

**THE CASE FOR
SPECIALIZED HEALTH CARE RESPONSES
TO RECOGNIZE AND PREVENT
CHILD SEXUAL ABUSE**

The Office of the Child and Youth Advocate

August 2017



Published by
The Office of the Child and Youth Advocate
Newfoundland and Labrador
193 LeMarchant Road
St. John's NL, A1C 2H5

Printed by:

The Queen's Printer
Government of Newfoundland and Labrador

Designed by:

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Message from the Child and Youth Advocate

Newfoundland and Labrador's Child and Youth Advocate is an independent Statutory Officer reporting directly to the House of Assembly through the Speaker and derives authority from the *Child and Youth Advocate Act*. As Child and Youth Advocate, my role is to advance the rights and interests of children and youth, ensure they have access to services, and to provide recommendations, information and advice to government, its agencies, and the community about how to better address the needs of young people.

This report responds to an investigation called by my predecessor in October of 2015. Upon my appointment as Child and Youth Advocate, one of my primary goals has been to expedite any outstanding matters so that recommendations may be implemented to address existing gaps in services. This case speaks to the vulnerability of children to abuse, and to sexual abuse in particular, and to the need for government departments, public agencies, professional associations, and community organizations to be vigilant in ensuring children's rights and safety are protected. Such protections were not in place in this case, and the child at the center of this investigation remained vulnerable despite engaging formal public health care and child protection services.

Pursuant to Section 24(1) of the Act, my office will continue to monitor and follow up on the recommendations arising from this investigation until they are all appropriately addressed by the applicable government department or agency. Status reports on recommendations are released annually.



Jacqueline Lake Kavanagh
Child and Youth Advocate

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Case Summary

This case involves a family who moved to Newfoundland and Labrador from another province for a period of approximately five months. The focus is a 12 year old girl who was sexually assaulted by her stepfather (whom she believed to be her biological father), became pregnant and sought to terminate the pregnancy. She and several younger siblings were also the center of multiple Child Protection Reports to the Department of Children, Seniors and Social Development (CSSD). During its short time in the province, the family had involvement with Eastern Health, CSSD, Newfoundland and Labrador English School District, the Royal Newfoundland Constabulary (RNC), and Planned Parenthood/NL Sexual Health Centre which offered a health clinic. The purpose of this investigation has been to determine if these children's needs were appropriately met, whether their rights were upheld, and to diminish the likelihood of a similar situation occurring in the future.

Shortly after arriving in the province, the stepfather brought the 12 year old child to Planned Parenthood/NL Sexual Health Centre's medical clinic seeking an abortion. He claimed to be her biological father. The mother resided out of province and was not involved. The clinic could not perform the requested service but could provide referrals. The clinic physician interviewed the child alone and in an interview with the Office of the Child and Youth Advocate advised that she provided education on sexually transmitted infections and birth control. The physician could not recall asking about the child's mother, but understood the family unit had relocated. The child said she had consensual sex with her teenaged boyfriend. The boyfriend's age was not questioned. Age is a significant consent issue and is critical in determining whether, legally, a sexual assault had occurred. The stepfather's guardianship status was not verified. The child was referred to Eastern Health to have the pregnancy terminated. Age-appropriate counselling services were not provided nor offered; no screening for potential sexual abuse or potential coercion occurred.

A nurse at Eastern Health met with the child and arrangements were made for the procedure. Again, no screening for potential abuse occurred, nor was a referral made to counselling services either before or after the abortion was performed. After the procedure was performed, the child was subsequently discharged from the health care facility with her stepfather. The surgery was performed despite two sections of the consent form being incomplete, one of which included the legal capacity of the stepfather

“ Age is a significant consent issue and is critical in determining whether, legally, a sexual assault had occurred. ”

to sign for consent. The nurse indicated that she assumed a 12 year old could provide consent unless there was a clear cognitive impairment. While a discussion occurred about birth control, there was no discussion about the child's sexual activities, the circumstances of the pregnancy, potential abuse or coercion, or how the child felt about the procedure. When interviewed, the physician indicated lack of familiarity with child protection legislation. The nurse expressed concern during the investigative interview about the inability to provide any detailed discharge instructions to the person escorting the patient home. She indicated this was not appropriate, given the risk of complications, and the child's age. The child had a follow-up medical appointment booked at the community clinic which she missed. Eastern Health had also encouraged her to follow up with her family physician, despite her being a new resident to the province, and the family physician being listed as "unknown." No further followup occurred from the Planned Parenthood health clinic or from Eastern Health. Neither the Janeway Children's Hospital nor CSSD were contacted regarding this child at the time.

CSSD became involved with this family approximately one month later as a result of multiple protection referrals. The first two referrals alleged a lack of appropriate supervision for the children, while the third alleged that the stepfather had physically abused the 12 year old and one of her siblings. After the first allegation, CSSD interviewed the siblings, stepfather and grandmother. The 12 year old initially refused but was eventually interviewed at school. Although CSSD was in contact with the school, no other outside collateral sources were sought in a timely manner, which would have enabled a more thorough assessment. Collateral sources were identified in the *Protection and In Care Policy and Procedure Manual* (2011) and the *Risk Management System* (2010) as sources for additional information related to child protection concerns. After the allegation of physical abuse, the grandmother and stepfather were uncooperative. The stepfather claimed harassment, while the grandmother refused to allow the children to be interviewed. CSSD struggled to maintain contact over the course of four months.

“ Two years later, the child disclosed to authorities in another province that she had been repeatedly sexually assaulted by her stepfather over a period of 26 months, resulting in two abortions...”

When the children could not be located, CSSD deemed them unsafe and engaged the RNC and the court to seek their whereabouts, including obtaining an Order to Access a Child from the court. CSSD and the RNC determined that the family had moved to another province. CSSD did not complete child welfare or criminal records checks on the stepfather until after the family had moved. CSSD contacted child welfare officials in the new province before closing the protective intervention file. Two years later, the child disclosed to authorities in another province that she had been repeatedly sexually assaulted by her stepfather over a period of 26 months, resulting in two abortions: the abortion that occurred in Newfoundland, and the second abortion that occurred in another province. The stepfather pled guilty to this and to other offences on other individuals, including sexual assault. He was sentenced to 16 years in prison.

Findings and Recommendations

The Public Health Agency of Canada (2012) defines child sexual abuse as an abuse of power that involves sexual activity forced on a child by either an adult or an older, more powerful child. According to the *Criminal Code of Canada*, the age of consent refers to the age at which a person can legally consent to sexual activity. The age of consent to sexual activity in Canada has been 16 since 2008. However, the Criminal Code provides some “close in age” exceptions. For example, “a 12 or 13 year old can consent to sexual activity with another young person who is less than two years older and with whom there is no relationship of trust, authority or dependency or other exploitation of the young person” (Department of Justice Canada, 2016).

In this case, a 12 year old child who had been sexually abused by her stepfather presented at a community clinic and subsequently at Eastern Health to terminate a pregnancy. She received inadequate screening and assessments, which potentially enabled the sexual abuse of the child to continue. As a result of a detailed investigation, the Child and Youth Advocate has identified several primary systemic areas for improvement.

1. There is a significant gap in the health care system which does not ensure appropriate screening for sexual abuse of children seeking abortion services. This is a high risk population for sexual abuse. Coordination is lacking for appropriate child-focused screening, as well as pre/post abortion counselling, follow-up and supports.
2. Medical personnel are not always familiar with relevant legislation addressing children’s protection. This includes provincial child protection legislation as well as the criminal law and definitions of consent for sexual activity.
3. The health care system has gaps in its policies and practices related to consent when children request and/or receive medical services and procedures. Significant gaps were noted in this area and require an enhanced focus and clarity (this is separate from the issue of legal consent for sexual activity).

“She received inadequate screening and assessments, which potentially enabled the sexual abuse of the child to continue.”

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4. CSSD requires enhanced and timely responses for appropriate protective intervention and followup, including criminal and child welfare checks. Documentation deficiencies were noted in the CSSD file, however some of these practices have since changed. These CSSD issues have been highlighted in previous Child and Youth Advocate reports. In this case, some file recordings occurred four months after the activity or intervention occurred, despite internal requirements for documentation within 24 hours for protective intervention investigations, and 48 hour documentation for other services.

a. Consent, Education, and Coordination

Eastern Health requires that a patient under the age of 18 must have parental consent to have an abortion, unless the patient is independent of her family and can provide the required court documents. Neither test was met in this case. The health care professionals involved in this case stated in interviews that they believed the child's boyfriend was the father. However they did not explore or attempt to verify this, and they did not question his age. They also believed that her stepfather was her biological father; however, this assumption was neither explored nor confirmed.

Eastern Health's Administrative Policy Manual states: "A common-law or legally married spouse of a natural parent may not consent [to medical intervention for a minor] unless there is formal adoption." This 12 year old child's biological mother did not accompany the family to this province, and health care professionals believed the stepfather when he claimed to be her biological father. A nurse from Eastern Health explained in an interview that no process existed to address areas of concern when dealing with minors. She said she would have followed policy at the time, which was to have an adult sign for a minor. The abortion proceeded despite two incomplete sections on the consent form: the date and time, and the "legal capacity" of the stepfather to "sign for patient, if applicable." The nurse admitted in an interview that this was an oversight on her part, and that she should have followed up to make sure the form was fully completed prior to the surgery. She commented that it was common in her work to encounter 12 year olds seeking an abortion.

The physician who performed the abortion advised in an interview that he did not usually question the circumstances of pregnancy, as he did not wish to appear judgmental, and would provide the requested medical service. He indicated that if the stepfather had verbally referred to himself as the child's father, he would have been able to give consent for the abortion. He noted that if the child was not a mature minor, he would normally seek parental consent. He also said he was unfa-

miliar with CSSD legislation at the time and was unaware of Eastern Health's terminology in policy regarding consent for minors. Contrary to the nurse, he said that it was uncommon in his work to encounter 12 year old children seeking abortions, and that this child was one of the youngest patients he had seen for this service.

There is currently no requirement in Eastern Health policy that a referral be made to CSSD or to a child-centered counselling service when a child under the age of consent presents for an abortion. This would only occur if there is suspicion that the child has been coerced or abused. However there is no process in place to assess for potential coercion or abuse. The professionals in this case assumed that the child was being forthright, was not being coerced, was not at risk, and that the stepfather was actually her biological father. Unfortunately, they did not consider a 12 year old seeking abortion services as an indicator for further assessment requiring expert services in interviewing vulnerable children. The health care professionals in this case focused more on completing the medical procedure than on fully assessing the child's overall safety and wellbeing. They were not knowledgeable about relevant child protection legislation or criminal law associated with consent to sexual activity, and were not practicing with a child-centered focus and knowledge.

“ The Child and Youth Advocate is unequivocal that a child who presents at a community agency or Regional Health Authority to terminate a pregnancy should not be treated as an adult. ”

While Planned Parenthood/NL Sexual Health Centre had a confidentiality policy which included accurate information on the age of consent and any exceptions, a more thorough screening process was needed to protect this child. The physician at Planned Parenthood should have at least questioned the age of the teenaged boyfriend, and ensured the stepfather's guardianship status was verified. In an interview, the physician said she could not recall anything unusual about the child or her stepfather, and that it was common to encounter sexually active children in her work, though uncommon to encounter pregnant children.

The Child and Youth Advocate is unequivocal that a child who presents at a community agency or Regional Health Authority to terminate a pregnancy should not be treated as an adult. A thorough assessment should occur, using specialized screening approaches by professionals with training and expertise in child-focused interviewing. This will help to better determine whether the child may have been coerced, abused, continues to be at risk, and whether she is proceeding with informed consent.

This investigation identified knowledge gaps for medical personnel in the following areas:

1. Child protection legislation and associated reporting requirements
2. Legal age of consent for sexual activity
3. Informed medical consent and age of medical consent for minors
4. How to recognize warning signs for sexual coercion, exploitation and abuse of minors

There are many stakeholders and professionals that play a vital role in the provision of services identified in this case. These individuals and organizations can play a key leadership role in preventing such occurrences in the future. A collaborative approach is encouraged. Partnerships bring together a wealth of expertise and resources therefore allowing for greater efficiencies and a more comprehensive response. The following recommendations are intended to fill this gap and to provide a stronger base of knowledge for medical professionals who may provide services to young people. However it remains in the best interest of the child that recommendations individually identify stakeholders who are thereby tasked with the responsibility of ensuring appropriate response and implementation. Given some of the common areas of practice, collaborative approaches seem to offer an efficient and effective approach. There are many activities, resources and formats that can address this continuing medical education need, and entities can decide how to best serve their members.

While recommendations are addressed to these entities, it should be clearly noted that Central Health, Western Health, Labrador Grenfell Health, Memorial University, the Newfoundland and Labrador College of Family Physicians, the College of Physicians and Surgeons of Newfoundland and Labrador, the Newfoundland and Labrador Medical Association, and the Association of Registered Nurses of Newfoundland and Labrador were not investigated in this matter, and were not involved in the events surrounding this case.

Recommendation 1

Memorial University's Faculty of Medicine and School of Nursing collaboratively address the professional education topics of child protection legislation and reporting requirements, legal age of consent for sexual activity, medical consent for minors, and how to recognize warning signs of sexual coercion, abuse and exploitation of minors.

Memorial University's Faculty of Medicine response:

The Faculty of Medicine will work collaboratively with the School of Nursing and other key stakeholders such as other health care professionals to develop potential simulated cases or inter-professional education, and to develop continuing professional education on the topics referenced in this recommendation. The postgraduate medical education program will develop an academic half day session for all postgraduate year one residents on the professional topics outlined in this recommendation. The pediatric residency program is in the process of developing a longitudinal competency-based child protection training component over its residency training.

Memorial University's School of Nursing response:

The School of Nursing noted that the draft report highlights an extremely disturbing series of events that speaks to the need for critical thinking in the face of uncommon scenarios/histories as well as knowledge of regulations and policies in the area of child and youth protection. Notwithstanding that the topics referenced in this recommendation are included in the School's undergraduate curriculum, the School will refer these topics to the Joint Curriculum Committee for Memorial University School of Nursing, the Centre for Nursing Studies and Western Regional School of Nursing with the suggestion to consider integrating content in scenarios. Further, the Deans of Memorial University's Faculty of Medicine and School of Nursing have had a preliminary conversation and plan to meet to discuss potential simulated cases or inter-professional education modules related to child protection.

Recommendation 2

The Newfoundland and Labrador Medical Association, the Newfoundland and Labrador College of Family Physicians, and the College of Physicians and Surgeons of Newfoundland and Labrador collaboratively address the continuing education topics of child protection legislation and reporting requirements, legal age of consent for sexual activity, medical consent for minors, and how to recognize warning signs of sexual coercion, abuse and exploitation of minors.

Newfoundland and Labrador Medical Association response:

The NLMA is deeply saddened to learn about the abuse suffered by the child at the centre of this report and is concerned about the lack of protective intervention provided for the child. The NLMA supports the Child and Youth Advocate's recommendation and will work collaboratively with the other stakeholders identified to address the matters in the recommendation.

Newfoundland and Labrador College of Family Physicians response:

The College would be very supportive of developing an educational program in collaboration with the Newfoundland and Labrador Medical Association and the College of Physicians and Surgeons of Newfoundland and Labrador that would address this recommendation. The College feels it could integrate these topics into a separate Continuing Medical Education event, incorporate them into its Annual Scientific Assembly or develop them as standalone modules with assistance from its partners.

College of Physicians and Surgeons of Newfoundland and Labrador response:

The College wishes to assist and cooperate. It can identify a role in future improvements to health care to recognize and prevent sexual abuse to this vulnerable population. The College has contact information for all practicing physicians and physicians in-training for Newfoundland and Labrador. The College communicates with its physician members by email and further states that every physician has a professional obligation to read all College communications. The College will be a partner in improving the health care system's handling of such cases as described in the report.

Recommendation 3

Each Regional Health Authority address the continuing education topics of child protection legislation and reporting requirements, legal age of consent for sexual activity, medical consent for minors, and how to recognize warning signs of sexual coercion, abuse and exploitation of minors.

Eastern Health response:

1. Eastern Health will establish a working group to review current education tools and develop appropriate education resources regarding:

a. Relevant Child Protection Legislation

b. Reporting requirements

c. Legal consent to sexual activity

d. Medical consent for minors

e. Signs of sexual coercion

f. Abuse and exploitation of minors

2. Education materials will be provided during orientation for all health care professionals working with children who undergo therapeutic abortion procedures and will be made available within their department.

3. Education sessions will be provided to all healthcare professionals working with children and youth who undergo therapeutic abortion.

Central Health response:

A revised policy on “Duty to Report/Warn” has been implemented, and an education plan, including live and video conference sessions, webinars, and resource material, has been developed. This includes a mandatory education session for all health care professionals/providers, including physicians, and other relevant Central Health employees. This education module will be a requirement in their orientation for all physicians who enter Central Health.

The policies on “Sexual Consent in Youth” and “School Health: Pregnancy Testing for Students” require revisions. As a result of this report, this work has been assigned.

Central Health indicated it did not have an education standard to offer healthcare professionals regarding child sexual abuse. It has reached out to CSSD about providing training, and will also consider seeking other resources, including the Janeway's resources if needed.

Central Health will provide additional information to staff about guidance and resources both internally and externally on these issues.

Western Health response:

Western Health is committed to working with the Office of the Child and Youth Advocate, as well as the other Regional Health Authorities and agencies to improve the protection of children and youth and their rights.

All clinicians must participate in an orientation process which includes the "Consent for Medical Intervention" and "Duty to Report" policies. In addition, Western Health has a policy on "Provision of Services for Minors" within community based Mental Health and Addictions services.

Western Health recognizes the need for continuing education on the topics identified in this report. Western Health has developed and introduced a "Child Maltreatment" continuing education module. This module is recommended for all health care providers who work with children and families of young children and those working in identified clinical areas including emergency departments. Western Health is committed to ensuring that all current and newly hired staff working within this capacity complete the "Child Maltreatment" module. Western Health also uses a formalized screening tool completed with all prenatal clients. Current work is underway to develop policy and training in the area of privacy and confidentiality of minors presenting to Emergency Departments.

Labrador-Grenfell Health response:

Resource materials will be presented to all Labrador-Grenfell Health front-line healthcare staff and will include information on protective intervention services, duty to report, child maltreatment and indicators, responding to a disclosure of child maltreatment, and issues of consent for minors/children, including information regarding the age of consent for sexual activity, and access to information. In 2014, this material was delivered in person and via conference call by staff from CSSD.

Labrador-Grenfell Health released its administrative policy on "Duty to Report/Warn" in January 2017. This policy contains an extensive section with protocols for staff on how to proceed in the event of the "Suspected Need for Protective Intervention of Children." This will be presented to nursing staff during orientation and at front-line healthcare staff education sessions.

Recommendation 4

The Association of Registered Nurses of Newfoundland and Labrador address the continuing education topics of child protection legislation and reporting requirements, legal age of consent for sexual activity, medical consent for minors, and how to recognize warning signs of sexual coercion, abuse, and exploitation of minors.

Association of Registered Nurses of Newfoundland and Labrador response:

The Association has reviewed the recommendation and will endeavor to work collaboratively with the other organizations referenced in this report. The Association commits to supporting relevant continuing education for their members as pertinent to the scope of nursing practice and the Association's mandate.

Recommendation 5

Eastern Health ensure the development and implementation of child-focused screening policies and protocols in conjunction with children’s mental health specialists and the Department of Children, Seniors and Social Development, specifically:

- (a) When a child presents for an abortion, the child is referred for a child-focused social work consultation in the interest of the health, wellbeing and safety of the child.**
- (b) Where there is suspicion or uncertainty regarding coercion or abuse of a child under the age of 16, those concerns are immediately communicated to the Department of Children, Seniors and Social Development to determine the need for protective intervention.**
- (c) Age-appropriate pre and post abortion supports and information are proactively provided to children and youth.**

Eastern Health response:

- 1. Eastern Health will identify a pediatric social work resource for referral of all children and youth undergoing a therapeutic abortion.*
- 2. Eastern Health in collaboration with the Department of CSSD will develop and implement a standardized referral process for a social work assessment and counseling pre-procedure. A process for post-procedure care/monitoring/assessment for all children and youth who undergo therapeutic abortion will also be established.*
- 3. Eastern Health in collaboration with the Department of CSSD will identify and implement processes to guide determination of need for protective intervention and notification of CSSD for children and youth undergoing therapeutic abortion.*
- 4. Eastern Health in collaboration with the Department of CSSD, will review and update all existing pre and post therapeutic abortion supports and written information provided to children and youth undergoing therapeutic abortion.*

Recommendation 6

Each Regional Health Authority review and update its policies and practices related to informed consent for medical procedures for minors.

Eastern Health response:

Eastern Health is currently reviewing and updating its Consent Policy; this will include a review of the process for obtaining informed consent for minors.

Central Health response:

Work to review Central Health's policies on "Authority to Consent: Age of Consent" and "Authority to Give Consent: Substitute Consent for Minors" began prior to this report being received and is scheduled to be revised by September 2017. Staff awareness and education sessions will follow, including a mandatory learning module for all healthcare providers at Central Health. This education module will be a requirement for orientation for all physicians who enter Central Health. The current process and resources on questions of consent will be communicated to the physician leadership to ensure they are aware that support and consultation is available within the organization.

Western Health response:

Western Health is currently reviewing and updating the "Consent for Medical Intervention" policy. The information and recommendations provided in this report by the Office of the Child and Youth Advocate related to informed consent for medical procedures for minors will be instrumental in Western Health's review of this policy.

Labrador-Grenfell Health response:

Labrador-Grenfell Health has a consent policy, and the related Mature Minor Declaration form to document when a healthcare provider determines that a minor meets the criteria. The policy includes sections with protocols, definitions and examples of how to proceed to obtain consent for procedures for minors and how to assess and document when a minor is being considered as a 'mature minor' or 'emancipated minor.' However, it has not been reviewed since 2008 and does not currently contain any specific reference to obtaining parental consent when an abortion is being sought by a minor. In light of the recommendations of the Office of the Child and Youth Advocate, Labrador-Grenfell Health will undertake a review of the current policy to consider these recommendations.

b. Appropriate Protective Intervention and Followup

CSSD did not have involvement related to the abortion services. However, there were clear deficiencies identified in the protective intervention and documentation practices. When CSSD first interviewed the stepfather, he indicated that the family had just relocated from another province and that the children had no contact with their biological mother. He denied having any previous contact with child protection services. Standard 4 of CSSD's *Risk Management System* (2010) states that protective intervention investigations should include various methods of gathering information, such as reviewing documentation from previous child protection involvement (within/outside the province), police and medical records. CSSD did not complete child welfare or criminal records checks on the stepfather until almost four months later when the family had already left the province. In an interview, the social worker admitted that best practice would have been to complete these checks in a timely manner; however, she indicated she was unable to do so for four months citing workload demands.

There were gaps in service throughout CSSD's involvement with this family. There were discrepancies noted in interviews regarding arrangements for the children's care and supervision. Documentation deficiencies were also noted in the CSSD file. In some cases, documentation was recorded as late as four months after the actual

“ CSSD did not complete child welfare or criminal records checks on the stepfather until almost four months later when the family had already left the province. ”

activity or intervention occurred. CSSD's *Best Practice Guidelines for Using CRMS* (2003) indicates that documentation at this time should have been completed within 24 to 48 hours of providing a service. Throughout the CSSD file, there were at least ten instances where notes pertaining to contact with this family were recorded later than the 24 to 48 hour time-frame. Several of these notes were added at the time of file closure. When asked in an interview about the social worker's late documentation of notes in CRMS, the clinical program supervisor noted that workload responsibilities at the time

impacted the social worker's ability to document according to guidelines.

CSSD's involvement in this case highlighted issues with protective intervention and followup, including documentation deficiencies, which have been the focus of recommendations in previous investigations released by the Child and Youth Advocate. During the investigation, CSSD provided information indicating that practices and supports for social workers had since changed and improved in this regard. It is imperative that CSSD maintain the progress it has made in these areas since this case occurred in order to better protect vulnerable children and youth in the future.

Recommendation 7

CSSD ensure appropriate practices, supports and responses are provided in child protection matters, specifically:

- (a) Investigation standards and practice requirements include the most accurate information available to assist with decision-making, including engaging collateral resources.**
- (b) Documentation standards and practice requirements are identified and met in a timely manner.**

Department of Children, Seniors and Social Development response:

The Department fully accepts this recommendation. The Department has:

- enhanced guidance to staff on the practical use of collateral resources*
- enhanced supervision practices*
- improved Quality Management reviews and resources*
- established daily documentation time to ensure documentation standards are met*
- directed the Training Unit to develop documentation training module*
- implemented a caseload tracking form for all social workers to improve compliance with documentation standards*

Conclusion

Child abuse is a priority area of concern for the Office of the Child and Youth Advocate. We fully appreciate that this concern is broadly shared. According to Statistics Canada (2013), female children and youth age 12 to 17 are at a higher risk of experiencing sexual violence than males. Females in this age group were eight times more likely than their male counterparts to be victims of sexual assault or another type of sexual offence. Given the greater risk to female children and youth, it is essential that those providing sexual health services to this vulnerable population possess specialized knowledge in recognizing coercion, sexual coercion, the power dynamics of abusive relationships, and the gendered nature of these crimes and actions.

This investigation examined the response to a 12 year old child who had been sexually abused by her stepfather and who sought to terminate the resulting pregnancy. It also explored the response to her and to her siblings when CSSD received referrals about concerns for lack of supervision and potential physical abuse. In short, the system's response was inadequate. Questions were not asked, risk was not assessed, consents were not appropriately obtained, child-centered responses were not provided, investigative responses were incomplete, and documentation deficiencies existed. Had appropriate measures been taken when this child presented to terminate her pregnancy, or when child protection concerns were reported, the abuse may potentially have been detected and stopped.

Canada signed the *United Nations Convention on the Rights of the Child* on May 28, 1990 and ratified it on December 13, 1991. All provinces and territories provided letters of support. The Convention is the most universally accepted human rights framework existing today. It speaks to the civil, political, economic, social and cultural rights of children throughout the world. Article 19 stipulates that children have the right to be protected from being hurt, mistreated, abused or neglected. Article 24 speaks to the child's right to the highest level of health and medical care. Article 34 states that children should be protected from sexual abuse and exploitation. Article 39 references children's right to receive help if they have been hurt, neglected or badly treated. There were many opportunities to intervene with this little girl and her siblings; but they were missed. The children's rights were not adequately protected. Based on the experiences and lessons from this case, a collective effort is required to do better for and by these children. Some of this work has already begun, and it is critically important that it is brought to fruition. Where brand new efforts are required, they should be undertaken without delay.

Appendix A

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United Nations Convention on the Rights of the Child. (1989).

Appendix B

Investigative Documents and Interviews

Documents Reviewed:

Department of Children, Seniors and Social Development
Protective Intervention File

Department of Education and Early Childhood Development
Regional School District File
All records regarding the children

Department of Health and Community Services
Eastern Health File

Department of Justice and Public Safety
All records regarding the children

Planned Parenthood/NL Sexual Health Centre
All records regarding the child

Investigative Interviews:

Investigative interviews included officials/staff with:

- Department of Children, Seniors and Social Development
- Eastern Health
- Planned Parenthood/NL Sexual Health Centre



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