family assessed at a high-risk. In the four months that Sharon worked on the file (Nov 2015-Mar 2016), she met with the family a total of four times. Excluding the two case transfer visits where she received the file from Robin (Dec 2, 2015) and eventually transferred it to Alex (Mar 24, 2016), Sharon only saw the family an additional two times. Alex was equally unproductive in visiting with the family, only managing to see them twice in the two months he carried the file. The first visit was when Sharon transferred the file to him (Mar 24, 2016) and the second occurrence fell on May 17, 2016, when Sheriff Services entered the home to evict the family. Alex made eleven attempts to visit, either scheduling ahead of time or else arriving unannounced, however, never succeeded in getting into the home.

Recommendation 4: That the Department of Social Development take immediate steps to ensure that all Child Protection and Family Enhancement Services social workers understand the legislative authority allowing them to enter any premises to remove a child whose security or development may reasonably be believed to be in danger. Additionally, and equally importantly, that the Department of Social Development review its governing legislation, the *Family Services Act*, to ensure that the Act's provisions are in accordance with the findings of the Supreme Court of Canada in the case of K.L.W.; the wording in the Act should not require an unduly high threshold in regard to the need to ascertain the serious and imminent danger to the security or development of the child before entering premises.

The Children Today

Nathan (11), Meghan (8), Adam (6), Jacob (4) and Hannah (almost 3) have been in their paternal grandparents' care for several months now and are making gains physically, socially and emotionally. They are getting accustomed to being together again, as the last time they lived under the same roof was on the day of eviction, about two and a half years ago. Meghan is very social and can often be found reading, riding her bike, or fussing over her dog, Max. Adam is excited and ready to start kindergarten. Like his older sister, he enjoys books and being read to. Jacob has a shy smile that lights up when offered the chance to play with others. Hannah is a true sweetheart who thrives on attention and loves being with people. Nathan is healing, although he continues to struggle with the separation from his parents, blaming himself and his brothers for going into care.

These five children are amazing individuals. They have survived circumstances considered both shocking and inhumane, and in their short lives, have overcome challenges that would cripple many adults. Their young age and inherent vulnerability left them without a voice and thus powerless to reduce the harm they were subjected to. Seeing them participate now in everyday 'kid' activities speaks volumes about the resiliency of childhood. But their story should not end here. We must ensure they continue to recover from the damage of their past by supporting them in realising their greatest potential. Their past was a series of doors closed to every opportunity. Their future must hold the key.

APPENDICES

APPENDIX A

The Office of the Child and Youth Advocate

The Child and Youth Advocate has a mandate to:

- Ensure that the rights and interests of children and youths are protected;
- Ensure that the views of children and youths are heard and considered in appropriate forums where those views might not otherwise be advanced;
- Ensure that children and youths have access to services and that complaints that children and youths might have about those services receive appropriate attention;
- Provide information and advice to the government, government agencies and communities about the availability, effectiveness, responsiveness, and relevance of services to children and youths; and
- Act as an advocate for the rights and interests of children and youths generally.

APPENDIX B

Review Process

This investigation involved reviewing the family's entire file with the Department of Social Development, including the Child Protection case opened on Melissa as a youth. Specifically, we looked at case notes documented by each social worker in every regional office, SDM® assessments completed, services and supports offered, referrals made to the Department, observations made by Family Support Workers, court affidavits, medical documentation and other notable information. To better understand the procedure taken by the Department upon receipt of a child protection referral, we requested a presentation by a Provincial Child Protection Consultant on the Structured Decision Making® process and Multiple Response Pathway. Following this, interventions done throughout the course of the file were evaluated against departmental policies, procedures and standards. A Child Rights Impact Assessment (CRIA) was completed to illustrate the infringement of the children's rights under the *UN Convention on the Rights of the Child*. Finally, valuable information and insight was gained through interviews with those connected with the family in each of the regions they resided. These individuals included Family Enhancement Services and Child Protection social workers and their supervisors, school personnel, former landlords, medical personnel and foster parents. To conclude the investigation, we met with the children now in the care of their grandparents.

APPENDIX C

Multiple Response Standards in Child Protection and Family Enhancement Services (2011)

Standard 1 Assessment of a Report

Standard 2 Disposition of the Referral

Standard 3 Developing the Intervention Plan

Standard 4 Child Protection Investigation

Standard 5 Child Protection Services

Standard 6 Family Enhancement Services

Standard 7 Transferring a Case

Standard 8 Case Closure

Standard 9 Conducting the Safety Assessment

Standard 10 Clinical Supervision and Case Consultation

Standard 11 Case Recording and File Documentation

Standard 12 Notification of Death and Clinical Injuries

APPENDIX D

Family Services Act Section 31(1)

31(1) The security or development of child may be in danger when

(a) The child is without adequate care, supervision or control;

(b) The child is living in unfit or improper circumstances;

(c) The child is in the care of a person who is unable or unwilling to provide adequate care, supervision or control of the child;

(d) The child is in the care of a person whose conduct endangers the life, health or emotional well-being of the child;

(e) The child is physically or sexually abused, physically or emotionally neglected, sexually exploited, including sexual exploitation through child pornography or in danger of such treatment;

(f) The child is living in a situation where there is domestic violence;

(g) The child is in the care of a person who neglects or refuses to provide or obtain proper medical, surgical or other remedial care or treatment necessary for the health or well-being of the child or refuses to permit such care or treatment to be supplied to the child;

(h) The child is beyond the control of the person caring for him;

(i) The child by his behaviour, condition, environment or association, is likely to injure himself or others;

(j) The child is in the care of a person who does not have a right to custody of the child, without the consent of a person having such right;

(k) The child is in the care of a person who neglects or refuses to ensure that the child attends school;

(l) The child has committed an offence or, if the chid is under the age of twelve years, has committed an act or omission that would constitute an offence for which the child could be convicted if the child were twelve years of age or older.

APPENDIX E

Glossary of terms

1) Child Protection: Branch of New Brunswick's Department of Social Development that investigates and provides services for cases of abuse and/or neglect of children under age 19.
2) Medicare: Provincially administered health care plan provided through New Brunswick's Department of Health.
3) Protective Care: The Minister of Social Development has custody, care and control of the child who is removed from their parents' custody because of a risk to their safety and/or development. The Minister must either release the child, make an agreement with the parent, or apply for a court order within 5 days. The child is placed in a setting approved by the Minister.
4) Family Enhancement Services (FES): A collaborative approach provided in conjunction with the Child Protection Program to maintain the child's security or development, when a plan for the care of a child is developed and implemented.
5) Early Intervention: Program offering targeted services of screening, assessment, intervention and case management to families of children aged 0 to 8 who are at greatest risk of developmental delays. Services are contracted by the Department of Education and Early Childhood Development.
6) New Brunswick (N.B.) Housing: Subsidized rental accommodation for lower socioeconomic families and senior citizens. Offered through the Department of Social Development.
7) Family Group Conference: A meeting of the social workers and service providers with extended family to develop a plan for the care and protection of a child.
8) Permanency Planning Committee: A regional decision-making body that oversees and approves major case decisions in child protection. The Committee must include the social worker and supervisor involved in the case.
9) After Hours Emergency Social Services (AHESS): Division of the Department of Social Development that provides emergency social services weekdays from 4:30 p.m. to 8:15 a.m. and 24 hours/day on weekends and holidays.
10) Contact Standard: The requisite number of face-to-face visits between the family and their social worker per month, as determined by the family's level of risk.
11) Collateral Contact: A contact made between the social worker and other service provider involved with the family.
12) Fresh Start Saint John: A community outreach agency aiming to reduce poverty and homelessness by offering support, education and advocacy to vulnerable individuals.
13) Referral: A contact made to the Department of Social Development regarding the safety of a child.

14) Safety Assessment: The procedure taken by the assigned social worker to evaluate whether or not the child can remain safely at home.

15) Intake Assessment: The procedure taken by the social worker receiving the referral at Centralized Intake to determine: if the referral screens in for a Departmental response, how quickly to respond, and whether to assign to FES or CP.

16) Risk Assessment: Assesses whether a family is more or less likely to have another incident of abuse or neglect without intervention, and informs the decision whether a case should be opened for ongoing services.

17) Human Services Counsellor: An individual who provides support and counselling to individuals in need.

18) Children's Rights Impact Assessment (CRIA): A method used to identify how actions contribute to or undermine the fulfillment of children's rights and well-being.

19) Foster Home: A family home environment for children in the care of the Minister when they are unable to remain with their natural families.

20) Custody Order: A court order granting temporary custody of a child to the Minister of Social Development.

21) Guardianship: A court order granting permanent custody of a child to the Minister of Social Development.