Turner

Review and Investigation

September 2006

PETER H. MARKESTEYN, M.D., F.C.A.P.
Newfoundland and Labrador
Child and Youth Advocate's Delegate

DAVID C. DAY, Q.C.
Legal Counsel

Volume II

Turner

Review and Investigation

September 2006

PETER H. MARKESTEYN, M.D., F.C.A.P.
Newfoundland and Labrador
Child and Youth Advocate's Delegate

DAVID C. DAY, Q.C.
Legal Counsel

Volume II

Library and Archives Canada Cataloging In Publication

Findings of Turner Review and Investigation / by Dr. Peter H. Markesteyn, Delegate of Child and Youth Advocate of Newfoundland and Labrador, and David C. Day, Q.C.

ISBN 1-55146-289-3

1. Child Welfare - Newfoundland and Labrador. 2. Child Death Review - Newfoundland and Labrador. 3. Child and Youth Advocate - Newfoundland and Labrador

I. Markesteyn, Peter H.	II. Day, David C.	III. Title
[pending]	[pending]	[pending]

Volumes One, Two and Three of the Findings of the Turner Review and Investigation, by Dr. Peter H. Markesteyn, M.D., F.C.A.P. and David C. Day, Q.C. are accessible, electronically, at the website of the Office of the Child and Youth Advocate: www.ChildAndYouthAdvocate.nl.ca

Table of Contents Volume 2

CHAPTER 6

Delivery of Justice Services

CHAPTER 7

Delivery of Community Services

CHAPTER 8

Delivery of Health Services

CHAPTER 9

Delivery of Financial Services

CHAPTER 10

Office of Medical Examiner

CHAPTER 11

Past Performance of Office of Child and Youth Advocate

CHAPTER 12

Child and Youth Advocate Act

CHAPTER 13

Recommendations

Chapter 6

Delivery of Justice Services

1. Introduction

What justice services may I examine in my Review? And, did providers of justice services that I may examine adequately deliver them?

The scope of the answer to the second question and, consequently, my examination of justice services depend on my answer to the first one.

My response to the first of these two questions is that my Review, as Child and Youth Advocate's Delegate, required me to perform my mandate relating to justice services in the context of the Advocate's statutory terms of reference under section 3 of the *Child and Youth Advocate Act*.[1]

My Review's mandate is to review and investigate the circumstances of, and surrounding, Zachary Turner's death.

Section 3 of the *Child and Youth Advocate Act*[2] which articulates the Advocate's terms of reference and, as such, provides the context for my Review's mandate, requires the Advocate

> **(a) to ensure that the rights and interests of children and youth are protected and advanced and their views are heard and considered;**
>
> **(b) to ensure that children and youth have access to services and that their complaints relating to the provision of those services receive appropriate attention;**
>
> **(c) to provide information and advice to the government, agencies of the government and to communities about the availability, effectiveness, responsiveness and relevance of services to children and youth; and**
>
> **(d) generally, to act as an advocate of the rights and interests of children and youth.**

Justice services delivery which may have affected - directly or indirectly - Zachary's rights and interests are described in the narrative of events underlying my Review's mandate (Chapter 5). They consist of:

(a) extradition proceedings under the *Extradition Act*[3] in Newfoundland Supreme Court - both the Trial Division and the Court of Appeal (e.g., decisions of Canada's Justice Minister and the process and decisions of the Court during extradition proceedings);

(b) judicial interim release - that is, "bail" - applications under the *Criminal Code*[4] by Dr. Turner during the extradition application to both the Trial Division and Court of Appeal of Newfoundland Supreme Court;

(c) family law proceedings related to parenting of Zachary under the *Children's Law Act*[5] in Unified Family Court which technically is part of the Trial Division of Newfoundland Supreme Court.

(d) performance of judicial interim release orders made by the Courts (e.g., the requirement that Dr. Turner provide "bail" sureties);

(e) incarceration of Dr. Turner for a short period during the extradition proceedings (particularly opportunities for access by Zachary to his mother while she was incarcerated);

(f) legal advice, if any, provided to justice as well as community, health and financial service providers

to the extent they were responsible for delivering services to Zachary Turner; and

(g) police law enforcement (e.g., in assisting Pennsylvania State Troopers and responding to complaints about Dr. Turner including any alleged breaches of conditions of her judicial interim release).

Consideration of this first question, "What justice services may I examine?" does not end there. As with community services (Chapter 7), health services (Chapter 8) and financial services (Chapter 9), the scope of my mandate to examine justice services delivery is limited.

The result is that not all justice services I have listed above were in reach of my Review. The reasons are legal in nature. They are as follows.

First, I have been advised that I am precluded constitutionally from examining the legislation governing delivery of justice services under (a) the *Extradition Act*;[6] or (b) under the *Criminal Code*.[7] And, I am not permitted,

constitutionally, to examine the deportment of federal officials - Canada's Justice Minister or the Minister's legal counsel - for the same reason.

Secondly, I have been advised that I cannot, in my Review, make an assessment of the proceedings - the manner in which proceedings were conducted (the process) and resulting decisions - under (a) the *Extradition Act,*[8] (b) the *Criminal Code,*[9] or (c) the *Children's Law Act*[10] because of the principle of judicial independence.

And, thirdly, examination of some aspects of justice services is, in any event, foreclosed to me, because doing so would not be relevant to my Review.

2. Limitations On Scope Of Review

2.1 Constitutional

Although my Review's mandate is clear and the context of the mandate's performance is explicit under section 3 of the *Child and Youth Advocate Act*,[11] the Canadian Constitution (in

particular, the *Constitution Act, 1867*[12]*)* imposes limits on what justice services I could examine under that mandate.

Specifically, the constitutional limits are imposed by section 92.14 of the *Constitution Act, 1867*.[13] Section 92.14, in effect, confines scrutiny of justice services by a provincial inquiry such as my Review to

> **The Administration of Justice in the Province, including the Constitution, Maintenance, and Organization of Provincial Courts, both of Civil and of Criminal Jurisdiction, and including Procedure and Civil Matters in those Courts.**

However, section 92.14 of the *Constitution Act, 1867* doesn't mean that, to the extent of the Review's mandate, I may examine anything involved in the "Administration of justice in the Province" of Newfoundland. Rather, the section limits scrutiny of justice services to

> **… matters connected with the administration of justice in the province [under section 92.14 of the *Constitution Act, 1867*] not within the jurisdiction of the Government of Canada … .**

The quoted limitation is from Newfoundland's *Department of Justice Act,*[14] section 6, which catalogues the responsibilities

of the Province's Minister of Justice, bearing in mind section 92.14.

Not included within the responsibilities of Newfoundland's Minister of Justice under section 92.14 of the *Constitution Act, 1867*[15] are enactment of legislation consisting of the (a) *Extradition Act,*[16] and (b) *Criminal Code.*[17]

Both of these statutes were enacted by the Parliament of Canada, not by the House of Assembly of the Province of Newfoundland. (I could, I suppose, make some comments about shortcomings I perceived in the content of that legislation but, in doing so, I would lack constitutional jurisdiction. For that reason I have not undertaken an examination of that legislation. I will leave that exercise to the public and its elected representatives).

Of the legislation forming part of the narrative of my Review, which may have, directly or indirectly, impacted Zachary's rights and interests, I was only entitled to consider the *Children's Law Act*.[18] This legislation was enacted by the Province's House of Assembly, not by Canada's Parliament.

Likewise, decisions made by Canada's Minister of Justice and counsel who represented the Minister in proceedings under the *Extradition Act* and the *Criminal Code* are not subject to my Review. In 1979, the Supreme Court of Canada decided, in *A.G. Quebec v. A.G. Canada*,[19] that federal ministers of the Crown and other federal public officers (which would include a federal minister's legal counsel) could not be compelled to testify or produce documents to a provincial inquiry.[20] If they cannot constitutionally be required to testify or disclose documents, their conduct is not subject to my scrutiny.

2.2 Judicial independence

Because of the constitutional principle of judicial independence[21] which is the foundation for the important legal concept that judges be impartial, I am prohibited from examining the judicial proceedings (the manner in which conducted and the judicial decision) under: (a) *Extradition Act*;[22] (b) *Criminal Code*[23] (reference judicial interim release), and (c) *Children's Law Act*[24] (reference family law parenting).

Granted, Mr. Justice Cory, in a 1989 decision of the Supreme Court of Canada - *Mackeigan v. Hickman*[25] **-** quoted Mr. Justice LeDain in the Court's 1985 judgment in *Valente v. R.*:[26]

> **[judicial independence … [is] fundamental not only to the capacity to do justice in a particular case but also to individual and public confidence in the administration of justice. <u>Without that confidence the system cannot command the respect and acceptance that are essential to its effective operation</u>. …. It is, therefore, important that a tribunal should be perceived as independent, …, and that the test for independence should include that perception. [Underlining added by Mr. Justice Cory]. The aim and goal of all aspects of judicial independence are to preserve and foster public confidence in the administration of justice. Without public confidence the courts cannot effectively fulfill their role in society. Where … the public confidence in the administration of justice has been called into question then in the interest of that public confidence which is essential to the functioning of the courts**

the Justices should be required to answer questions from an inquiry.

However, Mr. Justice Cory in his conclusion was in the minority among the seven members of the Supreme Court of Canada who decided *Mackeigan v. Hickman*.[27]

Involved in that case was a request to certain Justices of the Nova Scotia Supreme Court to appear before, and answer questions from, a royal commission of inquiry appointed by the Province of Nova Scotia in October 1986 to inquire into the prosecution of Donald Marshall, Jr. Mr. Marshall was convicted in 1971 of the criminal charge of murder. The Justices requested to appear before the inquiry had, in legal proceedings before them in 1983, set aside the conviction of Mr. Marshall and acquitted him.[28] (The chair of the inquiry, incidentally, was The Honourable T. Alexander Hickman, then Chief Justice of the Trial Division of Newfoundland Supreme Court). The inquiry wanted the Justices to testify because of "some public criticism" of certain statements in their 1983 decision - the decision which acquitted Mr. Marshall. The Justices' publicly criticized statements, which were not essential to the decision, included the sentence that[29]

> **[a]ny miscarriage of justice is, however, more apparent than real.**

Without detailing the history of legal proceedings which resulted from the Nova Scotia inquiry's request, suffice to say that a majority of Supreme Court of Canada Justices decided to

deny the inquiry's request. The Nova Scotia Justices did not have to appear before the inquiry to answer questions.

The principal majority decision of the Supreme Court of Canada, written by Madam Justice McLachlin (now Chief Justice of the Court) stated that,[30]

> **[t]he immunity of judges from testifying … is established by the authorities [that is, judge-made law] and by the general principles of judicial independence.**

And, that[31]

> **[t]he judge's right to refuse to answer to the executive or legislative branches of government or their appointees [that is, the Nova Scotia inquiry] as to how and why the judge arrived at a particular judicial conclusion is essential to the personal independence of the judge, one of the … main aspects of judicial independence: … . The judge must not fear that after issuance of his or her decision, he or she may be called upon to justify it to another branch of government.[32]**

The decision, written by Justice McLachlin, disagreed with Justice Cory's view that the Nova Scotia Justices in the Marshall inquiry should be required to testify before that inquiry, as did the decision by Mr. Justice Antonio Lamer,

another member of the majority of the Court in that case. His decision included the following:[33]

> **What evidence a court relies on for arriving at a given conclusion is an integral part of the adjudicative process. This requires decisions pertaining to the admissibility of evidence, and then an assessment of the weight to be given to it and its effect on the outcome of the case[,] applying the rules pertaining to the burden of presentation of proof and that of persuasion. The extent to which a court reveals these matters in a judgment is equally an integral part of the adjudicative process. …**

And Mr. Justice Lamer stated further that[34]

> **There are procedures through which courts can be invited … [to clarify and add to their judgment], such as applications for rehearings where courts are asked to reopen the case and make determinations they have overlooked; there are also the various review and appeal procedures …. .**

And if, as a result of performance of their judicial duties (instead of their decisions), complaints or allegations are made of improper conduct by a provincial or territorial Supreme Court of Justice, they would be addressed by the federal Canadian Judicial Council established under Part II of Canada's *Judges Act*.[35]

The lawyer occupying the position of Registrar of the Supreme Court of Newfoundland (since retired) aptly put the position of the Court in a letter to me dated 03 February 2006:

> **All decisions of the Court are subject to review on appeal, but none are otherwise subject to 'review and investigation.' The Court, in law, cannot voluntarily submit its decisions to other review and investigation.**

"Nevertheless," the Registrar continued,

> **the Court is anxious that the Office of the Child and Youth Advocate have available to it all of the information that the Court can properly provide. That would include the public record of any specific case and all general procedural information ordinarily available to the public, but would not include details of the application [by the Court] of procedures in any specific case, as that would be a matter reviewable only on appeal.**

I had posed to the Registrar of Newfoundland Supreme Court several written questions reference proceedings in Supreme Court of Newfoundland involving Dr. Turner. I did so in full knowledge that the Court's judicial independence placed limits on information the Court could supply. The Registrar's 03 February 2006 letter stated that the questions

can only be understood to be some sort of investigation of the specific decision of the Court of Appeal.

With respect, my written questions to the Court were intended solely to acquire narrative information about events which occurred in public hearings conducted by the Court. They were not designed to ask the Court about its adjudicative and administrative judicial functions. As will shortly become apparent (in my discussion below in Part 3(d) of this Chapter, of judicial interim release), the Court was forthcoming, without compromise of its judicial independence in any respect, with the information about justice services important for my Review.

Although I am legally unable to examine and assess decisions or conduct of Newfoundland courts in the extradition, judicial interim release and family law proceedings - which may have affected Zachary's rights and interests - or legislation governing those proceedings (other than the *Children's Law Act*[36]), the public is entitled to do so.

As Allan C. Hutchinson, Associate Dean (Research) at York University's Osgoode Hall Law School in Toronto wrote on 10 May 2006:[37]

> **In a democracy, it is imperative that judicial performance is the subject of vigorous questioning. If Supreme Court judges are to have such enormous powers in, and over, Canadian democracy, it is essential to debate robustly their decisions, their reasoning, and their status. …. We can at least allow the citizenry to comment on them without fear of reprimand.**

Exercise of the citizen's right to question legislation and judicial performance should, however, be reasonable. To be reasonable, public comment on the judiciary should be informed. To be informed, public comment should reflect knowledge of judicial proceedings - what is involved and what has happened - on which opinions about the proceedings are based.

For example, three subjects of public comment on judicial proceedings involving Dr. Turner were: (i) the time required to complete the proceedings; (ii) the manner in which Dr. Turner was treated during some of the proceedings; and (iii) the two decisions allowing bail to Dr. Turner in the proceedings.

Had I been legally permitted to assess proceedings involving these three subjects - I was not - I would have concluded as follows:

(i) Considering all the circumstances involved in the proceedings (outlined in Chapter 5) - scheduling in busy courts, complexity of the proceedings and gravity of the charges in another country against Dr. Turner, to mention a few - the time required to complete the proceedings was entirely reasonable.

(ii) Considering that Dr. Turner was not represented by legal counsel at some of the proceedings and was breast-feeding her infant son during recesses in others, the efforts of the Justices presiding at those proceedings (to explain court procedure to Dr. Turner and to allow her time for feeding Zachary and preparing her case, as examples) were entirely reasonable. (Bear in mind, as my legal counsel pointed out to me, Dr. Turner did not choose to be a self-represented litigant in her proceedings; she was, instead, an unrepresented litigant {not of her choosing} on some court appearances. This was because her financial resources were eventually exhausted and she was, at times, unsuccessful in obtaining assistance from the Newfoundland and Labrador Legal Aid Commission). I am informed

that accommodations made by Newfoundland Justices for Dr. Turner are congruent with those made for any unrepresented litigant in Canada's courts.

(iii) Considering that legal counsel for Canada's Justice Minister and the United States of America proposed Dr. Turner's release at her first "bail" hearing, and offered no evidence in the course of opposing her release at her second "bail" hearing, the reasonableness of the judicial decisions to release her on each of the "bail" hearings must be considered in light of those events.

2.3 Relevance

While all of the statutes and proceedings conducted under them relating to justice services with respect to Dr. Turner have been recounted in these Findings (Chapter 5), because they were integral to the narrative of events of my Review, most of those *Acts* and proceedings were not relevant in particular to Zachary. His individual rights and interests were not, and in law could not, be considerations in

Extradition Act[38] proceedings or in extradition "bail" proceedings under the *Criminal Code*[39] in the factual circumstances of my Review (in a phrase, "truth-finding"). Granted, his rights and interests collectively with those of all other members of the public (such as protection of the public) were germane. That is not, however, a basis on which I, as the Child Advocate's Delegate, can inquire into the little boy's particular rights and interests for constitutional reasons considered above in Part 2(a) of this Chapter. The exception is the *Children's Law Act* of Newfoundland.[40]

3. Subjects Reviewed

3.1 Overview

Although the conduct of judicial proceedings under the *Children's Law Act*[41] and decisions resulting from them were, because of the judicial independence principle, outside the boundaries of my Review, the legislation itself could have been and was considered and assessed by me. No constitutional barrier prevented me from doing so, because the statute was enacted by the Provincial Legislature. And certainly regard for the statute was relevant to the Review

because Zachary's paternal grandparents, the Bagbys, obtained several judicial orders dedicated to Zachary from Unified Family Court.

As with (i) the Newfoundland *Children's Law Act*, I was not prevented by the Canadian Constitution, judicial independence or evidence relevance rules from assessing other justice services issues. They are: (ii) Zachary's access to his mother while she was incarcerated; (iii) performance by Dr. Turner of the two judicial interim release orders under which she was on "bail," enabling her to have physical custody of her son (other than involvement of courts, their process and decisions, and of Canada's Justice Minister and Attorney General and his legal counsel); (iv) legal advice to providers of community, health and financial services to Zachary; and (v) law enforcement by the Royal Newfoundland Constabulary (assisting in or conducting investigations with reference to Dr. Turner, enforcing conditions of her judicial interim release and dealing with complaints about her that may have impacted Zachary).

Each of these subjects is factually detailed in Chapter 5 of these Findings. Only two of them (performance of the

judicial interim release order and legal advice to services providers) require extended treatment in my assessment of justice services delivery.

3.2 Legislation

The legislation I was entitled to review from the perspective of justice services delivery was the *Children's Law Act*[42] of Newfoundland. Zachary's paternal grandparents, the Bagbys, applied under the *Act* and were granted orders by Unified Family Court (with Dr. Turner's consent) for: (i) a declaration of the paternity of Zachary; (ii) access to Zachary when his mother was at liberty on judicial interim release; and (iii) physical custody of Zachary while his mother was incarcerated in Clarenville for about seven weeks between conclusion of hearings in Supreme Court Trial Division and commencement of her appeal to the Court of Appeal related to the extradition proceeding.

Nothing in the *Act* hindered Zachary's rights and interests. In fact, the advent of the *Act*[43] on 01 May 1989 afforded rights to grandparents that historically under judge-made law were not ordinarily recognized. From 01 May 1989

until 21 December 1995, a grandparent could apply for custody of, or access to, a child (a person under 16 years old) if evidence "demonstrated" under section 69(4)(b) of the *Act*[44] that he or she had "a settled intention to treat the child as a child of his or her family," or established under section 69(40)(d) of the *Act,*[45] that he or she "had the actual care and upbringing of the child immediately before the application" for custody or access. An amendment to section 69(4) the *Act,*[46] effective from 21 December 1995, specifically included a grandparent as a person entitled to apply for custody or access.

Moreover, the Unified Family Court's facilities were adequate and appropriately provided to facilitate access by the Bagbys to Zachary to the extent judicial orders required that the access occur there under supervision. Security, which governed the access, was arranged and provided with sensitivity by the Court's security personnel. Reports required by the Court of third party supervision of the access, both at and apart from the Court building provided by a court-approved, independent contractor - paid for by the Bagbys - were filed in a timely manner in the Court's file that documented the Bagbys' parenting application. All of this was competently done at the Court.

3.3 Corrections

The Corrections and Community Services staff at the Newfoundland and Labrador Correctional Centre for Women in Clarenville professionally accommodated visits by Zachary to his mother, while she was incarcerated there from 15 December 2002 to 07 January 2003, during part of the proceedings to extradite her. Accompanied by his paternal grandparents, Zachary uneventfully accessed his mother within the Centre as many as four times over each period of two successive days that he was brought to the Centre. This demanded exceptional patience by Centre staff, especially considering the difficulties Dr. Turner caused the staff while she was an inmate of the Centre.

3.4 Judicial interim release

(a) Orders

As reported in Chapter 5 of these Findings, Dr. Turner was twice admitted to judicial interim release during proceedings in Newfoundland Supreme Court to extradite her from Newfoundland to Pennsylvania on homicide charges.

She was granted release, first by the Trial Division of the Court on 12 December 2001 and, secondly, by the Court of Appeal on 10 January 2003.

3.4 (b) Recognizances

On each occasion, Dr. Turner was released under a judicial order which required her, before being released, to execute a Recognizance[47] (sometimes described as a "bail bond" or "bail Recognizance"). In effect, each of the two judicial orders granting release to Dr. Turner required her to sign a document imposing on her legal obligations to the Court. The judicial order specified the terms and conditions of the Recognizance.

The terms of the Recognizance consisted of the amount of the Recognizance to be signed by Dr. Turner and the total amount for which the sureties provided by her must sign. The amount for which each surety must sign was not specified. Each surety could sign for a portion of the amount specified. One surety could have signed for the entire amount specified.[48]

The conditions of the Recognizance were the duties Dr. Turner must perform while at liberty on judicial interim release.

Performance of a court's judicial interim release order involves two stages. First, the terms of the release order must be satisfied before an accused person is released. And secondly, the conditions of the release order as repeated in the release document (e.g., a Recognizance) must be performed by the accused after being released.

The reason for a court imposing a term of release that requires an accused to furnish sureties is to ensure performance by the accused of the release conditions.

The obligations of sureties are not comprehensively stated in the *Criminal Code*. To the extent they are provided for at all, they are contained in *Criminal Code* Form 32 authorized by *Criminal Code* section 841.[49] Form 32 provides that persons signing a Recognizance as sureties

> **acknowledge … themselves to owe to Her Majesty the Queen … the … amounts set opposite their respective names, … to be made and levied of their … goods and**

> **chattels, lands and tenements … to the use of Her Majesty the Queen, if the … [accused] fails in any of the conditions [stated in the Recognizance].**

In other words, if the accused breaches a condition of the Recognizance, the Crown may attempt to collect the amount for which a surety signed in the Recognizance.

There is no provision in the *Criminal Code*[50] requiring a Court to satisfy itself that a person signing a Recognizance as surety is capable of meeting his or her financial obligations under the Recognizance if an accused breaches a condition of the Recognizance and a court subsequently orders the surety to pay part or all of the amount for which he or she signed. Nor does the *Criminal Code* impose any obligation on a Court to explain to a surety the obligations he or she undertakes by signing a Recognizance.

A letter to the first Child and Youth Advocate, Mr. Wicks, from the Department of Justice for Canada dated 16 March 2005 states with respect to this issue:

> **On 10 January 2003, the Supreme Court of Newfoundland and Labrador (Court of Appeal) ordered Dr. Turner's release from custody pending determination of her appeal from committal [for**

> **extradition], provided that she enter into a recognizance with sureties in the amount of $75,000. Dr. Turner did not present any proposed sureties before the Court [of Appeal] during her bail hearing, and the Court did not name any person or persons.**

(I note here that the Court of Appeal was not obligated to identify the sureties who were required as a term of her judicial interim release to join with Dr. Turner in signing the Recognizance and the letter does not suggest otherwise).

The 16 March 2005 letter from Canada's Justice Department continues:

> **Therefore, the determination of the suitability of sureties lay solely with the justice of the peace, before whom Dr. Turner and her sureties entered into a recognizance. Counsel for the … [Attorney General of Canada] had no involvement in the selection and approval of these sureties. The justice of the peace who determined that the sureties were suitable was appointed by the … [Attorney General] of Newfoundland and Labrador, in accordance with provincial legislation.**

If obligations under a Recognizance are to be meaningful, sureties signing a Recognizance should only be permitted to do so if they understand the responsibilities they are undertaking by signing the Recognizance and, further, have

the means to meet their obligations if an accused breaches a Recognizance condition and a court in the result orders sureties to "pay up."

These issues form part of the "Administration of justice in the Province" under section 92.14 of the *Constitution Act, 1867*[51] for which the Newfoundland Minister of Justice is principally responsible.

In the absence of any Newfoundland legislation governing these issues in Newfoundland, courts in the Province long ago took the initiative of addressing them. The manner in which the courts have done so is very usefully and comprehensively summarized by the Registrar of the Supreme Court in his 03 February 2006 letter to me, in the context of the Court of Appeal:

> **There is no specific direction in the Criminal Code with respect to assessment of suitability of sureties. While the Court has made rules respecting criminal appeal procedures generally, no rules have been made respecting assessment of suitability of sureties. The Court, having neither the mandate nor investigative resources to initiate any inquiry as to suitability, must defer to the Crown whose mandate it is to protect the public interest.**

I agree.

The Registrar's letter continues:

> **It is quite usual for Crown counsel to ask the appellant or counsel for the appellant to provide the name or names of any proposed surety or sureties prior to appearing before a justice of the peace to sign a recognizance. Only if a question of suitability is raised by the Crown, in respect of a particular surety, and that questioning is disputed by the appellant [who is required to provide the sureties], would it become necessary for the justice of the peace or a judge to consider the matter.**
>
> **Court officials, when acting as a justice of the peace for the purpose of taking a recognizance, always make inquiry of a surety as to whether counsel for the appellant has explained the duties of a surety and the extent of the obligation being undertaken. If counsel has not done so, the court official does.**

There seems little doubt that Dr. Turner's sureties had some knowledge of their obligations under the Recognizances entered into by Dr. Turner and them. With respect to the 10 January 2003 Recognizance, one of the sureties acknowledged to the Royal Newfoundland Constabulary that when he learned on the morning of 18 August 2003 of the fact Dr. Turner was "missing," his initial concerns included the financial implications for him as a surety under that Recognizance,

especially considering he had minimal assets and was employed part-time at minimum wage.

The practices of the Court of Appeal respecting sureties are likewise followed in the Trial Division of Supreme Court and in the Provincial Court. The practices are carried out by Court staff members having justice of the peace authority.

Based on my legal counsel's past experience as a federal Crown counsel, from 1968 to 1985 at least, the practice was more extensive in some of the Newfoundland Courts. The justice of the peace taking the Recognizance, or Crown counsel, usually insisted on sureties producing documentation to establish their financial capacity to serve as sureties. And, from 1980 to 1985, if a married person offered himself or herself as surety, some justices of the peace or Crown counsel required the spouse of that person to join in the Recognizance if the financial means disclosed by a potential surety consisted of a matrimonial home (property jointly owned by the potential surety and spouse by reason of the *Matrimonial Property Act* (now the *Family Law Act*)[52]).

In Dr. Turner's case, the practices outlined by the Registrar of the Supreme Court in his 03 February 2006 were followed. Moreover, the staff person having justice of the peace authority at Court of Appeal, although not legally required, questioned potential sureties about their financial means and obtained their social insurance numbers.

In fact, had Canada's Minister of Justice applied successfully for forfeiture of Dr. Turner's Recognizance signed in the Court of Appeal after she committed suicide, some of the sureties who signed that Recognizance would have been hard-pressed to meet their financial obligations under the Recognizance.

My point is that no provincial law or directive from the Newfoundland Minister of Justice presently specifies clear, comprehensive, uniform requirements for informing potential sureties of their obligations or qualifying them to serve as sureties. On the other hand, I note that so far as I can ascertain, no significant concerns relating to these issues had ever been raised in Newfoundland prior to Dr. Turner's extradition proceedings.

Recommendation 6.1

THAT either by legislation or directive from the Minister of Justice for Newfoundland, provision be made for informing potential sureties of their obligations should they enter into a Recognizance, and for qualifying them to serve as sureties (including provision of documentation verifying their financial capacity to serve as sureties); and that the legislation or Ministerial directive designate who will be responsible for discharging these duties.

Recommendation 6.2

THAT before legislation is enacted or a Ministerial directive is issued, the Province shall consult with all Newfoundland Courts and obtain their views on the processes which will most probably facilitate informing potential sureties of their obligations under, and qualifying them to enter into, a Recognizance.

Although these recommendations are made in the context of a federal extradition proceeding, they will, if implemented, also benefit Newfoundland Courts in any proceedings before them in which a Recognizance is ordered. They include criminal and other prosecutions under all federal

statutes, provincial penal prosecutions and proceedings under sections 810 to and including 811 of the *Criminal Code*[53] under the heading of "Sureties to Keep the Peace" (although those proceedings do not result in a finding of guilt or a criminal record).

3.4 (c) Forfeiture

If a condition of a Recognizance is breached, *Criminal Code* sections 770 to and including 773 under Part XXV of the Code[54] authorize a proceeding to forfeit the Recognizance and, if the proceeding is successful, to enforce payment of amounts ordered to be forfeited under the Recognizance.[55]

Generally speaking, only the federal or provincial Crown (that is the Minister of Justice and Attorney General of Canada or of Newfoundland) may bring a forfeiture application. There is no legal obligation, however, that either Crown do so.

The position of the provincial Crown with particular reference to the issue of forfeiture of Dr. Turner's 10 January

2003 Recognizance is stated in a letter to me from Newfoundland's Justice Department dated 31 January 2006:

> **Shirley Turner was alleged to have committed murder in a foreign jurisdiction. That jurisdiction requested the Government of Canada to extradite Shirley Turner. The extradition proceedings, including the release conditions and bail hearings, were exclusively handled by the Government of Canada. The Attorney General of Newfoundland and Labrador had no standing in the extradition process.**
>
> **Proceedings under Part XXV [which provide for forfeiture of a "bail" Recognizance] are handled by the Attorney General who has carriage of the matter for which the recognizance was issued. In this situation that was the Attorney General of Canada.**
>
> **In order for … [section 771 under Part XXV of Canada's Criminal Code] to be invoked, there has to be compliance initially with … [section 770 of the Criminal Code, which provides for the first legal step in a forfeiture proceeding]. Although … [section] 771 permits a provincial Attorney General to be one of the parties that seeks a date for a [forfeiture] hearing, the entirety of the provisions do not suggest any involvement by a provincial Attorney General in a matter that is being handled by, and in the exclusive jurisdiction … of[,] the federal Attorney General.**

My legal counsel advises me that the position of the provincial Crown, as stated in the Justice Department's 31 January 2006 letter, is correct in law. In other words, the

provincial Crown did not have jurisdiction to apply to forfeit Dr. Turner's 10 January 2003 Recognizance.

As for the federal Crown, a letter to the first Child and Youth Advocate, Mr. Wicks, from federal Crown counsel in Dr. Turner's extradition proceedings dated 29 October 2004 stated:[56]

> **The Requirements for revocation of bail as well as the Roles/Responsibilities of Sureties are matters of law which have been discussed by various courts across Canada.**

The letter refers to a 1998 Ontario Court of Appeal decision[57] and "provisions of Part XXV of the *Criminal Code*, more particularly Section 771 - Proceedings in Case of Default."[58]

As to why the federal Crown has not applied to court for forfeiture of Dr. Turner's 10 January 2003 "bail" Recognizance, I did not constitutionally have jurisdiction to address that question for the same reasons that I could not consider and assess the extradition proceedings in which the Recognizance was judicially authorized (stated above in Part 2(a) of this Chapter).

3.5 Legal advice

The Provincial Government has competent legal counsel on staff to provide justice services advice to state-providers of community, health and financial services. Unfortunately, their expertise was not sought or at least not sufficiently accessed by community services providers considering the circumstances I examined during my Review.

The facts I found in my Review disclosed an expectant mother - more to the point, an expectant mother whose family was on the caseload of the then St. John's Regional Health and Community Services Board - charged with homicide in the United States. She was subject to a warrant of arrest issued by a United States judge. She had been arrested under a provisional warrant issued by a Justice of the Trial Division of Newfoundland Supreme Court. And, she was eventually committed by the Chief Justice of the Trial Division to surrender to Canada's Minister of Justice to await the Minister's decision whether to extradite her to the United States to be tried for the homicide. She was unemployed and under psychiatric care. When the homicide occurred she had been residing in the United States while her three children, by

two prior marriages, were primarily the responsibility of their respective fathers (although one of the three children was living in Ontario and another in St. John's).

I would not have expected Board social workers upon becoming aware of these facts to decide, based solely on these facts, to apprehend the child at birth. At minimum, however, the involved social workers and their superiors in the Region **should have availed of legal advice**. Specifically, they should have secured an opinion from Provincial Government legal advisers before the expected child's birth on whether, and the extent to which, an investigation was necessary to determine the need for protective intervention regarding Dr. Turner's expected child under the *Child, Youth and Family Services Act.*[59] Further, they should have obtained an opinion respecting the strength of the proof they would require to attempt to obtain a judicial order to separate mother and son.

After conduct on legal advice of their investigation, the involved social workers and their superiors in the Region should have obtained from Provincial Government legal advisers a detailed assessment of the cogency of results of their inquiries as a basis for separating mother and child, and

whether further investigation was essential before that opinion could be furnished.

Not least of all, the involved social workers and their supervisors should have ensured that the legal advice they sought and received included an opinion on advisability of addressing, before a court, the issue of separating mother and child if inquiries established the probability of Dr. Turner being convicted of the homicide for which she was formally accused in the United States. And, they should have obtained legal advice on the nature of expert evidence they would need, if satisfied of the probability of Dr. Turner's conviction, to attempt to convince a court that instead of the child's eventual separation from his mother, if convicted, the child's best interests required that separation occur immediately.

Likewise, Board social workers and their superiors responsible for the Turner file should have sought legal advice on the relevance and significance, to Zachary's best interests, of Dr. Turner's mental health. Knowing as they did that Dr. Turner was under psychiatric care from shortly after she returned to Newfoundland from Pennsylvania in November 2001, they should have determined their legal options to

inquire into and act on the basis of Dr. Turner's mental health. For example, if Dr. Turner did not consent, what grounds did they require to apply to Court in Newfoundland under *Child, Youth and Family Services Act* section 20[60] for Dr. Turner's medical information located in Newfoundland? Where and to whom should they be inquiring about Dr. Turner's mental health? What legal means were available to them to access Dr. Turner's psychiatric and other medical information elsewhere in Canada and in the United States? Should they ask Dr. Turner to voluntarily undergo psychiatric assessment by a qualified medical practitioner designated by the Board? If Dr. Turner declined to volunteer, what recourses were open to them?

There were other reasons I would have expected community services providers to seek legal advice. I sensed from testimony before me from Board social workers and their superiors - although none of them expressly said so - that they were concerned about their legal liability had they apprehended Zachary from his mother. The workers and their superiors could have profited in formulating services delivery decisions affecting this file from the fresh and detached perspectives of Provincial Government legal advisers.

3.6 Law enforcement

Justice services were delivered by Newfoundland law enforcement officers in three contexts relating to Zachary Turner and his mother. Delivering them was the Royal Newfoundland Constabulary. (The Royal Canadian Mounted Police, the other police force operating in the Province, was never involved or expected to become involved).

The Constabulary's performance of justice services involved:

(i) assisting Pennsylvania State Troopers, who sought the Constabulary's help in investigating Dr. Turner for Dr. Bagby's murder after Dr. Turner came from Pennsylvania (via Toronto) to Newfoundland prior to being charged in Pennsylvania for the homicide;

(ii) receiving complaints in July and August 2003 from a young men with whom she had a brief affair (reported in Chapter 5) about Dr. Turner's behaviour toward him, while Dr. Turner was on judicial interim release awaiting argument of her

appeal from judicial decisions which authorized Canada's Justice Minister to order her extradition; and

(iii) investigating the deaths of Zachary Turner and Dr. Turner in August 2003.

First, the Pennsylvania State Troopers regarded as exemplary the Constabulary's assistance to them in November and December 2001 during the Trooper's investigation of Dr. Turner for Dr. Bagby's homicide. The Constabulary's expeditious and careful inquiries about and surveillance of Dr. Turner yielded evidence the Troopers found to be helpful. After the Troopers charged Dr. Turner in Pennsylvania, in December 2001, for Dr. Bagby's homicide and the resulting application to the Trial Division of Newfoundland Supreme Court to extradite Dr. Turner from Canada to the United States was commenced, the Constabulary arrested Dr. Turner in St. John's. And when, during the extradition proceeding, Dr. Turner was, for about six weeks, held in custody in Clarenville's Correctional Centre for Women, they escorted her to and from the facility.

Secondly, on two occasions, in July and August 2003, the Constabulary received anxious telephone calls from the young man referred to above alleging extensive harassment of him by Dr. Turner. Constabulary members took no action, such as by investigating, arresting or charging Dr. Turner for allegedly breaching a condition of her judicial interim release. The Constabulary decided they were unable to act for two reasons. First, the complainant declined to identify himself in either telephone call he made to the Constabulary. And, secondly, he did not make a formal complaint; rather, reported Dr. Turner's conduct - which disturbed him - and asked about options available to him to deal with that alleged conduct.

I find that the police failed to take appropriate action. At the very least, the police should have attempted to discuss the complaints with Dr. Turner. They did not do so. Nor did they take any other investigative steps on the basis of these complaints. There is also no evidence that these complaints were brought to the attention of the Crown Attorneys handling Dr. Turner's file.

Crown Counsel should have been consulted as to whether or not there were reasonable grounds to charge Dr.

Turner, without the subject of the harassment identifying himself or making a formal complaint.

Had there been sufficient evidence, they could have charged Dr. Turner under *Criminal Code* section 145(2)[61] alleging breach of a condition of her "bail" Recognizance, or under *Criminal Code* section 372(3)[62] alleging harassing telephone calls. Or, Constabulary officers, without laying any charge, could under *Criminal Code* section 524,[63] either after obtaining (under section 524(1) or without obtaining (under section 524(2)) a warrant for her arrest, bring Dr. Turner before a Newfoundland Supreme Court Justice. Had that happened, the Justice would have determined whether Dr. Turner breached a condition of her Recognizance and, if so, would further have determined whether to cancel Dr. Turner's judicial interim release and remand her (return her) to custody or to again grant her liberty on a fresh release order.

Thirdly, Constabulary officers' response to receiving a report on 18 August 2003 that Dr. Turner was missing was prompt and thorough, details of which I have delineated in Chapter 5 of these Findings.

4. Observations

I cannot conclude without addressing a matter raised earlier in this chapter that I regard as critical to the best interests of Zachary - the mandate of the Child and Youth Advocate under section 3 of the *Child and Youth Advocate Act* and the Newfoundland public's understanding of the circumstances of, and surrounding Zachary's death - which is my mandate.

I am not a lawyer or a judge and have no legal training. I therefore must rely upon the advice given to me by my legal counsel with respect to the legal, constitutional and legislative limitations of my review of justice services. I accepted that advice. Specifically, that opinion advised me that I could not review the conduct of Canada's Justice Department or any of the Courts - the Trial Division, the Unified Family Court (which, my counsel informs me, is technically part of the Trial Division), and the Court of Appeal - in relation to Dr. Turner and her son Zachary (or, for that matter, her younger daughter).

While I have no concerns about the proceedings in Unified Family Court, the same cannot be said by me, at least to a limited extent, for the proceedings in the Trial Division and Court of Appeal. I also have concerns about the management of Dr. Turner's extradition proceeding by the federal Justice Department.

Although I am prohibited from examining these issues, I conclude that they are relevant to this Review, as did the first Advocate.

Because of my concerns, I raise the following questions:

First, on 11 December 2001, counsel for Canada's Justice Minister (representing both Canada and the United States) made an application to a Justice of the Trial Division of the Supreme Court of Newfoundland. The application was for a warrant to arrest Dr. Turner as a result of a request from the United States. The warrant is called a "provisional warrant of arrest" under extradition law. Apparently it is one of the first steps taken when another country asks Canada to extradite a fugitive (such as Dr. Turner). For a Justice of the Trial Division to issue a "provisional warrant of arrest," the Justice

must be satisfied by the federal counsel that "there are reasonable grounds to believe" that several circumstances exist. They are listed in section 13(1) of the *Extradition Act*. One of them is the following: where there are reasonable grounds to believe arrest is necessary in the public interest

> **to prevent the person from escaping or committing an offence.**

Federal counsel apparently convinced the Justice that if not arrested, there were reasonable grounds to believe that Dr. Turner would escape or would commit an offence, or do both. The arrest warrant was issued. The following day Dr. Turner was arrested, was brought before a Trial Division Justice for a 'bail' hearing and released. The *Criminal Code* provisions which, under the *Extradition Act* (section 19) apply to 'bail,' include the requirement under section 522 that the Justice requested to release a fugitive on 'bail'

> **shall order that the accused be detained in custody unless the accused, having been given a reasonable opportunity to do so, shows cause why his detention in custody is not justified …**

on grounds listed in section 515(10) of the *Criminal Code*.

Based on these facts, I ask:

(i) What evidence did federal counsel present to the Justice (I could not locate a record of that evidence) to satisfy the Justice that an arrest warrant was required for Dr. Turner to prevent her from escaping or committing an offence?

(ii) What happened from 11 December 2001, when the arrest warrant application was successfully made, to 12 December 2001 to convince federal counsel that Dr. Turner who was arrested about lunchtime on 12 December need not be held under arrest any longer?

(iii) What investigation did federal counsel request into Dr. Turner's background that resulted in counsel being satisfied no reasonable grounds existed any longer to believe that keeping Dr. Turner in custody under arrest was necessary to prevent her from escaping or committing an offence? Or, did counsel request any investigation? (Federal counsel was not lacking resources to investigate. They consisted of

the federal Department of Justice, the two police forces operating in Newfoundland, and the United States Government).

(iv) In either event, what was the basis on which federal counsel consented to Dr. Turner being released on 'bail' on 12 December 2001? (I ask this question because federal counsel did not offer any evidence or statement to the Justice who granted 'bail' that supported counsel's decision to consent to 'bail').

(v) What steps did federal counsel take to be certain the sureties who signed for Dr. Turner's 'bail' were financially capable of paying the amounts they signed for if a Court later decided that Dr. Turner breached any of her 'bail' conditions? And, to be certain the sureties understood their responsibilities as sureties including the obligation to 'bring in' Dr. Turner if any of them had reason to believe she breached a condition of her 'bail'? (Why should the Court, without Provincial Government directives or policies and without any legislation to inform or

require it, be left to perform those duties after making a 'bail' order?)

(vi) Generally, why didn't federal counsel insist under section 522 of the *Criminal Code* that Dr. Turner remain in custody unless and until she established to the Justice that she should be released? In other words, why, instead of relying on the *Criminal Code*, did federal counsel consent to Dr. Turner being released? (I know that the Pennsylvania District Attorney responsible for Dr. Turner's murder charges clearly did not want Dr. Turner to be released).

Also based on these facts, I ask whether a Court may, solely on the basis of the submissions and consent of federal counsel and defence counsel, release a fugitive who, under section 522 of the *Criminal Code,* must be held in custody unless s/he "shows cause" why being held in custody is not justified? In other words, are submissions and consent of federal counsel and defence counsel without more (such as evidence) sufficient to satisfy a Court that an accused has shown cause why continued detention is not justified?

As Chapter 5 shows, within a week of starting my Review several years after these events, I knew that Dr. Turner had attempted suicide multiple times; that Dr. Turner had threatened to murder or seriously harm a former boyfriend living in Pennsylvania (he described how Dr. Turner told him, albeit sometimes under the influence of drink, that she would slit his throat); that Dr. Turner had been under the care of at least four psychiatrists (two in Newfoundland, one in Nova Scotia, and one (perhaps more) in the United States) since 1998, including a Newfoundland psychiatrist since 20 November 2001; and that Dr. Turner had (by her own admission) driven halfway across the United States from her home, given Dr. Bagby her firearm (but said she had not murdered him) and driven back home.

Secondly, on 10 January 2003, Dr. Turner was again ordered to be granted 'bail,' this time by a Justice of the Court of Appeal. Unlike 12 December 2001 when Dr. Turner was first granted 'bail' by a Trial Division Justice, federal counsel opposed release. However, federal counsel called no evidence to support opposition to Dr. Turner's release (a fact the Justice pointed out in the 'bail' decision). When the Court of Appeal

Justice decided to release Dr. Turner, the federal Justice Department did not appeal the decision.

Based on these facts, I ask:

(i) During the 13 months (approximately) since the previous 'bail' hearing, what investigation did federal counsel request to learn about Dr. Turner's background (e.g., by having an examination undertaken of the record of Dr. Turner's incarceration at Clarenville Correctional Centre for Women from November 2002 to January 2003 during which she was under some form of suicide watch and admitted to "suicide attempts" historically)? Or did counsel request any investigation?

(ii) Why was no evidence offered to the Justice of the Court of Appeal to support federal counsel's opposition to Dr. Turner's release?

(iii) As federal counsel had apparently told the Court of Appeal Justice who was hearing Dr. Turner's 'bail'

application to the effect "that there is nothing specific to Dr. Turner that would raise unusual concerns" (Court of Appeal decision, 10 January 2003, paragraph 34), and apparently had provided the Justice "no indication of a psychological disorder that would give concern about potential harm to the public generally" (paragraph 36), what investigation was the basis for federal counsel taking those positions?

(iv) What steps did federal counsel take to investigate the accuracy of the affidavit filed in the Court of Appeal by Dr. Turner in support of her 'bail' application?

(v) Considering that another Court of Appeal Justice some two years earlier had, in deciding a 'bail' application under the *Extradition Act*, considered an important legal principle - whether the appeal was "frivolous" under *Criminal Code* section 679 (3)(a) - which the Court of Appeal Justice who released Dr. Turner decided could not be taken into account, why wasn't there an appeal by federal

counsel of the Court of Appeal's decision releasing Dr. Turner? Wouldn't an appeal have decided which of the Court of Appeal Justices was correct in the differing positions taken by them on 'bail' under the *Extradition Act*?

(vi) After Dr. Turner's release, on 10 January 2003 (for the second time), did the federal Justice Department routinely or ever contact the Royal Newfoundland Constabulary or anyone else to learn whether Dr. Turner was complying with the conditions of her release by the Court of Appeal? Was any effort made to determine whether anyone was expressing concerns about Dr. Turner's behaviour while on 'bail?' (Certainly, the former Kelligrews boyfriend of Dr. Turner had serious concerns about her conduct toward him).

Also based on these facts, what did the Court of Appeal Justice rely on for the statement in the 'bail' decision that

> **[r]egarding the public safety issue, while the offence with which … [Dr. Turner] is charged is a violent and serious one, it was not directed at the public at large?**

I agree with the Court of Appeal that the alleged offence was not "directed at the public at large." In fact, my experience both as a Forensic Pathologist and as Manitoba's Chief Medical Examiner is that most murders are not "directed at the public at large." My understanding of the criminal law, when I was a medical examiner, however, is that public safety is but one of the elements of the public interest. And, a person appealing to the Court of Appeal, if s/he is to obtain release, must

> **establish that … [his/her] detention is not necessary in the public interest [emphasis mine]**

under *Criminal Code* section 679(3). The public interest, in turn, means the public's confidence in and respect for the Court of Appeal in its administration of the criminal law.

(When I say "the public," I mean ordinary, reasonable, fair-minded members of society or persons informed about the law and the circumstances of the case).

To refine this question of mine, is confidence maintained in the Court of Appeal among ordinary, reasonable,

fair-minded citizens or persons informed about the law and case circumstances, when a Justice of the Court releases someone usually resident in the United States, who (although not convicted of any offence) has been committed to custody - after the Trial Division heard evidence in 2002 of her involvement in the circumstances of a murder - to await the federal Justice Minister's decision whether to surrender her to the United States to be tried for the murder? For example, in deciding whether to release Dr. Turner, did the Court of Appeal Justice have authority to say to federal counsel:

> **No evidence is before me about her background, other than the documents sent from the United States and her own affidavit. You say you have no concerns specific to Dr. Turner. You give no indication she suffers from a psychological disorder. On what do you base your position? Are you certain there is nothing more you can provide me about Dr. Turner that may better inform me, in deciding whether, in the public interest - or her own interest - she should be released until her appeal is heard and decided? I ask these questions because I know little about Dr. Turner, one way or the other?**

Maybe the answer is that the Court of Appeal must rely on legal counsel and unrepresented accused (as in this matter) appearing before the Court to obtain and provide to the Court everything relevant to the issue of 'bail.' Maybe the Court of Appeal Justice, if she asked the questions I suggest, would

have been seen as failing to remain impartial - a cardinal obligation of a Justice. Maybe a Justice is entitled to make assumptions about a person's psychological condition (e.g., assume the person is psychologically well) and make important decisions based on those assumptions if counsel or an unrepresented accused does not inform the Court otherwise. Quite frankly, we do not know.

Because we do not know, I therefore recommend:

Recommendation 6:3

THAT the Child and Youth Advocate, after having determined who is legally entitled to conduct a Judicial Review (acting along with the authority of the Federal Government), do so in order to <u>fully</u> examine how the justice system functioned in relation to Dr. Shirley Turner and hence affected the rights and interests of Zachary Turner.

Recommendation 6:4

THAT the Child and Youth Advocate report her findings to the House of Assembly and the Newfoundland public.

Had Dr. Turner not been released on 'bail' on 12 December 2001 or on 10 January 2003, my Review would have been unnecessary. Zachary would be alive today.

[Notes to Chapter 6]

[1] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.9.

[2] Ibid.

[3] Statutes of Canada 1999, Chapter 18.

[4] Revised Statutes of Canada, 1985, Chapter C-46, Part XVI.

[5] Revised Statutes of Newfoundland and Labrador, 1990, Chapter C-13.

[6] Statutes of Canada 1999, Chapter 18.

[7] Revised Statutes of Canada, 1985, Chapter C-46, Part XVI.

[8] Statutes of Canada 1999, Chapter 18.

[9] Revised Statutes of Canada, 1985, Chapter C-46, Part XVI.

[10] Revised Statutes of Newfoundland and Labrador, 1990, Chapter C-13.

[11] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.9.

[12] 30 & 31 Victoria, Chapter 3 (U.K.).

[13] Ibid.

[14] Revised Statutes of Newfoundland and Labrador, 1990, Chapter D-16.

[15] 30 & 31 Victoria, Chapter 3 (U.K.).

[16] Statutes of Canada 1999, Chapter 18.

[17] Revised Statutes of Canada, 1985, Chapter C-46, Part XVI.

[18] Revised Statutes of Newfoundland and Labrador, 1990, Chapter C-13.

[19] [1979] 1 S.C.R. 218.

[20] See: Anthony, Russell J. and Lucas, Alastair R. *A Handbook On The Conduct Of Public Inquiries In Canada* (Toronto: Butterworths, 1985), pp.1-10.

[21] "Judicial independence" governs the relationship between members of the judiciary and the other two branches of government - the executive and the legislative branches. The two main elements of judicial independence are: (i) administrative privilege, such as the right to decide who hears a particular case without having to account for the administrative decision to the other branches of government; and (ii) adjudicative privilege which essentially means not having to account to the other branches of government for judicial decisions or how they are reached. "Impartiality" refers to the state of mind of judges in performing their judicial duties, including decision-making. To be truly impartial, judges must be independent of the other branches of government.

[22] Statutes of Canada 1999, Chapter 18.

[23] Revised Statutes of Canada, 1985, Chapter C-46, Part XVI.

[24] Revised Statutes of Newfoundland and Labrador, 1990, Chapter C-13.

[25] [1989] 2 S.C.R. 796.

[26] Ibid., 673, paras.43-44.

[27] Ibid., 796.

[28] Ibid., para.59.

[29] Ibid.

[30] Ibid., para.87.

[31] Ibid., para.90.

[32] In this context, I expect I would be regarded as an appointee of the legislative branch of government because I was delegated by the Advocate, an officer of the Newfoundland House of Assembly, to conduct the Review.

[33] Ibid., para.4.

[34] Ibid., para.5.

[35] Revised Statutes of Canada, 1985, Chapter J-1.

[36] Revised Statutes of Newfoundland and Labrador, 1990, Chapter C-13.

[37] The Globe and Mail, 10 May 2006, p.A.15, col.2-3; 5.

[38] Statutes of Canada, 1999, Chapter 18.

[39] Revised Statutes of Canada, 1985, Chapter C-46, Part XVI.

[40] Revised Statutes of Newfoundland and Labrador, 1990, Chapter C-13.

[41] Ibid.

[42] Ibid.

[43] Ibid.

[44] Ibid.

[45] Ibid.

[46] Ibid.

[47] In bail law, as provided for in Part XVI of the *Criminal Code* [Revised Statutes of Canada, 1985, Chapter C-46, Part XVI], a Recognizance is but one of the options available to a Court which decides to grant "bail" to an accused. The Recognizance can be required with or without sureties. It represents one of the most stringent bases for obtaining "bail." The requirement of entering into a Recognizance does not carry with it any obligation to deposit a money sum with the Court, although a Court may impose that obligation instead of requiring sureties. In most factual circumstances, a Court has discretion to decide whether or not to require a Recognizance at all. In Dr. Turner's situation, on the facts of Dr. Turner's case, a Recognizance had to be imposed by the Trial Division of the Court once the Court decided on 12 December 2001 to release her because that is required under *Criminal Code* section 515(2)(e) [Revised Statutes of Canada, 1985, Chapter C-46] where, as here, the accused was then "not ordinarily resident in the province in which the accused is in custody." By the time the Court of Appeal granted "bail" to Dr. Turner on 10 January 2003, a Recognizance, although ordered, was not legally essential because by then she was probably resident ordinarily in Newfoundland.

[48] The Court could have ordered that the total for which sureties must sign be less than the amount of the Recognizance for which Dr. Turner was required to sign. Under each of the two judicial interim release orders relating to Dr. Turner, however, the amounts were the same.

[49] Revised Statutes of Canada, 1985, Chapter C-46.

[50] Ibid.

[51] 30 & 31 Victoria, Chapter 3 (U.K.)

[52] Statutes of Newfoundland and Labrador, 1979, Chapter 32, Part II; Revised Statutes of Newfoundland and Labrador, 1990, Chapter F-2, Part II.

[53] Revised Statutes of Canada, 1985, Chapter C-46.

[54] Ibid.

[55] The proceeding is sometimes described as "estreatment." A leading case on the subject in Canada was decided by the Newfoundland Supreme Court in October 1975 as a result of which $300,000 was ordered by the Court to be forfeited [*R. v. Andrews* (1975), 9 Nfld. & P.E.I.R. 168, Furlong, C.J.]. If the Crown commences an estreatment application, the court hearing the application has discretion to order forfeiture of some or all of the money sums paid into court as a term of judicial interim release, and/or some or all of the amounts a principal (for example, an accused) or a surety has, under a Recognizance, promised to pay if the Recognizance is breached. Alternatively, a court, on hearing an estreatment application, has discretion to decline to order any forfeiture. The court's decision will depend on the facts of a particular estreatment application.

[56] The Ontario decision [*R. v. Huang* (1998), 127 C.C.C. (3d) 397, para.11] referred to in the 29 October 2004 letter involved a "bail" forfeiture application by the federal Crown in a narcotics prosecution mounted by the federal Crown. And, in deciding the application, the Ontario decision applied the October 1975 forfeiture judgment of the Newfoundland Supreme Court [*R. v. Andrews* (1975), 9 Nfld. and P.E.I.R. 168, Furlong, C.J.]. As in the Ontario case, the Newfoundland proceeding involved "bail" forfeiture in a narcotics prosecution by the federal Crown.

[57] *R. v. Huang* (1998), 127 C.C.C. (3d) 397.

[58] Revised Statutes of Canada, 1985, Chapter C-46.

[59] Statutes of Newfoundland and Labrador, 1998, Chapter C-12.1, Appendix 5, p.A.25.

[60] Ibid., pp.A.42-43.

[61] Revised Statutes of Canada, 1985, Chapter C-46.

[62] Ibid.

[63] Ibid.

Chapter 7

Delivery of Community Services

1. Introduction

Conduct of the agency of the Provincial Government charged with the welfare, including protection of children and youth, in delivering services to and for Zachary - the heart of my Review - is the subject of this chapter. In addressing my mandate to review and investigate the circumstances of, and surrounding, Zachary Turner's death, I discovered it to be necessary to explore the nature and degree to which the best interests of another of Dr. Turner's children were served. By virtue of bringing one of her children to live with her, Dr. Turner initiated contact and gained support from Child, Youth and Family Services (CYFS). Her behaviour vis-à-vis this child also provided insights into Dr. Turner's parenting. In carrying out my mandate, I have examined how services are organized and delivered under the *Child, Youth and Family Services Act* and, in particular, how the organization and delivery of these services were used with respect to the best interests of both these children.

The organization and services, as they existed at the time, failed both children. Zachary died at the hands of his mother. The records show that his half-sister, while living

with her mother at a particularly vulnerable developmental stage, suffered negative effects on her education and was left with feelings of guilt. At the time of Zachary's murder and Dr. Shirley Turner's suicide, she was visiting her father in western Newfoundland. She experienced the guilt that somehow, had she been in St. John's, she might have prevented her mother's suicide and her infant half-brother's death. This experience and the inevitable grief surrounding the loss of her mother and infant brother have put her at risk for emotional harm. Further, a preoccupation with Dr. Turner's needs somehow obscured the primary obligation of providers of child, youth and family services to focus on her children's safety and well-being.

It is important to reiterate here that it is not my intention to attribute blame or to scapegoat any one individual. Social workers and health care workers from the agency who had direct contact and/or input into the Turner file cooperated fully with the Review and responded to all questions and requests put to them. Overall, the impression they conveyed was that they believed they had done everything they could, given their legislative and policy mandate, to assist the children's mother, Dr. Turner, in caring for her children. Indeed, through an internal departmental review conducted immediately after

Zachary's death, the conclusion was drawn that work done in the delivery of child, youth and family services was in keeping with standard child protection practice and complied with the Province's legislation, policy and standards (Appendices 6 and 7). If further tragedies are to be prevented, I believe it incumbent on me to examine this system in detail in order to understand how apparently acceptable and standard practice did in fact fail to protect Zachary.

Accordingly, this chapter will first examine the pertinent legislation, policy and organizational structure. Discussion of the structure will include my analysis of the interventions provided, both from the managerial and supervisory levels and the direct practice level. Professional training and qualifications, and the various ways in which these are acquired, will also be addressed including such issues as in-service training, performance evaluations, case management and supervision, and skills required for intervention. Finally, all of this information will be incorporated into my summary analysis and conclusions.

2. Child Welfare Legislation

2.1 Overview

The implementation of the *Child, Youth and Family Services Act*[1] began in January 2000, just under two years before Andrew Bagby was killed. It replaced the *Child Welfare Act* which had been repealed.[2] The new legislation brought about some significant changes with respect to how representatives of the Director (Director in Region) of Child, Youth and Family Services (CYFS) at the St. John's Regional Health and Community Services Board (Board) could intervene on behalf of children who might be at risk of abuse or neglect. This section of the chapter will provide a discussion of those changes and how they affected services to two of Dr. Turner's minor children - Zachary and his 12-year old half-sister. For the sake of expediency, these two pieces of legislation will be referred to throughout as the former and current legislation. Both *Acts* uphold the principle of "best interests," but the current legislation provides a stronger prerogative in that the words of the former legislation,

> **The paramount consideration . . . shall be the best interests of the child (Section 4.1)**

have been replaced in the current legislation by:

> **The overriding and paramount consideration . . . shall be the best interests of the child (Section 7(a)).**

However, section 7(b) of the current legislation declares that:

> **services shall be provided using the least intrusive means of intervention.**

These changes constitute some ambiguity for the worker at the front line with respect to parental rights vis-à-vis children's rights. In fact, Professor Thomas, Professor of Law at Dalhousie University, draws attention[3] to how, at the Supreme Court of Canada level, parental rights have trumped those of children. He quotes Justice La Forest in *B. (R) v. Children's Aid Society of Metropolitan Toronto* in 1995[4] who drew on the *Canadian Charter of Rights and Freedoms*[5] to invoke the liberty interests of parents:

> **…. the right to nurture a child, to care for its development, and to make decisions for it . . . are part of the liberty interest of a parent. …**
>
> **… the state can properly intervene in situations where parental conduct falls below the socially acceptable threshold, but in doing so it is limiting the constitutional rights of parents rather than vindicating the constitutional rights of children [emphasis mine].[6]**

A conclusion that Thomas draws is, that being so, family support provisions must be "more firmly entrenched as a policy expectation."[7] The corollary is that legal definitions of the threshold of harm must be carefully crafted. I have examined the two pieces of legislation to determine the extent to which they address these twin requirements. This has allowed for a review of the degree to which the current legislation helped or hindered protection of Zachary.

The current legislation has met the need for "firm entrenchment" by consolidating provisions for family support in a positive way in section 10 (Family Services). This section should hopefully reduce the numbers of children taken into care because of circumstantial neglect (where parents' circumstances are such that it is impossible to meet their children's needs because of lack of concrete and/or social resources).

Definitions of threshold of harm (grounds for protective intervention) are more problematic and could well create difficulties for CYFS in shifting services to Dr. Turner's children from section 10 (Family Services) to section 14

(Protective Intervention), despite the belief of senior management that there were protective concerns.

The current legislation provides much greater clarity with respect to physical and sexual abuse. The fact that its definitions include the risk of, as well as actual, abuse allows for intervention to prevent abuse. Emotional abuse has been included for the first time, though not the risk of emotional abuse. Curiously, living with domestic violence has been removed at a time when other provinces have been including this as grounds for protective intervention. However, it is important to note that in the Canadian[8] and Quebec[9] Incidence Studies (of maltreatment), exposure to domestic violence seemed to be synonymous with a categorization of emotional abuse. Presumably children in Newfoundland and Labrador can be protected from the effects of violence in the home through invoking the emotional abuse clause. There are various other differences between the two *Acts* as to what constitutes the need for protection. For the purposes of this Review, I will simply compare how Dr. Turner's children might or might not be (have been) eligible for protective services under the former and current legislation.

2.2 Former child welfare legislation

Subsection 2(b)(i) could certainly apply to Zachary's half-sister and subsection 2(b)(iv) to both children. Subsection 2(b)(i) reads:

> **a child who is without adequate care and supervision.**

This was clearly the situation during the time that Dr. Turner was incarcerated in the Newfoundland and Labrador Correctional Centre for Women in Clarenville.

Subsection 2(b)(iv) reads:

> **a child in the care or custody of a person who is unfit, unable or unwilling to provide adequate care for the child [emphasis mine].**

It could conceivably be argued that "unable … to … care" was an apt description for a mother in Dr. Turner's situation. This was a mother who had been temporarily incarcerated in Canada, was facing extradition and, whether found innocent or not, was likely to be incarcerated for some time in the United States during the judicial proceedings. Because of the

demonstrated flight risk, the chances of bail in the United States, if extradited, would be remote.

However, the circumstances being reviewed occurred when the current legislation was in force. I now shift to an examination of its provisions.

2.3 Current child welfare (Child, Youth and Family Services) legislation

It became clear in my interviews with them that senior management of the Board had apparently determined this was a situation in need of protective intervention:

> **I had already made the decision - that we were going to consider this as an ongoing long-term protective intervention file.**

This decision, however, was not documented in the case files nor was there identification of the possible grounds under the current legislation that could be established. This was a very serious omission.

Conceivably one could argue that Zachary's half-sister fell under subsection 14(c):

> **[the child] is emotionally harmed by the parent's conduct.**

A fact that might undermine this argument before a Court was the suggestion, in the Board records, that the child herself would deny it. Nevertheless, there is factual information on record that could be brought forward as counter argument. According to this child, her mother had nothing good to say about her father who had cared for her for most of her life and to whom she was evidently well attached. There was the further consideration that he was the parent who would be taking over her care, once more, while her mother faced judicial proceedings. To attempt to alienate his child from him surely lies in the realm of emotional harm. In addition, the emotional strain of her mother's situation affected the child's education. She missed days from school when living alone (in November and December 2002) and later (in June 2003) when emotionally supporting her mother as they were waiting for the result of the extradition decision of Canada's Justice Minister. In the spring of 2002, she was identified by her school counselor as a very bright child "excelling academically." By

the following year, her school work had deteriorated and she failed two subjects.

In the current legislation, the "without adequate supervision" clause now only applies to a child under 12 years of age. At the tender age of 12½, Zachary's half-sister spent some considerable time, ordinarily residing alone, in an apartment without a telephone, without adequate supervision and, apparently, sometimes short of food - a situation not covered by the child protection legislative provisions. There is no question that CYFS knew these facts and yet allowed the situation to continue with limited monitoring. For instance, CYFS did not know that the child had returned to her father in Portland Creek until the end of December when the worker learned that her half-brother and half-sister (visiting from Toronto) had driven her there on Christmas Eve.

With respect to Zachary as well as his half-sister, the former subsection 2(b)(iv) has been replaced by a much weaker provision but one that clearly reflects least intrusion. Subsection 14(i) reads:

> **(the child) has no living parent or a parent is unavailable to care for the child and has not made adequate provision for the child's care [emphasis mine]**.

The clause I have underlined undermines the ability of the Director in Region of a regional health and community services board to intervene in Zachary's case as his mother agreed to leave him in his paternal grandparents' care while she was temporarily incarcerated.

In brief then, the wording of the current legislation virtually handcuffs the Director in Region, or her representatives, with respect to more intrusive intervention. With the benefit of hindsight, two procedures could have made a difference; either a family group conference or an interdisciplinary case conference (or both):

1. Section 13 of the legislation allows the Director in Region to convene a family group conference. Such a conference would have allowed David and Kathleen Bagby (the only surviving representatives of Zachary's paternal family) and the ex-husband of Dr. Turner (who, up until this time, had parented the younger daughter,

Zachary's half-sister), to inform the Director in Region what they thought was in the children's best interests.

2. An interdisciplinary case conference would have brought to light the very serious risk factors that were at play here including: indicators from past history; current information that Dr. Turner, at the instigation of a psychiatrist, had been on suicide watch during her period of incarceration; and the fears of a member of the Royal Newfoundland Constabulary (RNC) that she might harm herself and/or her [then unborn] child if the decision were made to remove the child after birth because, in the RNC member's view, her children were all Dr. Turner had to attempt avoiding extradition to the United States.

Notwithstanding these suggestions, my conclusion is that the definitions of "a child in need of protective intervention" in the *Child, Youth and Family Services Act*[10] are not sufficient to enable child protection workers to uphold the

overriding and paramount consideration of the best interests of the child.

I am recommending a major overhaul of the grounds for protective intervention. This includes removal of the clause in 14(i) (has not made adequate provision . . .) that weakens its intent, and adding "a parent" to 14(k)(ii) and 14(k)(iii).

Recommendation 7.1

THAT Section 14 of the *Child, Youth and Family Services Act* be amended, in order to ensure better protection of the child, by providing:

> **A child is in need of protective intervention where the child[11] is, or is at risk of being**
>
> **(a) physically harmed by the action or lack of appropriate action by the parent of a child;[12]**
>
> **(b) sexually abused or exploited either by the child's parent, or through lack of appropriate action by the parent of a child;**
>
> **(c) emotionally harmed by the conduct of a parent of a child;**
>
> **(d) physically harmed by a person and the parent of a child does not protect the child;**
>
> **(e) sexually abused or exploited by a person and the**

parent of a child does not protect the child;

(f) emotionally harmed by a person and the parent of a child does not protect the child;

(g) in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;

(h) abandoned;

(i) left with no living parent or a parent is unavailable to care for the child;

(j) exposed to domestic or other violence; or,

(k) where the child

(i) has been left without adequate supervision appropriate to the child's developmental level; or

(ii) has allegedly, or whose parent has allegedly, killed or seriously injured another person or has caused serious damage to another person's property; or

(iii) on more than one occasion caused, or whose parent has caused, injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing;

(l) the child is living in circumstances in which the child's safety, health or well-being otherwise is, or is at risk of, being endangered."

I also have grave concerns, as mentioned before, that despite the comment by CYFS senior management of the Board that,

> **we were going to consider this as an ongoing long-term protective intervention file,**

there was no documentation to this effect and such a belief was not communicated to all involved personnel. There was an obvious difference of opinion here between senior management and the front line workers. While the former made these statements in their Review interviews, the workers providing direct service never seriously considered the situation to be one which required "protective intervention." In fact, they did little to carry on any ongoing kind of investigation to substantiate protection concerns. The situation underlined the inherent inconsistency and lack of formal communications within the Board. There was apparently a reliance on informal direction which was not recorded or documented in any way. Since senior management <u>believed</u> there were protection concerns, then it seems that section 15 (duty to report) also needs to be strengthened to enable the making of child (and youth) centred decisions based on such belief.

Recommendation 7.2

THAT Section 15(4) be amended to add "to suspect or believe that a child is, or may be, in need of protective intervention."

2.4 Child and Youth Advocate Act

I have referred to the *Child and Youth Advocate Act*[13] in many other chapters. As I discovered, Dr. Turner not only had CYFS assisting her, she also contacted the Office of the Advocate to intervene on her behalf. I digress briefly from consideration of CYFS to outline the substance of that intervention.

Section 3 of the *Child and Youth Advocate Act* states that the Office of the Child and Youth Advocate is established:

> **(a) to ensure that the rights and interests of children and youth are protected and advanced and their views are heard and considered;**
>
> **(b) to ensure that children and youth have access to services and that their complaints relating to the provision of those services receive appropriate attention;**
>
> **(c) to provide information and advice to the**

> **government, agencies of the government and to communities about the availability, effectiveness, responsiveness and relevance of services to children and youth; and**
>
> **(d) generally, to act as an advocate of the rights and interests of children and youth.**

And, section 15 of the Act authorizes the Advocate, among other things, to:

> **Receive and review a matter relating to a child or youth or a group of them, whether or not a request or complaint is made to the advocate (Section 15(a)); Initiate and participate in, or assist children and youth to initiate and participate in, case conferences, administrative reviews, mediations, or other processes in which decisions are made about the provision of services (Section 15(d)).**

The facts of the Child and Youth Advocate's Office involvement are set out in Chapter 5. The involvement was fairly brief over the course of nine weeks from 02 June 2003 to 18 July 2003. Dr. Turner informed the Intake Officer that she had been referred by her younger daughter's counsellor. Worth noting is that this counsellor was actually employed within a branch of CYFS.

The two primary concerns brought to the Advocate's Office by Dr. Turner were planning for Zachary in the event

that she was incarcerated, and legal representation in Unified Family Court regarding custody of Zachary, should the decision be made to extradite her. With respect to the former, she was looking for an independent assessment to determine what was in Zachary's best interests. This assessment was at issue since there were conflicting views of the Board and Advocate's Office as to whether it was the responsibility of the Court or of CYFS to obtain an assessment. The Advocate's Office referred Dr. Turner to Janeway Family Services for an assessment. The issue of legal representation was referred to Legal Aid. The door was left open for Dr. Turner to return to the Advocate's Office if the issue of legal representation was not resolved.

It is my opinion that if there were limits on the services that could be provided by CYFS, the worker employed by CYFS should, in the first place, have raised this as a systemic issue to the Provincial Director of Child, Youth and Family Services (Provincial Director) and Directors in Region and, only then, if necessary, to the Advocate's Office.

The Advocate's power to initiate a case conference under section 15(d) of the *Child and Youth Advocate Act* might

have benefited Zachary. To me, it is most relevant that there had been considerable media exposure and resulting knowledge of the Pennsylvania criminal charges which Dr. Turner was facing. She was not simply a parent with some minor child-related issues, but one who was notoriously in the public eye. Despite this knowledge, there appeared to be little or no concern on the part of the Advocate's Office for the rights and interests of the children involved. Yet the rights and interests of children constitute the *raison d'être* of the Office. It appears that, since CYFS was involved, the Advocate assumed any Turner child welfare issues were being addressed. There is very limited evidence that the Advocate knew or understood the complexity of the case. Nor did the Advocate's Office do much proactively to investigate and identify the issues to brief itself. It seems that the situation was treated as that of an ordinary citizen asking for advocacy services, which she got. It raises the question whether the first Advocate really understood the issues and their implications, and just how independent from CYFS the Advocate was in practice, despite being independent in the legal sense. Whatever the explanation, the brief contact in 2003 between the Advocate's Office and Dr. Turner's long-term CYFS worker, on the one

hand, and Legal Aid Commission services, on the other, was apparently deemed sufficient action.

Recommendation 7.3

THAT where the Advocate's Office is contacted by someone already receiving services under the *Child, Youth and Family Services Act*, the Advocate shall consider initiating a case conference with those mandated under the *Act*.

The purpose of the case conference, if determined to be warranted, would be to bring together all involved professionals to ensure that the rights and interests of the child are protected and the child's needs are being met. Relevant inquiries in the United Kingdom have shown repeatedly that when the various agencies involved are not in communication with one another, the child's needs "fall through the cracks."[14] Outcomes, as tragically was also the case with Zachary, have been lethal.

3. Child Welfare Policy

3.1 Overview

Legislation with respect to child welfare and child protection sets out the parameters within which social workers practice. On its own, it is a somewhat crude tool; policy and procedures help to fine tune approaches that they may take. My Review disclosed that all workers have a copy of the policy manual, receive initial training in its use and are kept informed of changes through printed updates. It is a somewhat formidable document made more manageable by its list of contents. I was told by the Board's senior CYFS management that, at the time of these events, there was a degree of confusion with respect to the transition from earlier policy and legislation. This was in part due to the fact that there were two manuals in place providing policies and procedures. The "Child Welfare Policy and Procedure Manual"[15] had been the primary resource used prior to the proclamation of the *Child, Youth and Family Services Act*[16] on 05 January 2000. This manual had been updated over the years, based on a broad range of consultations. A second manual, the "Child, Youth and Family Services Act Standards and Policy,"[17] was introduced upon proclamation of the *Act*. I was informed as recently as 11 April 2006 that the Department of Health and Community Services was still in the process of integrating the two manuals:

> **The goal is to have a single manual available by mid to late 2006.**

Nevertheless, the lack of one coherent manual did not appear to be a major detriment to activities at the front line regarding the Turner file.

I turn now to policy directives concerning those aspects of service relevant to Dr. Turner and her children. They include definitions, investigation and assessment tools, the use of case conferences and the issue of confidentiality.

3.2 Definitions

The decision to conduct an investigation requires "reasonable grounds." The policy definition reads:

> **For child protection purposes reasonable grounds means that there is some reasonable and reliable information upon which the social worker determines that a child may be in need of protection (Policy Reference No. 02-03-02).**

The Manual then proceeds to provide guidelines respecting factors to consider. These include examples of direct and indirect evidence. During my Review, a senior manager

within the Board informed me that, to her knowledge, there was no policy to help workers understand the concept. In answer to my legal counsel's question

> **Q. … did you have policy to help you, help your workers, understand what "reasonable grounds" means when being applied to a protection case?**

she replied:

> **A. No, not to my knowledge.**

The recent Supreme Court decision of *Bella v. Young*[18] stated that "reasonable grounds" required for reporting of alleged child mistreatment could not be based merely on speculation. Two conclusions could possibly be drawn: first, that this particular section of the policy manual is not sufficiently clear; and secondly, that child welfare personnel may well have considered their protection concerns with respect to Dr. Turner's children to be still at the speculative stage.

The definition of "least intrusion" is even more problematic. It is not defined in the legislation or in the policy manual. Consider the following from one of my interviews with a social worker in a senior CYFS position:

David C. Day, Q.C. (Review legal counsel):

> **Is there a legal definition or a practice definition, either in policy or otherwise, that attempts . . . to define what is meant by least intrusive means of intervention?**

Answer:

> **I can't say that there is. I think it's based on our practice and our experience.**

Review legal counsel:

> **Your best judgment?**

Answer:

> **Yes. Which is obviously open to individual interpretation. But like all principles would be.**

In the absence of such, the most common interpretation is - and has been - to equate it with removal of the child as a last resort. This is not necessarily what the term means, or in the child's best interests. The latest child welfare text currently in use in Schools of Social Work, including that of Memorial University, has this to say:

> **The manifest intent of child welfare services is to serve children. But an underlying theme within the various chapters presented here is that children's best interests are at risk of being lost sight of, or are subverted to the interests of others. In part this is an unintended consequence of the introduction, in the mid 1980s, of the**

> **least intrusive philosophy (that is, to the degree possible, children should remain with their own family).**[19]

Across Canada, an unintended consequence of the principle of "least intrusion" is a **tendency to view the parent, rather than the child, as the primary client**. This has been a key factor in deaths of children in other provinces; for example, Matthew Vaudreuil[20] in British Columbia and Jordan Heikampf[21] in Ontario. My Review discovered a similar dynamic. Once family support services were in place, not only were the children no longer viewed as primary clients, but Dr. Turner, in effect, became her own case manager. She basically drove the services delivered to her. Family Services under section 10 is not intended to be simply "parent support," nor is it expressed that way in the legislation. "Family" became very narrowly interpreted in practice in dealing with Dr. Turner to mean just the maternal parent, and family services delivery often involved how the children could adjust to ensuring that their mother's needs were being met.

Recommendation 7.4

THAT the policy manual be amended to include clear directions with respect to interpretation of "least intrusion" within the context that the best interests of the

child are the paramount consideration under the *Act*. The amendments must provide clarification as to when the practice becomes a form of negligence and contributes to a child being "in need of protective intervention."

There is, as yet, no policy definition of what constitutes "Family Services" under section 10 of the *Child, Youth and Family Services Act*. It appears, from what I have seen, that it can be used at the point of Intake as a useful back-up provision (where there are concerns with respect to a child's safety and well-being) if there is insufficient evidence that would constitute "reasonable grounds" for intervention. In any case, as I discovered, Dr. Turner had made a "self-referral" and certainly there was sufficient information available that she might well need assistance.

The policies in existence did provide considerable information about the provision of family support. However, these sections of the Policy Manual appear to be more concerned with situations where there is a need to place a family support worker in a home that appears inadequate in some way. In fact, there may be an implicit class bias that the norms applied would be those of a well functioning middle-

class family. These policies did not quite fit the needs expressed by Dr. Turner, an intelligent, well-educated, professional woman who herself had chosen to draw her younger daughter into the maelstrom caused by the judicial proceedings in which Dr. Turner was involved.

Recommendation 7.5

THAT policy with respect to Section 10 Family Services be drafted and disseminated through in-service training to all personnel.

3.3 Investigation and Assessment

The policy is as follows:

> **The investigation/assessment of all referrals of a child in need of protection is the primary responsibility of the Child Protection Social Worker. The Child Protection Social Worker shall however, when actioning the referral, consult with/elicit the cooperation of other professional and community resources … (Policy Reference No. 02-02-03).**

The policy states further that:

> **There may be sharing of information pertinent to the investigation and/or follow up intervention (where possible with the written consent of the parents/guardians) between the systems. The lack of**

> **parental consent will not prevent consultation with collateral contacts during the investigation stage [emphasis mine] (Policy Reference No. 02-02-03).**

Despite the fact that in this case Dr. Turner had given permission to contact her psychiatrist, when he did not return CYFS calls, no more rigorous attempts were made to consult with him.

> **Review legal counsel:**
>
> > **Dr. Doucet, you attempted to contact him more than once as I understand, but you were unsuccessful in reaching him?**
>
> **Answer:**
>
> > **Correct.**

The same lack of rigorous investigation occurred when Dr. Turner did not return calls during investigation of a child abuse complaint against her in 1993. The final notation on that file, dated 11 January 1994 and apparently signed by a supervisor, is as follows:

> **Mother needs to be spoken to directly regarding her use of physical discipline. Case summary will need to be done on running record sheets.**

However, the file was closed on that same date - 11 January 1994. No case summary was placed on file and no further attempts were made to reach Dr. Turner.

In fairness to Dr. Turner's assessment worker in 2002, it appears that at the time when she was attempting to reach Dr. Doucet, she assumed that she was assessing the service needs of the mother rather than a need to explore child protection issues. In answer to my legal counsel, she said:

> **My understanding was that it was because these are the services in place, that it was part of assessing, you know, whether or not there was any change in her mental health circumstance. How she was coping with various stressors and that kind of thing. So it was basically just sort of following up with the services to kind of make, you know, that assessment.**

I must repeat again here what I stated earlier. The failure on the part of senior Board management at CYFS to document the belief, as stated by a Board representative at senior level, that

> **I had already made the decision - that we were going to consider this as an ongoing long-term protective intervention file**

was a serious omission that left the assessment worker at a disadvantage in pursuing her investigations.

So far as I can tell, the assessment seemed to be that Dr. Turner was a mother caring for children in a highly stressful situation that was not of her own making, given the workers' presumption of her innocence. She therefore needed supportive services. Nowhere did I find any ongoing assessment of the safety needs of the children. The focus seemed to be on Dr. Turner's needs.

It also seems to me that when a CYFS social worker designates a case as family support at intake, it becomes very difficult to shift to child protection, unless CYFS has some very concrete evidence. The failure to assess her background and, in particular, the circumstances around the murder allowed for a narrow definition of Dr. Turner as a "single mother under considerable stress, requiring supports."

A more general concern I have, certainly apparent in my investigation with respect to Dr. Turner, relates to an internal culture within CYFS throughout the Province that is passive and reactive in nature. In order to provide adequate protection

to the children of the Province, that culture must change. It must be child-focussed and child-centred. Admirable as the focus on family preservation and family support is, it must not divert attention from proactive concern for the overriding and paramount consideration of the best interests, including the safety of the child. Mandatory training is essential as the first step in bringing about the necessary culture shift.

Recommendation 7.6

THAT the Province develop and deliver mandatory, multi-disciplinary education and training (including but not limited to) from police, health care professionals, educators, lawyers and caregivers,[22] the focus of which is investigation and assessment of the need for protective intervention on behalf of the child or children.

Recommendation 7.7

THAT the investigation and assessment of the need for protective intervention, at all times, only be carried out by someone who has successfully completed the education and training proposed in Recommendation 7.6.

3.4 Assessment tools

In the search for tools to guide practice, it is generally acknowledged that there is no tool that can be used in the absence of competent worker judgment. Any tools, such as "safety assessment" and "risk management systems," should be used to enhance, if not substantiate, the professional judgment of the social worker as cases become more complex and demanding. They are not intended and should not become a substitute for competency.

Newfoundland and Labrador policy provides two such tools. One is the "Initial Safety Assessment." This is a very simple check-list of 13 indicators. An "Initial Safety Assessment" was completed on 16 April 2002, shortly after the self-referral, dated 10 April 2002, from Dr. Turner. According to CYFS records, in her first request for support services, which was for her younger daughter, Dr. Turner provided full disclosure of the fact of the murder charges and the possibility of extradition. Despite these disclosures, the assessment discounted the presence of any safety factors. In my opinion, at least two of the 13 indicators should have been flagged:

#1. Parent's behaviour is violent or out of control.

There should have been at least a notation that the mother was facing charges of premeditated murder (of Zachary's father).

#12. Parent's emotional/health status seriously affects his/her ability to supervise, protect, or care for the child.

This indicator warranted a notation that the current situation was a major emotional stressor.

The other tool, a "Risk Assessment" instrument, was not mandatory and was not used. The policy manual provides considerable detail as to how the various indicators of risk are to be assessed, but does specify that the instrument is not to be used until social workers have been trained in its usage. Would its use have affected intervention? My opinion is that it may not have raised any red flags with respect to Dr. Turner. It appears to be designed to assess the more common complaints of actual direct abusive behaviour towards a child. I was, in fact, informed that in 2002 its use was limited to cases of severe physical and sexual abuse. If it had been used, Dr. Turner's self-referral in 2002 and, further, her self-disclosure of slapping her daughter in June 2003, and her apparent willingness to work cooperatively with the worker,

would all contribute to her being assessed as low risk based on the risk assessment instrument's application.

According to senior Board CYFS management, a traditional social work assessment tool - that of the development of a comprehensive social history - is no longer standard practice. A CYFS manager testified:

> **Frankly I don't think there are very many times that a comprehensive social history is completed . . . I don't think that I do them, you know, in 99 out of a 100, and I didn't do [one in] Shirley's [case]. I think that I don't complete them.**

And a CYFS supervisor testified:

> **I think in some instances there would be social histories on file but it's not something, you know, it's considered to be best practice and you know, yes it would be ideal if we could have social histories on every child protection file, but that's certainly not, not the practice due to resources.**

I did note that a social history is, in policy, mandatory for children entering care:

> **When a child enters care, whether by court order or non-ward agreement, the Social Worker shall compile a social history and family health history. Both histories**

> **shall be completed as soon as possible and within 30 days of the child entering case (Policy Reference No. 02-07-05).**

However, the amount of information to be collected on the parents for a social history is fairly minimal (Policy Reference No. 02-09-08) and would not provide the depth of information required for a comprehensive assessment. As well as basic demographic facts required by current policy (age, ethnicity, education, occupation, income), a comprehensive social history includes - but is not limited to - biographical details, family history and knowledge of extended family. Thus, parents' childhood experiences and any prior relationships would be documented, as well as current functioning.

I do have concerns that a person in a senior management position would accept that lack of resources is sufficient reason to dispense with best practice, particularly where the welfare of children is at stake. When I use the term "best practice," I am referring to practice that

- is proactive;
- is evidence-based; and
- evaluates outcomes.

Evidence takes two forms. There is the evidence that can be drawn from research with respect to what works in practice. Just as important is the evidence to be gained from gathering facts with respect to a particular case file.

Recommendation 7.8

THAT the definition of parental social history be expanded and the collection of a full social history, as outlined above, be mandatory not only for all child protection investigations and assessments, but also in long-term family services cases.

3.5 Case conferences

Another useful tool in this case very early in the investigative stage would have been a case conference or, at least, a co-ordinated contact with each of the collateral agencies and/or professionals involved with Dr. Turner. This would be in accordance with policy which states that the worker shall

> **…consult with/elicit the cooperation of other professional and community resources. This will serve to minimize any negative consequences brought about**

> **by the involvement of several agencies and to maximize the potential for intervening effectively in order to best serve the child and treat the family (Policy Reference No. 02-02-03).**

Such action had the potential to warrant more intrusive intervention. I heard from more than one professional within the CYFS system that none of these other agencies had come forward with information. However, policy is clear. The investigation is the **"primary responsibility of the Child Protection Social Worker."** I concur with this. Furthermore, it is my opinion that child welfare personnel should not wait passively for others to bring information forward when there are intimations that a child is at risk.

The policy manual (Reference No. 02-03-04) refers to case conferencing "where practical and appropriate." Also, the directive quoted above in the section on "Investigation and Assessment" provides implicit sanction. In addition, the manual contains a Memorandum of Understanding (MOU) (effective date 1993-10-08), allowing for information sharing between the Department of Health and Community Services, the Department of Justice, the Royal Canadian Mounted Police (RCMP) and RNC. This MOU was prepared at a time when there was heightened concern about child sexual abuse. It is

therefore likely that, in practice, this has been interpreted narrowly.

Front line workers informed me that there were barriers to convening case conferences. The most common were concerns about confidentiality and the time element involved in coordination of such meetings. On the other hand, informants at the CYFS management level indicated, when asked whether case conferences were a regular or frequent practice:

Review legal counsel:

Would it be what I regard as a normal practice in appropriate circumstances in Region?

Answer:

Yes, and a frequent one.

Review legal counsel:

Have you ever [felt a need to call one]?

Answer:

Oh yes, lots of times.

Review legal counsel:

Have inter-disciplinary case conferences been done … to address the issue of particular child

welfare files?

Answer:

Definitely, regularly.

One CYFS manager saw no reason for a case conference with respect to Dr. Turner.

> **I don't see how it would have been beneficial because I don't know who[m] I would have invited, frankly. I mean, I didn't have that many people involved.**

From that comment, I assumed that the references to meetings were to internal case conferences rather than inter-disciplinary, that is, inter-agency meetings. Nevertheless, there seems to be some ambiguity about what exactly constitutes a case conference as indicated by another answer given to me:

> **Workers are so busy quite often that it's very hard to be the person who has to coordinate 10, 15, I've been at case conferences with 25 people. It's got to be a, it's horrible for the families and it's got to be logistically very difficult. There might be pros and cons in terms of, you know, how the family would feel about it, how the workers would feel about it. It would <u>probably be good</u> from the child's point of view [emphasis mine].**

With all due respect, I would say that if it "would probably be good," then it should happen.

One CYFS manager expressed to me that this matter had raised awareness of the need to share information.

> **Since the matter came up, since my first interview through this process, I have certainly been more aware of the need to make sure that case conferences are occurring, to make sure that I call them on a regular basis, and especially those matters where psychiatry is involved, and I tend to not get as much information as frequently from those sources as I do from other sources. It's also the sharing responsibility.**

And, perhaps, that is the bottom line. If information is shared, there is less likelihood of key information being missed and all involved become aware of, and responsible for, the safety of the child. It is done in the best interest of the child and to ensure that a child is not left in need of protective intervention.

Recommendation 7.9

THAT whenever a child comes to the attention of CYFS, if and when it is discovered that the child and/or family are involved with more than one professional or agency, a case conference involving all parties be a regular part of policy.

3.6 Confidentiality

The issue of confidentiality is covered in policy by the same section of the policy manual quoted above. The policy is that:

> **There may be sharing of information pertinent to the investigation and/or follow up intervention (where possible with the written consent of the parents/guardians) between the systems. The lack of parental consent will <u>not</u> prevent consultation with collateral contacts during the investigation stage (Policy Reference No. 02-02-03).**

I was informed by a Director in Region appointed by the Board, in accordance with the legislation, that this whole issue is unclear, but the direction workers would receive from her (the Director in Region) is:

> **It's the best interests of the child that guides my practice, that, yes, I respect people's rights to privacy and confidentiality but not at the expense of a child's safety or well-being.**

My assumption is that the concern of the front line workers with respect to confidentiality was affected by their adherence to their professional code of ethics.

The Canadian Association of Social Workers has recently released a revised Code of Ethics.[23] It is supplemented by *Guidelines for Ethical Practice*. When a child is potentially

or actually at risk, it behoves social workers to be cognizant of the ability to override confidentiality. Sections of the guidelines that are particularly helpful in this respect are as follows:

> **Section 1.1.5**
> **In exceptional circumstances, the priority of clients' interests may be outweighed by the interests of others, or by legal requirements and conditions. In such situations clients are made aware of the obligations the social worker faces with respect to the interests of others (see section 1.5), unless such disclosure could result in harm to others.**
>
> **Section 1.4.3**
> **When a social worker is court-ordered or agrees to conduct a legally-mandated assessment, the social worker's primary obligation is to the judge or designate. The social worker, however, continues to have professional obligations toward the person being assessed with respect to dignity, openness regarding limits to confidentiality and professional competence.**
>
> **Section 1.5.1**
> **Social workers discuss with clients the nature of confidentiality and limitations of clients' right to confidentiality at the earliest opportunity in their relationship. Social workers review with clients when disclosure of confidential information may be legally or ethically required. Further discussion of confidentiality may be needed throughout the course of the relationship.**[24]

A well known text on ethics in social work practice also addresses the issue of child safety taking precedence over confidentiality.[25]

Recommendation 7.10

THAT Social Work education and in-service training include coverage of the ability to override confidentiality, where a child's safety is at issue.

4. Implementation of Current Legislation and Policy

4.1 Overview

To guide CYFS employees in the implementation of the Province's legislation, the policy manual provides the following directives:

> **Child Protection Services (CPS) are specialized services designed for intervention in family situations where a child is under the age of 16 and in need of protection.**

Their task is to ensure the safety of the child, while fulfilling the requirements of the *Child, Youth and Family Services Act* in accordance with the "least intrusive" principle:

> **The primary goal of the CPS is to ensure adequate care and protection for children within their families.**

However,

> **the provision of family support services is an essential component of child protection and must be considered before a decision is made to apprehend.**

Additionally, the standards, incorporated in policy do include recognition of the fact that the child's safety may be secured by placement with family members other than the parents:

> **If the need for protection is established then it must be determined how this protection can best be provided:**
> - **in the child's own home;**
> - **with the assistance of a relative, family members, friends, either in the child's or relative/friends' home;**
> - **or substitute care (foster care, group care).**
>
> **(Policy Reference No. 02-01-01).**

In this next section I address the way in which the Province of Newfoundland and Labrador deploys its personnel in order to accomplish these policy aims. In other words, how is the organization structured? I then conclude with a summary of the social work intervention.

4.2 Organization for delivery of child welfare legislation and policy

This description refers to the structure existing during the years 2000-2003. Then, as now, child welfare services of Newfoundland and Labrador existed within a somewhat complex structure governed at the ministerial level within the Department of Health and Community Services. Both legislatively and organizationally, there is a two-tiered structure at the provincial and regional levels.

4.2 (a) Provincial structure

The Department of Health and Community Services is described in the Government's web site as providing

> **a leadership role in health and community services programs and policy development for the Province. This involves working in partnership with a number of key stakeholders including regional boards, community organizations, professional associations, post-secondary educational institutions, unions, consumers and other government departments.[26]**

To fulfill that role, it has a number of branches, each under the direction of an Assistant Deputy Minister. The CYFS Program resides within the Community Programs and Wellness Branch. The professional staff include the Provincial Director, who also carries responsibilities legislated by section

5 of the *Child, Youth and Family Services Act*, a Child, Youth and Family Services consultant, an adoptions and foster care consultant, and two program and policy development specialists.

I understand from discussion with the Provincial Director that the duties of the consultants and specialists are related to her office's responsibilities and rarely are there direct contacts with the field. Primary duties appeared to be concerned with the setting of policies and standards. Representatives from regional boards (part of regional integrated health authorities since 2005) are recruited to committees organized to deal with particular issues. One example is a committee struck to assist with implementation of the new computerized Client Referral and Management System (CRMS).

Before regionalization of Health and Community Services, and certainly under the provisions of the former legislation, the Provincial Director had overall centralized responsibility for the protection of children. That changed and functions and responsibilities were decentralized and devolved to the Regions (the Health Boards), and now to the Integrated

Health Authorities. The Provincial Director no longer has line authority over the Directors in Region. Nevertheless, even today, the Provincial Director has significant powers that would enable her to exercise a certain amount of influence over activities at the regional level. That influence lies within section 5 of the *Act* under which she is responsible for:

- **establishing province-wide policies, programs and standards;**
- **monitoring, evaluation and research of the established policies, programs and standards;**
- **a province-wide, computerized child, youth and family service information system.**

The Provincial Director informed me that, of the consultants and specialists identified above, the equivalent of 1.5 positions assist her with these responsibilities. The latest budget (2006) provides for more support. Otherwise, when the need arises, external consultants are hired for specific work.

According to the Provincial Director,

> **under the former structure when it was a line department, there were a lot more people in the structure to support the work of what we knew as traditional child welfare. And to bring it down to 1.5, it became very quickly the realization, as early as 2001, that wasn't enough to support the Director. So in this**

> **year's budget I am pleased to say that we do have some additional resources coming.**

Apparently the Provincial Director has considerable optimism about the ability of CRMS to meet the section 5 responsibilities:

> **I think the vision of how you would carry out responsibilities is that there would be some ability through evaluation and monitoring and some of that would come as a result of the work that we're doing to develop our computerized system.**

I would caution the Provincial Director, however, that excitement about CRMS ability should not distract line workers' attention from their clients' needs. In correspondence from one of her consultants, I learned that the amount of time social workers spend at the computer is a concern. The same correspondence alerted me to the distractions and extra burdens imposed when a system is implemented before being fully tested and having "bugs" taken out. Governments are placing increasing reliance on the transition to a more computerized information system. While it may mean significant improvements in how data is recorded and managed, there is a serious risk that the trade-off may be at the expense of direct services to clients.

In that respect, I am mindful of the findings of a 2002 Social Work Workload Review conducted for the Department of Health and Community Services.[27] The results of that review suggest to me that if there is work overload, then it has to do with administrative or bureaucratic demands rather than caseload size. I note that only one-third of all time is spent in direct contact with clients. Hence, my caution to the Provincial Director is that her plans to monitor "compliance with standards" may in fact lead to poorer outcomes for the children and families served. One of the values of the "Looking After Children" assessment and action method that has been recommended by the Minister's Advisory Committee[28] is that it monitors through direct interaction with children and their caregivers, thus increasing client time. It has also been proven to lead to better outcomes for children.

Although she no longer has line authority, section 3 of the *Child, Youth and Family Services Act* does provide the Provincial Director with some implicit authority over the Directors in Region:

> **Where, as a result of a report of the provincial director, the minister believes that a director is not carrying out his or her duties and responsibilities in accordance with this Act or the policies established by the provincial**

> **director under paragraph 5(a), the minister may direct the board which employs the director to take remedial action or other action the minister considers appropriate, and the board shall comply with the minister's direction.**

I understand that there are regular meetings between the Provincial Director and the Directors in Region. Presumably this allows the Provincial Director some opportunity to monitor the activities at the regional level.

More generally, the Provincial Director can be involved in a consultative capacity. In the case of Dr. Turner, there was some direct interaction early on with the person who was Provincial Director at that time.

> **The first contact with the Provincial Director on this file was when she contacted me [said a Regional Director]. And that was, you know, within a day or so after I had become involved in the matter [that is, after a visit from the Bagbys' lawyer on 17 June 2002]. And I recall when I got the phone call, thinking, you know, yes I was going to discuss this case with you and, coincidentally, here you are now already involved.**

Dr. Turner was very skilful in engaging various professionals. The way in which the contact with the former Provincial Director came about is just one illustration of how she was prepared to use everybody and anybody in providing

her with support. Indeed, she was very skilful in her attempts to create an image of a thoughtful and caring mother.

As I heard from a CYFS Director in Region:

> **My understanding is that she [the former Provincial Director] received a phone call at home from a relative of hers who was somehow indirectly connected with someone who was connected with Shirley Turner. And the information was that Shirley had been advised … by [the Director of the Newfoundland and Labrador Human Rights Association] to make contact with … [that official] to have a discussion around plans for her unborn child in the event that she was not available to parent him.**

There did, apparently, ensue some further contact between Dr. Turner and the former Provincial Director.

> **I think … [that official] had several phone conversations and a meeting, a face-to-face meeting, I believe.**

Details of such contacts do not appear in the records. Information supplied to me by the former Provincial Director clarified that there was one meeting in June 2002 in which Dr. Turner

wanted to be familiar with all services that may assist her in meeting the needs of her son.

The telephone calls to arrange the meeting were from a friend of Dr. Turner's. A final call to the former Provincial Director from this friend in the early months of 2003 was to confide that trying to assist Dr. Turner was causing stress and conflict within her own family. She was advised to put her own family's needs first.

If one subscribes to the concept of "centralized accountability with decentralized responsibility," then one of the major questions which arises is "who was in charge of what was happening?" One of the problems that I encountered was determining who ultimately was in charge and accountable for what had happened. And no one seemed to take responsibility for the outcomes. Yes, individuals were upset and sad when Zachary was murdered, but what was really confusing was the limited sense of accountability in terms of the hierarchy and lines of authority. Was it the worker, the supervisor, or the Director in Region at the Board; the Provincial Director, the Board's Assistant Executive Director, or who? Was it all of them or none of them? Was there an abandonment of traditional bureaucratic or

organizational management models? Was the Director in Region who legally had responsibility for protection of the children really in charge? What was the function and involvement of the Board's Assistant Executive Director in Region? There were no clear answers.

I also had difficulty in getting an accurate sense of how communications were transmitted within the departmental or regional hierarchies. Outside of the "internal departmental review" prepared in 2003 for the Minister,[29] I had problems learning just how much even the Minister knew about the Turner case. This certainly has not been my experience with provincial departments in other provinces where the Minister, if briefed, knows what is happening in high profile cases on a day-to-day basis.

4.2 (b) Regional structure

At the time of the Review events, six regional health and community services boards were responsible for child protection, according to the provisions of the *Child, Youth and Family Services Act*. Each board had the responsibility of appointing a Director of Child, Youth and Family Services,

usually referred to as Director in Region, in accordance with section 4 of the legislation. Although that Director had, and continues to have, overall responsibility for these services, she herself was subject to two levels of authority: the Chief Executive Director and the Assistant Executive Director for the Region.

While the Director in Region of CYFS was, and is, responsible for all the duties and responsibilities defined by the legislation, the actual line authority for social workers exercising those duties on her behalf was in the hands of a person serving the role of Regional Director of Services. Both Directors reported to the Board's Assistant Executive Director, Client and Organizational Services.

At the next level are local manager/supervisors reporting to the Regional Director of Services (not to the Director in Region of CYFS). They in turn supervise the CYFS front line workers.

4.2 (c) Senior management

This structure and the legislation were both relatively new at the time of these events. I was informed that this initially caused some confusion with respect to the roles of the legislated Director in Region of CYFS and the Regional Director of Services in St. John's Region. As the Director in Region herself said

> **There's a lot of concern about how the role of the Director in Region is going to play out, how it's going to look, what reporting structures are going to be like . . . it's always simpler when you have line authority and you know who you're reporting to;**

and from a CYFS manager,

> **There was some role confusion … It seemed to me that as time evolved, the supervisors …responsible for guardianship of children in care …, gravitated to speak to [the legislated Director in Region of Child, Youth and Family Services]. And the supervisors that were doing protection work for the most part would have gravitated to [the Regional Director of Child and Family Services, the line manager].**

I did not detect any formal effort to resolve the role confusion. Nevertheless, as far as I can tell, this confusion did not impact on the course of events in the Turner file as the two Directors were in collaborative communication with one another. I can only surmise that, if the chain of command had

been simpler, a clearer direction might have been transmitted to the workers intervening directly with the family, as well as there being a follow-up to the assigned tasks.

According to the records, the Chief Executive Director of the Board was not involved at all. The Director in Region of CYFS reported to the Assistant Executive Director of the Board and periodically briefed him with respect to issues surrounding work with Dr. Turner:

> **As a matter of my practice, I believe that I would have informed [the Assistant Executive Director] of the fact that we were involved and the nature of the involvement at that time.**

When asked whether she continued to brief or inform him of the progress of this file from time to time, the answer was "yes" and that these briefings were verbal. No records at all were kept of these contacts and an affidavit, from the person who was the Board's Assistant Executive Director at that time, refers only to events after Zachary's death. Thus, I have no information regarding any advice or consultation he might have provided.

The other senior staff members involved in the Turner file were two manager/supervisors, one who supervised the short-term assessment worker and another who supervised the long-term protection worker. Actual reporting lines for regional line manager/supervisors - ten in all - were to the Director of Services. However, they are able to approach the Director in Region of CYFS for consultation. For this purpose, the latter maintained an "open door" policy.

It is important to note that, parallel to all of Child, Youth and Family Services' involvement, there was intense media coverage with respect to the circumstances of Andrew Bagby's death, the charges laid by United States police and the request for extradition of Dr. Turner. In the absence of any other information, I assume that this might have been the reason for periodic briefing of the Board's Assistant Executive Director.

Dr. Turner was already in contact with the Department of Human Resources, Labour and Employment (HRLE) for income support as a result of her application on 14 January 2002 (see Chapter 9). A transfer to long-term financial assistance was arranged about one month later. Her first contact with the Board's CYFS, other than a brief contact in

February, was on 25 March 2002, expressing concerns about her younger daughter's father. This was deemed to be a custody matter. Normally CYFS will not get involved in such situations. She did, however, engage with the Board's Health Services, applying for the Healthy Baby Club and a breast-feeding support group.

Although she obtained legal custody when she divorced each of her two husbands, Dr. Turner kept her children of both marriages for only a few days after the divorce from her second husband in 1997. Then in medical school in St. John's, she had asked her two former husbands to take over their children's care. So the younger of Zachary's half-sisters had been living with her father for most of her life until, at her mother's request and against her father's advice, she visited her mother on 29 March 2002, and then stayed and lived with her. It is relevant to the unfolding of this story that Dr. Turner's older daughter, then living in Ontario, had also joined her mother on 29 March 2002. The presence of the two daughters increased the amount of income support to Dr. Turner and also provided Dr. Turner with eligibility for a larger apartment. Dr. Turner told HRLE that the older daughter returned to Toronto on May 1; however, the daughter

herself explained that within a week she left - in early April 2002 - because of 'rows' between her mother and her, and being slapped by her mother.

On 10 April 2002, the day before a custody hearing initiated by her second ex-husband because their daughter did not return to him after an agreed visiting period, Dr. Turner tried again to engage CYFS, this time with respect to her younger daughter's "emotional needs." Once more she was told that this was a custody matter. She then alleged that the child had been struck by her stepmother and emotionally abused by her father. The custody hearing on April 11 was adjourned in order for Dr. Turner to obtain counsel through Legal Aid, but the judge granted "liberal access" to her ex-husband.

On April 16, following up on the report made by Dr. Turner with respect to the alleged abuse by the child's stepmother and father, CYFS registered a complaint with the RCMP and arranged counseling for the child through its Family Services program. It was determined that the alleged physical abuse was inappropriate discipline. The child herself did not see it as abusive. Further, she denied Dr. Turner's

allegations that she had been forced to stay in her room for several hours as her father tried to persuade her, in March 2002, not to move to St. John's. On the contrary, she explained that she was free to leave throughout.

However, Dr. Turner was persistent in obtaining services. On 01 May 2002, she had a third party make a referral to CYFS on the basis that she was very upset and wanted to develop a plan of care for her unborn child.

The Director in Region informed me that she was alerted to the Department's involvement by both the Regional Director of Services and the Provincial Director in June 2002. On 17 June 2002, she received a visit from Jacqueline Brazil, legal counsel for David and Kathleen Bagby. Although she never categorized this visit as a "referral," during its course she was made aware of several issues that might point towards a need for child protection. The issues identified were that Dr. Turner:

- experienced problems, including mental instability, while at medical school;
- had a series of relationship problems;

- was charged with a pre-meditated murder in Pennsylvania; and
- had not been a full-time parent to her three older children in the past.

She also had some awareness of Dr. Turner's marital breakdowns:

> **Yes, we had some information related to the marital breakdowns. We didn't have a lot of detail but we certainly knew that there were difficulties related to parenting. Her availability, her work, her studies. We knew about those issues and those stresses that were present in her relationships.**

She was never aware of allegations of past physical abuse of the two oldest children in 1993.

As a result of Jacqueline Brazil's visit, the Director in Region did immediately convene a meeting with the Regional Director of Services and the short-term assessment social worker (whose manager was not in the office that day and so was not part of the briefing).

The following directions were given to the worker:

- that there be an interview with Dr. Turner's younger daughter;
- that she obtain permission to interview, and interview Dr. Turner's psychiatrist;
- that she contact the RNC to see whether Dr. Turner posed a risk to herself or her unborn child;
- that permission be given to contact the young daughter's counsellor and assess progress; and
- that there should be a full assessment of Dr. Turner's parenting and the impact of current stress on her ability to parent.

The Director in Region also stated that she had requested an in-depth inter-generational analysis of Dr. Turner's upbringing, as well as contacts with other siblings and family members:

> **I think the other significant outstanding piece that wasn't followed through for me was the in-depth inter-generational or analysis of her upbringing, as well as the contacts that I had recommended with the other siblings and family members. That would have been significant information to have obtained.**

However, there is no formal file record of these requests, although it was acknowledged with hindsight that these requests, if performed, would have provided significant information. Nevertheless,

> **Based on what I knew at that time, I do not think that there was anything available to us that I could have done differently. That's based on that time.**

The apparent intentions in carrying out these directives were to determine the degree of risk and promote the possibility of moving to protective intervention. Certainly, as indicated earlier, I was told that at the management level there was a determination of protective concerns. However, Dr. Turner and her children continued to be served under section 10 of the *Act* (Family Services). If Jacqueline Brazil's visit had been identified under the *Act* as a section 15 protective intervention "referral" thus requiring, under the *Act*, full assessment under section 16 of all the information she provided, one might expect there would have been a more rigorous investigation.

There were two factors, possibly three, that militated against this:

1. This was not considered to be a child abuse complaint or 'referral.' The CYFS Director in Region said:

   My understanding primarily from that meeting was that she wanted me to have that information and to consider it in the event that we were deciding to remove the baby from Shirley Turner's care upon birth.

2. A request for confidentiality. The Director in Region said:

   She [Ms. Brazil] did not want Shirley Turner to find out the intent of the Bagbys.

3. It is also possible that other sections of the *Act* were not invoked because, with the existing section 10 classification, there was an assumption that the situation was being monitored.

Nevertheless, this visit from the Bagbys' lawyer was clearly intended to raise concerns about the expected baby's safety. I had some very frustrating moments when asking the question: "When is a referral, a referral?" For the most part, I simply could not get any clear answers in the interviews with

senior management or supervisors. The one definition that was given to me was:

> **A referral would be, a referral would be information that was called into an in-take worker or any social worker or anybody working within the program, I guess, professional person in the program, to outline or describe what that person believed was a situation where a child was at risk. So we would refer to that information as referral information and it would go on a Child Protection Report so that would be what a referral is.**

Overall, it seems that the key influential factors in how Dr. Turner was dealt with were, in the words of the Director in Region:

> **She was a client who voluntarily was involved with us, who willingly accepted services, who willingly accepted every announced and unannounced visit that was done by us, who signed every consent that I asked her to sign; who, you know, participated in the sharing of information with us. So that makes the situation a little different from most other classical child protection cases.**

In hindsight, I can say that Dr. Turner knew how to "play the game." This apparently made all the difference in ensuring that there was never a formal categorization of her children being in need of protective services.

The policy is clear with respect to protection concerns. Senior level personnel appeared to consider the Turner situation to be that of actual or potential protective intervention, although the lack of a 'referral' (whatever that was) seemed to limit activities. Here are examples of what various senior personnel told me:

> **Given what we already knew about this situation, about the various charges, and the other family dynamics that we were aware of, we had, you know, I would suggest that we had already made the decision - that we were going to consider this as on ongoing long-term protective intervention file.**
>
> **Her role was to assess; yes, I'm going to provide support to Ms. Turner and that young girl . . . and to determine whether or not it was appropriate for follow up in long-term protection which obviously it was.**

Although:

> **I don't know that we placed a whole lot of emphasis on whether or not - to speak specifically to this case - whether or not this was a family services or protective intervention case.**

And with respect to Family Services (under section 10 of the *Act*):

> **It's a voluntary service and any time the family can withdraw our services from, you know, anything that they once said they required from us, they can say, 'No, I'm sorry, I don't need your involvement anymore,' which is quite different from protective intervention.**
>
> **The file, you could assign it as a 10 and go out and find out that there are protection issues, that <u>if this is not purely voluntary service</u>, then it could be changed at any point in time along the way [emphasis mine].**

There is no written evidence, nor was I told by workers assigned at the front line that they were aware this referral was to be treated as protective intervention.

Recommendation 7.11

THAT the Director in Region of Child, Youth and Family Services be responsible for both line and legislated authorities, to ensure effective and efficient formal lines of accountability and communication.

Recommendation 7.12

THAT where there is an open file related to a matter under the *Child, Youth and Family Services Act*, all activities and/or discussions pertaining to it shall be recorded on that file, no matter at which level they occur.

In order to provide the most effective services, it is extremely important that the assigned worker know and have access to all current, accurate and concise information pertaining to an active file. All activities (including discussions) under the *Child, Youth and Family Services Act* must be recorded on that file, no matter the level at which they occur. In this way, any worker carrying the file will be privy to opinions and concerns expressed at a more senior level.

4.2 (d) Middle management

The internal review of the involvement of CYFS shortly after Zachary's death[30] reported that the initial assessment worker had

> **several consultations with . . . the Regional Director of Child, Youth and Family Services, and . . . Director of Child and Family Services.**

It further states that:

> **Social worker (long-term protection worker) had on-going clinical consultation with her supervisor.**

I have no reason to doubt this. However, preferred practice would be to include the content of such consultation in service

notes or, at the very least, in quarterly case-notes summaries (See Recommendation 7.12). I did find that the assessment worker herself recorded some contacts with senior management but they seemed more in the nature of passing on information than of actual consultation. Overall, the assessment worker's supervisor had minimal contact with the file. She was out of the office when the Director in Region of CYFS called a meeting after the visit from the Bagbys' lawyer, and was on holiday when the file was transferred to the long-term protection worker. In addition, she seemed unclear about reporting channels. When asked, her reply was:

> **I don't remember exactly. I mean its common practice that I go to whoever was there [See Recommendation 7.11].**

To return briefly to the issue of service notes - more particularly, lack of notes - from supervisors, an example of significant gaps that can occur was the absence of any record of a critical call made to the legal counsel responsible for prosecuting the extradition proceeding. A supervisor testified:

> **I wanted to know what the process was around extradition, you know, what their plans were, the time frame, how long she could potentially be in jail for because she had advised all of the information that she**

knew, but I felt that it might be important to clarify just to make sure. I mean we were helping to sort of clue up plans for the baby.

This information was not a part of the record. The worker, who was meticulous with her own records, noted that her supervisor was to make the call but wrote, "See her case notes for details." Nowhere did I find any such case notes.

I heard from the supervisors of the frontline social workers dealing with Dr. Turner that their major work was clinical supervision. In my opinion, it would be helpful to have that evidenced in service notes. There would be benefit in periodic review of case plans with tasks and timelines identified. In the assessment phase, some of the assessment tasks lapsed over time and some were never recorded as such. In long-term protection at CYFS, the establishment of a clear child-centred focus with specific tasks outlined would have assisted the case worker and, most importantly, enhanced planning for the children. In the absence of clearly specified goals, it appears to me that Dr. Turner was the director of the interventions.

Focused, child-centred work would promote a more proactive type of intervention. As it was, it appeared that child protection work in Newfoundland and Labrador, as elsewhere, tended to be reactive and episodic. Early in my investigation, I consulted at a round table with three experts in another province, all of whom have served on the Board of the Canadian Association of Social Workers. One of them had this to say:

> **One of the patterns that we see is child welfare dealing with each incident as a separate incident . . . and not going back and saying there are a series of things that have happened.**

A clear example of this type of practice is illustrated by the response given when a CYFS supervisor was asked in my Review whether,

> **When the Turner child was born, the child should be simply removed . . . was there ever a discussion between you, in any respect surrounding that?**

The response to this question was:

> **No, I mean the baby wasn't born.**

Another example of reactive rather than proactive practice is the comment that:

> **In this case I didn't have a referral, nobody, if you look in this file there is one referral on file. Actually, two, one is screened out and the other one in … a referral that Ms. Turner made.**

It is a curious fact that this reference to not having a referral came up over and over again in the course of my inquiries. It appeared there was a presumption that, unless someone external to CYFS made a complaint, then there was no cause for action. A further curious fact is that the possibility the children's mother was capable of killing somebody was not considered a risk factor. One CYFS professional employee testified:

> **The criminal matter, I guess, was left with the police and with the Crown to deal with. We weren't aware that there was any child protection issues that were, you know, hidden in all of those things . . . so I didn't make any attempt to get any other information.**

In order that child protection interventions attend to the best interests of the children, all possible sources of information need to be investigated. There should be established long-term, as well as short-term, goals that take

into account all possible scenarios, from the best to the worst case. If not, any chance of permanency planning - a key concept in child protection - is delayed too long.

There were indications that the CYFS supervisors felt overloaded:

> **I think that I managed the best I could. However, the Child Welfare League of America would tell you that a child protection worker should have no more than 17 cases. I don't believe that I had any worker with that low of a caseload. They all generally, like I said before, had about 25 cases each. A supervisor should only have seven staff and at that time I had ten.**

Manager/supervisors had other responsibilities, including committee work at the provincial level, over and above supervision of the workers in their CYFS unit.

One issue of major concern is that of coverage during supervisors' or workers' vacations. The fairly intensive involvement of the worker with Dr. Turner ceased after a home visit on 05 August 2003 because of social worker vacations. Her daughter's counsellor was also on leave. There is no recorded mention of these facts, or whom to call if an

emergency arose. I was told by a supervisor that when somebody is off for whatever reason,

> **the case load management would then become the responsibility of the program manager, program supervisor. With that person you would decide what was urgent or not.**

However, during the two weeks prior to the deaths of Dr. Turner and Zachary, there was no monitoring or support provided.

Recommendation 7.13

THAT when a child comes to the attention of CYFS as possibly in need of protection, the responsible worker be proactive in thoroughly and expeditiously seeking out and documenting all relevant sources of information.

Recommendation 7.14

THAT policy be clearly established that part of the manager/supervisor's mandate and responsibility is to assist the worker carrying a file to establish long-term as well as short-term goals. The goals must be translated into specific tasks, with projected time lines attached, to enable periodic reviews of outcomes.

Recommendation 7.15

THAT when a worker responsible for a child entitled to any service under the *Child, Youth And Family Services Act* is on leave, or absent for whatever reason, another worker must be assigned and the persons responsible for the child's care be informed of the name of that person to ensure constant monitoring of the child's safety and security.

4.3 Direct service delivery

In this section I take a critical look at work at the front line. The purpose, as stated elsewhere in my Findings, is not to assign blame, but to ascertain what it is about the activities at that level that can contribute to the failure of a system. Such a critique is essential in order for this Review to have a positive effect.

At the round table discussion referred to earlier, one of the experts had this to say after hearing a summary of events:

> **From a professional practice perspective, what you are describing is unskilled child welfare practice.**

While it looked like that through the 20/20 vision of hindsight, my own observations did not warrant such an indictment. What I did see was extensive social work that was not inherently unskilled but was affected, indeed attenuated, by the following influences:

1. the organizational culture;
2. caseload management issues;
3. incomplete knowledge of all the relevant facts;
4. erroneous assumptions about who was the client;
5. restrictions imposed by the "least intrusive" principle, with a failure to recognize the complex nature of contemporary families; and
6. assumptions with respect to restraints imposed by confidentiality.

None of these is discrete in itself. Each affects the others. However, I will provide a brief explanation of each in turn.

1. The organizational culture.

Social work in child welfare and child protection is complex, demanding and time consuming. Despite its importance in its mandate of ensuring the safety and security of Canada's children, it is practiced in a relatively unsupportive community environment. Because of confidentiality issues, an aura of secrecy surrounds its activities. The general public only hears when things go wrong. The organizational response is either to defend its performance or else to find a scapegoat. Neither reaction is helpful in gaining public support or in sustaining morale at the level of direct practice.

One common defense is work overload. While there is certainly an element of truth in this, the very defense becomes a self-fulfilling prophecy. The somewhat negative external climate is matched by an internal culture of feeling sometimes disempowered and undervalued - certainly overburdened. Dr. Turner's long-term worker told me:

> **The volume of the caseload is high. There are a lot of confusing demands on your time as a social worker. Every day it's about balancing priorities.**

This both affects and is affected by an approach to the work that is crisis driven and, as I noted above, reactive in nature.

Further, this question of overload did not seem to be a major factor for her, given her ability to respond readily to any and all of Dr. Turner's demands. The front line assessment worker felt competent to deal with a caseload that she believed could range from 15 to 30. And she told me that supervisors were helpful:

> **There are times when I'm not able to handle the amount of crisis that presents itself each day, and there are times when I have to go my supervisor and say, 'I'm not able to do this . . .' When I go to a supervisor to say that I'm having some difficulty managing due to the amount of crisis or the amount of every day work coming at me directly, part of my job and my supervisor's job is to sit down and prioritize what work needs to be completed first, and to assess the level of risk to children, and to use my own clinical skills to decide what has to be completed first. I do this jointly and if there are things that I'm not able to complete because of time, then it becomes my supervisor's job whether or not to delegate that to some other social worker.**

What most definitely did seem to be a factor was the reactive approach to the task. Dr. Turner was the beneficiary of quite considerable social work attention; more often than not, this was in response to calls from her. She invariably

received a quick response. Attentive as the workers were to her, the core issues of the safety and long-term planning for Zachary and his half-sister seemed to be secondary to meeting Dr. Turner's needs. This echoes the findings of the Gove enquiry in British Columbia in 1995 into the death of Matthew Vaudreuil. A great deal of attention was given to Mrs. Vaudreuil at the expense of protecting Matthew, with tragic results. The same dynamics, as I mentioned before, contributed to the death of Jordan Heikampf. In fairness to the workers involved, there was a difference in the Turner case in that Zachary appeared to be thriving and his half-sister was content to be with him and her mother.

I would surmise that there was a degree of stress for Dr. Turner's worker who evidently felt enough responsibility for this woman's well-being that she responded quickly whenever she was called. A problem with reactive social work such as this is that, without a clear set of goals and objectives, there is an absence of the intrinsic rewards that arise from goal achievement.

2. Caseload management issues.

The prevalence of a crisis-driven reactive approach contributes to problems in case load management. Consideration of Parkinson's famous law,

> **"work expands so as to fill the time available for its completion"**

helps explain why this is so, especially when one considers the corollary that we expend 80 percent of our time on the trivial many tasks, leaving 20 percent for the vital few. If work is not planned proactively, then it is not at all surprising that the conscientious worker will be responsive to whatever episode or crisis emerges in the course of the day. This may well be to the detriment of other needs elsewhere in the caseload, but so "… the work expands …" Effective caseload management requires a small amount of time allocated to the vital task of developing clear case plans and goals for all children on the caseload. In this way, priorities can be established for each child and the caseload managed accordingly. Such purposeful planning should reduce the number of crises. It is also likely to assist in more effective time management. Most importantly, it should contribute to better outcomes.

I have no way of knowing what the other caseload demands were on the time of Dr. Turner's worker. However, I did note that the caseload did not seem to be a deterrent to responding quickly to Dr. Turner's calls, and even having time to take the young daughter to her counselling sessions. A more planned approach to the children's needs might have allocated time to researching the crucial subject of Dr. Turner's own background and emotional state, as well as the weight of evidence against her.

I have noted that the Bachelor of Social Work (BSW) curriculum includes case management, but does not appear to address caseload management.

Recommendation 7.16

THAT mandatory in-service training which incorporates skills in caseload management and time management be developed and delivered to supervisory and direct service personnel.

3. Incomplete knowledge of all the relevant facts.

A great deal of information existed about Dr. Turner that could have shifted any concerns about Zachary into a high risk category if he were to remain in his mother's custody. They included the serious nature of the charges against her; in particular, that this appeared to meet all the criteria of a coldly premeditated murder, accompanied by meticulous planning, not only with respect to its execution but also with establishing an alibi and a flight plan. The presumption of innocence and proof beyond reasonable doubt are appropriate in criminal proceedings. In matters of child welfare, decisions must be made on the basis of probabilities, dedicated to the protection of children.

Apparently unknown to the workers was the occurrence of at least one previous suicide attempt, and a suicide watch endorsed by a physician and a psychiatrist during Dr. Turner's incarceration in Clarenville. Personnel in the Newfoundland and Labrador Correctional Centre for Women in Clarenville, and the doctors visiting there, had the potential to be useful informants, as did Dr. Doucet. The very fact that Dr. Turner had regular sessions with a psychiatrist, coupled with the information that she was being medicated for an emotional problem of some kind, ought to have heightened concern about

her parenting ability. Even her self-confessed slapping of her younger daughter in June 2003 did not seem to alert her social worker to the fact that she might be reaching the limits of her endurance in dealing with her stress.

Indications of some type of personality disorder could be gleaned from exploring earlier relationships in medical school, as well as current complaints of harassment lodged with the RNC by a man she had met since she moved back to St. John's in 2001. With respect to parenting capacity, it is surprising that no valence appeared to be attached to the fact that Dr. Turner had, early on in motherhood, decided not to parent her other children. Her refusal to acquiesce to her youngest child's request to come and live with her, once established in her career in the States, is a strong indicator to me that her children's interests were not high priority to her. It is certainly of concern that knowledge of the earlier complaint of physical abuse of her two older children (in 1993) was obscured by her name change.

It is very important that the new computerized system now in place (CRMS) includes identifying markers such as date of birth, SIN number and the like, thereby ensuring that

prior complaints are not lost. I have been told that some older records (some, at least, on index cards) are not at present recorded in the computer system, nor is there a plan to do so. It is imperative that no prior records of child abuse are lost or overlooked. Such was the case in the murder of little Jeffrey Baldwin in Toronto.[31] I have already noted how a prior allegation against Dr. Turner in 1993 was missed.

Greater emphasis should be given in practice to Policy Reference No. 02-02-03, and particularly to the following:

> **The Child Protection Social Worker shall however, when actioning the referral, consult with/elicit the cooperation of other professional and community resources. This will serve to minimize any negative consequences brought about by the involvement of several agencies and to maximize the potential for intervening effectively in order to best serve the child and treat the family.**

Recommendation 7.17

THAT all assessment workers be provided with ongoing and regularly scheduled in-service training on the meaning, the importance and the implementation of Policy Reference No. 02-02-03 (Coordinated Response).

Recommendation 7.18

THAT <u>all prior records</u> of child abuse and neglect, currently held on card indexes, be transferred to CRMS as soon as possible and be easily accessible to all CYFS staff.

Recommendation 7.19

THAT all child abuse and neglect records include sufficient identifying information such that a name change will not result in their being overlooked.

4. Erroneous assumptions about who was the client.

During the course of my inquiry and investigation, I have been inevitably reminded of British Columbia's high profile Gove Inquiry that had this to say:

> **Matthew's story is filled with examples of decisions based on social workers' self-interest, Verna Vaudreuil's interest or the ministry's interest, rather than Matthew's interest. If those decisions had been child-centred, it is likely that Matthew would have been taken into care, either by apprehension or by agreement.[32]**

As in British Columbia, in Ontario and elsewhere, child welfare services in Newfoundland seemingly on occasion also

lose sight of who really is the client. In Zachary's case, I did not see any evidence that workers' decisions were based on their own or their employer's interest. On the contrary, I observed dedicated professional social workers caught up in systemic issues and losing sight of the fact that the primary client was, and always should be, the child. However - I will say it again - the interests of the mother directed interventions and activities at the cost of overlooking those of her child. **Nowhere did I find the question asked: "What is in the best interest of an infant whose mother is facing a lengthy period of incarceration and court proceedings that are likely to be protracted?"** Nor were there questions raised about whether Zachary's half-sister's move to St. John's in March 2002 (and again early in 2003), disruption of her schooling, and spending some time alone in the apartment in November and December 2002 during her mother's temporary incarceration, were designed in her best interests or for her mother's interests.

5. Restrictions imposed by the least intrusive principle.

The "least intrusive" principle is a major contributory factor in this displacement of end goals. Without doubt, if the

decision is to provide family support to ensure the child's safety, then attention does have to be paid to the parent's needs, **but not at the expense of long-term planning for the child.**

In the Turner case there were two factors that exacerbated the problem. One was the absence of policy to direct activities under section 10 of the *Child, Youth and Family Services Act*. The other was a failure to recognize the complex nature of contemporary families. The concept of what constitutes a family unit has been undergoing dramatic changes over the past three decades. In today's society, marriages fail and the effects (both legal and emotional) of such events on all concerned are profound.

Grandparents are increasingly recognized as having a legitimate interest in their grandchildren. To confine family support to Dr. Turner only was unduly restrictive. This again relates to who in fact is the primary client. Truly child-centred practice would include all those with a legitimate claim to, and interest in, caring for a child. Further, there was an uneven bias here in favour of mother to the detriment of fathers. This is all the more disappointing in that her younger daughter's

father had been her primary caregiver for practically her whole life; yet he was never consulted or, for that matter, supported in determining what was best for his daughter. A request to have him relocate to St. John's temporarily to care for his daughter in November and December 2002, rather than returning her to his and his wife's care, was unrealistic in the extreme.

A further indication of bias was the very different reactions to Dr. Turner's allegations of abuse in April 2002 against her ex-husband and his wife, and her self-disclosed hitting of her daughter in June 2003. If the latter had been reported to the RNC, joint discussion of potential risk might have been enlightening. **Yet it seems that an assumption was made that the police would not be interested.** At the very least, it should have prompted the need to be more proactive in consulting with Dr. Doucet about current stress levels.

However, there was never any parenting assessment carried out on any of the interested parties, including the paternal grandparents, the Bagbys.

In keeping with worker assumptions about least intrusion, planning for Zachary was assumed to be solely the purview of his mother. His father was dead and his mother had been charged with the murder of his father. His only paternal relatives were his grandparents (the Bagbys) who, having lost their only child, had an even more compelling interest than most grandparents. Yet they were never approached, consulted or even supported. They thought they had made a 'referral' through their lawyer. Internally this apparently was never viewed as a formal referral.

6. Assumptions with respect to restraints imposed by confidentiality.

One activity that could have overcome these various influences would have been an inter-disciplinary case conference. Despite the fact various agencies were involved, this was never envisaged. Assumptions about confidentiality appeared to be the deterrent as suggested by the comments of an assessment worker:

> **…by the nature of the fact that a client has a right to confidentiality; that I would not necessarily go up to a, their family doctor just by doing that then the assumption is that they are involved with my agency.**

> **So in terms of their confidentiality, I wouldn't necessarily do that.**

Another worker, when asked directly why there was no inter-disciplinary case conference, stated the following:

> **There were probably a few reasons for that, one being that it wasn't an action that Shirley Turner necessarily wanted. She didn't ask that there would be a conference, a case conference - which would have caused some difficulty in terms of confidentiality [emphasis mine].**

In the absence of child-focused case work, Dr. Turner seemed able to become the case manager herself. Client empowerment is respected within the profession but, where a child is the true client, the child protection worker must be in charge. Zachary is another victim in the long litany of children who have died at the hands of their caregivers, despite the presence of child welfare services intended to protect them.

As a footnote to this discussion of how services were and are delivered, I detected some slippage or inaccuracy in important record keeping and file transfer. A referral was made by St. John's Region to Western Region on 22 August 2003, a few days after the occurrence of the murder/suicide. It

was a very appropriate referral in response to the stepmother's request for counselling for her stepdaughter (Dr. Turner's second-marriage daughter) in order to deal with her grief and anger over events.

The referral by the St. John's Director in Region to the Acting Director in Region in Corner Brook stated:

> **CYFS became involved with Dr. Shirley Turner in April 2002 when she made a self-referral indicating that her 12-year old daughter returned to her care and was refusing to return to live with her father and stepmother. . . . At that time there were custody/access issues being disputed between Shirley Turner and [former husband] with respect to [their child]. Shortly after, the referral was assigned for Supportive Services; Dr. Turner advised that while [the child] was living with her father there had been incidents of physical discipline and emotional abuse (See the attached Transfer summary dated July 19, 2002 for details and outcome of the assessment into these issues) [emphasis mine].**

In fact, the transfer summary states that this information was given by Dr. Turner in April 2002 when informed by the CYFS worker that CYFS "does not typically become involved in custody cases." Additionally, the transfer summary indicates how Dr. Turner's allegations were resolved. Of concern is the fact that biased information from Dr. Turner was still being

passed on with a potential result of clouding the real issues which this child had to face. The most serious of these was the fact that the mother, whom she had loved and supported, could destroy her own infant child. Along with this was the loss, for her, of the little brother to whom she had become attached.

Evidence-based practice requires that reports should be factually based. The reason for the referral was the stepmother's request that the child be given help in dealing with her emotional response to the tragic events. This should be clearly stated at the outset. Reference to the earlier complaint made by Dr. Turner, to be factually sound, would identify the findings, with the full cooperation of the child and her father and stepmother, that part of the complaint was incorrect and, respecting the rest of the complaint, the parents acknowledged an incident of inappropriate discipline.

Recommendation 7.20
THAT all reports be founded on fact to promote evidence-based practice.

4.4 Summary of social work intervention

It appears the premise upon which the activities of all the CYFS professionals were founded was that, since Dr. Turner was a voluntary family support services client, CYFS could not pursue any child protection interventions. Although the case was considered "unique" and "high profile," the consistent belief was that since CYFS had not received any external referrals or reports of child protection/child abuse, there was no basis on which to handle the case as a child protection matter.

Ironically, while on the one hand CYFS continued to handle the case under section 10 of the *Child Youth and Family Services Act* as a Family Services file, on the other hand, CYFS consistently rationalized that it was taking the same actions as if this had been a Child Protection matter. If this was the case, it re-emphasizes the concern I have that the child, as primary client, is overlooked.

CYFS never completed any comprehensive assessment, social history or analysis of Dr. Turner and her family. CYFS never sought important past history or background information as part of its intervention and case planning strategy.

There was no question that the assigned social workers, both in terms of the short-term assessment and the long-term supportive services, were conscientious, committed and caring in their intervention with Dr. Turner and her family. The effectiveness of that intervention was seriously hindered by the assumptions on which it was based and the failure to obtain and use key background information.

The interviews I conducted raised some serious questions as to the general practice with respect to supervision and the linkage of accountability within St. John's Region. The respective supervisors and senior management sometimes failed to provide the kind of quality supervision and focused direction which truly would assist the social workers to handle even the day-to-day crises in a far more effective manner. Often the supervision was described as being casual, on an *"ad hoc"* basis, going from one crisis to the next. Even though the Turner case was given a "priority" status and reflected an intensity of involvement by assigned workers, there was limited evidence that the social workers enjoyed the benefits of any in-depth supervision, discussion or analysis of the key dynamics or case planning. This resulted in an absence of clear goals, measurable objectives and planned evaluations.

When specifically asked whether she was approached for direction, one supervisor said:

> **I'm not sure that I could say she came to me and asked me for specific direction as to where should I go from here. However, our conversations were generally about where we are with what's happening with Shirley now, and what the next, I guess, what's expected to happen now and the work that she's done. And I really thought she was doing a fine job.**

One would anticipate that, given the seriousness of the charges of premeditated murder, the past history of broken relationships, the alleged incidents of physical abuse, the abandonment of child caring responsibilities while pursuing her medical degree and beyond, and past and continuing mental health problems, efforts would have been made to obtain some form of a deeper understanding of Dr. Turner. Yet, beyond relying on a subjective "ongoing assessment," no significant assessment or social history was completed. Indeed a CYFS supervisor had this to say:

> **…based on my ongoing work with Shirley on the information that I had and, you know, I knew she was married. I knew she had older children. I knew she hadn't parented her older children for some time. Her history was, I guess, not that unusual based on other families that I work with, with regards to her life's history and growing up in, you know, being married and having kids, get divorced, those kinds of things**

> **were a pretty normal thing. I don't have the resources, I guess, to be doing those kinds of really formal background history, social histories on families.**

As part of sound social work practice, the concept of "study, diagnosis and treatment" through the use of the casework relationship has long been established as one of the fundamental principles for effective intervention. One of my consultants, a social worker who had enjoyed a long career in child welfare in another province, discussed this issue and cited one of the earlier social work texts to say that it has long been argued that "treatment begins at the first contact"[33] in the course of any social work intervention. The social worker's responsibility to analyze and understand the situation with which s/he must deal, before taking action, is an essential of all professional practice. It involves:

(a) *analysis* (the use of observations, interviews, documentations and other means) including the interaction between the people and their environment;

(b) *the identification of critical factors* (a key ongoing step which must be repeated many times

as the situation changes and understanding grows);

(c) *the exploration of alternatives and defining objectives for action*; and

(d) *deciding what actions must be taken* with a formal or informal agreement with the client.

Essentially what was employed in the Turner case was a series of reactive short-term strategies. The pattern was to analyze the current crisis or stress-producing event(s), identify the key stressor(s), determine what would be the most immediate way to lessen the stress and/or ameliorate the situation, and then take a short-term action. For the most part, the nature and extent of the CYFS interventions were governed by what Dr. Turner herself gave as information, and from the day-to-day observations. At the end of 16 months of CYFS intervention, there appeared no greater understanding of this client than at the beginning with the exception that she was resilient, intelligent and attempting to be a "good parent."

While these comments appear to single out the assigned social workers, there definitely were implications for the workplace setting. The general attitude throughout the supervisory and senior levels of CYFS management was that, in the absence of any 'referral,' a more comprehensive assessment was not necessary. Basically, the CYFS argument was that they would not have done anything differently.

Throughout there was almost a desensitization of the seriousness of the personal history, underlying dynamics and the murder charges. I know that child protection services are often complex, fluctuating, emotive and stressful. Front line staff require the security and clear direction of supportive quality supervision, appropriate legislation, standards and policies, a predictable organizational structure and reasonable workloads. While the absence of some of these may have been contributing factors, overall, personnel seemed to be oblivious to systemic issues at play.

5. Community Health

As well as receiving considerable help from CYFS, Dr. Turner was also being supported by community health nurses

through the Healthy Beginnings Program of the Board's Health Services. She was admitted to the program with a documented "history of depression" and received support throughout Zachary's life. Community Health knew that she had social services contact but not that there were any protection issues. The Community Health Nurse herself told me:

> **I wasn't aware of, for protection issues, but mostly for financial issues.**

The last recorded contacts respecting Zachary were two telephone calls on 12 August 2003, just a week before his mother drowned him.

Examination of the activities of Community Health illustrated two aspects of Dr. Turner's personality: (i) her adeptness in enlisting support; as with CYFS, she was designated as high priority; and (ii) her ability to manipulate.

During most visits there were plaintive reports of lack of funds, sometimes couched as her concern for meeting her daughter's needs. She was able to have a home support worker provided for two periods during the first weeks of

Zachary's life. This person did her housework and also provided child care at times when she herself was out and about. Despite her high priority admission into the program because of her reported history of depression, she presented to her nurse as coping well.

> **Shirley did not show signs to me that she was depressed early on, and so I didn't really see the need to phone anyone to see why she was depressed because it wasn't an issue at the time.**

Some of Dr. Turner's requests and questions appeared to me to be unusual, coming from someone who was a qualified physician. It was at her request that she joined a breast-feeding support group. At another time, she asked how long milk could be left at room temperature during hot weather. There were complaints about stress related to Zachary's grandparents (the Bagbys) as well as the risk of extradition. She managed to have the visiting nurse write a letter to Canada's Minister of Justice on her behalf arguing against extradition.

Child, Youth and Family Services and Community Health both operated under the same Regional Board and, more recently, operate under the same Health Authority, yet

there are interesting differences. Health workers receive six weeks training at the outset and regular in-service training,

> **usually, probably a dozen times a year where we have one specific day as in-service.**

In addition, there are annual performance evaluations that include file reviews, but are also

> **a review of your skills. So they come with you on a home visit and they supervise you on child health clinic and some of our skills.**

The section that follows will reveal that the child protection workers do not currently have such comparable training and evaluation.

Care is also taken to ensure that there is no gap in service due to a nurse's illness or vacation,

> **when she covers for me, or when she covers for anyone, then when I come back or whoever the nurse is, then she gives a report on the visits and the telephone calls that she has done on all my cases [See Recommendation 7.15].**

6. Training and Qualifications of Child, Youth and Family Service Workers

6.1 Overview

In order to apply, enforce and deliver services governed by child welfare legislation and policy, social workers and other involved professionals require particular qualifications. The components of these qualifications are acquired through formal education, in-service training, performance evaluation, in-service management and supervision, and experience. I must emphasize at the outset that, in examining the training and qualifications available and acquired by CYFS personnel, I will focus on those that are pertinent to child protection and child welfare. In doing so, I had some particular concerns in mind. How well does the education available address the unique nature of the field of child welfare? Do social workers enter this field with a solid understanding of the law, of the skills for gathering evidence and presenting that evidence in Court? As well as understanding normal growth and development, are they able to discern symptoms of socio- or psycho-pathology? What approach is taken to the development of skills in social diagnosis and assessment?

6.2 Formal education

With the coming into force of the *Social Workers Association Act*[34] in September 1993, the minimum

qualification for child protection work became the BSW. In most other provinces, the BSW was already a prerequisite and a Master's Degree in Social Work (MSW) with experience, more often than not, the background for supervisory and managerial positions.

Across Canada, child protection continues to be considered an appropriate entry level position. Despite the complexity and high demands of child protection, it is a fact that the majority of newly qualified social workers across Canada begin their careers in this field of social work. The question of how well the BSW curriculum prepares its graduates for such a complex field, therefore, becomes crucial. All of the social workers who dealt with Dr. Turner, with one exception, obtained their BSW from the Memorial University (MUN) School of Social Work. None of the workers, including managers, involved directly or indirectly with monitoring Dr. Turner had an MSW prior to moving into their current positions. I have therefore confined this part of the investigation to the BSW curriculum at MUN.

In common with other faculties and schools of social work, there is no mandatory course in child welfare and child

protection at MUN. The calendar lists two elective courses, one of which is now taught using distance learning technology. The percentage of students who have taken these courses during the past six years has ranged from 31 percent to 64 percent. The average percentage is 43. The assumption then is that less than half of the graduates have had some exposure to child welfare issues. Family Law for Social Workers, also an elective, is listed but has been inactive for some years. This course which, I am told, was very popular with students when offered, included invaluable clinical training in court room technique. The Director of the School drew my attention to a law-related module in each of two elective classes (child welfare and mental health). Although useful in the context of those courses, it would be impossible in one module to provide the solid grounding that is needed when working within the bounds of applicable legislation, particularly where the gathering of evidence and the ability to present it is so crucial. Social work students study normal growth and development with some reference to mental health issues, as well as suicide ideation, in the field instruction courses. However, a concentration on mental health issues is available only in one elective course. The required program of study allows for two social work electives in years four and five. In short, **the BSW**

program provides very limited preparation for work in the child welfare field.

I turn now to training in assessment as in my investigation of social work activity related to Dr. Turner I became aware of the limitations of the assessment conducted in two particular respects:

1. the various agencies and professionals involved with the matter were not consulted and so information relevant to the safety of the children was missed; and

2. there was no investigation of Dr. Turner's family and social history or, what is termed in social work vocabulary, her ecosystem.

I was therefore particularly interested in how well social workers are trained in this respect. I found that texts used in the courses that cover social work methods have not entirely abandoned the concept of "study, diagnosis and treatment" that was mentioned earlier in this chapter. Shulman's text, *Skills of Helping,* in its various editions[35] was used at MUN in the

1990s and is still required reading. Shulman promotes the concept, but is critical of how he perceived its former use.

> **It tended to make us think of clients in static terms. The emphasis was on pathology.**

He goes on to say:

> **The impact of dynamic systems theory on the way helping professions viewed the clients has been profound. One central idea has been the emphasis on viewing a client in interaction with others. Instead of a client being the object of analysis, concentration was on the way in which the client and the client's important systems were interacting.[36]**

This, and references in course readings to ecomaps and genograms, reassures that the foundations, at least, for comprehensive assessment are offered to social work students.

An important tool for social workers, one emphasized by Shulman, is the development of what is termed the casework relationship, or the helping relationship. This provides a clue to the slippage that seems to have occurred in this case. It may well be similar to the dynamics found in other incidents of child deaths. As with Dr. Turner, the relationship with the mother appears to have taken precedence

over any focus on the children and their safety and well-being. Maintaining a friendly and supportive relationship with the mother in each case appeared to be the important end goal.

In fairness to workers involved with Dr. Turner, the children of concern were not exhibiting any serious safety concerns on the face of it, **but it would appear there was seemingly no attempt to dig beneath the surface.**

A point that I emphasize here again and again, which should never be underemphasized, is that **the primary client in child welfare and child protection is the child.** Relationships or partnerships developed with parents and caregivers should be focused on how such partnerships can protect and serve the child. In the absence of any mandatory child welfare courses or emphasis on this important distinction, the difference between protection work and family therapy may not be clearly understood.

I note that the calendar for the School of Social Work has listed a postgraduate diploma in clinical counseling for addictions. Since such a diploma is available, it would therefore seem feasible to be able to offer a postgraduate

diploma specializing in child welfare and child protection. For such a diploma course the need is even more compelling.

Recommendation 7.21

THAT a multi-disciplinary committee be struck, including representation from NLASW and the Province, to consult with the Memorial University School of Social Work (within three months of the release of these Findings) to investigate the feasibility of establishing a postgraduate diploma in child welfare and child protection.

Such a diploma should be multi-disciplinary and include special attention to legal and medical considerations, evidence-based practice and assessment of needs, as well as risk and safety, and attachment issues.

The Government of Newfoundland and Labrador is the largest employer of social workers, but apparently does not have a vehicle for input into course content or the relevance of current courses. I understand that at one time the School of Social Work did invite input from Government personnel on a curriculum committee. It may be timely to reactivate this.

Certainly such a large employer should have representation on the School's Academic Council.

Recommendation 7.22

THAT the Memorial University School of Social Work give a seat on its Academic Council to the Province.

With respect to concerns over work overload and the emotional stresses of child protection, I did discover that in some of the required courses there is coverage of stress management and case management. However, as far as I could tell, caseload management and time management are not taught. These are important skills that are needed in a high intensity work place. It may be that these are considered matters for training rather than in social work education. The Director of the School made this distinction in his covering letter to me:

> **I would like to make explicit the distinction between education and training … education in social work is an intensive and cumulative process in which students not only acquire practice knowledge and skills, but … are challenged to think critically and creatively … and understand the conceptual and research underpinnings of professional practice … Training is an activity which**

> **… teaches skills and procedures which pertain to the performance of a particular job or task.**

Recommendation 7.23

THAT caseload management and time management be included in course work at the Memorial University School of Social Work.

Considering the demanding nature of the profession, these are skills that all social workers should possess.

6.3 In-service training

I gather from the comments of the Director of the School of Social Work about training, as well as from an examination of which courses are mandatory, that a new BSW graduate is unlikely to be in possession of all the skills and abilities that are needed in the child welfare field. It would therefore make sense to provide initial in-service training and/or a period of internship. I was told by a senior manager employed by the Board that there used to be an initial three to six week in-service training that ceased when services were regionalized:

> **One of the deficits that I think the Program experienced in moving from Government where we were Social Services and Human Resources and Employment, and then became Child, Youth and Family Services with the Community Health Board, one of the things that happened that personally had a negative impact was that we lost a considerable amount of funding for training for our staff. So that there was a three to six-week orientation and training that they did, that stopped.**

Before or when the new legislation came into force in 2000, all workers received two three-day workshops as orientation to the changes, but that has been all.

An added concern is that the Minister's Advisory Committee on the Operations of the Child, Youth and Family Services Act (MAC) found that even this training was not adequate. The Committee recommended updated training and education for the service providers. I agree with the Advisory Committee that, if people know what is happening and how the legislation is being interpreted, it will help "to better inform practice and improve client service." I can do no better than reinforce a key recommendation from that report:

> **Training for social workers must become a priority for government. Best practice in this area supports the need for specialized skills, knowledge and expertise as outlined in the numerous reports cited in this review.**

> **Without this, the retention rate cannot be stabilized and inexperienced social workers will continue to struggle with the complexities of this work.**[37]

The present lack of in-service training and opportunities is neither helpful to morale nor to improving the quality of service. As one of the managers informed me,

> **I think that that whole business of not being able to provide appropriate levels of professional development for staff had been a huge obstacle in staff development from the program perspective.**

Recommendation 7.24

THAT training on legislation, policy and procedures, and other appropriate in-servicing be updated semi-annually, and be the responsibility of the Provincial Director to ensure province-wide equity of opportunity.

6.4 Performance evaluations

Performance evaluations can be a valuable means of identifying any deficiencies and training needs, as well as providing positive feedback when merited. In this way they improve client service both by ensuring that service providers are competent, and by providing support and encouragement to

the worker. Surprisingly, they are not part of regular practice, either for supervisors or for front line staff, although I was told by a supervisor that she thought it was part of policy:

> **I think the expectation is on a yearly basis except for new employees who are usually on probationary period for six months, but there's an expectation that they have an evaluation completed around the end of their six-month period.**

There did not seem to be consistency either in application or non-application. One supervisor had been evaluated but did not evaluate her staff.

> **Review legal counsel:**
>
> > **Are you subject to professional evaluation as a supervisor, and I ask that question for the period from March 2000 forward?**
>
> **Answer:**
>
> > **I have received one evaluation …**
>
> **Review legal counsel:**
>
> > **As far as you know, how often should you be professionally evaluated?**
>
> **Answer:**
>
> > **I believe it should be done on a yearly basis.**

Review legal counsel:

> **As a practical matter, however, since March 2000 you have had one evaluation?**

Answer:

> **That's actually the only one I've ever had.**

One would anticipate that regular evaluation would be even more crucial for those providing direct service to clients. But, as a supervisor told me, it is just not happening:

Review legal counsel:

> **In practice, have you had the time to evaluate each of the frontline workers under your supervision on an annual basis, laying aside those who are newly-employed since March 2000?**

Answer:

> **The intents are there but it hasn't happened, no.**

The explanation provided to me for this failure to adhere to policy was the lack of time. I was also informed that there has been no concern expressed further up the line about the lack of evaluations.

Another supervisor, on the other hand, had never been evaluated herself but did evaluate her staff.

Review legal counsel:

Did you, in practice, do performance evaluations on the social workers …?

Answer:

I did complete them, yes.

Review legal counsel:

And was this an annual exercise or did you typically do it more frequently?

Answer:

I did it when I had a chance.

Clearly, performance evaluations are too important a policy initiative to be shunted aside by other priorities or time constraints. It was my impression that the service demands are high within the Regions and that, like training opportunities, this expectation would be better performed through the Provincial Director's office. Having said this, I do believe that there is a misunderstanding at the highest level with respect to evaluation. Apparently there is to be heavy reliance on CRMS which may result in displacement of goals, or result in

evaluation based on the wrong set of criteria. An example supplied to me by the Provincial Director related to the new risk management system.

> **We'll have the ability to look and see if people are meeting the standards that are set under that.**

One of those standards is completion of the risk management instrument at minimum once every three months. Even monthly application of such an instrument would not have saved Zachary's life.

The problem, as I see it, is twofold:

1. evaluation based on compliance with standards does not have the ability to measure child outcomes; and

2. emphasis on such bureaucratic requirements may have the unintended consequence of deflecting workers' attention from monitoring the child.

Evaluation must be based on quality of practice and child outcomes, and may include random periodic review of

files. To be effective, it should be used not to find fault or assign blame but to enhance practice and improve child outcomes.

Recommendation 7.25

THAT regular performance evaluations be provided to all personnel using child-centred criteria to fit with the monitoring duties of the Provincial Director under section 5 of the *Child, Youth and Family Services Act*.

6.5 Management and supervision

Yet another way in which skills can be enhanced is through goal directed leadership, clinical supervision and informal mentorship that can be provided on the job by more experienced workers. I noted evidence of availability of management and supervisors. However, there was insufficient documentation for me to evaluate its quality. For example, I was told by the Director in Region that, after a quite crucial meeting,

> **some direction was given, for example, I don't think there was a note, to my recollection; in fact, I**

> **immediately met with a social worker and provided direction,**

but there was no evidence, at least on file, that there was any follow-up or evaluation of outcomes with respect to advice given.

Recommendation 7.26

THAT record keeping, beyond what may already be required by law or policy, be a fundamental obligation at all levels. Records to include purpose of the event, strategies used to achieve objectives, decisions made, directions given, those responsible for implementing actions, time lines, plans for follow-up and evaluation, and whether objectives have been achieved.

Recommendation 7.27

THAT mandatory in-service training be developed in the theory and practice of documentation and record keeping.

Recommendation 7.28

THAT there be group supervision as well as individual supervision beyond what is already required by law or policy.

Group supervision is not only effective in terms of time management; it enhances team building and problem solving. It is also invaluable for less-experienced workers.

6.6 Skills in intervention

My Review has examined education and training in order to understand the degree to which social workers were prepared for their work responsibilities. I was also interested to see how such preparation played out in practice. Case records available to me provided good information on client input and context, but were sparse in describing the particular interventions used. Therefore I was unable to judge.[38]

6.7 Summary

In this section I have looked at preparation for social work in the child welfare field. The BSW provides a solid generalist education and the courses and texts used in field education provide good coverage of a variety of approaches to intervention including attention to the larger systems in which clients function. Of concern is that graduates of this generalist program can move directly into child welfare positions without

the necessary specialist training. This lack of specialist training is compounded by the current lack of in-servicing or internship.

Some serious gaps include understanding of the special nature of the work and the different approaches needed when the primary client is a child. Relationship-building with the adults involved is important but is secondary to considerations of the child's safety and well-being. Assessment of the need for protection, and decision-making with respect to the degree of intrusion that is needed, require very special skills. An analogy is decision-making in medicine. Where the choice is between surgery and less intrusive medical treatment, none of us would be satisfied with anything other than a specialist's opinion. It is not unlikely that a second opinion would be called for. The decision to remove a child or to provide family support is just as crucial. As in medicine, it may well be a life or death decision, as attested by the litany of child deaths in families known to child welfare authorities. I use the term "litany" advisedly. The list of deaths of children known to child welfare authorities is too long and continues to grow. In the course of the Ontario Child Mortality Task Force alone, inquests into deaths of twelve children known to Children's

Aid Societies were announced publicly.[39] If we are to put a stop to such tragedies then the quality of service must improve. Child protection is too complex and too important to be left to workers who are inadequately prepared.

Other specific skills that are needed include training in the law, rules and techniques of evidence gathering and presentation, record keeping, caseload management and working in inter-disciplinary teams. It would be useful to have Government lawyers ensure that workers are kept cognizant and up to date on relevant judicial decisions, especially Unified Family Court decisions.

7. Ministry's Internal Review

Before leaving this chapter I need to present my own critique of an internal Board review presented to the Minister on 08 September 2003.[40] The review concluded that:

- **the assessment that formed the basis of the intervention plan was in keeping with standard child protection practice;**

- **there was compliance with legislation, policy and standards; and**

- **there was significant evidence to support the decision to leave Zachary in his mother's care as there were no indications that would lead us to suspect or to conclude that Dr. Turner was suicidal, or that Zachary was at any risk of imminent harm.**

I will examine each of these conclusions in turn.

Was the assessment that formed the basis of the intervention plan in keeping with standard child protection practice?

I assume, from the conclusion in the internal review, that the assessment was in accordance with standard child protection practice in the Province of Newfoundland and Labrador. In my inquiry, I consulted with social workers with outstanding national and international reputations. The unanimous opinion of all was that the assessment was not carried out in accordance with standard child protection practice elsewhere. Data collection was deficient.

She's [Dr. Turner] your first … witness. Your first source of data … You start out with her and, again based on your training, you come to a certain assessment of her. And based on that kind of information you start looking other places.

An assessment should include a total history including family dynamics, health, mental health and life course. This would involve consulting with a variety of other people. A major gap was the failure to be more assertive and persistent in connecting with her psychiatrist. In any case, in view of all the circumstances, the charges against her and her own admission of stress, a psychological assessment would have been in order.

A comprehensive psychological or psychiatric assessment would have been warranted to help CYFS social workers determine Dr. Turner's capacity for parenting Zachary. In the event that Dr. Turner would not voluntarily submit to the assessment, CYFS could have applied to Unified Family Court for an order requiring Dr. Turner's participation in the assessment. The Court appears not to have any authority under the *Child, Youth and Family Services Act* to consider a CYFS request for, and decide whether to grant, an assessment order. However, because Unified Family Court is part of the Supreme Court, it may, separate from the *Act*, have discretion to do so. (The discretion is based on authority developed historically under English law called *parens patriae* authority - meaning public guardian for persons lacking mental capacity

to look out for themselves). Unclear, however, is whether the Unified Family Court would find that discretion to be broad enough to order an assessment, especially if Dr. Turner opposed the assessment. I note the Provincial Court of the Province does not have any authority to exercise that discretion even though the Provincial Court also hears proceedings under the *Act*.

As part of my Review, I made enquiry as to whether a request for such an assessment might be routine elsewhere. I received the following information from a Court Services Specialist in Alberta: child protection workers there routinely ask for parenting, psychological and sometimes even psychiatric assessments. The judges then routinely order that the assessment is to take place. This can be done under a Supervision Order or Temporary Guardianship Order. This is either paid for by the Department, the parent or jointly as agreed upon as Court ordered. The legislation[41] allows the Court to grant anything the Court deems necessary under Supervision Orders, Temporary Guardianship Orders.

Not infrequently, potential or actual psychological and psychiatric health problems derive from or are contributed to

by neglect of the physical or emotional health of an adult (a caregiver) or child. Records of Provincial Court proceedings under the *Child, Youth and Family Services Act* lend considerable support to this observation. (I am here excluding situations where section 32 of the *Act* is engaged because of an allegation that a child's parents refuse to obtain or permit essential medical, psychiatric, surgical or remedial treatment that is recommended by a qualified health practitioner).

Recommendation 7.29

THAT the *Child, Youth and Family Services Act* be amended to authorize the Supreme Court of Newfoundland and the Provincial Court of Newfoundland to receive, hear, decide and make orders resulting from applications for psychological and psychiatric assessments, and for health care treatment of persons having, or being considered by CYFS or the Court to have, custody of or access to children, as well as children themselves, where established to be relevant from the perspective of a child's best interests in either a CYFS investigation or in a proceeding under the *Act*.

Recommendation 7.30

THAT reports of the course and results of assessment or treatment be provided to CYFS, the ordering Court and the persons assessed or treated, or their caregivers.

I acknowledge that this recommendation spawns the issue of availability of professional resources to provide assessments and treatment. There are parts of the Province - Labrador communities, for example - where a dearth of resources will render the performance of judicial assessment and treatment orders difficult. That is not peculiar to (parts of) Newfoundland. The problem exists in many parts of Canada. The remedy, albeit expensive, is to either bring resources on a case-by-case basis to where they are lacking, or to send persons requiring services to the resources as is presently done in criminal cases where an assessment is required. The alternative of risking children's best interests is not acceptable.

Of further relevance is an observation, with which I agree, at my round table consultation:

> **The difficulty I have is that any social worker, any kind of social worker, would not need a risk assessment tool to figure this one out. This isn't something where**

> **absence of the tool is the cause of a problem. This is asking questions, getting information and making good decisions based on the information received.**

In short, if an assessment is to be in keeping with standard child protection practice in the Province, then serious attention must be given to raising fact-finding standards immediately.

Was there compliance with legislation, policy and standards?

There was general compliance with legislation though, as noted earlier, there were unused sections in the legislation that could have been employed to advantage. Policy and standards were adhered to marginally. Quarterly case notes summaries appear to be non-existent. A particular lack of compliance, crucial in this case, was failure to adhere to policy guidelines regarding assessment, namely:

> **The Child Protection Social Worker shall however, when actioning the referral, consult with/elicit the cooperation of other professional and community resources. . .**

And the fact that:

> **There may be sharing of information pertinent to the investigation and/or follow up intervention (where possible with the written consent of the parents/guardians) between the systems. The lack of parental consent will not prevent consultation with collateral contacts during the investigation stage [emphasis mine] (Policy Reference No. 02-02-03).**

Therefore, I have to disagree with the findings, in this respect, of the internal review.

Was there significant evidence to support the decision to leave Zachary in his mother's care?

I would turn this around and say that there was no significant evidence uncovered to support the decision to remove Zachary from his mother's care. A considerable amount of background and familial information was available. Much of my Review has been amassing this evidence. Collection of these facts would have led to a more informed judgment than existed. This might well have led to a decision to seek formal protective custody of Zachary. I will return to this issue in my conclusions.

Were there no indications that would lead CYFS to suspect or to conclude that Dr. Turner was suicidal or that Zachary was at any risk of imminent harm?

The indications were there. I had no difficulty in uncovering them. It is particularly extraordinary that no credence was given to, and no resulting inquiry based on:

(a) the statement of the RNC officer who predicted that Dr. Turner would harm herself and/or her expected child if the child was removed from her following birth; and

(b) the fact that she had been the subject of two charges alleging she committed a particularly grave criminal offence, and proceedings related to those charges. Apparently this was not considered a risk factor.

It seemed extraordinary to me that the Director in Region herself saw no connection between Dr. Turner's possible propensity for extreme violence and the likelihood of protection concerns, even in the face of representations from the Bagbys' lawyer. Her explanation to me was:

> **The fact that she was charged with a crime that she was indicating that she was not guilty of. That concern fell outside the normal allegations of maltreatment that we deal with on a daily basis. You know, we looked at**

whether or not this fit in the definition of a child in need of protection intervention. There wasn't any, outside of the crime that she had committed.

Finally, I wonder, did the CYFS personnel ever ask themselves questions such as:

- Was their natural compassion for a woman in a difficult situation blinding them to the risks for the children, or to the need to question her motives?

- What was the significance, in its context, of the abuse complaint against her ex-husband and his wife? It was made by Dr. Turner when denied service just the day before a Unified Family Court custody hearing.

- Why would an intelligent woman, purporting to have the interests of her children at heart, take a child from the family with whom she had been living and then ask protective services to assist with the child's resulting emotional needs?

With respect, I must say that my findings differ from those of the internal investigation.

8. Observations

Clearly, it has been possible to identify where things went wrong. However, as I stated at the outset, the purpose of this Review is not to point fingers or to scapegoat. That would be counterproductive. I will not cast blame, but I intend to be forthright. I ask for my advice and recommendations for Zachary and for other children generally to be accepted. There are definite systemic problems that must be addressed. I hope that my Findings will be used to discern ways in which child welfare services in Newfoundland and Labrador can be strengthened to ensure that children's best interests are paramount and that measures are taken to prevent the death of children like Zachary. My recommendations are intended to assist in this process.

8.1 Legislation

In the task of protecting children, legislation and regulations are merely tools which can be used with the finesse

of a surgeon or with the blunt edge of a hammer. If the tool itself has flaws, problems are compounded. I have already identified weaknesses in the legislation. I have been critical of the family preservation philosophy, not because it is inherently faulty but because, when its use or workers' understanding of it, lacks finesse, the safety of the child is compromised. In Canada, as in the United Kingdom and elsewhere, a whole litany of children's names could be chanted; children who died, not because there had been no "referral" but because of displacement of goals and systemic problems in the manner the referral was handled.[42]

In my Review, I discovered lack of understanding and even lack of consensus at senior CYFS Board levels in services delivery under the *Child, Youth and Family Services Act*. Quite frankly, I am baffled.

Repeatedly, I have asked persons employed by the Board about the principle of family preservation. Comments of senior Board personnel informants during their interviews reflect both ambivalence and lack of consensus:

Informant A:
I do not believe that the principles of the Child, Youth and Family Services Act places more emphasis on family preservation.

Informant B:
I know that the whole philosophy of family preservation and, you know, the long-term impact of a model that supports family preservation certainly needs to be evaluated. We have seen some impact on children that, you know, we have retrospectively looked at and said, you know, if we had removed that child 5 years ago or 6 years ago rather than making all these attempts to improve the family functioning, you know, would we be in a different place with this child, and we do have those conversations. The Act has not been formally evaluated [since its enactment in 1998].

A study had, however, been carried out in Newfoundland and Labrador in collaboration with a committee of Department personnel, prior to formulation and enactment of the new legislation, that predicted the truth of Informant B's observations regarding family preservation and least intrusion:

This study provides both good news and bad news with respect to the least intrusive philosophical approach to child welfare. On the positive side of the balance sheet there are indications that policy change can affect practice. The ability to access funds for in-home family support made a considerable difference to the numbers taken into care. Nevertheless … some disturbing findings emerge. For instance, a serious question with respect to the increase in average age of those entering care is whether it was wise to leave these children at

> **home. Are they entering care more damaged …? What is the extent of the abuse and neglect that they endured before receiving protection?[43]**

The data collected during the study suggested that approximately one-third of family reunification efforts were unsuccessful. This statistic matches that cited by a highly regarded expert and Director of a Family Violence Research Program, Dr. Richard Gelles.[44] The study not only highlighted the increase in average age of those entering care, but also the re-labeling of abused children as "out of control" as they reached the teen years - a serious case of "blaming the victim."

The late renowned Canadian advocate and champion of children, Dr. Paul Steinhauer, was an influential and early proponent of family preservation or, rather, the search for what he termed "the least detrimental alternative."[45] Although he recommended that removal of children should ideally be last resort, he nevertheless cautioned:

> **Rather than being seen as a panacea for all families, family preservation should be targeted selectively towards families that meet the following criteria that suggest they have the capacity to improve their level of parenting:**
>
> - **The family has a history of having functioned and**

> **raised its children successfully over an extended period, until an influx of major stresses … created a crisis …**
>
> - **In the absence of the above the family does not have a history of repeated and malicious physical or sexual abuse.**
>
> - **If drug or alcohol abuse is present, the parents have succeeded in a program for substance abusers …**
>
> **The family shows a reasonable potential for change in parenting capacity.**[46]

The first criterion is especially relevant. The question that was apparently never asked, either in the initial assessment or in the ongoing assessment, is: "Why would a woman who had not in the past five years been interested in parenting her children, abruptly want to take her 12-year old from the family in which she was being raised?" Is it possible that if it had been asked, the social workers might have concluded what the child herself had accepted: this might be their only chance of being together? But even so, there is an obviously inherent contradiction in Dr. Turner's actions. She kept her daughter from a stable environment and then asked for supportive services to help them both deal with the current instability into which she moved her. This is not the action of a responsible caring parent. A further indicator of parenting capacity is that

her older daughter quickly removed herself from Dr. Turner's home because of conflict. No doubt, at the time, workers were influenced by Dr. Turner's - well timed - complaints against her ex-husband and his wife, even though investigation quickly established that the complaint had been exaggerated and, further, that these two parents took full responsibility for their behaviour. My investigation uncovered that Dr. Turner herself had demonstrated much more serious negative behaviour towards her children in and since 1993.

Alternatively, Dr. Turner's likely motive was to create a situation in which her parenting role was indispensable - a ground occasionally relevant in Canada declining to extradite a fugitive. Making allegations against the 12-year old daughter's father and his second wife, and concurrently having the daughter reside with her commencing in March 2002 enabled Dr. Turner, in correspondence to Canada's Justice Minister in advance of his extradition decision in June 2003, to trumpet her parenting role in the younger daughter's life as being essential. Reinforcing this position which Dr. Turner raised at her extradition hearing, and again in subsequent correspondence to the Minister, was Zachary's birth. (Breast-feeding Zachary, which the Trial Division facilitated during

extradition hearings, was no doubt essential for the infant. Its urgency from Dr. Turner's perspective, however, was less apparent at night when, away from the glare of the extradition proceedings, Dr. Turner often socialized, leaving Zachary in the care of others). Dr. Turner was also mindful of the prospect her parenting role may impact the Minister's decision whether to extradite her - however remote - in approaching at least one CYFS social worker and one community health nurse, who had interacted with her, to ask them to write to the Minister to oppose her extradition. Moreover, Dr. Turner's resolve to create an indispensable parenting role for herself would not have been served by permitting the Bagbys, Zachary's paternal grandparents, to grow too 'close' to Zachary - a result she fought to achieve both in and out of court until (but not after) June 2003 when the Justice Minister decided to extradite her. Finally, Dr. Turner was unreservedly willing by June 2003, unlike earlier, to permit the second-marriage daughter to visit her father after the Minister's extradition decision.

8.2 Policy

Across North America, reform in child welfare has been

in the direction of being "case managers" with a lesser emphasis on the traditional study/diagnosis/treatment approach. Increasingly the system is driven by a cost/benefit mentality which has been reinforced by the use of computer systems. Social workers no longer necessarily "know" their clients well; check-lists may replace professional judgment. The overall result is that reforms of child welfare systems have become very legalistic and driven by legislation, regulations and standards. Child welfare services in Newfoundland and Labrador should be very cautious that their efforts towards reform not increase the bureaucratization of the service to the detriment of observing and meeting children's needs.

I will use issues involving "risk management systems" as one example. I did commission, early on, a review of child welfare risk assessment.[47] That review highlights the controversial nature of its application and serious questions with respect to reliability and validity. For the purposes of these Findings, I will simply make a summary observation. Overall, risk assessment models may have the potential to improve child protection practice, but only if they are properly implemented and the instruments themselves are validated on the basis of an empirical foundation. The American educator

Cicchinelli[48] advocates reserving the use of the term "risk assessment" to predict future events, employing currently available information. To be useful, a risk model must include factors that a worker can actually measure with some degree of certainty.

A recent proposal for developing an evidence-based model for assessing risk in child sexual abuse cases said this:

> **Currently available models for assessing risk for physical abuse and neglect are, at best, irrelevant, and, at worst, dangerously misleading in sexual abuse cases.[49]**

If this is the case with respect to child sexual abuse, then how likely is it that such a tool can pick up the more subtle variations of abuse and neglect? Until empirical evidence is available for the predictive validity of risk assessment tools, they should be thought of as ways to organize case material to inform clinical judgment. At this point, any greater emphasis on these instruments is premature. Yet, a reform introduced in August of last year in the Province imposed a standard of completing the risk assessment instrument **at minimum once every three months**. Completing it, as I said before, even on a monthly basis for Zachary, would not have prevented his

death.

In any case, I note that risk assessment is intended for the Protective Intervention Program (section 16 of the *Act*), not for the Family Services Program (section 10 of the *Act*), on which Board CYFS social workers relied. Government and senior managers must understand that, ultimately, there is no substitute for sound professional judgment. Such risk assessment tools should serve to substantiate and support the social worker's judgment, not replace it.

I digress briefly to a discussion I had about risk assessment tools with my roundtable of experts. These are some of their remarks:

> **There are a variety of things one uses as tools. One of them may be a risk assessment. But it ultimately never replaces the ability to understand the information that one collects and to make judgments based on that . . . I watch practice where people explain-away or attempt to explain-away what they've done based on this tool. Well no, because no tool that we know of, ever says 'with this, do this.' . . .**
>
> **We could have long and heated debates about it. I guess, my concern is ultimately, what people hear out of a recommendation such as that is that without tools nothing is possible. I simply don't believe that.**

One of the other problems with tools is that people don't want to have to learn the hard way. They want to have a piece of paper they got out of college and check it out.

And how many of them have been evaluated?

I drew certain conclusions from this discussion:

- no one tool is fool proof;
- too heavy a reliance on the check-list approach limits the development of assessment skills;
- time spent on documenting and computerizing a time consuming exercise may take away time from the important other work that must be done; and
- the tool itself may have questionable validity; in turn, worker evaluation may be based on the wrong criteria and, therefore, limit the worker's learning.

The Minister's Advisory Committee (MAC) reported in 2005 that:

> **Many asked when Looking After Children (LAC) would be introduced in this province and viewed its implementation as a critical component in planning for children.[50]**

I agree with this comment. Unlike the narrow focus of risk assessment, LAC requires a profound culture shift in the way child welfare services are currently provided. It expands social workers' thinking from the somewhat narrow, reactive, protection focus with a dependence on assessing risk, to that of a proactive child development, child well-being approach focused on need. It monitors in comprehensive fashion all key dimensions of child development: health, education, family and social relationships, identity, social presentation, emotional and behavioural development, and self-care.

"Lack of time" has been offered as the reason for it not being implemented. While the time dimension cannot be minimized, it should be noted that where used successfully, workers have reported that the initial investment of time pays off in the future as crises are avoided and work is well planned. While designed for children in foster care, users have recommended that it be used more widely. I have been told that a new assessment framework has been developed for use in England, building on the same child dimensions as the LAC

instrument. Similarly, users elsewhere in Canada have suggested that the LAC materials would be much more valuable to children at risk in the community than present risk assessment tools. Also, unlike risk assessment, LAC is not a check-list but a document for guided dialogue with all involved including the child. A major child welfare agency, Barnardos Australia, is using LAC with considerable success and has developed as a support to it, a well tested computerized system (LACES) for maintaining key information. It would be worthwhile for the Provincial Director to consult with that organization.

News headlines demonstrate that child protection and child abuse systems are in trouble across the country as, for instance, most recently in Ontario, British Columbia and Manitoba, as well as Newfoundland and Labrador. History becomes forgotten. Cutbacks in British Columbia unraveled some of the improvements instigated by the Gove Inquiry. In the United Kingdom, the inquiry into the tragic abuse and death of Victoria Climbié[51] highlighted the fact that lessons learnt from Maria Colwill's abuse and death a generation earlier had no lasting effect.[52]

I understand the challenge created by my advocacy for change. Change is not easy at the best of times. It requires courage, humility and commitment to the purpose of one's endeavour.

My conclusion regarding my investigation of the delivery of Child, Youth and Family Services with respect to the death of Zachary Turner can best be articulated by addressing the central question: Should or could Zachary have been taken into protective custody (formerly referred to as "apprehension")?

In public discussion of the tragedy, questions have been raised as to whether Zachary should have been taken from his mother at birth. It is my opinion that to attempt to do so would have been neither wise nor practical on the part of the Board's CYFS. It was therefore in Zachary's best interests that his mother should be allowed to bond and carry through with her plans to breast feed. The time immediately after birth is a very critical time with respect to forming that initial bond.

At that time - which was known by CYFS - there existed a possibility that the United States' application for an order to have Dr. Turner surrender to Canada's Justice Minister on the Pennsylvania murder charges would be unsuccessful. Or, if successful, that after surrender of Dr. Turner to Canada's Justice Minister, the Minister, for parenting reasons, could exercise his discretion to refuse to extradite Dr. Turner to the United States. Why separate mother and child at the child's birth if legal proceedings then outstanding against the mother may not result in her extradition from Canada? In that event, Dr. Turner would be available to parent her son.

However, as time went on, if there had been the depth and quality of ongoing assessment that a protection concern requires, then more intrusive intervention would have been possible.

It is unfortunate that the workers on the front line, who were in direct interaction with Dr. Turner, were never apprised of protection concerns at higher levels. It is also unfortunate that there was not more rigorous direction and supervision given to them with respect to the broader scope of investigation and assessment that should have been conducted.

I have already analyzed in some detail the systemic issues that militated against this and will not repeat them here. Suffice it to say that it seemed to me that the workers responsible for the day-to-day conduct of the provision of Family Services for the children in Dr. Turner's care were acting in good faith according to the mandate that they thought they had been given.

However, Shirley Turner's incarceration in the Newfoundland and Labrador Correctional Centre for Women in Clarenville, from November 2002 until January 2003, put a very different complexion on affairs. This was a time when every level of the CYFS system should have been alert to a major change in the situation. If Zachary's best interest had been the overriding and paramount consideration, then this was a time when no stone should have been left unturned to discover the weight of evidence against Dr. Turner, the likelihood of extradition, and her plans. This period of time would also have provided opportunity to assess the quality of the care then being provided by the Bagbys.

Clearly, such an investigation would have provided a great deal of evidence with respect to Shirley Turner's

emotional state, her parenting capacity, as well as risk factors for Zachary. Dr. Turner's plans to appeal the extradition, to once again obtain bail and to resume care of Zachary, would - and should - have been a trigger to intercede on his behalf. On the basis of the wealth of information that was available, but never accessed by CYFS, there was ample reason to move to obtain protective custody.

In accessing Unified Family Court, the possibility existed to ask the Court to appoint a lawyer for Zachary, on the basis that he was a fatherless child and his mother was charged with premeditated murder of his father. Zachary should have been represented in his own right, because of the weaknesses in the Act that I referred to earlier.

Zachary's lawyer (if appointed) and the Board's lawyer with respect to CYFS's interest, in referring to the *Child, Youth and Family Services Act,* had recourse to principles 7 (a), (b), (d), (e) and (f) as well as 14(c) in support of an application.[53] Well within the parameters of the Act was the ability for the Board's CYFS to apply for custody of Zachary, but to leave the infant in the Bagbys' care in accordance with principle 7(f). It is important to emphasize that such a

placement would be precarious if Zachary's mother retained guardianship, given the information that could have been uncovered regarding her attitude to the mutual bond between Zachary and his grandparents.

A useful argument for protective custody rests within Section 14(c) of the Act, that the child *is emotionally harmed by the parent's conduct*. There was potential emotional harm in bouncing such a young child back and forth between caregivers as would be inevitable, given the likelihood of extradition and, at minimum, a lengthy and potentially life-long period of incarceration for Dr. Turner. While the outcome of a Court application could not be predicted with certainty, at very least, CYFS would have marshalled a strongly-arguable case for protective intervention and custody.

I believe that despite the relative weakness of the Act, such a move could have been successful. At the very least, given the time it would have taken to hear arguments from all sides, Zachary would have been safe in the care of Mr. and Mrs. Bagby.

The Board's CYFS failed Zachary Turner by not knowing what could be learned, and then taking the necessary protective intervention steps, including a protection application to Court.

Instead of investigating exhaustively, the Board's CYFS committed themselves, from the beginning, to provide family services for Zachary while in the custody of his mother. In so doing, the Board knew precious little about Dr. Turner, beyond what Dr. Turner chose selectively, incompletely and inaccurately to tell the Board.

Board CYFS were legally obligated and ethically expected to undertake a comprehensive, thorough, expeditious and impartial investigation. There were steps, legally permitted and required, that if used in Zachary's best interests rather than those of his mother's, would have assisted in removing Zachary from Dr. Turner's custody.

The shortcomings that contributed to Zachary's death did not originate at the front line level. I have identified systemic problems pervasive at all levels, provincially and

regionally, of Newfoundland and Labrador's Child Welfare services.

[Notes to Chapter 7]

[1] Statutes of Newfoundland and Labrador, 1998, Chapter C-12.1 (as amended in 1999, 2000, 2001 and 2004), Appendix 5, p.A.25.

[2] Ibid, p.A.25.

[3] Thomas, P. (2003). Charter Implications for Proactive Child Welfare Services, in Kufeldt, K. and McKenzie, B. (eds.) *Child Welfare: Connecting Research, Policy and Practice*. (Waterloo: Wilfrid Laurier Press), p.365.

[4] [1995] 1 S.C.R. 315.

[5] *Constitution Act, 1982*, Parts I; VII.

[6] [1995] 1 S.C.R. 315, at paras. 83, 86.

[7] Thomas, P. (2003). Charter Implications for Proactive Child Welfare Services, in Kufeldt, K. and McKenzie, B. (eds.) *Child Welfare: Connecting Research, Policy and Practice*. (Waterloo: Wilfrid Laurier Press), p.365.

[8] T Trocmé, N., Phaneuf, G., Scarth, S., Fallon, B. and MacLaurin, B. (2003). The Canadian Incidence Study of Reported Child Abuse and Neglect: Methodology and Major Findings, in Kufeldt, K. and McKenzie, B. (eds.) *Child Welfare: Connecting Research, Policy and Practice*. (Waterloo: Wilfrid Laurier Press), pp.13-26.

[9] Chamberland, C., Laporte, L., Lavergne, C., Malo, C., Tourigny, M., Mayer. M., and Hélie, S. (2003). Psychological Maltreatment of Children Reported to Youth Protection Services: Initial Results from the Quebec Incidence Study, in Kufeldt, K. and McKenzie, B. (2003). *Child Welfare: Connecting Research, Policy and Practice*. (Waterloo: Wilfrid

Laurier Press), pp.53-66.

[10] Statutes of Newfoundland and Labrador, 1998, Chapter C-12.1 (as amended in 1999, 2000, 2001 and 2004), Appendix 5, p.A.25.

[11] Child is defined by the *Child, Youth and Family Services Act*, section 2(1)(d).

[12] Parent of a child is defined by the *Child, Youth and Family Services Act*, Section 2(j).

[13] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4.

[14] The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming presented to Parliament January 2003; Parton, N. (2004). From Maria Colwell to Victoria Climbié: Reflections on Public Inquiries into Child Abuse a Generation Apart. *Child Abuse Review*, 13, pp.80-94; Howells, J.G. (1973). *Remember Maria*. (London: Butterworth).

[15] Department of Social Services Child Welfare Program Standards.

[16] *Child, Youth and Family Services Act*, Statutes of Newfoundland and Labrador, 1998, Chapter C-12.1, Appendix 5.

[17] Ibid.

[18] (2006), 261 D.L.R. (4th) 516.

[19] Kufeldt, K. and McKenzie, B. (2003). *Child Welfare: Connecting Research, Policy and Practice*. (Waterloo: Wilfrid Laurier Press), p.276.

[20] Gove, T.J. (1995). Report of the Gove inquiry into child protection in British Columbia: Vol. 1, Matthew's Story; Vol. 2, Matthew's Legacy. (Victoria: British Columbia Ministry of Community and Social Services).

[21] National Post Online (2001). *Baby Jordan.* www.fathers.ca/baby_jordon.htm

[22] Caregiver is defined by the *Child, Youth and Family Services Act*, Section 2(1)(c).

[23] Canadian Association of Social Workers (2005). *Code of Ethics* (Ottawa: CASW).

[24] Canadian Association of Social Workers (2005). *Guidelines for Ethical Practice. (*Ottawa: CASW).

[25] Loewenberg, F. and Dolgoff, R. (1992). *Ethical Decisions for Social Work Practice.* (Itasca, Illinois: F.E. Peacock).

[26] Health and Community Services Departmental Profile in www.gov.nl.ca.

[27] IHRD Group and Goss Gilroy Inc. (2002). *Social Work Workload Review Final Report.* St. John's, NL: IHRD Group and Goss Gilroy Inc.

[28] MAC (2005). *How Are We Doing? A Report of the Minister's Advisory Committee on the Operations of the Child, Youth and Family Services Act*, p.56.

[29] Health and Community Services St. John's Region (2003). *Report – A Review of HCSSJR Involvement with Shirley Turner and Zachary Turner and younger daughter* submitted on 08 September 2003. In fact, there were two reports; see Appendices 6 and 7, pages A.70 to A.101.

[30] Ibid.

[31] *Toronto Star*, 08 April 2006.

[32] Gove, T.J. (1995). Report of the Gove inquiry into child protection in British Columbia: Vol. 2 Matthew's Legacy. (Victoria: British Columbia Ministry of Community and Social Services), p.293.

[33] Hamilton, G. (1940). *Theory & Practice of Social Casework.* (New York: Columbia University Press), p.166.

[34] Statutes of Newfoundland and Labrador, 1992, Chapter S-18.1.

[35] Shulman, L. (1984). *The Skills of Helping. 2nd* Edition and (1999) 4th Edition. (Itasca, Illinois: F.E. Peacock).

[36] Shulman, L. (1999). *The Skills of Helping. 2nd* Edition. (Itasca, Illinois: F.E. Peacock), p.4.

[37] MAC (2005). *How Are We Doing? A Report of the Minister's Advisory Committee on the Operations of the Child, Youth and Family Services Act*, p.56.

[38] The only description I received about intervention currently in use came from an in-house family therapy program. Apparently the approach used in that program is that of post-modernism. Despite its name, its theme of building on client's strengths is not entirely new. The central message of building on client's strengths has always been a part of good social work. What may be of concern, in the context of what happened, is the degree to which a misunderstanding of its use may or may not be pervasive among graduates of MUN, and/or whether in teaching it any critical analyses have been ignored. [Noble, C. (2004). Postmodern Thinking: Where is it Taking Social Work? *Journal of Social Work*. 4(3), pp.289-504]. One of my sources, when asked to describe the elements of post-modern therapy, had this to say:

> **Years ago people would often say they're eclectic; they could use whatever approach came up. But we hope we have kind of moved a little beyond that and that you have some basis for the work you do. So we looked at narrative and solution-focused approaches to looking at clients and based our work on the information that we learned, you know.**

Yet eclecticism, defined as the free selection and borrowing of ideas or styles from diverse sources, has been one of the strengths of social work.

It has been said, for instance, that if the only tool we have is a hammer, then perforce we have to use a nail. In other words, a 'one-size fits all' can narrow the focus of intervention. Certainly there are writers, such as the President of the Chicago Erikson Institute for Advanced Study in Child Development [Garbarino, J. (1992); *Children and Families in the Social Environment* (New York: Aldine de Gruyter)]; who have

challenged social work to broaden its analyses of human risk and opportunity. He has cautioned practitioners to look both beyond and within; beyond to the broader social context and within to the interpersonal relationships. Too narrow an adherence to post-modernism (at least as described to me) may explain why Dr. Turner was considered to be the key informant at all times, and there was never an attempt to put together a comprehensive history and assessment. Thus, valuable pieces of information that would have raised levels of concern were missed.

[39] Ontario Child Mortality Task Force Interim Report. Supplement to the Journal of the Ontario Association of Children's Aid Societies (OACAS) April 1997, Volume 41 (1).

[40] Health and Community Services St. John's Region (2003). *Report – A Review of HCSSJR Involvement with Shirley Turner and Zachary Turner and younger daughter* submitted on 08 September 2003. In fact, there were two reports; see Appendices 6 and 7, pp. A.70 to A.101.

[41] *Child, Youth and Family Enhancement Act*, R.S.A. 2000 c. C-12.

[42] During the course of my investigation, other cases of abuse in families known to the protection agencies have been profiled in the media, including some in Newfoundland and Labrador. The most recent conviction in this Province resulted from the starvation of an infant who had been visited by both a social worker and nurse in the weeks and months prior to his eventual hospitalization. This happened in the year following Zachary's death. [www.cbc.ca/nl/story/nf-child-neglect-200060418.html].

[43] Kufeldt, K. and Klein, R. (1998). *Review of Children in Care in Newfoundland and Labrador: 1984-1995.* St. John's: Government of Newfoundland and Labrador, p.39.

[44] Gelles, R. (1996). Family Reunification: Penicillin or Poison? *International Foster Care Organization Journal,* Vol. II (2), pp.13-14.

[45] Steinhauer, P.D. (1991). The Least Detrimental Alternative: A Systematic Guide to Case Planning and Decision Making for Children in Care. (Toronto: University of Toronto Press).

[46] Steinhauer, P.D. (2002). When Should Children Be Taken Into Care? In *Permanency Planning in the Child Welfare System. Children in Limbo Task Force. (*Toronto: Sparrow Lake Alliance), p.30.

[47] Christianson Wood, J., "Risk Assessments" (at the request of Dr. Peter H. Markesteyn as delegate of Child and Youth Advocate for Newfoundland and Labrador).

[48] Cicchinelli, L.F. (1995). Risk Assessment: Expectations and Realities. *APSAC Advisor,* 8, pp.3-8.

[49] Levenson, J.L. and Morin, J.W. (2006). Risk assessment in child sexual abuse cases. In *Child Welfare*, 85, 1, pp.59-82.

[50] MAC (2005). *How Are We Doing? A Report of the Minister's Advisory Committee on the Operations of the Child, Youth and Family Services Act*, p.39.

[51] The Victoria Climbié Inquiry: Report of an Inquiry by Lord Laming presented to Parliament January 2003.

[52] Parton, N. (2004). From Maria Colwell to Victoria Climbié: Reflections on Public Inquiries into Child Abuse a Generation Apart. *Child Abuse Review*, 13, pp.80-94.

[53] See Appendix 5.

Chapter 8

Delivery of Health Services

1. Introduction

Community Services, the subject of the previous chapter (Chapter 7), addressed how the St. John's Health and Community Services Board delivered services, from April 2001 to August 2003, that were supposed to provide for the best interests of Dr. Turner's younger son, Zachary Andrew Turner, and her younger daughter. Those services were delivered through the most significant programs administered from day-to-day by the Board. They were programs delivered by social workers (including workers with specialty training in counseling) and community health nurses, responsible for family support of children - usually within families - and protective intervention that, in appropriate circumstances, could separate children or youth from their families. The administration of the *Child, Youth and Family Services Act,* under which services were delivered, is ultimately the responsibility of the Minister of Health and Community Services. This included, in the language of section 4 of the executive order, which created the Board (since replaced by one of four regional integrated health authorities), "the supervision, direction and control" of all matters relating to the

Board's programs. Principal focus of the programs are children.

But what about Dr. Turner? Except when incarcerated at the Newfoundland and Labrador Correctional Centre for Women in Clarenville or at St. John's (from 12 December 2002 to 10 January 2003), she was the caregiver to both their younger son and younger daughter; the son from his birth on 18 July 2002 until his death on 18 August 2003; and the daughter from April 2002 to August 2003 (other than when she stayed with her father).

Dr. Turner was known to Board-employed social workers and community health nurses - who dealt with her (and their supervisors and directors) for most of the period the Board provided services to her younger son and daughter - to be a parent who was charged with murder, was under psychiatric care, and was subject to a proceeding to extradite her to the United States. She was also known as a parent who had delegated to the fathers of her older son and daughter (first marriage), and her younger daughter (second marriage), much of the responsibility for parenting them.

As the Board social workers, their supervisors and directors decided against taking any steps to intervene in Dr. Turner's parenting of the younger son and daughter, what precautions were taken to ensure the parent was capable of providing for the best interests of the children?

This chapter describes the extent to which, and the reasons why health care service providers - specifically the psychiatric profession in Newfoundland - helped or failed to help Dr. Turner and, as a consequence, how they might have served to prevent the death of Dr. Turner's younger son, Zachary.

From 20 November 2001 until 15 July 2003, Dr. Turner was a patient of Dr. John R. Doucet, a clinical psychiatrist in St. John's. I will first outline Dr. Doucet's interaction with the Office of the former Child and Youth Advocate and with my Review. I will then discuss assessment, diagnosis and treatment of Dr. Turner by Dr. Doucet, and (very briefly) by the psychiatrist who looked after her during her incarceration in Clarenville.

2. Contact between Dr. Doucet, the Office of the Former Child and Youth Advocate and this Inquiry

In the latter part of June 2004, the first Child and Youth Advocate invited Dr. Doucet for an interview by the Advocate's Assessment Officer, Dr. Michele Neary, and by a member of the Advocate's Advisory Council, Professor Elliott Leyton. On 30 July 2004, Dr. Doucet's counsel informed the Child and Youth Advocate's Office (CYAO) by letter that, although under no obligation to do so, Dr. Doucet would - and did - meet with Dr. Neary on 10 August 2004. Dr. Doucet wished

> **to cooperate in a proactive manner, like any physician, in a wish to be helpful as a responsible member of the community.**

I have read the resulting transcript of that meeting, which consisted of an interview.

However, for reasons of a possible breach of confidentiality,

> **no copy of Dr. Turner's medical records would be provided.**

Access to the medical records would either require subpoena power[1] (which the CYAO was reminded it did not have) or, by remiss, the permission of the next-of-kin. In addition, the CYAO was informed that Dr. Doucet might only be in a position to answer some of the questions the CYAO would put to him.

The permission from Dr. Turner's adult children was forthwith sought, obtained and forwarded to his counsel on 06 August 2004. However, on 13 August 2004, Dr. Doucet's counsel, from what appears to me an abundance of caution, requested the CYAO, although not legally required, to obtain the consent of Dr. Turner's minor child as well. This was also pursued with diligence by the CYAO. The consent was sought on 19 August 2004, received on 12 October 2004 and forwarded on 13 October 2004. The next day, more than two months after the initial request, a copy of Dr. Turner's medical records was finally received by the CYAO.

In the early course of my own Review, I invited Dr. Doucet, via Notice of Witness, to be available to answer some further questions and, if need be, some expansion on the answers to questions asked at the previous interview. By

letter, dated 13 July 2005, I was informed by Dr. Doucet's counsel that Dr. Doucet,

> **having previously been interviewed by the Child Advocate's Office, and being under no obligation to appear as a witness, … that Dr. Doucet is still willing to assist the office, where possible.**

However, unless sufficient statutory authority can be provided … ,

> **he would not appear before me.**

If Dr. Doucet had consented to meet with me, I would have asked him questions deriving from the following "topics of discussion:"

- his involvement with Shirley Turner;
- diagnosis/treatment plan;
- medications prescribed;
- knowledge of suicide attempts and other prior history;
- sharing of information between him and agencies and individuals who had dealings with Shirley Turner;
- provision by him of a surety for Dr. Turner on 12 December 2001;

- his understanding of responsibilities/obligations of sureties;
- his understanding of the role of CYFS with Shirley Turner;

I also would have put the following question to him:

- If you had known all, or most, of the information held by other agencies and persons, would your diagnosis and management of Dr. Turner have been different?

I still do not know all the answers to these questions. It must be left to others to provide them. All I can do is present the reader the facts known to me, limited as they are. Otherwise, I recommend the following:

Recommendation 8.1
THAT the Departments of Psychology and/or Psychiatry at Memorial University of Newfoundland (MUN) complete a psychological autopsy on Dr. Shirley Jane Turner.

The function of the psychological autopsy (a post-mortem psychological investigation) is explained in a review

article in a 1998 volume of the Journal of Affective Disorders ("affective" meaning feelings and emotions, rather than thoughts):[2]

> **The psychological autopsy method of research is a valuable means of expanding our understanding of the factors that contribute to suicide and identifying potential preventive strategies. This intensive approach can also help ensure the correct interpretation of the results of epidemiological investigations [study of disease].**

Sources of information on which psychological autopsies rely include records of psychiatrists, psychologists, social agencies, law enforcements and the involved medical examiners; general practitioners (who treated the subject during his or her lifetime); hospital records (for the subject); and relatives and friends (of the subject).

However, the article cautions that

> **Psychological autopsy has its limitations and is associated with considerable problems. Careful planning can improve the reliability and value of this approach.**

The problems and resulting limitations of psychological autopsies, which may affect their validity and reliability,

include the results of interviews with relatives and friends. These interviews may involve 'recall bias' and/or unreliability. The authors of the review article explain:[3]

> **[Reference 'recall bias:'] Because of the complex nature of both bereavement following suicide and memory for emotion-laden events and relationships, the recall of information about a close relative or friend may be distorted. There may be selective recall of certain aspects (e.g., positive characteristics) and selective forgetting of others (e.g., negative characteristics), or vice versa.**
>
> **[Reference unreliability:] [I]nformation may be unreliable for other reasons, including the informant being unaware of certain factors (e.g., parents may not be aware of problems, such as drug taking, concerns about sexual orientation and relationship difficulties), and deliberately withholding information, especially that which may cast the dead individual in a bad light.**

However, the authors provide advice on steps which may be taken to minimize these shortcomings.

The "psychological autopsy," as defined in the article referred to by Dr. David Craig, M.D., FRCPC, a psychiatrist at the Health Sciences Centre in St. John's,[4] during his interview,

> **indicates a process which is both more extensive and more formal that what I have done in the past.**

However, Dr. Craig (who had professional dealings with Dr. Turner during her medical training and twice dealt with her professionally at the Clarenville Correctional Centre for Women), has undertaken several psychological autopsies during his professional career. He explains:

> **As is true for most psychiatrist practicing inpatient psychiatry, a number of patients have died by suicide while under my care. During the earlier years of my practice, in keeping with the recommendations of the literature, I would have these suicides reviewed by my peers by presenting the case in detail in a "case conference" approximately three months after the death of a patient. The presentation would include a full psychiatric history and mental status examination (i.e., the identification of the patient, his/her chief presenting complaint, the history of his/her presenting illness, his/her medical and psychiatric history, his/her personal history, his/her family history, his/her premorbid personality, his/her circumstances prior to admission, and the mental status examination findings) followed by a presentation of any relevant physical examination, the results of any laboratory and/or other investigations, the treatment given, and his/her subsequent in hospital or out of hospital course up to and including the events and/or circumstances preceding and/or leading up to death and the suicide itself. Following the medical presentation, there would normally be a presentation of the nursing findings by nursing staff and, if applicable, presentation by psychology staff and social work staff as well. All presenters would answer whatever questions were asked to the best of their ability, after which there would be discussion during which all present would express their opinions regarding the diagnosis and management of the patient as well as any**

recommendations for changes in the future care of other patients.

Dr. Craig said that

[t]he entire exercise was seen as a "quality assurance" activity, the main goal being to learn whatever lessons could be learned from the case in the hope of improving the care of future patients.

3. Psychiatric Services

3.1 Introduction

After Dr. Shirley Turner returned to St. John's, on 16 November 2001, she was seen by Dr. Doucet. Dr. Doucet first came to know her in 1997 when she was in her fourth year at Memorial University's Faculty of Medicine. While she was in training as a clinical clerk, she spent six to eight weeks in the Department of Psychiatry at The Health Sciences Centre, where Dr. Doucet was one of the staff psychiatrists. He met Dr. Turner again, but now as a patient, on 20 November 2001. She had been referred to him in particular, at her request, by her family physician in St. John's on 18 November 2001 for "having trouble with bereavement."[5]

Dr. Doucet saw Dr. Turner at regular intervals; in total 21 times. Initially, for a few visits, he saw her weekly; then, as needed, every two or three weeks. He last saw her on 15 July 2003. She missed her appointment with him on 18 August 2003. That was the day of her death.

3.2 Assessment

Dr. Turner's psychiatric treatment started with an assessment which consisted of obtaining a medical, psychological, psychiatric, social and family history, and included an evaluation of current stressors and a current mental status examination.

3.2 (a) Medical History

There was no recorded history of any serious medical problems.

3.2 (b) Family and Personal History

As recorded in the clinical notes by Dr. Doucet - based on what Dr. Turner told him - Shirley Turner's father may

have had problems with alcohol and drugs. Her mother had many problems in her life.

Dr. Turner informed Dr. Doucet that she had been born and raised in Bonne Bay; about the middle of eight children in the family. Her father died when she was very young, so she never knew him. But, she did have a close relationship with her stepfather. (I observe that, based on other findings in my Review, some of this information in Dr. Doucet's records is incorrect).

Some of Dr. Turner's early emotional needs, Dr. Doucet noted, were not met because she was a member of a large family. Her mother was rather strict and not very affectionate. She denies any abuse by her mother.

Shirley Turner always did well in school. She attended Memorial University and then taught for several years before, at the age of 35, entering medical school. She was married for the first time at age 20 and had two children, a son and a daughter, from that marriage. She remarried and had a daughter from the second marriage, who was 11 years of age at the time her mother returned to Newfoundland, in 2001. Prior

to starting medical school (in 1994), Shirley Turner separated (in 1991) from her second husband, although for a time he did occupy the same home in St. John's to care for the children while she pursued her studies. She completed her medical school training at Memorial University and did a Family Practice residency in this Province (1998-2000) before starting work in the United States (in 2000).

3.2 (c) Premorbid Personality

She was described as

always having goals and always pushing herself to achieve them.

3.2 (d) Psychiatric History

She had a history of depression during pregnancy.[6]

In 1991, a psychologist diagnosed a post-traumatic stress disorder (PTSD) after a motor vehicle accident. While a teacher in Arnold's Cove, she had struck a pedestrian and

thought she had killed him.

Dr. Turner did not reveal to Dr. Doucet - at the initial assessment, when such matters are dealt with - that she had gestured or attempted suicide on previous occasions. Some months later, after this information had become public knowledge, she informed Dr. Doucet of one such attempt. She apologized to him for not having told him about this before.

> **She forgot to mention it.**

She called it

> **a very impulsive act. It was just the pressure and being so overtired on the initial visit.**

She told Dr. Doucet that the suicide attempt, while undertaking her Family Practice residency program from 1998 to 2000, was triggered and fuelled by a combination of stressors:

> **the break up of a relationship, being away from the children**

while, at the same time,

> **trying to meet the strenuous demands of the general practice residency program.**[7]

(Unclear is which suicide attempt Dr. Turner eventually reported to Dr. Doucet. From 1998 to 2000 she was undertaking her medical residency training. The attempted suicide, which had become public knowledge, occurred on 07 April 1999 in Pennsylvania. The suicide attempt of which she spoke to Dr. Doucet occurred in 1998).

Dr. Turner never informed Dr. Doucet of the other suicide attempts in the United States.[8] She also failed to mention that she had suffered from a major psychiatric disorder involving depression in 1998 and 1999, for which another St. John's psychiatrist had treated her.

She also consulted psychiatrists in Halifax and in the United States. Just prior to returning to Canada, on the advice of her American lawyer, she consulted yet another psychiatrist and a psychologist.[9]

3.2 (e) Medication History

Dr Turner denied any alcohol or drug abuse. One of her psychiatrists in the United States had prescribed Ambien, a sleeping pill, and Ativan, a tranquilizer. She had stopped

taking these medications just prior to her visit with Dr. Doucet because

> **she had become aware, a few days earlier, that she was pregnant.**

On the first visit (20 November 2001), Dr. Doucet prescribed Celexa, an anti-depressant, and Lorazepam (Ativan). Again, she stopped taking these drugs because of her concerns regarding the possible effects of these medications on her unborn child.[10]

Dr. Turner was a recipient of medications for herself and Zachary through the Prescription Drug Program, a benefit provided to clients, such as her, receiving income support. Following a request by the CYAO to the Department of Human Resources, Labour and Employment (HRLE), copies of the drug program usage of both Shirley and Zachary Turner were obtained. These reports do not reflect any over-prescription or dual-prescription patterns.

3.3 Diagnosis

Dr. Doucet's diagnosis, at the time of the initial assessment, was that Dr. Turner probably suffered from what is classified in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-IV-TR)[11] [12] as an "adjustment disorder"[13] with mixed features of anxiety and depression (which are also bereavement[14] features), as well as some features of post traumatic stress disorder (PTSD). According to the medical records, and as stated in Dr. Doucet's interview with Dr. Neary and in a letter from him to the Royal Newfoundland Constabulary on 25 August 2003, this diagnosis, in essence, never changed from the primary assessment to the final event.[15]

3.4 Treatment

Dr. Doucet's treatment of Dr. Shirley Turner consisted of psychotherapy with supportive medicinal therapy. Psychotherapy is essentially based on talking with the patient, trying to define issues and discussing possible solutions and coping mechanisms.

The prescribed drugs were intended to alleviate Dr. Turner's anxiety, depression and insomnia. Most of the

medications were prescribed (and used) on an "as needed" basis.

3.5 Dr Turner's Psychiatric Profile

It is in fairness to all parties, including the late Dr. Shirley Turner, that she be understood and judged - if we must - not only by her actions, but also by the revelation of some of her thoughts, fears, motivations and illness from as much as she was willing (or able) to reveal of herself to her psychiatrist who, by all accounts, cared for her with compassion.

I would be remiss if I were not to give you some insight of what was going on in Dr. Turner's mind, based on the recorded information, which documented the professional interaction with her psychiatrist.[16] Why am I doing this? Because this information could have been obtained from Dr. Doucet by CYFS Social Workers. Dr. Turner, as we know, had given a CYFS social worker permission to contact Dr. Doucet and thus have access to the contents of these records and, more importantly, have an opportunity to mutually evaluate with Dr. Doucet any present or future implications of Dr. Turner's mental health on the well-being of Zachary.

As a physician, I am very much aware that medical records often contain sensitive material that could invade and impact on the privacy of third parties. I have therefore, to the extent possible, not included any information in my Findings contained in Dr. Turner's medical records which, in my view, was not necessary for the purpose of this Review.

I have summarized my Findings under three headings: (i) Psychiatric; (ii) Legal/Financial; and (iii) Familial.

3.5 (a) Psychiatric

On 20 November 2001, Dr. Shirley Turner visited Dr. Doucet for the first time. At that visit, as documented in a letter from Dr. Doucet to her referring physician, dated 22 November 2001, and in Dr. Doucet's assessment notes, she was

> **emotional, overwhelmed, fatigued, with a sense of being out of control, with an overwhelming sadness, and a feeling of being consumed by shock, disbelief, sadness and grief.**

She complained about

> **crying spells to the extent of exhausting herself, lack of sleep, poor appetite and distressing dreams. She suffered from horrific nightmares with images of bullet holes [in Andrew's body] as described by a friend.[17]**

Dr. Turner was, increasingly, severely stressed with episodic feelings of disassociation, unreality and shock. She felt overwhelmed by the death of Andrew, her pregnancy and the health of her older son. The media reports which implicated her as a suspect in her boyfriend's murder were very upsetting and hurtful to her. She suffered from episodes of excess worry, self-doubt, fears and loss of sleep, and expressed feelings of hopelessness and

> **fear for future, for self and her baby.**

Her stresses were considered extreme and, on occasion, overwhelming.

In January 2003, following her discharge from the Correctional Centre for Women, she suffered from increased emotional liability with

> **nightmares and recurrent themes of death, fear of death and dying of children.[18]**

I will account for Shirley Turner's last visit with the psychiatrist in more detail, now that we know what happened next.

On her last visit, 15 July 2003, she again expressed fear for the future for both herself and her children. Her uncertainty and lack of resolution were considered a chief stressor. Her mood was generally good; she was trying to be optimistic but was fatigued at times. She was not taking care of herself with respect to eating and sleeping. (The dates set for the hearing in the Newfoundland Court of Appeal of her appeal from the 14 November 2001 extradition order and related matters were 25 and 26 September 2003). She was prescribed 30 tablets of Ativan (Lorazepam), 0.5 mg twice a day, with no repeat.

She was due to be seen again on 18 August 2003, but without notification - which was unusual for her - she did not keep the appointment. That day Dr. Doucet was informed that Shirley Turner and her baby Zachary had been missing since the night before. They had been found dead.

I never had any concerns about her safety or the safety of the baby.

3.5 (b) Legal-Financial

Dr. Turner was continuously and increasingly concerned about and felt trapped by her legal and financial problems which at times overwhelmed her. Dr. Doucet noted:

> **More aware of the danger to self and unborn child from wrongful legal prosecution.**

Frustrated by her loss of control and inability to work, she applied for employment benefits and medical license.[19]

She feared for her baby, Dr. Doucet recorded,

> **for not being able to raise him, if she is imprisoned,**

and she feared there may be

> **no resolution to finding Andrew's murderer.**

Previous and ongoing experiences had undermined her confidence in the justice system, yet she

> **wanted resolution and the opportunity to clear herself against the charges**

at the upcoming extradition appeal hearing. However,

> **her experiences had shown how unreliable the justice system is and recognizes…risk of being found guilty, in spite of her innocence…. Feels a lack of support for her knowledge of herself as innocent.**

3.5 (c) Familial

Again from Dr. Doucet's notes, I learned she felt a need to protect her children and tried to help them cope with their fears for her:

> **Episodes of intensive fears of harm coming to them, somehow.**

She feared further losses: the loss of her friend;[20] the loss of work and independence.

Dr. Turner delivered Zachary, on 18 July 2002, following a difficult labour resulting in a C-section. She was exhausted and stressed after the delivery, but also relieved and happy with her healthy baby. She bonded well. She felt traumatized by the fact that, the day after the birth, Dr. Bagby's parents had attempted to see the baby and were trying to get custody of the child.

Recognizes they are clearly trying to take the baby away from her. She, nevertheless, would like not to prevent them from having access to the baby, if she can be assured of the baby's safety.

Dr. Turner often revealed tensions that existed between her and David and Kathleen Bagby, the paternal grandparents of her child. She felt that they did not accept her at first and was ambivalent about them. She felt powerless and helpless

to resolve what had happened to Andrew,

and how this

was interacting on her and on them.

She was feeling compelled to rely on the baby's grandparents and was

upset about loss of independence and fears of the increased control of the grandparents over the baby.

Shirley Turner was trying to balance her fears with what was best for the baby.

3.6 Interactions of Dr. John Doucet with government agencies, departments and other persons

During Dr. Turner's lifetime, there was, in essence, no communication by Dr. Doucet with CYFS, the CYAO, the community health nurse, and/or officials from the Provincial and Federal Departments of Justice, or any other professional people from other groups.

Any evidence I could find of contacts with other agencies is contained in the following sections (i) to (v):

3.6 (a) Department of Justice

(i) Surety

The only contact Dr. Doucet had with the justice system, while Dr. Turner was still alive, was in the form of a discussion with Dr. Turner's lawyer in the Court House on 12 December 2001 at the time he posted the $65,000 surety for Dr. Turner.

Regards the surety, Dr. Turner had telephoned Dr. Doucet from the Court House. He interpreted her request as

> **a cry for help.**

She later apologized to him for having asked him to do that for her.[21]

Dr. Doucet was not familiar with the conditions of the surety. He considered the surety merely

> **a temporary measure put in place by him prior to Shirley Turner's ability to get other sources in line, to prevent her from going to jail and thus not be able to look after her children.**

Dr. Turner told him she was stressed, unsure of whom else to call or who was available that afternoon. Dr. Doucet stated that he had no idea what it all meant - the conditions of the sureties. He only knew that she was charged with a murder and did not stay in court to hear the evidence.

> **He had never done this before,**

but, he wrote, acted in what he perceived to be

> **her best interest and his intent was to look after her health and well-being.**

His surety obligation was to stay in place until she found alternatives. It stayed in effect, in fact, until 14 November 2002, when she was incarcerated in Clarenville.

3.6 (a) (ii) Royal Newfoundland Constabulary (RNC)

On 20 August 2003, two days following Dr. Turner's death, Constable Noel Stanford of the RNC requested a report of Dr. Doucet's assessment and visits to him by Dr. Shirley Turner for

> **inclusion in his report.**

Following consents from the next-of-kin to allow Dr. Doucet to release the information, the report - a letter dated 25 August 2003 - was released to Constable Stanford on 27 August 2003.

Dr. Doucet mentioned in the letter he wrote to the RNC:

> **I saw nothing in my relationship with her that would indicate - she would be a risk to self or others, or that**

> **she could have harmed anyone else, and that is particularly the crime she was accused of.**

3.6 (b) Community Services

Dr. Doucet was not aware that, apart from their assumed involvement in the custody proceeding commenced by the Bagbys (an assumption that was incorrect), any of the social agencies were involved with Dr. Turner. Dr. Doucet stated in the interview:

> **I don't know who belongs to what here, in terms of government departments, which is Child Protection, which is social workers, which are Community Services, which are Public Health, etc. It is all a confusing array.**

Dr. Turner never discussed her involvement with 'community services' with Dr. Doucet.

As Dr. Doucet did not have contact with any of the social workers involved with Dr. Turner,[22] he was not aware that she had given CYFS permission for him to be interviewed by the assessment social worker. That interview never took place.

One may ask: Why did Dr. Doucet never seek information from CYFS or the police? To what extent was he responsible to check-up on the veracity of what he was told by Dr. Turner? Was she 'putting him on'? Did she deceive or lie to him?

Dr. Doucet stressed the fact that a treating Clinical Psychiatrist, like himself, does not have the same responsibility or approach to the patient that a Forensic Psychiatrist would have. That is true and, in order to be fair to him, I will address this in more detail.

A treating psychiatrist may check out certain facts but only as they may play a role in the treatment and care of the patient, not to assist in the administration of justice. Dr. Doucet is not a Forensic Psychiatrist.[23] The relationship with a Clinical Psychiatrist (a therapist) is different from that of a Forensic Psychiatrist (an assessor):

> **A therapist does not get overly involved with what "really" happened. The patient's psychic reality is reality. In part, this is related to the fact that psychotherapy is a context laden with persuasion and suggestibility. Therapy has been described as "developing a storyline" with the patient - where**

they have been, where they are, and where they want to go.

Clinicians (Clinical Psychiatrists) … are concerned with sympathetically treating presumptively victimized patients, not with any skeptical analysis of historical claims.

Mental health professionals are not trained fact-finders. It is neither the function nor the goal of the clinician in the normal therapeutic setting to determine the factual reality of what the patient is saying; the purpose of the clinical experience is therapy and, by and large, the truth is whatever the patient says it is. The therapeutic relationship must be based on acceptance and trust, and a therapist is not going to enhance this relationship by challenging or questioning the patient's story when she describes what happened to her as a child. In many instances, the therapist will, instead, assure the patient … that he believes her story. The factual truth is not the point in therapy; rather, the point is for the patient to make sense of the experience and to heal. Sometimes this principle is referred to in psychiatry as "the shared delusion." Other psychiatrists sum it up differently: "The patient never lies." Therapists are, by nature and training, healers, not truth finders.[24]

3.6 (c) Interaction with the Chief Medical Examiner's Office

Dr. Doucet met, briefly, with Dr. Charles Hutton (the pathologist who conducted forensic autopsies of the remains of

Dr. Turner and Zachary) on the morning prior to the autopsies. He informed the pathologist that,

> **in spite of severe stress that she had been under, I never had any concern about her safety or the safety of her baby.**

Dr. Simon Avis decided not to have contact with Dr. Doucet.

3.6 (d) Interaction with public health

Dr. Doucet did not know that the community health nurse had so-called "admitted" Shirley Turner into her program for depression in June 2002. There was no formal or informal communication between the psychiatrist and community health, or any of the other health services for that matter.

3.6 (e) Interaction with the Newfoundland and Labrador College of Physicians and Surgeons

(i) Complaint of David and Kathleen Bagby

On 22 October 2004, the first Child and Youth Advocate requested information regarding a complaint made by David and Kathleen Bagby to the Newfoundland Medical Board (now the College of Physicians and Surgeons) in their letter dated 05 December 2003. The first Child Advocate stated:

> **hearing about the results of such an inquiry (with regards to the appropriateness of the surety posted by Dr. Doucet), might impact on the recommendations in his Report.**

The Child and Youth Advocate received a letter on 17 December 2004 in which the Medical Board, in essence, responded that in accordance with policy, they were not in a position to either confirm or deny that the grandparents of this child had laid a complaint with the Medical Board against Dr. John Doucet.

3.6 (e) (ii) The Medical Board (Newfoundland and Labrador College of Physicians and Surgeons) hearing

As the posting of $65,000 in surety by Dr. Doucet on behalf of Shirley Turner on 12 December 2001 might be considered a violation of boundaries between doctor and patient, the matter was addressed in a public hearing held in St.

John's on Sunday, 26 February 2006. On 20 March 2006, the Newfoundland and Labrador College of Physicians and Surgeons found Dr. Doucet guilty of professional misconduct. As it is the College of Physicians and Surgeons that had the authority to deal with the complaint of David and Kathleen Bagby and that Body, now having heard, decided on the complaint and exacted a penalty, it is not appropriate, nor necessary, for me to comment further.

3.7 Psychiatric care in Newfoundland and Labrador Correctional Centre for Women in Clarenville

There was one other opportunity for Shirley Turner to obtain help for her mental health issues. Both Her Majesty's Penitentiary in St. John's for men and the Newfoundland and Labrador Correctional Centre for Women in Clarenville have the benefit of a visiting psychiatrist, Dr. David Craig, who is a staff member of the Health Sciences Centre in St. John's. When admitted to the Correctional Centre in Clarenville, this psychiatrist examined her. He placed her on suicide watch but took her off all medication. Not being a psychiatrist, I was puzzled by this apparent contradiction. I was informed, by other sources, that it is not uncommon for Dr. Craig to withdraw all prescribed medication on admission to prison.

During her time in the Correctional Centre, Shirley Turner's behaviour was disruptive and disturbing to her fellow inmates. She was only provided, for a short time after admission, with Ativan as previously prescribed by Dr. Doucet.

3.8 Conclusion and recommendations

As with community services, there seemed to be so many opportunities lost to fully assess Shirley Turner's psychological state or to assist her in facing the reality of her situation. As I have stated before, this was a situation that was highly publicized, so not a private matter. I cannot imagine that there were many people in Newfoundland who were not aware of the serious charges pending against Dr. Turner, and that the welfare of a very young infant was involved. What remains particularly troubling to me is the failure of community and psychiatric services to consult with one another. Clearly, the impetus for such consultation should come from the community services system. Nevertheless, I would have expected that within psychiatric services there might be some concern for the safety and security of a child as young as Zachary.

I recommend, therefore:

Recommendation 8.2
THAT issues in Forensic Psychiatry be addressed not only in the education and training of general psychiatrists, but also be part of a continuing medical education program.

Recommendation 8.3
THAT lectures in "Physicians and the Law" be offered at Memorial University's Faculty of Medicine, both at the undergraduate and postgraduate levels, such lectures to include coverage of child protection issues.

Implementation of these recommendations - indeed, implementation of all the recommendations in my Findings - will not serve as a panacea capable of rectifying the oversights I found during my Review, which may have contributed to Zachary Turner's death.

The reason?

This requires reference to the question posed near the start of this chapter: what about Dr. Shirley Turner?

Professional services providers, who interacted with Dr. Turner from her return to Newfoundland in November 2001 until the deaths of her and Zachary in 2003, had one thing in common. Dr. Turner provided each of them with misinformation, exaggerated information and incomplete information, and withheld from them pertinent information.

Without accurate, complete, pertinent information, service providers were impeded in their ability to properly assist Dr. Turner. Likewise, they were unable to properly assist her younger son and younger daughter.

Critically acquiring, recording, assessing, analyzing and applying complete and relevant information - absent in abundance in the circumstances of my Review - is crucial to the effectiveness of these and the other recommendations in my Findings.

[Notes to Chapter 8]

[1] The CYAO's lack of subpoena power has caused considerable delays and much frustration, not only in the delivery of my Findings but also at the initial CYAO review.

[2] Hawton, Keith; Appleby, Louis; Platt, Stephen; Foster, Tom; Cooper, Jayne; Malmberg, Aslog, and Simkin, Sue, "The psychological autopsy approach to studying suicide: a review of methodological issues," Journal of Affective Disorders 50 (1998), pp.269-276.

[3] Ibid., p.274.

[4] Interview with, and letter to David C. Day, Q.C., 24 February 2006.

[5] In the letter to Dr. Turner's general practitioner, Dr. Doucet expressed the opinion that Dr. Turner "*had a very high risk for development of a major depressive disorder."*

[6] Dr. Turner certainly manifested that again during her pregnancy with Zachary. According to the Health Sciences Centre records, she was not considered depressed on discharge from the hospital; yet she called for medical help the next day.

[7] During her second year of medical clerkship in 1997, when her children left St. John's to live with their father, Shirley Turner "had a very difficult time." She had two weeks of stress-leave prior to starting the Family Practice residency program in 1998. As well, there were some severe conflicts with her capacity to carry on in her role as a mother and the demands from a residency supervisor. During the residency program, she suffered from severe headaches and was seen by a neurologist. A brain CT scan was entirely normal.

[8] Nowhere in the clinical notes of Dr. Doucet does he give any indication that he ever asked about suicidal tendencies of Shirley Turner.

[9] I do not consider the enlisting of Dr. Carol Ross, a friend and confidant, as her psychiatrist, a valid psychiatric consultation.

[10] Regards access to drugs by Dr. Turner (i.e., Ativan, which possibly played a role in her death and certainly in Zachary's death), Dr. Turner was, since her return to Newfoundland in November 2001, not licensed to practice medicine in Newfoundland. She could therefore not have self-prescribed. There is no recorded evidence that, as a patient, she obtained

free drug samples. She could, however, have "saved" any of the prescribed medications including, but not limited to, Ativan. On the day prior to her and her son being found dead, she had filled a prescription for Ativan prescribed to her a month earlier on 15 July 2003 by Dr. Doucet. There is credible evidence in the form of an empty vial in her apartment that, certainly, the July 2003 prescription was used around the time of her and Zachary's death. As mentioned elsewhere, no complete drug analysis - only a screen for Ativan - was done on Dr. Turner.

[11] The DSM mostly concerns itself with the description of behaviours while largely ignoring the issue of what causes those behaviours. One can be given the label of borderline personality disorder, for example, if one manifests five out of a list of nine rather vague behaviours such as inappropriate intense anger, chronic feelings of emptiness, a persistently unstable self-image, or a pattern of unstable and intense interpersonal relationship. But there is no mention of what might cause such symptoms. Often avoiding the issue of cause, the DSM encourages psychiatrists and therapists alike to believe they have diagnosed the patient when they have only described the patient's symptoms. (DSM-IV-TR, p.147).

[12] One of the foundations of modern psychiatry and psychology, the authoritative *Diagnostic and Statistical Manual of Mental Disorders* (DSM-lV) - an encyclopedic catalogue intended to be used to diagnose, in a consistent fashion, psychiatric diseases based on clinical symptoms - has been exposed as an arbitrary nosology rather than a scientific work.

[13] The essential feature of an adjustment disorder is a psychological response to an identifiable stressor or stressors that results in the development of clinically-significant emotional or behavioural symptoms. By definition, the disturbance in adjustment disorder begins within three months of the onset of a stressor, and lasts no longer than six months after the stressor or its consequences have ceased. If the stressor or its consequences persist, the adjustment disorder may also persist. (DSM-IV-TR, p.683).

[14] "Bereavement" is generally diagnosed instead of an adjustment disorder when the reaction is an expectable response to the death of a loved one.

[15] Dr. Doucet did not consider Dr. Shirley Turner's symptomatology indicative or consistent with a Personality Disorder such as "Borderline" (BPD). If one were to take into consideration the excessive rejection reactions, the suicidal attempts, the manipulation of others that Dr. Turner manifested, and the other personality traits addressed in my Findings, other psychiatrists (and indeed Dr. Doucet himself), if aware of these behaviour patterns, may well have reached a different diagnosis.

[16] During Dr. Doucet's last hearing before a tribunal of the Newfoundland and Labrador College of Physicians and Surgeons, the medical records were not entered into evidence as they were deemed not to be relevant to the subject of the hearing. If they had been entered into evidence, I would have been legally less (but ethically still) restrained in my accounting of them in that they would have been part of the public record.

[17] Dr. Carol Ross.

[18] Apparently, in accordance with policy, Dr. Turner was abruptly taken off her anti-depressant medication on admission to the Clarenville Correctional Centre in December 2002. The medication was later continued (half-strength), prescribed by another physician.

[19] In a letter dated April 5, 2005, Dr. Robert Young informed me that the College was unable to disclose whether Dr. Turner ever applied for her medical license, but was able to inform us that no license was issued. *"The College is not authorized to disclose information regarding an application for purposes other than assessing that applicant for licensure, in the absence of any statutory or other lawful authorization for making such disclosure."* Later I was informed by the College that Dr. Turner did apply and had been approved for licensing as stated. No license was ever issued.

[20] Dr. Carol Ross (who had committed suicide) in April 2003.

[21]None of this is recorded in Dr. Turner's medical records.

[22] According to the social worker, he did not return her calls to him.

[23] Dr. Doucet received "a couple of months" training in forensic psychiatry. This training, to his knowledge, is optional in the training of clinical psychiatrists in Canada.

[24] Harry N. MacLean, *Once upon a Time: A True Story of Memory, Murder and the Law* (New York: Harper Collins, 1993), pp. 356-357.

Chapter 9

Delivery of Financial Services

1. Introduction[1]

Financial services delivered by the Government of Newfoundland and Labrador to Dr. Shirley Turner for herself and two of her four children - the younger son, Zachary, and the younger daughter - disclosed little of significance to my Review concerning circumstances of and surrounding Zachary's death. Nonetheless, financial services' delivery confirmed and augmented my insights respecting Dr. Turner.

Although she arrived in St. John's (via Toronto and Deer Lake) from Iowa on 16 November 2001 and was unemployed, Dr. Turner did not avail of financial services until January 2002. Meanwhile, she made frequent substantial bank withdrawals in cash, which depleted what appeared to have been her savings. Her deposition of these funds I was unable to establish.

Commencing January 2002, however, she was as resourceful in obtaining financial services from the Department of Human Resources, Labour and Employment as she was in accessing services from the St. John's Regional Health and Community Services Board (see Chapter 7).

In summary, from 14 January 2002 until her death on 18 August 2003, she was dependent on financial support in the sum of $23,428.56 disbursed under the provisions of the *Social Assistance Act* administered by HRLE. The payments were:

(i) short-term, for herself from 14 January to 16 February 2002;

(ii) long-term, for herself (except for most of the period she was incarcerated) and for her younger daughter during part of the period 16 February 2002 to 18 August 2003, and for her younger son Zachary from his birth date, 18 July 2002, until 18 August 2003.

Included were HRLE payments of:

(iii) $400 for furniture (2 beds) based on inadequate disclosure or misrepresentations to HRLE by Dr. Turner;

(iv) $50 for moving expenses;

(v) $3,664.52 for Dr. Turner's funeral (of which a substantial portion was recouped from a Canada Pension Plan Death Benefit); and

(vi) $525 for apartment damage deposits.

(Additionally, Dr. Turner received some financial assistance for eye-examinations, medications, a breast pump and bus transportation).

2. Short-Term Assistance

Upon arrival in St. John's, on 16 November 2001, when her older (first-marriage) son was admitted to hospital (for his 12 November auto accident related injuries), Dr. Turner settled in the son's apartment. She continued to stay there after her older son was discharged from hospital, on 27 November 2001, until 05 January 2002. When her son left St. John's to spend the New Year's season with his paternal grandmother in Parsons Pond in late December 2002, he asked his mother to vacate his apartment by the time he returned; principally because she sold a computer he and friends had built.

On 05 January 2002, about the time her older son came back to St. John's, Dr. Turner moved into a 'bachelor' apartment on Campbell Avenue, St. John's (taking her son's camcorder with her).

On 09 January 2002, she applied for social assistance (File # 694-992) through the HRLE application process. She noted that she was pregnant (expected date of confinement - July 2002) and therefore unable to work. HRLE's file recorded that she had been previously employed as a physician at Alegent Health Clinic in Council Bluffs, Iowa, but had been "fired" - followed by the notation (in brackets):

charged with murder.

On 12 January 2002, Dr. John Doucet, her psychiatrist, provided a letter to HRLE stating that Dr. Turner was being followed by him

on a regular basis, [and that she was] **presently unable to work.**

The HRLE file records show the following sequence of events:

(a) 09 January 2002 - Dr. Turner signed "Reporting Requirements" and "Release of Information" forms;

(b) 14 January 2002 - an "Application for Income Support" completed by Dr. Turner was received by HRLE;

(c) 14 January 2002 - short-term monthly assistance payment was issued to Dr. Turner (in the amount of $806);

(d) 17 January 2002 - Dr. Turner was seen by HRLE when an "Intake Screening Information Form" was completed.

3. Long-Term Assistance

On 16 February 2002, Dr. Turner was transferred by HRLE to long-term assistance.

Apparently anticipating a visit from her two daughters, Dr. Turner, in March 2002, sought to justify to HRLE the need for a larger apartment

> **due to my change in family status and my new baby due July 13/02, we are looking for a larger apartment. Do you help with a damage deposit?**

(The quoted excerpt is from a letter, dated 05 March 2002, from Dr. Turner to HRLE which, in reporting "my change in family status," omits reference to the fact her two daughters were coming to visit, not to stay).

Back in Iowa, the State's unemployment insurance administration was considering a benefits application from Dr. Turner. Its 2002 decision shed light on the circumstances of Dr. Turner's departure from Iowa on 12 November 2001, shortly after Dr. Bagby's murder in Pennsylvania on 05 November 2001. Dr. Turner told various persons she had taken (i) vacation or (ii) a leave of absence from her professional position in Iowa to travel to Canada on 12 November 2001, and subsequently said that she had eventually resigned from the position. The Affidavit she filed in support of her application to the Court of Appeal for 'bail,' sworn on

07 January 2003 (an application granted on 10 January 2003), included the following:

> **I traveled from [Council Bluffs, Iowa via] Omaha, Nebraska to Toronto [on 12 November 2001] to visit family during leave from my occupation as a family physician. My employer (Alegent Health Clinic) had granted me an indeterminate unpaid period of leave after I had received news of the death of a very close friend on November 6th, 2001. I had originally planned to spend about three weeks in Canada and my return flight was booked and paid for (return date of November 30th, 2001). …. [Because her son was involved in a motor vehicle accident on 12 November 2001 in Newfoundland] I was trying to arrange through counsel in Omaha a period of unpaid leave to include the month of December 2001. I hoped to return to work early in the New Year 2002. I wished to extend my leave in order to deal with the new stressors in my life. …. [After a warrant for her arrest on charges she had murdered Dr. Bagby was issued in Pennsylvania in late November 2001] I was informed that the media had reported I was fired from my occupation.**

However, in a 26 March 2002 decision, the Iowa unemployment insurance administration refused Dr. Turner's benefits application because

> **[o]ur records indicate you voluntarily quit work on November 6, 2001, by refusing to continue working. Your quitting was not caused by your employer.**

(Dr. Turner had been granted licensure and hospital privileges in her position with Alegent Health Clinic in Council Bluffs, Iowa, effective 05 November 2002. On that date she was traveling to, then back from, Latrobe, Pennsylvania. The following day, 06 November 2002, was the first - and only - day she worked in the Clinic position; a day when she arrived late, because she was returning from Pennsylvania. As well as having to have her vehicle washed, she needed to shower and change her clothes before going to work).

To return to Dr. Turner's dealings with HRLE in St. John's, Dr. Turner's application for a larger apartment was approved and she moved to Pleasant Street on 01 April 2002.

In the interim, on 29 March 2002, Dr. Turner's two daughters came for a visit (the older daughter from Toronto; the younger daughter from Portland Creek).

Within a week of arrival, the older daughter left in early April 2002 after Dr. Turner slapped her face. When, on 23 April 2002, HRLE discovered that the older daughter had left

in early April, Dr. Turner's long-term assistant payment was reduced accordingly.

Dr. Turner had made a verbal agreement with her second ex-husband, father of the younger daughter, that following the visit with her, the younger daughter would return to him on 07 April 2002. As noted previously (see Chapter 5), the younger daughter did not return to her father's home in Portland Creek on 07 April, but continued to reside with Dr. Turner at her Pleasant Street apartment after the agreed visiting period.

On 06 December 2002, during the period (14 November 2001 to 10 January 2002) when Dr. Turner was incarcerated, the HRLE file states

As per previous decision relayed to client will issue . . . .

Four codes are then documented, two from 01 to 15 December and two from 01 to 31 December, for a total amount of $528.27

to be picked up by either Ms. … or Ms. …

(friends of Dr. Turner). Presumably this amount represented or included funds to maintain accommodation for Dr. Turner's younger daughter who stayed on in St. John's from the date her mother was incarcerated, on 14 November 2001, until 23 December 2002 when she departed St. John's to travel by road to her father's residence in Portland Creek.

Long-term assistance resumed on 10 January 2003, the date Dr. Turner was granted release by the Court of Appeal.

Dr. Turner resided with her St. John's girlfriend and the girlfriend's husband from 10 to 15 January 2003, and then rented an apartment on O'Reilly Street.

On 01 August 2003, Shirley Turner was successful in obtaining a home on Brophy Place - a two-storey attached dwelling in a complex owned by the Newfoundland and Labrador Housing Corporation. The web site of the Corporation states that:

> **Through the Rental Housing Program we help low-income households that cannot obtain suitable and affordable rental housing on the private market.**

At the time of her death, Shirley Turner, Zachary, her older son and his girlfriend were all residents of Brophy Place. Her younger daughter was also officially a resident but was then visiting her father.

4. Furniture

On 12 April 2002, there were notations in the HRLE file including the fact Dr. Turner

> **is presently charged with murder and awaiting trial.**

She then applied for funds for beds for both of her two daughters. She was issued $400 (the maximum allowance payable) to purchase them. By the time Dr. Turner had applied for the beds, the older daughter had long gone. The younger daughter was still living with her.

Interestingly, the HRLE Income Support Policy and Procedure Manual (paragraph 5201) states that

> **Except for emergencies (Section 5202), clients should be in receipt of Income Support for at least <u>twenty-four consecutive months</u> [emphasis mine] before furniture item(s) may be approved.**

Section 5202 of the HRLE Manual states that emergency situations include the following: (i) victims of a non-declared disaster (fire, flood, etc.); (ii) those leaving abusive situations, and (iii) extreme hardship.

The request for the beds was granted, I assume, on the basis of Dr. Turner's misinformation to HRLE that both – when, in fact, only one - of her daughters were living with her at Pleasant Street. (Only the younger daughter was living with her, and that daughter's continued residence with Dr. Turner was then an issue before Unified Family Court on the strength of an application by the younger daughter's father which the Court was never called upon to resolve).

The HRLE Financial Assistance Officer noted on Dr. Turner's file that the older daughter had

> **recently returned from Ontario and is attending school in this province.**

Further, letters from Dr. Turner in the HRLE file stated that the younger daughter moved in with her on 05 March 2002 (a letter, dated 05 March 2002), and her older daughter took up

residence with her on 25 March 2002 (a letter dated 03 April 2002). An undated note on the file from Dr. Turner states

> **my oldest daughter … has decided to return to Toronto, Ont (Mississauga) on May 1, 2002.**

All of this information was false.

The two daughters had traveled to St. John's together on 29 March 2002. The older daughter's paternal grandmother recalled that Dr. Turner had been trying for some time to persuade her younger daughter, then in Portland Creek, to join her in St. John's, but that the child's father was not in agreement. When the older daughter returned to Newfoundland in March 2002 for a visit, however, the father permitted the younger daughter to travel with her to St. John's for a short visit with their mother.

When interviewed on behalf of the first Child and Youth Advocate, the older daughter was asked whether she was with her mother from 25 March 2002 to 01 May 2002. The daughter was quoted as replying:

> **That wasn't true. I know she wrote the letter saying I was, but I wasn't.**

Her mother told her she was going to write a letter to HRLE saying that the older daughter was living with her, but that daughter could not remember why Dr. Turner wanted to do this. The older daughter went on to say:

> **I remember now. I was home living with her for a while. I was supposed to be staying with her, but we rowed out.**

Apparently her boyfriend returned from Ontario to Newfoundland around that time and she wanted to be with him on the west coast of the Province. However, Dr. Turner had wanted her older daughter to stay with her. During the 'row,' her mother slapped her face. The older daughter felt that she deserved to be slapped because she had called her mother a "bitch." Following that incident, however, her paternal Parsons Pond grandmother purchased a plane ticket for her to visit there (via Deer Lake). The older daughter's recollection was that she stayed with Dr. Turner for about one week.

5. Child Support

Social Assistance Regulations (1027/96) section 25 required that

> **[e]very person receiving social assistance on behalf of himself, or herself or a family shall promptly notify an officer of the department of the following: (a) a change of address …; (b) if any of his or her children leave home; … [and] (i) a change in the financial circumstances of the family.**

When Shirley Turner included both her daughters in her financial services claim, HRLE was by law required to collect on any existing financial support orders for the two daughters. On 15 April 2002, Dr. Turner's HRLE worker wrote

> **Client has 2 separate court orders for support which when SEPS [Support Enforcement Program Services] was checked no account exists for either. Client is going to register these.**

By April 2002, the HRLE file included a judgment (Divorce Registry No. 96/08341) issued by the Unified Family Court on 21 February 1997. Under the judgment, Dr. Turner was awarded custody of the younger daughter, subject to the second-marriage birth father being granted "reasonable access." The former husband was required to pay $150 monthly to the Director of Support Enforcement.

Dr. Turner stated to HRLE that this former husband was in arrears of child support from 01 April 2002.

I note that although Dr. Turner had left the younger daughter with her father from February 1997, when the child support order was made, to 31 March 2002, he had nonetheless paid Dr. Turner the Court-ordered $150 support amount throughout that period (even though the daughter lived continuously with him for all of that period).

The support order, obligating the father of Dr. Turner's younger daughter to continue paying child support, was registered effective from 13 May 2002.

As for the older daughter, the obligation of her father to pay for her support, ordered when Dr. Turner divorced her first husband in 1988, had lapsed in 2000 when the daughter left Dr. Turner's custody to reside in Ontario. An undated note on the HRLE file stated that Dr. Turner did not complete the form (Assessment for Referral for Child/Spousal Support) as per discussion with (the worker) because her oldest daughter had

> **decided to return to Toronto on May 1, 2002. She has lined up a job there in a factory.**

The HRLE file shows that Dr. Turner had, by April 2002, been requested by HRLE to apply for an order that the

first-marriage husband resume child support payments for the older daughter. (HRLE based this request on its understanding from Dr. Turner that the older daughter was now living with her). Dr. Turner never filed the requested application, of course, because the older daughter wasn't living with her.

Of interest was that Dr. Turner's United States income tax return for 2001 did not include any indication that she had been receiving any child financial support.

6. Summary

My Review did not identify any major issues or problems with respect to the performance by HRLE except for an overpayment of $525 for apartment rental damage deposits. Efforts to recover this payment involved having Dr. Turner repay the overpayment, by small installments, which were deducted from her subsequent monthly social assistance cheques. A balance of $192.49 owing after Dr. Turner's death was written off.

It is evident that HRLE provided a consistent level of financial support for the basic needs and housing of Dr. Turner and two of her four children in a timely manner.

I saw no evidence that HRLE was aware of any protection concerns. File notes on 10 January 2003 (apparently based on what Dr. Turner told HRLE) state

> **She has been released from custody today . . . 6 month old son Zachary has been given to the mother.**

The wording is interesting, and perhaps significant. The fact that it states Dr. Turner was "given" the child would, presumably have indicated to HRLE that there were no concerns about the care she would provide. The notes also briefly refer again to her being charged with murder.

The only recorded contact by HRLE with Child, Youth and Family Services at the St. John's Board was an internal HRLE record, dated 30 August 2002. It concerned supplementary payments Dr. Turner had requested with respect to her younger daughter and Zachary. This record referred to a

call from social worker - Child Abuse and Family Services supporting Dr. Turner's financial hardship situation.

I found no evidence of any resulting coordinated plan of action to provide supplementary payments for the two children.

[Notes to Chapter 9]

[1] Chapter 9 relies on the following documentary sources: (i) Department of Human Resources, Labour and Employment File No. 694-993; (ii) sworn statement from The Honourable Paul Shelley, Minister of Resources, Labour and Employment dated 19 January 2006; (iii) sections of Department of Human Resources, Labour and Employment: "Income Support Policy and Procedure Manual" (revised: 01–06–2001) with respect to Basic Assistance; Special Needs; and Administration of Social Assistance; and (iv) *Social Assistance Regulations* under the *Social Assistance Act* (1996 to 2003).

Chapter 10

Office of Medical Examiner

1. Introduction

1.1 Origins

The Chief Medical Examiner is responsible for investigating questionable (sometimes called, sudden and unexpected) deaths under the *Fatalities Investigations Act*.[1]

Investigation of these deaths is regarded by the Province as being in the public interest; serving both the criminal and civil justice and public health systems, and informing the public (for its protection and public safety).

Historically, most provinces and territories adopted England's coroner system. A coroner is a state-appointed person, who routinely investigates questionable deaths at an inquest. An inquest is a public hearing conducted by a coroner who, in the presence of a jury, receives relevant evidence - testimony, documents and other matters - from persons summoned by the coroner. The evidence customarily includes results of an autopsy. An autopsy involves the dissection of a body and examination of its organs and tissues. An autopsy is performed by a pathologist. A pathologist is a medical doctor

specially trained in the study of causes, symptoms and effects of disease in the human body. A forensic pathologist examines not only what diseases do to persons, but also what people do to each other and to themselves.

Based on evidence received by the coroner at the inquest, the jury makes findings of fact and recommendations mainly designed to avoid repetition of the death being investigated at the inquest.

Newfoundland, at least for part of its colonial period, had a coroner system. I am not acquainted with the inception date. However, the system operated in Newfoundland up to 18 April 1875.[2] Commencing 18 April 1875, stipendiary magistrates (since 1979 know as provincial court judges) exercised all the powers of a coroner but functioned in that role without juries.[3] On or after 31 March 1949 when Newfoundland joined Confederation, responsibility for investigating deaths was given to pathologists appointed by the Province, subject to the Province's right to direct magistrates (later, provincial court judges) to conduct a judicial death inquiry where the Province felt to be necessary.

I served as a Province-appointed forensic pathologist, while employed as Chief of Autopsy Services at The General Hospital, St. John's, from 1970 to 1976.

As a state-appointed forensic pathologist, I was mandated to investigate and determine the circumstances of and surrounding questionable deaths including the cause(s) - but not the manner - of death. Questionable death investigations were conducted under *The Summary Jurisdiction Act*[4] up to 03 November 1980 and, from that date, under *The Summary Proceedings Act*[5] subject, as historically, to the Province's right to direct provincial court judges (formerly magistrates) to conduct a judicial death inquiry.

Recently, like some other provinces, Newfoundland adopted a medical examiner system. The medical examiner system reflects some characteristics of the coroner process.

Although I was appointed the Province's first Medical Examiner (Designate) in 1974, the Office of Medical Examiner was not established until 1996.

1.2 Legislation

The medical examiner system in Newfoundland is administered by the Chief Medical Examiner. The Office of Medical Examiner was created by the *Fatalities Investigations Act*[6] which came into force on 01 September 1996. At times material to my Review the officer-holder was, and continues to be, Dr. Simon Avis. As required by section 3(1) of the *Act*,[7] he is a pathologist

with training or experience in forensic pathology.

Dr. Avis has had considerable training and experience in this specialized medical field. (Forensic pathology is a specialty of medical science that employs medical knowledge for legal purposes. For example, a forensic pathologist may render an opinion, resulting from the conduct of an autopsy, that damage to the structures of the neck of a deceased who, during his or her lifetime, had physical contact with another person, is consistent with manual strangulation; a manner of death classified by pathologists as "homicide." Whether a homicidal death in turn amounts in law to murder is an issue that only a court can determine).

Dr. Avis was appointed the Province's present Chief Medical Examiner by the Lieutenant-Governor-in-Council (in

effect, the Cabinet) of the Government of Newfoundland and Labrador).

The *Fatalities Investigations Act* details the functions, powers and duties of the Chief Medical Examiner.

1.3 Functions

Speaking generally, as stated before, the function of the Office of the Medical Examiner is to investigate questionable deaths. The Chief Medical Examiner is expected to conduct the questionable death investigations in co-operation with, although independently from, the Director of Public Prosecutions, and the Royal Newfoundland Constabulary (RNC) and Royal Canadian Mounted Police (RCMP) - the two police forces operating in the Province.

"The Chief Medical Examiner," to quote esteemed Newfoundland lawyer Gerald F. O'Brien, Q.C., "is not a police groupie."

To help him perform his work, the Chief Medical Examiner has appointed a number of physicians in

Newfoundland as Medical Examiners. He is also assisted by Medical Examiner Investigators, subject to his direction, who are members of the RNC and RCMP, and other persons who are appointed by the Chief Medical Examiner.

Questionable deaths, subject to investigation by the Office of the Medical Examiner, include those which he is satisfied have occurred - in the language of section 5(a) of the *Fatalities Investigations Act*[8]

as a result of violence, accident or suicide.

Other death circumstances which, in the Chief Medical Examiner's judgment, may require investigation are enumerated elsewhere in section 5 as well as in sections 6, 7 and 8 of the *Act*.[9] They include deaths in health care facilities, jails and workplaces.

The principal means employed by the Office of the Medical Examiner to investigate death is the post-mortem (after death) examination.

The post-mortem examination may include examination of an unclothed body without removal of any organs, tissues or fluids, or may involve an autopsy. As defined by section 2(a) of the *Fatalities Investigations Act*,[10] an autopsy means

> **the dissection of a body for the purpose of examining organs and tissues to determine the cause of death or manner of death or the identity of the person and may include chemical, histological, microbiological or serological tests and other laboratory investigations.**

A chemical investigation may include drugs or poisons and sugar and salt (electrolytes) levels. Histology involves the microscopic examination of body tissues. Microbiology involves the study of bacteria, parasites and viruses. Serology involves the examination of blood, now often replaced by DNA profiling. The autopsy will usually involve the removal and retention of some or many body organs, tissues and fluids.

The goals of a death investigation by the Office of the Medical Examiner are to attempt to establish under section 10(1) of the *Fatalities Investigation Act:*[11] (i) identity of the deceased; (ii) date, time and place of death; (iii) cause of death (e.g., the mechanisms involved in drowning); and (iv) manner of death.

"Manner of death" as defined by *Fatalities Investigations Act* section 2(f)[12] means

> **the mode or method of death whether natural, homicidal, suicidal, accidental or undeterminable.**

Until the advent of the *Fatalities Investigations Act,* persons responsible in Newfoundland for questionable death investigations - coroner, magistrate (later, provincial court judges) and state-appointed pathologists - were required to determine cause but not manner of death. (For example, they could conclude that a person's cause of death was drowning, but not that the manner of death, caused by drowning, was suicide).

After a questionable death has been investigated by the Office of the Medical Examiner, a medical certificate of death[13] must be issued and signed in the person of either the Chief Medical Examiner, a Medical Examiner, or someone (a physician or nurse practitioner) he consents to doing so.

When a deceased's remains are no longer required, the Office of the Medical Examiner will release the remains,[14] usually to the deceased's next-of-kin.

1.4 Judicial death investigations

Where, under section 25 of the *Fatalities Investigations Act,*[15] the Chief Medical Examiner is

> **of the view that it is necessary for the protection of the public or in the interest of public safety,**

he may recommend to the Minister of Justice that a public inquiry (usually called a "judicial inquiry") be conducted into a questionable death. A judicial inquiry, if ordered by the Minister on the Chief Medical Examiner's recommendation, is conducted by a Provincial Court Judge without a jury. (Honourable Donald S. Luther of the Provincial Court of Newfoundland recently conducted the longest Newfoundland judicial death inquiry - two inquiries jointly, in fact - over 97 days from 2001 to 2003, into the police shooting deaths of two mentally-ill persons).

As stated before, it clearly lies within the mandate of the Medical Examiner's Office to recommend to the Minister to have a public inquiry into the deaths of Dr. Shirley Turner and Zachary Turner. Such an inquiry, having subpoena powers and held in public, would have greatly facilitated the need of

the Newfoundland public to know what happened here. Specifically, an inquiry would have informed the public whether all was done that could have been done to prevent this tragedy from having occurred. It could have been promptly commenced and expediently conducted. It would have been completed long before the completion of this Investigation and Review, considering its information-gathering authority and resources would have been far superior to those of this Review.

No such recommendation to the Minister was made and no public inquiry was called.

Why not? I tried to find the answer.

Before I was formally appointed to conduct this Review, I had an informal meeting with the Chief Medical Examiner. During this meeting I suggested to him that, although somewhat belated on his part, it might still - on reflection by him - be the right course for him to recommend a public inquiry to the Minister of Justice. He chose not to do so.[16]

It would appear from correspondence and personal communications with the Chief Medical Examiner that, in the Examiner's view,

the Child Advocate would do it.

An Advocate's Office Assessment Officer, Dr. Michele Neary, told Dr. Avis that they (the Office of the Child and Youth Advocate (CYAO)) wanted to do a "Child Death Review" (CDR). Moreover, Dr. Avis told Dr. Neary that the mandate of the Medical Examiner's Office is limited to the determination of identity and the cause and manner of death. Its mandate, he informed her, is not to do Child Death Reviews.

The CYAO, however, had no experience in conducting CDRs. The Children's Advocate Office of Saskatchewan was the only such Office in Canada doing them.[17]

Nationally, no child advocate legislation at present expressly authorizes a CDR., not even in Saskatchewan where the equivalent of Newfoundland's Child and Youth Advocate conducts them routinely.

When British Columbia's new child and youth advocacy legislation - the *Representative of Children and Youth Act* (enacted 18 May 2006)[18] - comes into force replacing *The Office for Children and Youth Act*,[19] the Representative for Children and Youth to be appointed under the new *Act* will be authorized by section 6(1)(c) of the *Act* to

> **review, investigate and report on the critical injuries and deaths of children … .**

The Representative in British Columbia could exercise this authority to determine, for example, under section 12(1)(a) of the new *Act*, whether

> **the services [reviewable by the Representative] or the policies or practices of … [a ministry of the British Columbia provincial government] or other public body responsible for the provision of the reviewable services [to children and youth] may have contributed to the critical injury or death, …**

In relation to Zachary Turner's death, the CYAO therefore relied heavily on the Saskatchewan experience in doing CDRs. That Office was invited by, and provided education and training to, the CYAO, respecting CDRs.

With the exception of Saskatchewan and now British Columbia, CDRs and any other kind of death reviews are done by the Chief Coroners and Chief Medical Examiners' offices, not by the Child Advocate Offices.

Although the Saskatchewan Children's Advocate advised the then Newfoundland Child and Youth Advocate against reviewing Zachary's death, the Child and Youth Advocate felt obliged in view of the fact that the Newfoundland Chief Medical Examiner and the Minister of Justice

were not going to do anything,[20]

to start and complete a CDR.

The Office of the Medical Examiner, as mentioned, did not recommend to the Minister of Justice to call a public inquiry or "inquest" as they are called in other jurisdictions. Elsewhere in Canada, these inquests are called by the Chief Coroners or the Chief Medical Examiners, often advised by advisory councils or committees.[21] The Solicitors- or

Attorneys-General or the Ministers of Justice hardly ever call them. [22]

Coroners' and medical examiners' inquests historically have limited themselves to being the finder of facts. They do not address culpability; in fact, are not in law permitted to do so. This inquisitorial process is an important tool in the findings of facts. Statements are made under oath and witnesses can be examined and cross-examined by counsel representing parties with an interest (who are granted 'standing') at the inquests.

The calling of an inquest by the Chief Coroner or the Chief Medical Examiner (elsewhere in Canada), and not by the minister of the Crown, takes this process out of the political realm. This is important as often, if not always, government departments and agencies and their policies and legislation come under review during an inquest.

To avoid the appearance of conflict of interest and/or undue perceived political considerations, I recommend:

Recommendation 10.1

THAT the decision to call a Medical Examiner's inquest in Newfoundland - a public inquiry into any death under its jurisdiction - lie with the Chief Medical Examiner and, when made, shall not be countermanded by the Provincial Government.

In making this recommendation, I do not intend to eliminate legislative authority presently possessed by the Minister of Justice, independently of the Chief Medical Examiner, to call a death inquiry in the same circumstances as may the Examiner. That authority is provided for under section 43 of the *Provincial Offences Act.* I am not aware that the Justice Minister of Newfoundland has ever relied on that authority to call a death inquiry. Nonetheless, that authority should be retained by the Justice Minister, to be employed, however, only in extraordinary circumstances. Those circumstances may include: where the position of the Chief Medical Examiner is vacant; the Chief Medical Examiner would be in conflict of interest or could be perceived to be in conflict of interest; or where the Chief Medical Examiner has not called a death inquiry and, in the judgment of the Justice

Minister, a death inquiry is necessary for the protection of the public interest or in the interest of public safety.

The present appointment by the Lieutenant-Governor-in-Council of the Chief Medical Examiner "at pleasure" does not guarantee sufficient, perceived or actual independence for the Chief Medical Examiner to perform his/her duties. In fact, it is presently perceived as the exact opposite.

Recommendation 10.2

THAT the Chief Medical Examiner be appointed <u>at arm's length from the Government of the Province</u> and only be dismissed "for cause."

To reinforce Recommendations 10.1 and 10.2, an investigation should be conducted into the feasibility for the Chief Medical Examiner to hold a non-tenured position at Memorial University. If found to be feasible and if implemented, the Office of the Medical Examiner would be, to the maximum degree possible, independent of the Provincial Government.

Recommendation 10.3

THAT an investigation be conducted to determine the feasibility of appointing the Chief Medical Examiner with a non-tenured position at Memorial University, partially or wholly funded by the University; for which purpose, the portion of the budget of Memorial University provided by the Provincial Government would include funding adequate - in the judgement of the Department of Justice and Memorial University - for the operation of the Office of the Medical Examiner.

Because of a child's age and vulnerability - especially children under two years old considering that they are entirely or largely unable to speak for themselves - all deaths of children, up to two years of age, should be subject to investigation, whether or not the death is questionable. Investigations into deaths of all children under two years old may presently be policy of the Office of the Medical Examiner. Whether or not currently part of policy, investigation of such deaths should be legislated in order to be made mandatory. I recommend, therefore:

Recommendation 10.4

THAT the Office of the Medical Examiner conduct an investigation into the death of all children under two years old.

1.5 Policies, practices and procedures

The Office of the Medical Examiner has produced a policy manual which assists the Office, its staff and the Medical Examiners around the Province in the execution of its mandate.

1.6 Standards

Death investigations vary considerably across Canada both in quantity and quality.[23] This not only applies to the investigation of adult deaths, but even to a greater extent, to deaths of children. The extent of the investigation and standards thereof also depends on the apparent, suggested or suspected manner of death, i.e., whether the deaths are due to natural causes, accidental, suicidal, homicidal, or whether the manner of death is - at the start of the autopsy - as yet undetermined.

The Chief Medical Examiner's policy and procedure standards guide is quite clear regarding the requirement that[24]

> **A drug screen should be performed on the following types of cases: (1) Suicides; (2) Homicides; (3) Undetermined causes; (4) Operators of all vehicles.**

Contrary to that policy, such a drug screen was not performed until the Office of the Medical Examiner was pressured by others to do so.

2. Death Investigations of Dr. Shirley Jane Turner and Zachary Andrew Turner

Judicial death investigations have three major components, often graphically depicted as a triangle; namely, scene investigation, autopsy and toxicology. The scene where the death occurred can, in some instances, be distinct from where the bodies are found. This was certainly the case here. The pathologist, Dr. Charles Hutton, also the Medical Examiner, attended the scene where the bodies were found. According to Dr. Hutton's notes dated 18 August 2003 at 2015 hours:

I received a call from the Royal Newfoundland Constabulary that the body of a female and a baby were found on Manuels Beach off Cherry Lane and the police would like me to attend.

It was near dark, raining hard and the temperature was 18 degrees Celsius. It was windy.

I arrived at the scene at 2050 hrs. The bodies were found approximately 100 yards east of a path leading to the beach. The bodies were approximately 50 yards apart and approximately 20 feet from the water. The tide was coming in.

The bodies had tentatively been identified as Shirley and Zachary Turner. Dr. Turner's car was discovered in Kelligrews approximately 3 to 4 miles west. The point of entry was at Kelligrews and that the current and low tide had deposited the bodies on the beach in Manuels.

The female body was of slight build and fully clothed in jeans, tank top, bra (exposed) and shoes. The body was wedged between large, smooth stones and face down with the left side of the face against the stones. The body was in full rigor.

The second body was that of a small child, fully dressed in a blue shirt and pants and socks, with no shoes. Full rigor was present. The body was face up.

Examination of the bodies was limited because of darkness and driving rain.

I instructed the police to convey the bodies to the HSC mortuary.

2.1 Previous interview with Dr. Simon Avis

On 28 July 2004, the Chief Medical Examiner consented to an interview with representatives of the Child and Youth Advocate.

Dr. Avis explained to Assessment Officer Dr. Neary that he, as the Chief Medical Examiner, is responsible for the administration of the *Fatalities Investigations Act* and to

> **ensure that all things are done appropriately.**

Dr. Avis explained that following the autopsies, the causes of death in both Zachary and Dr. Shirley Turner were determined to be **drowning** and,

> **given that the child did not enter the water on its own volition and that it was in the hands of a responsible third party, we determined that, in Zachary's case, the manner of death was homicide,**

and in Dr. Turner's case, **suicide** in that the

> **cause of the injury was self-inflicted and there was indication of intent.**

When asked by Dr. Neary why no tests for drugs had been performed, he stated:

> **We believe, based on autopsy findings, that drowning was the cause of death and therefore toxicology would not contribute, necessarily, to the determination of the cause of death.**

He further stated:

> **Ativan is a drug we cannot detect,**

later changed to:

> **It's extremely difficult to detect it. So for that reason we were unable to look to see if Zachary was, in fact, under the influence of Ativan at the time of the drowning.**

When asked if there had been toxicological tests performed to see if there were any other drugs, he responded that due to

> **the difficulties with the R.C.M.P. Crime Lab not doing the toxicology anymore, it was decided to develop toxicology at the Health Sciences Centre.**

He stated that,

> **there are about 30,000 drugs out there, and that to detect each drug a new method has to be developed.**

For that reason, the focus was more on drugs of abuse and drugs that were known to have been taken by the individual. In order to find out if drugs, other than Ativan, played a role in the death of these two individuals

> **… that would require a broad spectrum drug screening. It would take months and months and months for it to be completed.**

In spite of and in disagreement with Dr. Avis statement to Dr. Neary,

> **It really wouldn't matter to us whether or not drugs were present,**

I recommend:

Recommendation 10.5

THAT, in order to reduce or eliminate any further speculation surrounding the circumstances of both Dr. Turner's and Zachary's deaths, <u>full</u> toxicological analyses be done on all the still preserved body fluids of <u>both</u> decedents.

Dr. Turner's <u>manner</u> of death was classified as **suicide**

> **at the completion of the police investigation and having reviewed her medical files.[25]**

When asked if he was aware of Dr. Turner's previous suicide attempt (in fact, there were more than one), Dr. Avis stated,

> **Again, we would not have any involvement in anything. Until a person is dead, it's not our issue [emphasis mine].**

Dr. Avis was made aware of her previous suicide attempt, on 07 April 1999, through RNC Constable Stanford who informed him of this, and who was acting at that time as an investigator to the Medical Examiner's Office. Such knowledge often assists in the determination of a suicide, which is the mandate of the Office of the Medical Examiner.

In spite of a known cause of death, the manner of death (natural, accidental, suicidal, homicidal or undetermined) takes into account - and is sometimes determined - by the presence of alcohol and/or drugs in the body. These substances can have an influence or even impede (in cases of suicides or homicides) the person's ability to both form the intent and/or to carry out the intentional final act which may change the

manner of death to accidental. Therefore, I am at a loss to explain his statement:

> **The decision has been made not to pursue the toxicology, because it would not assist us in our mandate.**

Clearly, it is within the mandate of the Medical Examiner's Office to perform toxicological analyses, or have them performed elsewhere. I will return to this later.

Dr. Avis further said that,

> **Since this is not going to court, they (the RCMP Crime Lab) would not do it.**

As the RCMP stopped providing toxicological analyses for the Office of the Medical Examiner, in non-criminal cases, they are now done at the Health Sciences Centre. He warned that if he were to do the analyses now, the Ativan detection might take a long time as broad-spectrum drug screening would take

> **months and months and months**

to be completed. He further stated that there can be false positives for Valium (Ativan being another trade name) in urine screen tests.[26]

Dr. Avis stated that the history of previous suicide attempt is

> **not our issue**

and

> **It really would not matter to us whether or not drugs were present … The drug most often used by people to commit suicide is alcohol,**

which was negative in both decedents.

Dr. Avis further stated that the RCMP Toxicology Laboratory in Halifax,

> **since this case was not going to court, would not do the tox.**

When asked,

> **Only homicide?**

he answered,

> **Yes.**

As the interview narrative indicates, the (initial) non-performance of toxicological analysis on the body fluids of Dr. Turner and Zachary Turner became problematic. It was only after pressure by third parties, i.e., the grandparents of Zachary and the CYAO, that the analysis for the presence of drugs in Zachary was performed.

Having been pressured by the CYAO to just do the toxicology, in spite of all these "obstacles," Dr. Avis ordered limited toxicology tests to be performed. He reported on 19 January 2005 that a drug abuse screen on the urine of Shirley Turner and on the blood of Zachary Turner showed "the presence of Ativan." This was to be followed up by the performance of further toxicological examinations,

> **the result of which would be forwarded when available.**

This will be referred to later.

2.2 Interaction with Delegate of Child and Youth Advocate

In accordance with the requirements of this *de novo* Review, when requested to do so, both Dr. Avis and Dr. Hutton in a letter to me dated 13 July 2005 refused to depose (swear or affirm to the truth of the matter) of their interviews held under the auspices of the first Child and Youth Advocate. This did not surprise me.

I now, however, had no other resource but to put the questions that needed answering to both Dr. Avis and Dr. Hutton, in writing. In spite of repeated requests, I was unable to have the following questions answered, expanded upon, clarified and deposed:

(i) Re Dr. Shirley Jane Turner

1 Was any microscopic examination done to determine the presence or absence of any organic brain disease in the brain of Shirley Turner? If not done, why not?

2 Was any microscopic evidence done to determine if Shirley Turner was menstruating on the day of her death? If not done, why not?

3 Were any vaginal, oral and/or anal swabs obtained from Shirley Turner? If not, why not?

4 Was any microscopic examination done on the scalp and/or facial injuries of Shirley Turner to ascertain the time interval between these injuries having been sustained and her death? If not, why not?

5 Were the Ativan levels in Shirley Turner ascertained in her vitreous humor and urine? If not, why not?

6 Were the gastric contents of Shirley Turner preserved?

(ii) Re Zachary Andrew Turner

1 Considering that Zachary Turner was the victim of ultimate child abuse, were total body x-rays done on the body of Zachary Turner? If not, why not?

2 Was any microscopic examinations done on the brain of Zachary Turner to determine the presence or absence of any ante-mortem hypoxic states? If not, why not?

3 Were the Ativan levels ascertained in the vitreous humor of Zachary Turner? If not, why not?

4 Were the gastric contents of Zachary Turner preserved?

Following a long period of silence, I then in desperation decided to put those questions by, letter dated 02 December 2005 to the Deputy Minister of Justice, to whom the Chief Medical Examiner is accountable. I considered it (and still do) most important to have definite answers regarding these

questions. In response to this request, I was referred to documents in the files held in the Medical Examiner's Office which, by consent, were copied by my legal counsel's law clerk. The gist of the response I received from the Medical Examiner's Office was,

> **You may look at the files, take copies of what I've got, but I will not appear before you to answer any of your questions.**

I concluded from examining the document copies I received that many of the tests I asked about were not done. I do not know why not. It could be due to lack of funding, resources, education, training or some other reason. As a consequence, I now cannot make any recommendations that could have addressed such issues.

2.3 Previous Interview with Dr. Charles Hutton

Dr. Neary interviewed Dr. Hutton on 23 November 2004. He was the pathologist who had performed the autopsies and he also was the Medical Examiner who had completed the Medical Examiner's reports. Dr. Hutton did not recommend to the Chief Medical Examiner that a public

inquiry be held. I do not know why not. He had the authority to do so.[27]

Dr. Hutton was asked by Dr. Neary why he had not requested tests for the presence of drugs on either Dr. Turner or Zachary Turner. After all, Dr. Hutton was aware through a brief conversation prior to the autopsies with Dr. Turner's psychiatrist at the time, Dr. Doucet, that Dr. Turner had been prescribed Ativan.[28]

He explained that the analyses were not asked for because

> **One of the problems with the toxicology report and the bureaucracy of its delays.**

Dr. Hutton stressed

> **the backlog and the cost of these tests**

being factors of not having done the toxicology.

> **They are a thousand cases behind.**

The interviewers were also informed of

policy changes that had occurred in the R.C.M.P. Lab in Halifax, which had put the burden on Provincial resources.

Dr. Hutton stated, referring to Benzodiazepine marketed under such trade names as Librium and Ativan**,**

you have to take a shovel full of those to do any harm, you know.

Normally a drug screen is performed and, when positive, a test is undertaken. They are done at the Health Sciences Centre. But Dr. Hutton mentions that they

are backed up by the thousands.

Zachary's blood and vitreous humour were saved; and in Shirley - blood, vitreous humour and urine. Dr. Hutton stated:

I learned that Ativan had been prescribed by Dr. Doucet that morning [18 August 2001].

Dr. Hutton said that doing or not doing the toxicology

does not change our diagnosis, really.

It was considered important to ask Dr. Hutton about his knowledge of the circumstances surrounding the deaths. Dr. Hutton repeatedly stated that he did not have his notes. He had no access to them, but he remembered taking them. I asked for them but they were never received.

Dr. Hutton stated that the ignorance of previous suicide attempts in Dr. Turner's case

> **made no difference in order to determine suicide was the manner of death.**

Yet, in his statement, he adds,

> **She may very well have fallen off the dock.**

2.4 Interaction with the Delegate of Child and Youth Advocate

Dr. Hutton was also sent an invitation to answer further questions for this Review. He declined to do so, or to even meet in person to answer any questions. As Dr. Hutton was about to retire from his contractual involvement with the Medical Examiner's Office, the questions initially addressed to

him were put to Dr. Avis as well. Dr. Hutton has now retired. Dr. Avis did not answer the questions.

2.5 The Autopsies

The autopsies on the bodies of Dr. Shirley Turner, and Zachary Andrew Turner were ordered and performed in accordance with provincial legislative authority.

2.5 (a) Zachary Andrew Turner

The autopsy on Zachary Andrew Turner was performed, on 19 August 2003, by Dr. Charles J. Hutton in the presence of Constable G. Stanley and Constable J. Stanford of the RNC. Photographs were taken by Dr. Charles Hutton and Constable G. Stanley.

The autopsy report states the cause of death to be **drowning**, and the *manner* of death to be **homicide**.

The external examination of the body, the report stated, was in essence unremarkable.

> **There was a watery discharge from the mouth and nose, and there was "washer woman" effect to both palms and soles of the feet.**

The only evidence of injury was

> **a faint pinkish discoloration of a superficial scratch over the right side of the forehead and right cheek without associated bruising of the tissues underneath.**

The internal examination showed the presence of

> **pinkish foam in the airways.**

The stomach contained approximately 150 cc of undigested food which appeared to be small French fries. Dr. Hutton does not mention the presence or absence of any swallowed seawater and/or recognizable medication residues.

No total body x-rays were taken.

2.5 (b) Dr. Shirley Jane Turner

The autopsy on Dr Turner's body was performed, on 19 August 2003, by Dr. Charles Hutton in the presence of

Constable Stanford of the RNC. Photographs were taken by Dr. Hutton and Constable Stanley of the RNC.

The autopsy report states the cause of death to be **drowning,** and the manner of death to be **suicide.**

The external examination showed

> **some evidence of injury in the form of superficial scratch-like injuries about both knees and shins, across the abdomen and shoulders, as well as the forehead and right side of the face.**

These abrasions were associated with bleeding underneath which was described as

> **rather extensive with a thickness of 5 mm.**

The nose, as did the mouth, exuded some white foam and

> **washer woman**

effect was seen in soles and palms. The lungs exuded foamy fluid with slight pink tinges of blood. There also was some

foamy, slightly pink material in the larynx area. The stomach contained approximately 50 cc of undigested French fries. Dr. Hutton does not mention the presence or absence of swallowed seawater in the stomach. The uterus was non-gravid. Dr. Hutton does not mention any marks on the feet, ankles and/or shins.

2.6 Scene

The scene may be examined before the autopsy or later. This part of the death investigation can be and often is delegated to law enforcement personnel acting as the Medical Examiner's Investigators under the *Act,* with or without attendance of the Medical Examiner, as deemed required or feasible by either the Medical Examiner or law enforcement personnel.

The scene (where the death occurred) was visited and re-visited by Constable Stanford, by my legal counsel alone, by myself alone, and by counsel and myself on several occasions (both in daylight and at night). This matter has already been dealt with extensively in Chapter 5 and will not to be addressed again here.

2.7 Toxicology

(a) Zachary Andrew Turner

The level of Ativan (Lorazepam) in Zachary's whole blood was 1.2 mg/L. The toxicologist, Dr. Ed Randell, in the Interpretative Comments of his report to Dr. Avis stated:

> **Levels of Lorazepam are consistent with those found in drug related deaths,**

with a handwritten note:

> **("insufficient experience with Lorazepam to establish fatal levels").**

A consultation was sought and received by me from Dr. Milton Tenenbein, Professor of Pediatrics and Pharmacology at the University of Manitoba. In his letter to me dated 12 January 2006 he stated:

> **A serum concentration of 1.2 mg/Litre is very high. It is approximately 100 fold greater than the therapeutic concentration. I would expect with such a finding to be severely obtunded and in marked coma. As there are no precedents of fatalities from the ingestion of**

Lorazepam, in the absence of other drugs, it would seem that this child was the victim of drowning. At the very least, he did not suffer.

2.7 (b) Dr. Shirley Jane Turner

No drug analysis was performed on Dr. Shirley Turner.

Vitreous humor, blood and some urine were retained for alcohol and drug analysis. The alcohol was negative and the toxicology result in the form of a urine screen, reported at a later date, showed the presence of Ativan.

3. Child Death Reviews

3.1 Relationship of Child and Youth Advocate's Office with Medical Examiner's Office

Across Canada, the relationship between the Chief Coroner and Chief Medical Examiner's offices and the Offices of the Child (and Youth) Advocate differ in many aspects in their interaction after the death of a child.

Contrary to the acknowledgement that

nothing we can do will bring this child back,

much has been done, and still can and needs to be done, toward the prevention of deaths under similar circumstances by a careful and impartial review of the circumstances that led to the death central to my Review.

This has resulted, Canada-wide, in the establishment of CDRs. In some of the provinces, these have been performed for many years. So far, such has not been the practice in Newfoundland and Labrador.

Child Death Review Committees in other jurisdictions are multi-disciplinary with representatives from Child, Youth and Family Services; the Coroner/Medical Examiner's offices; forensic pathologists; pediatric forensic pathologists; senior Crown attorneys; law enforcement (RCMP, provincial and municipal police forces); representatives from Aboriginal communities; members of Child Protection Units; representatives from Colleges of Physicians and Surgeons; and by invitation on a case-by-case basis, person(s) with special and specific knowledge of the case in question.[29]

One might say that these CDRs are "post-mortem case conferences," which have in common the frank, positive and co-operative sharing of information. Whereas in many circumstances, for many reasons (as addressed elsewhere), it is not as yet possible for all or some of the members to exchange this information in writing, it certainly has proven to be most effective for them to meet and exchange information verbally. Each discipline often needs this information in order to better function, or at least to be better informed regarding any further actions that may be taken by themselves and/or the other members of the Committee. These actions may involve sibling protection, further investigations surrounding the lack of safety measures, or protective devices. In my experience over many years, these round-table discussions have led to further investigations by law enforcement personnel resulting, on occasion, in a re-classification of a death from accident to homicide, and vice-versa, with consequent investigative and legal implications.

As I have mentioned before, in the Provinces of Saskatchewan and British Columbia, these CDRs are done under the auspices of the Children's Advocate.

There is, however, an inherent problem with this. The Child and Youth Advocate's Office (in Newfoundland) may well find itself in conflict of interest by conducting CDRs in that the circumstances leading up to and/or surrounding the death of a child could have, or should have, required the advocacy of that Office while the child was still alive. That advocacy, depending on its nature and intensity, may have played a preventive role in the death of the child subjected to a CDR. The Office should not investigate itself.

The Medical Examiner's Office usually does not have, by its very nature, any involvement in the care of a child prior to his/her death.

Recommendation 10.6
THAT the Medical Examiner's Office establish and conduct Child Death Reviews, chaired by the Chief Medical Examiner, with multi-disciplinary membership including the Child and Youth Advocate.

The Child Death Review Committee could assist the Chief Medical Examiner in making recommendations to government regarding measures that may prevent deaths under

similar circumstances from occurring. This is not possible in Newfoundland and Labrador at this time due to lack of legislative authority for the Chief Medical Examiner to do so. Dr Avis, quite rightly, reminded Dr. Neary of this reality.

However, making such recommendations is not the same as holding a public inquiry.

Recommendation 10.7
THAT the Chief Medical Examiner be given the legislative authority to make recommendations to respective Ministers of the Crown (with opportunities to follow-up on these recommendations).[30]

Such legislation is cost-effective and often outcome-effective as well. In my personal experience, the opportunity for the Chief Medical Examiner to make recommendations is often more effective than the calling of an inquest.

In cases where it is found that finding the answers to questions sought would exceed the resources of the Medical Examiner's Office, the Chief Medical Examiner, assisted, but not bound by the Child Death Review Committee, would still

have the legislative powers to order that a public inquiry (inquest) be called.

4. Conclusion

The Office of the Chief Medical Examiner:

(i) by failing to recommend to the Minister of Justice that a public inquiry be held;

(ii) by failing to conduct timely and complete toxicological investigations in the death of both Dr. Turner and Zachary;

(iii) by not providing complete answers to Dr. Michele Neary of the Office of the Child Advocate;

(iv) by refusing to depose of the interview; and

(v) by refusing to answer my questions, as the Advocate's Delegate, to clarify or correct the previously given, what now appears to be, evasive and contradictory answers;

causes me grave concern.

The Office of the Medical Examiner, in my opinion, would benefit from **an external review** by the National Association of Medical Examiners. This is the only U.S.A. organization, of which Dr. Avis is a member, that provides such a service at little cost.

I therefore recommend:

Recommendation 10.8
THAT the Office of the Chief Medical Examiner seek accreditation by the National Association of Medical Examiners.

[Notes to Chapter 10]

[1] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[2] Boys, William Fuller Alves, *A Practical Treatise on the Office and Duties Of Coroners in Ontario and the Other Provinces, and the Territories, of Canada, and in the Colony of Newfoundland.* (Toronto: The Carswell Co. Ltd., 1905), p.13.

[3] Ibid.

[4] Revised Statutes of Newfoundland 1970, Chapter 365, sections 126-130.

[5] Statutes of Newfoundland 1979, Chapter 35, Part III.

[6] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[7] *Fatalities Investigations Act*, Revised Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[8] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[9] Ibid.

[10] Ibid.

[11] Ibid.

[12] Ibid.

[13] *Fatalities Investigation Act*, Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1, section 10(5).

[14] Ibid., section 9(5).

[15] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[16] Notwithstanding Dr. Avis's decision not to recommend such an inquiry to the Minister, in fairness to Dr. Avis, it is noted that the Minister does not require such a recommendation in order to direct a Provincial Judge to hold one: *Provincial Offences Act*, Statutes of Newfoundland and Labrador, 1995, Chapter P-31.1.

[17] The legislative authority to do "Child Death Reviews" under that legislation and under the Newfoundland legislation has not been clearly explained to me.

[18] Statutes of British Columbia, 2006, Chapter 33 (enacted 18 May 2006).

[19] Statutes of British Columbia, 2002, Chapter 50.

[20] Personal communication with the first Child and Youth Advocate.

[21] In Alberta, an Inquest Advisory Committee, of which the CME is a member, recommends to the Minister.

[22] Not all deaths that are investigated in Chief Coroners' or Medical Examiners' offices require an "inquest," but - once called - cannot be revoked by any party other than the Chief Coroner or Chief Medical Examiner themselves.

[23] Ontario Association of Children's Aid Societies and Office of the Chief Coroner of Ontario. *Ontario Child Mortality Task Force - Final Report* (Toronto: 1997).

[24] "Policy and Procedure - A Practical Guide for Medical Examiners," Province of Newfoundland and Labrador.

[25] There is no copy of Dr. Turner's medical record in the Chief Medical Examiner's files, nor is this information-sharing reflected in Dr. Doucet's records.

[26] In very low levels, not likely to be misinterpreted (F.L.W., Manitoba). J.M. Duthel; H. Constant; J.J. Vallon; et al. (1992). "Quantitation by Gas Chromatography with Selected Ion Monitoring Mass Spectrometry of "natural" Diazepam." *Journal of Chromatography*, 579, pp.85-91.

[27] "Policy and Procedure - A Practical Guide for Medical Examiners," Province of Newfoundland and Labrador. "A medical examiner may recommend, in writing, to the Chief Medical Examiner that a public inquiry into the circumstances surrounding the death of an individual within their jurisdiction be conducted." The ultimate recommendation for such an inquiry resides with the Chief Medical Examiner.

[28] The policy manual does not indicate that the permission of the Chief Medical Examiner is required for the medical examiner to order such a drug screen.

[29] In some provinces, (some of) the members are financially compensated for their services; for most this is not the case as the members function under the auspices of the offices they occupy.

[30] In Manitoba, the Ombudsman's Office (the People's Representative's Office), having the authority and the resources to do so, took it upon itself to fulfil that role.

Chapter 11

Past Performance of Office of Child and Youth Advocate

1. Introduction

Zachary Turner was born on 18 July 2002. He died on 18 August 2003. The Office of the Child and Youth Advocate opened on 18 November 2002, nine months before Zachary's death.

I therefore wished to interview Lloyd L. W. Wicks (Judge - Ret'd), who was the first incumbent of the Office of the Child and Youth Advocate from 16 September 2002 (about two months before the Office was sufficiently organized to open on 18 November 2002) until 31 March 2005.

My objectives, relevant to this Review, for wanting to interview Mr. Wicks were two-fold.

First, I wanted to learn what steps, if any, were taken respecting Zachary during his lifetime by the Advocate's Office in exercise of the Office's statutory mandate and performance-enabling authority under the *Child and Youth Advocate Act.*[1]

In particular, I wanted to ascertain what the Advocate's Office did, if anything, in discharge of its obligations, specifically under sections 3(a) and 3(b) of the *Act*[2] which require the Advocate:

> **(a) to ensure that the rights and interests of children and youth are protected and advanced and their views are heard and considered;**
>
> **(b) to ensure that children and youth have access to services and that their complaints relating to the provision of those services receive appropriate attention.**

For example, before Zachary's death, did information disclosed by Dr. Turner to the Advocate's Office in June and December 2002 or reported by news media prompt the Advocate's Office to wonder whether she needed advocacy assistance in obtaining state services for her son Zachary? Or, did the Advocate's Office pause to ponder whether she required the Advocate to help her ensure the proper state services were fully and appropriately provided for her son? Dr. Turner was after all a single, unemployed, expectant and eventual mother of Zachary, living in St. John's, and charged in Pennsylvania with murder, possibly punishable by death, for which she was subject to extradition proceedings in a Newfoundland court that involved incarceration.

Further, did this information alert the Advocate's Office to consider the prospect of a review under section 15(1)(a) of the *Act*, and an investigation under section 15(1)(c) of the *Act*,[3] either before or after the birth on 18 July 2002 of Zachary to determine whether his rights and interests in any respect were or could be in jeopardy, either because of the persona of his mother, Dr. Turner, or the - potentially destabilizing - impact of her critical legal dilemma on the mother's parenting capacity? (Precious little was known about either of these subjects, except what Dr. Turner chose to say). Whether or not a request for assistance was received, the Advocate's Office is empowered by section 15(1)(a) of the *Act*[4] to decide whether to conduct a review. And, if a review is conducted that results in the decision to investigate, the Advocate's Office may initiate an investigation under section 15(1)(c) of the *Act*.[5] In deciding whether to conduct a review or an investigation, nothing in section 18 of the *Act,*[6] which affords grounds on which the Advocate may decline to deal with a matter, impeded the Advocate if the Advocate considered the factual context of this matter.

Further, did the Advocate's Office assess whether, apropos the rights and interests of Zachary, the child could

benefit from the collective information-sharing, wisdom and synergy offered by a case conference under section 15(1)(d) of the *Act,*[7] attended by social workers, police, counsel for Canada's Justice Minister, Dr. Turner and (if she consented) her psychiatrist, and others capable of contributing to a case conference?

The second reason why I wanted to interview Mr. Wicks was to learn what steps the Advocate's Office undertook after Zachary died to determine the circumstances of and surrounding his death. (I knew some steps were taken, but not the specifics of them, and I knew the steps, whatever they were, had not been completed due to Mr. Wicks' premature retirement).

Interview answers from Mr. Wicks could, in my view, assist me to determine whether the *Child and Youth Advocate Act*[8] provides all tools necessary for the Office of the Advocate to perform its mandate and whether the *Act* does so adequately. And, in turn, assist me to provide guidance, in my Findings, to the current Advocate to enable her to decide whether and, if so, what recommendations to make about legislation, policies,

standards and practices - in this instance, focused on the *Act* itself - under section 15(1)(g) of the *Act*.[9]

To achieve my two objectives - to learn what the Office of the Advocate had done for Zachary both before and after Zachary's death - I wrote to Mr. Wicks by letter, dated 13 September 2005. In the letter I requested Mr. Wicks to participate in an interview.

The requested interview did not occur. Mr. Wicks's reply letter to me, dated 27 September 2005, stated that the regrettable illness of both him and his wife precluded him traveling from his residence in St. John's to my St. John's office. A subsequent invitation to Mr. Wicks by 01 November 2005 letter to be interviewed by me at his residence and, consequently, avoid any possibly onerous travel from his residence to my office was, by his 13 November 2005 reply e-mail, declined for the same reason. However, he agreed in the e-mail to provide answers to 36 questions sent to him with my 01 November 2005 letter, provided his health permitted.

In a letter to me dated 31 January 2006, Mr. Wicks stated:

> **I have previously expressed to you my deep personal commitment to the Zachary Turner matter and my confidence in you in relation to your conduct of the review. Against my doctor's advice, it remains my desire to assist you in carrying out your review to the extent I am able. Unfortunately, I have not been well enough to do so to date.**
>
> **I should also mention that I am at severe disadvantage in my ability to assist in view of the fact that I no longer have the quality of recollection that I possessed prior to my illness. This is of course exacerbated by the fact that I have no access to files and other sources of information with which to refresh my failing memory. Finally, let me observe that having given more than I reasonably could have to the establishment of the Office of the Child and Youth Advocate, I am retired, trying to live a quiet life under difficult circumstances and yet being prevailed upon to give more and I might add, in a manner that causes extreme and pervasive stress to my health and the peace of mind of myself and those around me.**

In spite of the disadvantages to which he refers in his 31 January 2006 letter, Mr. Wicks furnished written answers to my 36 questions on 28 March 2006. For that effort, I am grateful to him.

Before turning to the written responses from Mr. Wicks, I quote the following from the letter which accompanied his answers:

> **…. When the terrible and tragic death of baby Zachary**

Turner occurred, the interest of the office was engaged. It was a high profile matter not only locally but with national and international overtones.

There was considerable controversy in the media and calls for answers. So it was shortly after the death of Zachary Turner and his mother, as the Advocate I was asked by the Minister of the Department of Health and Community Services to conduct a review. That review was to include all aspects of the work of that Department in relation to the Turner matter. A written report of an internal review of their activities was prepared by the Department very hastily and presented to me. I agreed to undertake this review given my authority to do so in accordance with Section 15 of the Act.

I took all necessary steps to ascertain if there were to be other inquiries. I debated long and hard as to how to proceed and took counsel from my colleagues from other provinces. I came to the inevitable conclusion that if the Advocate were to be worth his salt, and if there ever were a case that cried out to be reviewed in what is generally called a child death review by the Child Advocate, this had to be the one.

There were many issues and serious concerns. The media was ripe with questions. In my view there was no other possible answer than to proceed. I had already agreed to take on a review of a major part of the government's involvement, namely Health and Community Services, but it was clear that if the memory of baby Zachary Turner was to be at all valued, and if the public expectations were to be met, then the fullest possible review of all agencies who had any involvement in the life of Zachary Turner should be reviewed. In essence had the Child Advocate of this province decided not to conduct a review of the death of baby Zachary Turner, there was no one left to do it other than the media and that in my view was not good

enough.

I then announced that the Advocate's Office would conduct what was to be our very first such review of the death of a child. I had hoped that it could have been done in a more timely manner but the difficulties and struggles and the road blocks that were put in the way caused it to go on much longer than necessary.
What I can say is that I approached this matter with great passion, dedication and commitment. From the beginning I took all reasonable steps to ensure the integrity, confidentiality and credibility of the work.

While there were a couple of unexpected problems during the review with regard to certain individuals, when they occurred I met them. I dealt with them appropriately and in a timely manner.

There were delays in the review process caused by others. When I decided to take on this work, I prescribed the p[a]rameters of what needed to be done. We needed and respectfully sought the cooperation of many agencies. Some of these were reluctant to provide any cooperation. It dragged out the work and caused me great stress.

Though there were others, I will mention one as an example. For instance we were actually stonewalled by the Federal Ministry of Justice. No one will ever know how hard I worked to try to break through that barrier, because it was essential in my view. I spent hours in phone calls, wrote many letters, each one stronger than the other trying to achieve some level of cooperation from the Federal Department of Justice so that we could have leave to talk to some of their people and especially counsel who appeared for the Federal Crown in the Turner matter, so that we could look inside matters such as bail and the extradition process, etc. to more fully understand how it impacted on the events which led to the release of Shirley Turner and the

untimely death of this child.

Despite my best efforts I could get no cooperation. It took weeks and weeks on end to get a telephone reply or a letter, sometimes months. I went as far as to intercede personally and to buttonhole the Federal Minister of Justice, … . At an event, in Ottawa or Montreal, where he was a guest speaker at a function to which I had been invited. As soon as he stepped from the podium, I approached him, knowing that sometimes Ministers do not know everything going on in their Department. I felt as I filled him in in some detail, he might then arrange for a greater degree of cooperation. I gave him the background and he told me that he did not have much time, he had a flight to catch and his handlers were trying to rush him out. I told him of our predicament and I told him that I wanted his department to have a fair opportunity to provide us with any useful information. That I was being terribly delayed in completing this process by his officials and time was running out on this important matter. I further indicated to him that this lack of cooperation could negatively impact on the work I was carrying out and on the comments we would be obliged to record in the final report of the review. I advised him of our involvement with the American legal authorities and their cooperation, as I had sent staff down there to interview the District Attorney and others with respect to how they could help as a result of the murder of Zachary Turner's father. I tried desperately to make progress through [the] Minister … . He advised me he would put me on to two of his staff people who were there and were staying overnight and I could expect something from them. I met with these people shortly after. That was a Friday, and I was assured that I would hear on Monday, and I took it that it would be something significant. Nothing changed. This was a huge disappointment to me. To my knowledge no good ever came of that intervention. But for this, I would have been able to complete the Turner review,

> **submitted the report before I became ill and retired. There were other incidents on the local provincial scene where cooperation was not forthcoming.**
>
> **My commitment to finding the truth about the circumstances leading to the death of Zachary Turner remains with me and it is one of my great sorrows that I could not see it to completion. Let there by no mistake however that the work was carried out as best it could and I remain satisfied and proud of the efforts as far as I could go.**
>
> **My remaining hope is that when this work is completed it will focus on the real reason for the review, the untimely and totally unnecessary death of a precious child under such tragic circumstances, the death of Zachary Turner.**

(Mr. Wicks makes no mention that the Department of Justice of Canada, on 29 October 2004, faxed to him a letter of the same date, which answered some of his questions to the Department's Minister and requested clarifications of others. And that, in response to Mr. Wicks's letters to the Department on 10 December 2004 and 10 and 15 February 2005, the Department, on 16 March 2005, provided additional answers to Mr. Wicks's queries. The letters were found in the general correspondence file of the Advocate's Office relating to Zachary Turner and his mother, Dr. Turner, which I obtained from that Office shortly after I commenced my Review).

I have reproduced my questions to Mr. Wicks and his answers to them in the following two parts of this Chapter, which provide an account of the performance of the Office of the Advocate before and after Zachary's death.

2. Performance of Office Before Zachary's Death

Question 1 (a):

What was the scope and nature of the mandate of the Office of the Child and Youth Advocate (OCYA) under Sections 3 and 15 of the *Child and Youth Advocate Act*, specifically in relation to Zachary Turner and his mother, Shirley Turner, concerning issues that were brought to the OCYA's attention

(a) prior to their deaths?

Answer to Question 1 (a):

I have no knowledge of any mandate or of any involvement with either Shirley Turner or Zachary Turner prior to their deaths.

Question 1 (b):

What was the scope and nature of the mandate of the Office of the Child and Youth Advocate (OCYA) under Sections 3 and 15 of the *Child and Youth Advocate Act*, specifically in relation to Zachary Turner and his mother, Shirley Turner, concerning issues that were brought to the OCYA's attention

(b) after their deaths on August 18, 2003?

Answer to Question 1 (b):

To the best of my recollection, I learned after the death of Shirley and Zachary Turner that one of the staff of the office had been approached by Shirley Turner seeking some advice about the future of her child.

The Minister of Health and Community Services invited the office, in accordance with Section 16 of the Act to refer the matter to the Advocate. Letters are on file to that effect. We agreed to undertake a review of all of the activities surrounding Zachary Turner leading up to his death as it related to the activities of the Department of Health and Community Services and its agencies. We continued on that piece of work and enlarged on it to review all issues surrounding any other agencies that would have impacted on this event.

Question 2:

When and how did you learn that Shirley Turner, while charged in the Commonwealth of Pennsylvania with

murder, gave birth to Zachary Turner at St. John's on July 18, 2002?

Answer to Question 2:

I suspect that I would have learned through the media when that occurred.

Question 3:

When, how and what did you learn of services provided by any department or agency of the Government of Newfoundland and Labrador to Zachary Turner or Shirley Turner during the following period July 18, 2002, when Zachary Turner was born, to August 18, 2003, when Zachary Turner died?

Answer to Question 3:

I, like most people, would have been generally aware through the media of the Turner matter, but I had no particular knowledge until after the deaths when the Minister submitted to the Advocate's Office a review of their involvement with Shirley Turner and Zachary Turner and I had an opportunity to read that document which is on file.

Question 4:

Before the deaths of Zachary Turner and Shirley Turner,

(a) what was the nature and extent of the services provided by the OCYA

(i) to Shirley Turner, and/or

(ii) to Zachary Turner?

(b) who provided them?

(c) who assigned provision of the services to the person(s) who provided them?

Answer to Question 4:

Let me say at the beginning that services in the strict sense of the word are not provided by the office of the Child and Youth Advocate. The office assists in seeing that services are provided, but the actual services are provided by other agencies. To be more specific, to my knowledge there were no services provided. To the best of my recollection I later learned that Shirley Turner had visited the office and had discussions with an Assessment Officer, … . I think it is fair to say that there is a statement on file with the review made by … [the Assessment Officer] who outlined her involvement with Shirley Turner. I recall reading that statement but my memory doesn't give me much assistance other than to say that I seemed to recall that Shirley Turner wanted some advice and wanted to talk to somebody about what the best options were for her child Zachary, if she were to be incarcerated. I think that was the issue for her. I am not aware nor do I recall anything further. She came in off the street as it were and met with an Assessment Officer as many, many do and I knew nothing of it until after things became more serious.

Question 5:

Before the deaths of Zachary Turner and Shirley Turner,

(a) what was the nature and extent of the services provided by the OCYA to Kathleen and/or David Bagby?

(b) who provided them?

(c) who assigned provision of the services to the person(s) who provided them?

Answer to Question 5:

I know of no services to Kathleen or David Bagby. I have no recollection of any contact with the office to that time.

Question 6:

Before Zachary Turner's death, what was the nature and extent of the OCYA's knowledge of the care provided to Zachary Turner by

(a) Shirley Turner?

(b) Kathleen Bagby and/or David Bagby?

Answer to Question 6:

To the best of my recollection I had no knowledge at all.

Question 7 (a):

Before Zachary Turner's death

(a) what was the nature and extent of concerns raised with the OCYA about the nature and quality of care Zachary Turner was receiving from Shirley Turner?

Answer to Question 7 (a):

To the best of my recollection, I had no knowledge of any concerns.

Question 7 (b):

Before Zachary Turner's death

(b) if any concerns were raised with the OCYA about the nature and quality of care Zachary Turner was receiving from Shirley Turner, who raised them?

Answer to Question 7 (b):

To the best of my knowledge it was not reported.

Question 7 (c):

Before Zachary Turner's death

(c) if any concerns were raised with the OCYA about the nature and quality of care Zachary Turner was

receiving from Shirley Turner, what did the OCYA do in response?

Answer to Question 7 (c):

To the best of my knowledge there was no response.

Question 7 (d)(i) and (ii):

Before Zachary Turner's death

(d) (i) if any concerns were raised with the OCYA about the nature and quality of care Zachary Turner was receiving from Shirley Turner, did the OCYA inform any public or private entity of the concerns; and (ii) if so, who was informed of what?

Answer to Question 7 (d):

Not to the best of my knowledge.

Question 7 (e):

Before Zachary Turner's death

(e) if any concerns were raised with the OCYA about the nature and quality of care Zachary Turner was receiving from Shirley Turner, and if the OCYA

informed any public or private entity of the concerns, what action did you expect to be taken by those informed of the concerns?

Answer to Question 7 (e):

To the best of my knowledge, I was not aware of any concerns being reported.

Question 7 (f):

Before Zachary Turner's death

(f) if any concerns were raised with the OCYA about the nature and quality of care Zachary Turner was receiving from Shirley Turner, who monitored any action taken in response?

Answer to Question 7 (f):

To the best of my knowledge, I am not aware of any monitoring action.

Question 8 (a):

Before Shirley Turner's death

(a) were any concerns raised with the OCYA about the mental health of Shirley Turner?

Answer to Question 8 (a):

Not to the best of my knowledge.

Question 8 (b):

Before Shirley Turner's death

(b) if any concerns were raised with the OCYA about the mental health of Shirley Turner, what were they and who reported them to the OCYA?

Answer to Question 8 (b):

To the best of my knowledge it was not reported.

Question 8 (c):

Before Shirley Turner's death

(c) if any concerns were raised with the OCYA about the mental health of Shirley Turner, what did the OCYA do in response?

Answer to Question 8 (c):

To the best of my knowledge there was no response.

Question 8 (d):

Before Shirley Turner's death

(d) (i) if any concerns were raised with the OCYA about the mental health of Shirley Turner, did the OCYA inform any public or private entity of the concerns; and (ii) if so, who was informed of what?

Answer to Question 8 (d):

Not to the best of my knowledge.

Question 8 (e):

Before Shirley Turner's death

(e) if any concerns were raised with the OCYA about the mental health of Shirley Turner and the OCYA informed any public or private entity of the concerns, what action did you expect to be taken?

Answer to Question 8 (e):

To the best of my knowledge, I was not aware of any concerns being reported.

Question 8 (f):

Before Shirley Turner's death

(f) if any concerns were raised with the OCYA about the mental health of Shirley Turner and the OCYA informed any public or private entity of the concerns, who monitored any action taken in response?

Answer to Question 8 (f):

To the best of my knowledge, I was not aware of any monitoring action.

Question 9:

(a) Did you personally have any knowledge about the care provided to Zachary Turner before his death by

(i) Shirley Turner?

(ii) Kathleen and/or David Bagby?

(b) If so, (i) how did you come into possession of that information; and (ii) what was the information?

Answer to Question 9:

To the best of my recollection, I had no personal knowledge other than what might have been reported in the media.

I will return, shortly, to the remainder of my questions to Mr. Wicks, and his answers to them.

3. Performance of Office After Zachary's Death

3.1 Overview

A previous review into Zachary Turner's death had been commenced, although not completed, under the *Child and Youth Advocate Act,*[10] from about January 2004 to March 2005 during Mr. Wicks's tenure as Advocate.

That review and investigation was undertaken by an Assessment Officer employed, and an Advisory Council appointed, by the Advocate's Office with approval and under direction of Mr. Wicks.

3.2 Assessment Officer

The Assessment Officer was Dr. Michele Neary, a psychologist and researcher.

She was not an investigator, I was informed by Mr. Wicks (in answer to my Question 15(a), reproduced below in this Chapter), because "[w]e were not on an investigation … but rather a review." On advice of my legal counsel, however, I took a different position. I concluded I needed to undertake both a review and an investigation. I could not rely solely on the record of information in existence when I commenced work last year to fulfill my mandate of examining the circumstances of and surrounding Zachary Turner's death. The then existing record was by no means adequate for that purpose. Indeed, my mandate (from Mr. Wicks's temporary successor as Advocate) required, and I performed, both a review and investigation which, for brevity's sake, I have referred to throughout these Findings as a Review.

3.3 Advisory Council

Constituting the Advisory Council exclusively for the previous review were:

(i) Dr. Elliott Leyton, Professor of Anthropology (Retired) and author;

(ii) Dr. Ted Rosales, pediatrician and geneticist in the Newfoundland and Labrador Medical Genetics Program;

(iii) Ken Barter, Ph.D., R.S.W., professor at the School of Social Work, Memorial University of Newfoundland;

(iv) G.G. Leahy, R.C.M.P. Assistant Commissioner (retired); and

(v) Stephanie L. Newell, LL.B., a member of the Newfoundland and Labrador Bar and Law Society, practicising with the St. John's law firm of O'Dea, Earle.

The mandate of the Advisory Council was drawn up by Mr. Wicks in the form of Terms of Reference, dated January 2004. It required the Advisory Council members:

1. **To advise the Child and Youth Advocate on the design of the appropriate processes for carrying out the review.**

2. **To provide advice on the procedures to be used in the completion of the review.**

3. **To assist in the identification of issues to be considered, including files to be reviewed, service providers and others who should be interviewed.**

4. **To assist in the analysis of information gathered.**

5. **To assist in the identification of findings related to the review.**

6. **To assist in the identification and description of any systemic issues related to the review.**

7. **To provide advice on recommendations, if any, that may arise from the review.**

8. **Perform such duties from time to time as determined by the Advocate.**

Although outside the Terms of Reference of the Council, its members participated in varying degrees in partnership with the Assessment Officer, Dr. Neary, in the interviews with some of the persons questioned during conduct of the previous review.

3.4 Legal Counsel

Retained to furnish legal advice to the Office of the Advocate was James M. Smith, Q.C., a member of the Province's Bar and Law Society, practicing with the St. John's law firm of Smith, Coffey.

I return here to the remainder of my questions to Mr. Wicks and his answers which relate principally to the uncompleted review.

Question 10:

(a) When and how did Zachary Turner become a matter the OCYA addressed?

(b) Considering sections 15(1)(a) and 15(1)(d) of the *Child and Youth Advocate Act*, did the OCYA

  (i) initiate involvement in the Turner matter and/or

  (ii) initiate or become involved in case conferences?

(c) If so, how and to what extent?

(d) If not, why not?

Answer to Question 10:

I do not recall specifically except to say that there were discussions with officials of the Department of Health subsequent to the death of Zachary Turner which resulted in the Minister of Health and Community Services referring the matter to the Advocate under the Act for review.

I think the history of the thing speaks for itself. Having agreed to review the matter in accordance with Section 15(1)(a) of the Act as a review of the death of Zachary

Turner, I took whatever steps I could to find the necessary resources to carry out that work and engaged people I thought would be helpful. I had difficulty, in that, immediately or very soon thereafter, as there was some allegation that 2 of the staff members of the office, through their employment there, had been employees of the Department of Health and Community Services and there was a suggestion that there could be a perception of conflict of interest. That was dealt with appropriately and in a timely manner. I made a public statement when I was aware of the matter, that to avoid any perception of such conflict, neither of these employees would have anything to do with the Turner matter.

As a matter of fact one of the two [the Deputy Advocate], … had been stricken with Leukemia and was fighting for her life in Halifax and was not even working at the office. She became ill a few months after the office opened and didn't return for a full year. She had no connection whatsoever with the Turner matter during her tenure with the office. Even after she returned, it was made clear that she would not be involved and in the short time up until the time I became ill and left, she was not involved in any way, shape or form.

The other person was [the Assessment Officer] … . As I indicated earlier she had made me aware that she had some minimal involvement. As a result when the suggestion of conflict of interest arose, I advised … that she was to have nothing to do with anything relating to the Turner matter. That was the way I maintained it right through. It left me in a difficult position of having to find somebody else because I had no one of the senior nature or with the necessary qualifications that I could assign this matter to. I needed a lead person so I sought the approval of the Internal Economy Commission to hire another Assessment Officer and that was done. I hired the best person who applied. She had a PHD in psychology and I felt that I had a reasonably well

qualified person to take the lead on the day to day work of this matter.

Question 11 (a):

(a) What was the nature and extent of communications between the OCYA and the Office of the Chief Medical Examiner before the OCYA commenced what it characterized a "child death review?"

Answer to Question 11 (a):

I should refer to the repeated reference [in the Questions] to what is characterized as a "child death review." I note that throughout the questions and I am surprised by it. There is nothing magical or mystical about the term a child death review. I took the term from other Advocates much senior to me from other parts of Canada who conduct child death reviews. That's what they called them. They had, almost word for word, the same legislation as we had because our legislation was almost word for word taken from Saskatchewan and Manitoba. We talked about these matters when we met at conferences. There was discussions about child death reviews and I assumed that it would be something we would be doing. As a matter of fact I brought in staff from western Canada to train my people and I sent staff out to western Canada for further training not only in general advocacy work, but also in child death reviews. The term itself is self-explanatory. It is fair to say that the term takes on greater significance because it involves the most serious of all matters, the death of a child.

To return to the question regarding the Chief Medical Examiner, before I decided to do anything, I contacted the Chief Medical Examiner and had a discussion with him as to what his plans were, as I knew he had authority under his Act to either conduct or recommend to the Department of Justice that a judicial inquiry or other form of inquiry be held. I talked to Dr. Avis and we had a very frank and friendly conversation and he told me that he had concluded the matter was a murder-suicide and that his file was closed and he had no intention of proceeding further. Knowing also from my experience, having been a judge for 30 years, that the Minister of Justice always has the right to order a judicial inquiry under any circumstance of unusual or unexplained death, I thought that even if the Medical Examiner doesn't recommend it, the Minister may still order a judicial inquiry. I wanted to find out if that would be the case. I called the Deputy Minister of Justice at the time and discussed the matter with him. I asked what intention, if any, that he might have to order an inquiry of any kind. The response as I best recall it was that the Medical Examiner had closed his file and had no intention of making any recommendation to the Department of Justice. They were satisfied with that and they would not be ordering an inquiry. Given these responses, as the Advocate I concluded that our review should be enlarged to consider not only the Health Department's role but other agencies which might have been involved leading to the death of Zachary Turner. It was clear that had I not decided to undertake the Review into Zachary Turner's death, there would not have been anything further done. In my view this would have added significantly to the tragedy and created public outrage.

Question 11 (b):

(b) What was the nature and extent of communications between the OCYA and the

Office of the Chief Medical Examiner while the OCYA conducted what it characterized a "child death review."

Answer to Question 11 (b):

There wasn't a lot, although I think there was some. Again, I apologize for my lack of recall on detail. Much of which was done by Ms. Neary in her position as the lead person on the review. I do recall discussions with her and I may have had discussions with Dr. Avis, I don't recall. I know there were discussions about toxicology because we were quite surprised that there was no toxicology analysis carried out on either Shirley Turner or Zachary Turner. I insisted, when I found out that there were still specimens available, that this be done. My recollection is that the Medical Examiner's position was, if there had been drugs of a given nature consumed by either of the two deceased, that it would be difficult to tell and difficult to tell the level and so on. The indication was for that reason, they did not bother. I thought that was not a sufficient response and I insisted that they be done. They agreed to have them done. I do not remember ever seeing the results up until the time I became ill. I do know that I insisted that they be done for whatever worth they were.

Question 12 (a):

(a) What advice or suggestions, not to conduct what the OCYA characterized a "child death review," did the OCYA receive?

Answer to Question 12 (a):

To my knowledge or recollection, none.

Question 12 (b):

(b) What advice or suggestions, to conduct what the OCYA characterized a "child death review," did the OCYA receive?

Answer to Question 12 (b):

I don't think I received any advice to do so. To me, having done as much learning and training as I could have from my very valued colleagues in other provinces in meetings and so on and in reading their reports of child death reviews that they sent me, although it was the very first one and a very unusual one, it would have been normal for us to have done it. Mind you I should say, even if the Medical Examiner did an investigation, and if there had been a judicial inquiry, that would not, from my understanding, have precluded the Child Advocate from doing a child death review at a later date, because what comes out in legal forums can be far less than can be gathered in a child death review. As the Advocate, an Independent Officer of the Legislature empowered under the Child Youth Advocate Act I proceeded with the work.

Question 12 (c):

(c) From whom did the OCYA receive advice or suggestions referred to in above questions 10(a) and 10(b)?

Answer to Question 12 (c):

No one to the best of my recollection.

Question 13 (a):

(a) What provisions of the *Child and Youth Advocate Act* required or permitted the OCYA to conduct what it characterized a "child death review?"

Answer to Question 13 (a):

Section 15 (1).

Question 13 (b):

(b) What events and other considerations influenced the OCYA in conducting what it characterized a "child death review?"

Answer to Question 13 (b):

The events were that a child who was in receipt of services from the Province had been murdered by its mother. She had been charged with murdering the father of the child in the US. She left the jurisdiction and came to Newfoundland. She was granted bail and had custody of the child and ultimately murdered the child. These were briefly the events and considerations. As I said before, we were an office set up to look into all matters involving children and it therefore was the appropriate route to follow.

Question 13 (c):

(c) With whom did the OCYA consult for advice or suggestions respecting conduct of what it characterized a "child death review," before and while it did so?

Answer to Question 13 (c):

I took advice frequently from different child advocates in Canada as I felt the need. I brought in the most experienced of such people to help and further enlighten us.

Question 14:

Please explain the process and resulting policies and procedures you put into place as a guide for the OCYA in conducting what it characterized a "child death review."

Answer to Question 14:

We discussed many aspects and I do not recall them all. I am at a serious disadvantage in that I am doing my best to assist you in this process with absolutely no reference materials. I took nothing from the office other than a few personal papers. I didn't even go to the office to clear it out because of my illness, and my secretary at the time just sent me the bare bones of what belonged to me. I have not had the benefit of any documents that would refresh my failing memory which has been exacerbated by my illness. So I am left with only what I can recall. I gave a great deal of thought as to how this

review should be done. I wanted, if possible, to even improve on what others did. In some cases they engaged people to assist them in an advisory capacity and I thought it was a good idea to have some professional advisors who would represent the disciplines you are going to be dealing with. I spent many hours considering the type of persons who would be helpful. I know this city and province very well. I drew up a list of people who I felt would be really helpful in reaching the best possible outcome of this terrible matter. I put together what I thought to be five or six people who were eminently qualified to assist us through this in an advisory capacity. They were only to advise the Advocate in the review. Terms of Reference for the Advisory Council clearly stating this point, which are on file, were drawn up and given them. They were sworn to confidentiality. They were clearly told that they could not maintain any documentation. There was a special rubber stamp made and every piece of paper that went to them was stamped confidential and not be copied or reproduced in any manner. We took all these kinds of steps and many others to make sure that the integrity of this piece of work was maintained to the highest degree. These were some of the policies we put in place.

Question 15 (a):

(a) Why did the OCYA retain Michele Neary ("investigator") and appoint an Advisory Council to review and investigate Zachary Turner's death?

Answer to Question 15 (a):

We didn't hire Michele Neary as an investigator. She was hired as an Assessment Officer. However Ms. Neary was appointed to be the lead staff person in the review. We were not on an investigation which is covered under Section 15(1)(c) but rather a review under Section 15 (1) (a).

Question 15 (b):

(b) Under what provisions of the *Child and Youth Advocate Act* or other legal authority was the investigator retained and the Advisory Council appointed?

Answer to Question 15 (b):

As stated earlier she wasn't an investigator. She was a temporary staff member; an Assessment Officer. As also mentioned earlier we had one staff member away on long term sick leave so we were short handed as well. I had an office to run. I only had one or two other staff members. My education officer was one of them. She was a half time education and half time Assessment officer. I couldn't take her away from that. So I had to go and seek somebody else. The authority for that came from the Internal Economy Commission which the Advocate would go to for approval. Also the Act is quite clear that the Advocate with the approval of the IEC shall hire such staff as he needs to carry out his work. We advertised openly for the position. We didn't have a lot of time. Of the candidates who applied, Ms. Neary appeared to be the best suited for this temporary position. There is no specific provision in the Act for an Advisory Council, but as I indicated, in some other provinces they operate in a similar manner. They retain them on a moderate fee or retainer to assist. They were not employees. They are an advisory committee or council as we call them here. I tried to determine what kind of professional disciplines should be represented. Then I made a list of all the people who would fit these needs. We had a Social Worker with a doctorate who was well published and well experienced in children's matters. We had a medical doctor with a lot of knowledge of children. There was a prominent

lawyer and president of the Law Society who practiced in family law. We had a distinguished former RCMP officer who went all the way to Assistant Commissioner and who I had known for years as a competent and well balanced person. We also had a person who was a University Professor of Anthropology, whom I didn't know, had never met, but had read some of his writings and knew of him by reputation as a man with a great insight into the minds of people who commit murder. So I thought I had a five star group of people. If you look at the Terms of Reference as you will see, their work was to advise the Advocate in the review, not to make decisions.

Question 16:

What was the mandate of the investigator and the Advisory Council?

Answer to Question 16:

The mandate of the Review was under my direction. Ms. Neary was the lead staff person and the terms of reference of the Advisory Council are on file. Basically she was to gather together all the facts that we could from all the agencies that might have impacted on this case, to gather the files; to interview people who could shed some light on this matter and to do as much research as possible and useful. At the end of the day with the assistance of Ms. Neary and the input of the Advisory Council, we hoped to decipher all that information to reach conclusions and recommendations which could form the basis for a final report.

Question 17 (a):

(a) What were the qualifications required or needed for an investigator in the OCYA to conduct what it characterized a child death review?

Answer to Question 17 (a):

I repeat, we did not hire an investigator.

Question 17 (b):

(b) Did the investigator retained possess the qualifications required or needed for an investigator in the OCYA to conduct what it characterized a child death review?

Answer to Question 17 (b):

Ms. Neary was hired as an Assessment Officer. She had the best qualifications that I could find when I advertised for an Assessment Officer. She held a PHD in Psychology. I thought that was going to be very helpful in the Review, and I believe it was.

Questions 17 (c/d):

(c) What was the method of selecting and retaining the investigator?

(d) Who retained the investigator?

Answer to Questions 17 (c/d):

We did not hire an investigator. We hired Michele Neary the way we did all others. We had a matrix developed and we did that in a very diligent manner. My officer manager was very good at that sort of thing. She had a lot more experience than I did and the Assessment Officer was hired. I made the ultimate decision as to who was hired. Based on our process she had the best qualifications of those available.

Question 18:

(a) Who in the OCYA directly supervised the retained investigator?

(b) What was the nature and extent of the supervision?

Answer to Question 18:

She was not an investigator. I was Ms. Neary's supervisor. There was nobody else to do so. That worked very well. She kept me well briefed and we met daily if not several times a day. The nature and extent of the supervision was that it was a good working relationship whereby we made plans for what we would do at any particular time, as the case might be. We were not always successful but we tried hard.

Question 19:

(a) What were the qualifications required or needed for Advisory Council members?

(b) Did the Advisory Council member possess these qualifications?

(c) What was the method of selecting and appointing them?

(d) Who appointed them?

(e) From what part of the OCYA budget was compensation paid to each Advisory Council member?

Answer to Question 19:

I looked for the people that I thought would be able see into the various issues and problems that would likely present themselves and had a good background in the law, in social work and in all the other disciplines that I thought were needed. I thought we had a really good, rounded body of people. They were the kind of people that I thought, and I am sure did, add to the piece of work. They possessed the qualifications that I thought they should have. I covered the method of selecting and appointing them. I was the Advocate. I had to do it. I proceeded to do it in the best way I knew how, being the first child death review. I appointed them. I swore them to secrecy and confidentiality. I told them that I would try to be reasonable and remunerate them as best I could, but they shouldn't take this for the money. I went to the IEC for money to remunerate them, like I did for all other funding needs of the office.

Question 20:

(a) Who in the OCYA directly supervised the Advisory Council?

(b) What was the nature and extent of the supervision?

Answer to Question 20:

There was not a lot of supervision. There were meetings which either I or the Assessment Officer would lead. It was quite informal. We would go over material. We would discuss and review various statements and various material that came before us. They would offer advice as appropriate. There were a couple of problems but I dealt with them appropriately and timely. Generally speaking it went very well.

Question 21:

(a) Why did Advisory Council members participate in direct questioning of witnesses?

(b) Who authorized them to do so?

(c) What was the extent of your knowledge that they did so?

Answer to Question 21:

To my knowledge this was very rare but there were occasions when it seemed the right thing to do. I don't recall being present on these occasions, but I agreed to and authorized it. It was only when there was a

particular individual with a professional background or some specific need whereby the Assessment officer would think it useful to have a council member of a certain professional skill and knowledge present. Whether they asked questions or not, it was to ensure that we achieved the best results. It was not very frequent to my knowledge that this was done, but that was the reason for it.

Question 22:

Why were persons not interviewed under oath or after affirming, by the investigator and Advisory Council members?

Answer to Question 22:

Simply because there was no provision in the Act for this.

Question 23:

(a) Should the OCYA have subpoena authority?

(b) Did you receive any advice or suggestions, such as from the Advisory Council, to seek to obtain subpoena authority to be exercised, where required, during the OCYA's conduct of what it characterized a "child death review?"

(c) Did you inform anyone outside the OCYA that you would seek to obtain subpoena authority, by

legislative amendment, to be exercised, where required, during the OCYA's conduct of what it characterized a "child death review?"

Answer to Question 23:

There were informal discussions about this issue from time to time. We didn't have the authority. There were times when I thought that at some point when the Act would come up for some amendment, as all legislation does from time to time, we would ask that that power be placed in it. It is in many other pieces of legislation. As a matter of fact I think it was in the Citizen Representative's Act, which was passed at about the same time as this one. I took counsel from my colleagues in other jurisdictions. Some had it and some didn't. The one that had it, said they never used it. I may have discussed that with the IEC or others, I'm not sure. My memory doesn't serve me clearly but I wouldn't be surprised if I had. It just seemed to be something that might be useful. We had the right to documents under the Act that existed.

Question 24:

(a) Did any of the Advisory Council members, other than in their respective capacities as Advisory Council members, have contact with the Bagbys?

(b) If so, which members?

(c) What was the nature and extent of that contact?

(d) If any of them had such contact, did you view this contact as appropriate?

(e) If inappropriate, what action, if any, did you take?

Answer to Question 24:

To the best of my knowledge with one exception I would not think so. The Advisory Council members were cautioned and given Terms of Reference and were all professional people. I made certain of their need to act in a very appropriate manner. To my knowledge, there was one incident which I dealt with appropriately and in a timely manner where a member of the Council, Dr. Leyton (who as I understand was teaching a class at the university and I stand to be corrected here), met the Bagbys who attended the class because of their interest. In the course of events, and I cannot recall exactly how it came to my knowledge, I became aware that Dr. Leyton who was a writer himself was going to provide some assistance to Mr. Bagby with a book that he was authoring. That came to me as a huge shock. I immediately contacted Dr. Leyton and told him that this could not happen. I outlined to him the potential hazards of such a relationship with respect to the integrity of the Review. I instructed him that he would either have to withdraw from the Advisory Council or withdraw from the relationship proposed with Mr. Bagby. After some consideration, Dr. Leyton wrote me, by email I think, and said he understood. As I recall the e-mail was copied to the Bagbys. He agreed that he would cease to carry on in this manner with respect to Mr. Bagby's book. I took this to be legitimate and honourable and that there would be no further difficulty.

Question 25:

What was the nature and extent of your involvement with the investigator and the Advisory Council?

Answer to Question 25:

I met with the Assessment Officer, (not investigator) Ms. Neary on a regular basis, several times a day. There were many phone calls in addition to that. We had a good relationship. I was satisfied with her work. I know there were challenges. There was so much to this piece of work that hardly any one person would have all the experience necessary to deal with all aspects. I was satisfied and there was rarely a day unless I was on the road when we didn't have some conversation about some aspect. She sent me prolific emails about things and provided me with material and so on. That was the level of involvement. With respect to the Advisory Council my involvement was mainly at the meetings we would have which would be about every 2 weeks. Sometimes there was a need for one for some specific purpose. Occasionally I would have to phone one or more of them. It was a more casual relationship than with Ms. Neary. I must say that for the most part the Advisory Council attended all the meetings whenever they could. They were loyal to the work during my period of office.

Question 26 (a):

(a) To what documents and other information did the investigator and Advisory Council members have access during what the OCYA characterized a "child death review?"

Answer to Question 26 (a):

The Assessment Officer (not investigator) and the Advisory Council had access to all the documents. They reviewed them. Sometimes they came in on their own

time with Ms. Neary, reviewed some material to get a better understanding or something like that. The purpose of this group was to advise the Advocate at the end of the day on various aspects. In my view, the way you do that is you entrust them with the information.

Questions 26 (b/c):

(b) What policies and procedures did you put in place respecting the sharing of documents and other information between the investigator and the Advisory Council?

(c) If no policies or procedures were put in place by you, what was your understanding of the access by the investigator and the Advisory Council to documents and other information, and the sharing between them of the documents and other information?

Answer to Questions 26 (b/c):

We had adequate procedures in place. Each person was provided with a security binder. They were given strong instructions that they were not to leave it in their cars or other unsecure places. They were not to allow it to fall into unauthorized hands. They were not to reproduce or copy any of it and it was all to be returned to the office and it was all confidential. We did what in my view were all the reasonable things. I even did research on the issue of whether their oath of

confidentiality endured beyond their tenure as it were and satisfied myself that it most likely was enduring.

Questions 27 (a/b):

(a) Were the investigator and/or members of the Advisory Council allowed to retain documents, copies of documents, and their notes after what the OCYA characterized a "child death review" by the OCYA stopped?

(b) If not, what steps did you put in place to ensure that you had control over documents, copies of documents, and notes in possession of the investigator and the Advisory Council?

Answer to Questions 27 (a/b):

The understanding I have is that everything was to be returned to the office. They could retain documents to review as I said. There were copies as a rule, but they were to be turned in on a rolling basis and that at the end everything was to be turned in. I became ill and I am at a disadvantage as to be able to say with certainty what happened after that. I can only conclude that reasonable steps were taken to make sure that that was carried out.

Questions 27 (c/d):

(c) Does the investigator or any Advisory Council member have documents, copies of documents, or

notes in her or his possession that they came into possession of or made in their roles as investigator or Advisory Council members?

(d) If so, who and what documents, copies of documents, and notes do they have?

Answer to Questions 27 (c/d):

I cannot speak to that. My strongest feeling is that it was all returned. I regret that I can't say and I was in no shape to take any steps at that time. I have not been back to the office since my retirement.

Question 28 (a):

(a) What role, if any, did the Deputy Advocate have in the Zachary Turner and Shirley Turner files of the OCYA

(i) before the deaths of Zachary Turner and Shirley Turner?

(ii) after their deaths?

Answer to Question 28 (a):

None. She wasn't at the office for one full year. She was off sick when this started and she came back towards the later part of it. I can assure you she had no contact with any of the files to my knowledge whatsoever, nor were there any conversations. Because

of the allegations [of conflict] that were made, we were all aware and the integrity of this work was to be maintained to the highest degree.

Question 28 (b):

(b) What role, if any, did [the Assessment Officer] have in the Zachary Turner and Shirley Turner files of the OCYA.

(i) before the deaths of Zachary Turner and Shirley Turner?

(ii) after their deaths?

Answer to Question 28 (b):

None to my knowledge or recollection with the exception of the interaction between Shirley Turner and [that Assessment Officer] … referenced to earlier.

Question 29 (a):

(a) Who wrote the drafts of the report into the deaths of Zachary Turner and Shirley Turner?

Answer to Question 29 (a):

Michele Neary wrote the drafts. I reviewed them.

Question 29 (b):

(b) Who had access to the drafts of the report?

Answer to Question 29 (b):

This was getting near the end of my time. I can't say with certainty if they were viewed by anybody other than her and I.

Question 30:

Describe the process by which the OCYA was prepared to share its report, when completed, with

(a) Government;

(b) the Bagbys;

(c) the surviving Turner children;

(d) the general public.

Answer to Question 30:

Up until the time that I fell ill, that had not been thoroughly vetted and decided. We had had discussions. In the case of the government, the Deputy Minister of Health and Community Services as I recall it, wrote me a letter toward the end of my time as Advocate and asked if they could have a copy of their part of report up front so that they could make comments. My reply to him was that we had not decided fully on the way it would be rolled out, but that we would follow the procedures laid out in the Act as closely as possible.

The Bagbys - There was some discussion about not only the Bagbys, but the surviving Turner children. Our thinking was that they should at least be given the courtesy of some kind of disclosure of the report before it hit the public media. It was thought that release to the general public was to occur after sharing with persons with a special interest. However as I say that had not been fully decided. We talked about a number of things. We talked about having a lock up like governments have for the budget. We talked about bringing together all the key players including the media and having a lock up. We talked about giving it to the key people before hand for comments and then depending on the comments, roll it out in a public fashion. We had not fine tuned that process to the time of my departure.

Question 31:

Describe your contact with Kathleen and/or David Bagby during the OCYA involvement in the Turner files, specifically

(a) before the deaths of Zachary Turner and Shirley Turner;

(b) after their deaths;

(c) during the "child death review;"

(d) from February 2005 up to this interview.

Answer to Question 31:

I don't believe I had any contact with the Bagbys before. I don't think I even met them. I knew that they were around the town and that they were talking to the

press and so on, but I can't say that I ever saw their faces or met them other than on the media before the deaths.

After the deaths as the office was becoming involved, I have no notes to tell me so, but I believe I invited them to come and see me as a courtesy and to establish a relationship with them. I knew they were going to be key players and while there had to be guidelines, I wanted to make sure that we had clear understandings and a good relationship.

During the child death review, Mr. & Mrs. Bagby came in and made representations to Michele Neary, I don't think I attended it. Other than that they would call either Michele or me or drop by from time to time. They were living in Newfoundland for up to [a] couple of years at that time, dislodged from their home. The[y] bore all the costs of that and the trauma they were going through having had their son murdered and then their grandson. They were determined to stay here as long as they could renting an apartment. They would call from time to time to see how it was going. They never sought any secrets or any material. They would inquire as to how it was going and when it was going to finished. They were always a perfect lady and a gentleman. That's all I can say. They were gracious about everything and did not seek to influence the work.

In approximately late 2004 I became ill. I would say that I had almost no contact from that point on. I have a recollection of talking to Mr. Bagby after I became ill. He may have called to say he was returning to the USA. I told him I was turning the matter over to Dr. Markesteyn. I told him that I anticipated that it would be done in a timely manner. That is all that I can recall. I regret that my recall of that period of time is very limited and very unclear.

Questions 32 (a/b):

(a) Were Kathleen and/or David Bagby promised an advance copy of the OCYA report, when completed?

(b) If so, who promised either of them an advance copy of the report, when completed?

Answer to Questions 32 (a/b):

As stated earlier we had not reached a conclusion on the method of handling the final report. To my knowledge, no promises as such were made. I would say however that Mr. & Mrs. Bagby were assured that they would be informed as the time drew near for release, so that they could have ample time to return to St. John's. Further I would add that my sentiments were that whatever method was ultimately devised for the handling of the final report, that Mr. & Mrs. Bagby, in view of all the circumstances and their suffering, should be extended maximum courtesy with respect to the final report.

Question 32 (c):

(c) Did Kathleen and/or David Bagby have access to the draft reports or any other information in the Turner file of the OCYA?

Answer to Question 32 (c):

Not to my knowledge.

Question 33:

Should the OCYA be responsible for conducting what it characterized "child death reviews?"

(a) If no, why not?

(b) If so, what are your recommendations to ensure the OCYA conducts "child death reviews" in an efficient and effective manner?

Answer to Question 33:

My simple answer is yes. A Child Advocate's mandate is very broad as it should be and to suggest that it be deprived of the right to conduct a review into the death of a child, the most frightening and terrible event that can happen to a child and family would be a most regressive step.

Question 34:

What are your recommendations with respect to the legislation establishing, and the mandate of, the OCYA that would assist the OCYA perform its mandate in an efficient and effective manner?

Answer to Question 34:

My recommendation would be that adequate resources be in place, both human and financial, to ensure timely and appropriate outcomes. That the office of the Child and Youth Advocate continue to be strengthened so that

it can carry out its mission statement and measure up to the tenets of the United Nations Convention on the Rights of the Child, to [which] Canada is a signatory.

Question 35:

Please state any information that, in your view, is not contemplated by the foregoing questions although is relevant to my *de novo* review and investigation.

Answer to Question 35:

(*unanswered)*

Question 36:

Please state all your views on: (i) your involvement with the OYCA, in relation to Zachary Turner and/or Shirley Turner or otherwise; and (ii) with respect to my *de novo* review and investigation not contemplated by the foregoing questions.

Answer to Question 36:

(*unanswered)*

(Except where mentioned by name, Dr. Neary is not the Assessment Officer referred to by Mr. Wicks in his answers).

Concerned that Mr. Wicks's health impediments may have prevented him from answering my 36 written questions, they were, on 29 November 2005, also sent by me to the former Deputy Child and Youth Advocate, who commenced her duties in the Advocate's Office on 28 October 2002. Although anxious to assist my Review, she was clearly unable to oblige because, I conclude from her 14 December 2005 reply letter and my examination of the Advocate Office's files on Zachary Turner, she was not present at the Advocate's Office for most of the period material to my Review (and out-of-province receiving treatment for part of that period) due to illness.

In providing an account in this Chapter of the performance of the Office of the Child and Youth Advocate relating to Zachary Turner, both before and after his death, I relied, in addition to Mr. Wicks's written answers to my questions, on: (i) general correspondence files maintained by Mr. Wicks while he was the Child and Youth Advocate and by his staff; and (ii) records made by the Assessment Officer, Dr.

Neary, and by the Advisory Council while they participated in the previous review.

No doubt, the Assessment Officer and the Advisory Council - functioning under Mr. Wicks's direction - performed much of the work done in the prior uncompleted review. They accumulated many relevant documents. They interviewed 44 persons (and arranged for transcription of 42 of the interviews).

4. Acknowledgement

The work by the Assessment Officer, Dr. Neary, and by the Advisory Council on the first Advocate's behalf was not completed and did not result in a report because of the premature retirement of the first Advocate, Mr. Wicks, due to illness.

Nonetheless, the industry of the Assessment Officer and Advisory Council, and the associated expense incurred in the course of the uncompleted review were not in any respect in vain. Their work was entirely considered in my Review.

Absent their work, my Review would have involved significantly more time, effort and cost.

I am grateful for the work of the Assessment Officer, Dr. Michele Neary, and of the Advisory Council, superintended by the first Advocate in the previous review.

[Notes to Chapter 11]

[1] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4.

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Ibid.

[10] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 2, p.A.3.

Chapter 12

Child and Youth Advocate Act

1. Introduction

Expectations of the Province's House of Assembly in creating the Office of Child and Youth Advocate are expressed in legislation. The legislation is the *Child and Youth Advocate Act.*[1] The *Act* established the Child and Youth Advocate's Office on 13 May 2002. The House of Assembly expected the Advocate's Office to employ the authority given by the *Act* to "generally, act as advocate of the rights and interests of children and youth."[2] Whether those expectations of the House of Assembly are met depends on how effectively the *Act* functions in practice.

During the past 12 months I have strived, as the Advocate's Delegate, to conduct a complete review of, and investigation into, the circumstances of and surrounding Zachary Turner's death ("Review"). My Review proved to be a severe test of the Advocate's statutory authority. I concluded that the *Act's* authority requires enhancement, especially the provisions empowering the Advocate to gather relevant information. I am therefore making recommendations to increase the Advocate's authority and, consequently, the

ability of the Advocate to meet the House of Assembly's expectations under the *Act*.

I am not for a moment conceding that the existing authority given the Advocate under the *Act*[3] prevented me from fully performing my mandate from the Advocate. Rather, I make the recommendations so that the Advocate's Office can, in future, avoid the substantial additional time and cost I incurred. Because there are currently limitations in the *Act's* authority, I had perforce to develop innovative ways to accumulate relevant information.

My experience in functioning as Advocate's Delegate is not, however, the only basis for my recommendations for amendment of the *Act*. I have also had the benefit of the following:

(i) a day-long, round table conference with three of Canada's most qualified experts in fields of, and related to child advocacy (who met without fee with my legal counsel and me in Calgary, on 08 August 2005);

(ii) beneficial discussions with delegates to the World Conference on Family Violence in Banff, Alberta, from 23 to 26 October 2005 (without expense to the Province);

(iii) publications of, and contributed to, by the Canadian Council of Provincial Child and Youth Advocates including the Council's publication, "Children's Advocates Services in Canada - 2003;"

(iv) legislation creating in other provinces the equivalent of the Office of the Child and Youth Advocate in Newfoundland including the *Representative for Children and Youth Act*[4] enacted by the British Columbia Legislature on 18 May 2006;

(v) annual reports since 1990, where published, of child and youth advocacy offices across Canada;

(vi) legislation of several states of the United States of America; and

(vii) my written interview with the first Advocate (Chapter 11).

I identified shortcoming in the content and application of the *Act*. They could materially restrict the proactive, thorough and expeditious performance under the *Act* of the current and any future Advocate.

The *Act's* deficiencies could detract from the legal feasibility of the Advocate adequately discharging the *Act's* mandate; specifically, reviews or reviews and investigations (the Advocate's principal functions) which the Advocate under section 15 of the *Act*[5] either: (i) initiates; or (ii) chooses to undertake in response to requests from the community; or under section 16 of the *Act*,[6] (iii) is requested to perform by the Provincial Government.

The amendments I propose address several features of the *Act,* not least being the *Act's* information gathering proviso.

2. Acquiring Information

2.1 Overview

Amendments to the *Act* that would, in my view, significantly improve the conduct of Advocate reviews and investigations involve: (i) acquiring information; (ii) reliable documentation of information; and (iii) other facets of reviews and investigations.

Efficient access to comprehensive, dependable information from both the public sector (which the *Act* for the most part authorizes) and the private sector (which the *Act* does not authorize) is critical to effective discharge of the Advocate's mandate.

Section 21 (1) of the *Act* states that:

> **The advocate has the right to information respecting children and youth that is**
>
> **(a) in the custody or control of a department or agency of the Government; and**
>
> **(b) necessary to enable the advocate to perform his or her duties or exercise his or her powers under the *Act*, except**
>
> **(c) information that could reasonably be expected to reveal the identity of a person who has made a report under section 15 of the *Child, Youth and Family Services Act*;[7] and**

> **(d) information that is not permitted to be made public by section 26 of the *Adoption of Children Act*.**

First, section 21(1) of the *Act* governs information disclosure to the Advocate by both: (i) departments; and (ii) agencies of the Provincial Government. Departments of the Government are identified under the *Executive Council Act*.[8] That statute provides for all departments of the Government. Agencies of the Provincial Government are, under section 2(b) of the *Act*,[9] defined to mean

> **a board, commission, association, or other body of persons, whether incorporated or unincorporated, included in the Schedule**

to the *Act*. The Schedule[10] lists six agencies or classes of agencies that, as a result, are subject to the information disclosure requirement of section 21(1) of the *Act*. And the Schedule further provides for agencies consisting of

> **[a] board, commission or other body added to this Schedule by order of the Lieutenant-Governor-in-Council.**

(None have been added to the Schedule to the *Act* since the *Act* took effect on 13 May 2002).

Should any agencies of the Provincial Government be added to the Schedule to the *Act*[11] to become scheduled agencies?

The answer is that any agency of the Provincial Government which has, in the language of section 21(1) of the *Act,* "information respecting children and youth in … [its] custody or control" that is "necessary to enable the advocate to perform his or her duties or exercise his or her powers under the *Act"*[12] should be included in the Schedule to the *Act*.

2.2 Regional Integrated Health Authorities

While Zachary Turner was alive, the Advocate's Office could have required - although never requested - information about state services being provided to or for Zachary by social workers employed by what was then the St. John's Regional Health and Community Services Board. The Board, created by the *St. John's Regional Health and Community Services Board Order*,[13] was an agency of the Provincial Government expressly provided for under the Schedule of agencies appended to the *Act*.[14] All regional health and community services boards in the Province, including the St. John's Board,

went out of existence effective from 01 April 2005 when the Order creating the boards was repealed by the *Regional Integrated Health Authorities Order*.[15] That Order had the effect of assigning to four regional integrated health authorities responsibilities formerly performed by the boards and by other state health care agencies across the Province. Responsibilities previously performed by the St. John's Board have, from 01 April 2005, been undertaken by the Eastern Regional Integrated Health Authority.

The regional integrated health authorities are not specifically listed in the Schedule to the *Act* among agencies required to satisfy requests for information made by the Advocate's Office under section 21(1) of the *Act*. The authorities are, however, covered by another scheduled agency; namely, a "hospital board or authority."

Nonetheless, to avoid possible confusion, the four regional integrated health authorities should be specifically listed in the Schedule to the *Act*.

Recommendation 12.1

THAT the four regional integrated health authorities created by the *Regional Integrated Health Authorities Order* be specifically listed in the Schedule to the *Act.*

2.3 Office of Medical Examiner

At least one agency of Government (there may be others) apparently not included in the Schedule to the *Act* that is likely to have custody or control of information contemplated by section 21 of the *Act*[16] is the Office of the Medical Examiner. Although the Chief Medical Examiner is, under section 3(4) of the *Fatalities Investigations Act*[17] (the legislation creating the Office of Medical Examiner), "responsible to" the Minister of Justice, that Office is not part of the Department of Justice or, for that matter, any other Provincial Government department. Rather, in my view, it is an agency of the Provincial Government. However, the Office of the Medical Examiner is not captured by the description of any agency or class of agencies identified in the Schedule to the *Act*.[18] (The Medical Examiner's Office is not even listed as an agency of the Provincial Government on its Internet website).

In circumstances of death defined by sections 5 through 8 of the *Fatalities Investigations Act,*[19] often described as sudden or unexplained deaths, the Chief Medical Examiner and Medical Examiners appointed by and under the supervision of the Chief Medical Examiner, have statutory duties; among them, the duty under section 10(1) of the *Act*,[20] to

> **investigate the death and where possible establish (a) the identity of the person; (b) the date, time and place of death; (c) the cause of death; and (d) the manner of death.**

Investigation of a death usually, but not always, includes an autopsy.

Fatalities the Chief Medical Examiner is by law obligated to investigate sometime involve questionable deaths of children. The Chief Medical Examiner conducts investigations into most, but not all child deaths - by no means. Barring legislative amendment, the Chief Medical Examiner will continue to do so. Information the Medical Examiner's Office has accumulated from investigations undertaken under the *Fatalities Investigation Act*[21] into child deaths may be relevant to the mandate of the Advocate.

Although the Chief Medical Examiner is, in circumstances prescribed by sections 5 through 8 of the *Fatalities Investigations Act,*[22] responsible for children after death, the Advocate is responsible for children before death.

That responsibility of the Advocate includes the discretion, under section 15, and the duty, under section 16 of the *Act,* to review and investigate matters triggered by deaths of children involving their lifetime "interests and well-being."

Not least of the Advocate's concerns after a child dies may be: (i) whether that child - including a child on the state's community services caseload - should have, during the child's life, been permitted to live with or, alternatively, should have been removed from the person in whose care the child has been living; and, (ii) whether circumstances existed during that child's life adverse to the child's "interests and well-being" which were known, or could and should and needed to have been known to state representatives, that caused or contributed to the child's death.

Or, the Advocate may decide or be requested to review or to review and investigate recurring circumstances or trends

respecting children, whether or not in receipt of state services, whose questionable deaths have been investigated by the Chief Medical Examiner.

The timeframe of the focus of the Advocate's review would be the lifetimes of those children; in particular, whether their "rights and interests" were, during their lives, "protected" under section 3(a) of the *Act*.[23]

As said before, the Medical Examiner's Office may possess information pertinent to such reviews and investigations.

The duty of the Chief Medical Examiner to release death information is governed by section 24 of the *Fatalities Investigation Act*[24] which states:

> **24(1)**
> **All reports, certificates and other records made by a person under this *Act* are the property of the government of the province and shall not be released without the permission of the Chief Medical Examiner.**
>
> **24(2)**
> **On completion of an investigation and on receipt of a request from the next of kin, the executor or executrix of the deceased or other interested party, considered valid by the Chief Medical Examiner, a report shall be**

completed and sent by the Chief Medical Examiner to the person making the request.

The purview of section 24 of the *Act*[25] does not expressly provide for disclosure of any information by the Chief Medical Examiner to the Advocate.

Even though "reports, certificates and other records" made under the *Fatalities Investigations Act*[26] "are the property of the government of the province," section 24(1) of the *Act* precludes their release, without permission of the Chief Medical Examiner, whose office is neither a department nor a scheduled agency of the Provincial Government obligated to disclose information to the Child and Youth Advocate under section 21 of the *Act*.[27]

On the other hand, the Office of the Chief of Clinical Biochemistry at the General Hospital Health Sciences Centre, St. John's, which performs most analyses requested by the Chief Medical Examiner, is part of the Eastern Regional Integrated Health Authority.[28] The Authority, in turn, comes within the list of "agencies" in the Schedule to the *Act*; specifically, a "hospital board or authority." Arguably, therefore, results of analyses prepared by the Office of the

Chief of Clinical Biochemistry for the Chief Medical Examiner would be accessible to the Advocate under section 21 of the *Act*[29] even if records in the Office of the Medical Examiner are not.

Recommendation 12.2

THAT an amendment of the Schedule to the *Act*[30] include the Chief Medical Examiner and any other agency of the Provincial Government likely to possess information relevant to the Advocate's responsibilities under the *Act.*

Recommendation 12.3

THAT an amendment of the *Act*[31] provide that the Chief Medical Examiner be obligated to perform, or cause to be performed, any feasible medical or laboratory analysis or other scientific procedure requested by the Advocate which the Advocate determines to be relevant to the Advocate's mandate under the *Act.*[32]

This recommendation contemplates circumstances where the Office of the Medical Examiner, during an autopsy, collects and retains a body's organs, tissues or fluids, but decides that analysis of them is unnecessary or necessary only

to a limited extent (as occurred in relation to the autopsy of Zachary's remains).

2.4 Other information sources

Secondly, section 21 of the *Child and Youth Advocate Act*[33] does not apply to sources of information other than Provincial Government departments and scheduled agencies.[34] For example, section 21 of the *Act* does not apply to the College of Physicians and Surgeons[35] (although the College went to pains to oblige me, to the extent permitted by the law governing information disclosure by the College), privately practicing physicians and members of the public. Unless citizens (including those citizens whose medical records are sought by the Advocate) volunteer their assistance to the Advocate, as many members of the public did during the previous review and during my Review, no legal mechanism presently exists to compel disclosure of information they possess. That information may be critically germane to matters the Advocate chooses or is requested by the Provincial Government to review and investigate.

I encountered during my Review several organizations and persons who, because they were neither a Provincial Government department nor an agency contemplated by the *Act*, declined to provide to me information in their custody or control that I requested from them. The information I requested was, in my view, necessary to enable me as the Advocate's Delegate - in the language of section 21 of the *Act*[36] - to "perform … [my] duties … [and] exercise … [my] powers under the *Act*."[37] But they were not obligated to disclose this information to me because they were not governed by section 21 of the *Act.*[38] And, no other legal recourse was available to compel them to disclose.

In the result, I was seriously delayed in performing, and substantially impaired in my ability to adequately complete, my Review in a manner congruent with the exceptional standards the Speaker of the House of Assembly justifiably expected from me and to which I have been committed.

Nonetheless, I was able to overcome the prospect of inadequately concluding my Review by taking discreet circuitous routes involving significant additional expenditures of time and resources. These expenditures could, in future, be

avoided if a process were in place to overcome these obstacles to accessing information necessary to the discharge of an Advocate's duties.

The remedy is amendment of the *Act*[39] to provide the Advocate with authority to subpoena persons, whether or not employed by Provincial Government departments and scheduled agencies.

2.5 Hearings

Thirdly, the *Act's* information disclosure provision (section 21) does not authorize hearings. This is a shortcoming of the *Act* that requires rectification.

I reached this conclusion on the basis of our information-gathering experience during the Review.

For example, while document requests to Provincial Government departments and scheduled agencies contemplated by the *Act*[40] were consistently and fully answered, I realized early in my Review that document disclosure was not always the most effective means of

gathering relevant information. What was lacking was the benefit to be gained from interviewing persons at a hearing. I am not thinking of a hearing in the sense of a trial. Instead, I have in mind an "oral examination for discovery" routinely employed in Newfoundland Supreme Court prior to trials to acquire information.[41] Documents disclosed by employees of Government of Newfoundland departments and scheduled agencies often required clarification or amplification. Or, the documents did not suffice, even when clarified or amplified by time consuming disclosure of additional documents and by correspondence exchanges.

Although not expressly authorized by the *Act*, I requested and was impressed by the willingness of employees of Provincial Government departments and scheduled agencies to attend hearings at which my legal counsel and I interviewed them. The interviews proved to be profitable in my Review. They enabled me to understand disclosed documents. More importantly, the interviews supplied me with considerably more information than did documents; information necessary for my Review.

The *Act* should authorize the Advocate to require persons, whether or not Provincial Government departmental or scheduled agency employees, having information pertinent to matters the Advocate is investigating, if summoned, to appear before the Advocate, the Advocate's Delegate or the Advocate's legal counsel and be examined.

The solution is amendment of the *Act* to provide the Advocate with the authority of subpoena power.

2.6 *Written interviews*

Although not expressly permitted by section 21 of the *Act* (the information-disclosure provision), I invited several persons to participate in written interviews. Almost everyone I invited to do so volunteered by providing written responses to my written questions.

I resorted to this information gathering process where the information I required consisted of particular facts that would not justify a verbal interview hearing or where persons I wished to interview were unable, due to illness, to be

interviewed verbally. Acquiring information in this manner proved inexpensive and reasonably efficient.

Recommendation 12.4

THAT section 21 of the *Act* be amended to authorize the Advocate to require information by written interview instead of depending on voluntary participation.

Investing the Advocate with subpoena power would also cure a refusal to respond to a written interview.

2.7 Subpoena power

A subpoena is, in effect, a summons to appear and, if specified in the summons, to bring documents specified in the summons which are in possession of the summoned person (a subpoena *duces tecum*). Subpoena power would furnish the Advocate with authority long possessed by courts to issue to, and serve on, organizations and persons not encompassed by the *Act's* obligatory disclosure provision. The summons should legally require them to disclose - by providing oral or written answers to questions and by producing documents - information requested by the Advocate that is required to

facilitate performance of the Advocate's statutory duties. Any organization or individual who, having been served with such a summons, failed or refused to comply with the summons would risk the prospect of a contempt hearing and, if found to be in contempt, suffer penalties involving fines and/or imprisonment.

Of course, as a matter of law, the Advocate's subpoena power, if authorized, could only have effect within the Province.

The existence (the prospect of exercising) of subpoena power in and of itself would likely, as in the Canadian jurisdictions where the authority is possessed by the equivalent of this Province's Advocate, serve as an inducement to co-operation with the Advocate without the Advocate having to exercise the power.

Naysayers may contend the subpoena power is an instrument that customarily is reserved by law to Courts, necessary to enable Courts to fulfill their obligations to make binding judgments and orders governing the affairs of litigants.

However, the subpoena power has been provided to the Newfoundland Citizens' Representative (sometimes in practice called an "ombudsperson")[42] whose conclusions are, like those of the Advocate, advisory rather than binding.

Further, social workers employed by integrated regional health authorities, who function under the *Child, Youth and Family Services Act* may, in reliance on section 20(1) of that *Act*,[43] apply to a judge for an

> **order [that] a person … produce information that is written, photographed, recorded or stored by other means, or a certified copy of the record, for inspection ….**

The "person" is not limited to an employee of the Province or an agency of the Province.

Critics may also contend that granting the Advocate subpoena authority to compel co-operation is disproportionate to the Advocate's mandate.

To the contrary, the Advocate has been entrusted with the formidable onus of advocating for society's most

vulnerable constituency - our children - who comprise 21.5 percent of the Province's population (2004 census data).[44]

In summary, addition to the Advocate's authority under the Act of discretion to issue a subpoena would ensure that the Advocate receives all relevant information from all sources, either at a hearing or in writing.

Recommendation 12.5

THAT the *Act*[45] be amended to provide for addition of the following section:

> **(1) For the purposes of a review or an investigation, or a review and investigation, subject to subsection (4), the Child and Youth Advocate may**
>
> **(a) summon by subpoena and enforce attendance of any witnesses;**
>
> **(b) summon by subpoena and enforce production by witnesses of any records and other things, and provisions of answers to written questions.**

(2) Where the Advocate exercises a subpoena power under subsection (1), a person or other legal entity who fails or refuses to

(a) attend;

(b) answer questions;

(c) produce the records or other things in the person's custody or possession, or provide answers to written questions requested by subpoena;

is liable, on application by the Advocate or his or her Delegate to a Judge of the Trial Division of the Supreme Court of Newfoundland and Labrador, to be committed for contempt as if in breach of an order, judgement or other process of the Supreme Court of Newfoundland and Labrador.

(3) The Advocate shall issue a subpoena provided for in subsection (1) in the manner authorized by the *Public Investigations Evidence Act*.[46]

(4) **The Advocate shall not exercise the powers prescribed by subsection (1) unless the**

Advocate is unable, under section 21 or voluntarily, to obtain evidence, records and other things that the Advocate determines to be necessary to a review or investigation.

2.8 Disputes about obligation to disclose

Fourthly, whenever during my Review I encountered disputes in my efforts to obtain information (documents, other things, verbal or written testimony), the *Act* did not provide for an arbiter to resolve the disagreements. Those with whom I was in dispute pointed to limitations of language in the *Act*, provisions of other legislation and the common law (judge made law) as bases for denying access to records or verbal testimony I needed. (I must say, however, that departments and scheduled agencies of the Provincial Government were, for the most part, forthcoming with information I required by disclosing documents and submitting to verbal and written interviews. Occasional disagreements I experienced with them were eventually resolved by negotiations between the department or agency involved and my legal counsel and me. Those disagreements usually centered on privacy of

information issues addressed by sections 21(c) and 21(d) of the *Act*).

Disputes we did experience in our efforts to gain information necessary for my Review proved to be distressing because they delayed us in our work. Significant additional time was required to negotiate with relevant, although reluctant, information sources or to develop inventive strategies for securing the information I regarded as essential.

Recommendation 12.6

THAT amendment of section 21 of the *Act* provide that, should the Advocate encounter any refusal or delay in response to an information request for documents or other things, verbal testimony, or written answers, the Advocate may apply for an information disclosure order from a Judge of the Provincial Court of Newfoundland on not less than seven days written notice of the application to the information source. And, that the Judge be given discretion to order payment by respondents to an application of some or all of the actual fees and disbursements incurred by the Advocate in making the application (depending on the outcome of the application).

2.9 Reliable documentation

Fifthly, the Advocate's information disclosure provision, section 21 of the *Act,*[47] is silent respecting how information is to be gathered and documented to best ensure reliability. For example, would telephone conversations or correspondence between the Advocate and information sources and photocopies of documents suffice? Or, should verbal or written interviews be conducted at which answers are given and documents are provided to the Advocate? And, if verbal or written interviews are conducted, should persons being interviewed provide answers and documents on oath or affirmation?

My opinion is that evidence must be gathered and documented by the Advocate in the manner that best ensures its reliability. Reliable evidence in turn contributes to the integrity - hence the reliability - of the Advocate's conclusions and, consequently, the value of those conclusions to Government departments and agencies, communities and individuals to whom the Advocate must or may report.

In the previous review, none of the 44 persons verbally interviewed (some of whom were required by section 21 of the *Act* to provide information, others of whom were not) were asked to swear or affirm the truth of answers they volunteered during their respective interviews. Consequently, their answers did not have legally probative value (the degree of reliability required to depend on the witnesses' answers as proof of the matters about which the answers were given). The Advocate did not direct the witnesses be sworn or affirm. The reason, I speculate, is that the *Act*[48] does not expressly require sworn or affirmed information.

To encourage if not assure its truthfulness and, consequently, its reliability, evidence was required from time immemorial to be given under the sanction of either: (i) an oath; or if a witness did not have a religious belief, (ii) solemn affirmation. (The sanctions of untruthfulness under oath or affirmation are, of course, criminal prosecution for perjury and public disapprobation).

Furthermore, in the previous review, documents were not verified by what the rules of some courts refer to as an "affidavit of documents."

Again, I speculate that documents were not verified, absent a specific requirement under the *Act*[49] to do so.

Documents provided to the Advocate should be accompanied by a sworn or affirmed statement from the document provider in a form prescribed by the *Act*, which states that the documents being disclosed are: (i) all the documents in the provider's custody or control; and are (ii) faithful reproductions of the disclosed documents.

Recommendation 12.7

THAT amendment of the *Act*[50] provide that during a review or investigation by the Advocate, all information (oral and written) on which the Advocate relies for reports the Advocate may or must make under the *Act*[51] to any department or scheduled agency of the Provincial Government or a community or community member, be received under oath or on affirmation.

Recommendation 12.8

THAT regulations be enacted under the *Act* which prescribe forms to be employed by the Advocate in

requesting and receiving information, e.g., documents and written interview answers.

3. Families

The purposes of the *Act* under section 3, the powers and duties of the Advocate under section 15, the Advocate's right to information under section 21, the reports which the Advocate may or must make and the provisions of the *Act* generally[52] relate to children and youth.

Yet, discharge of the Advocate's duties frequently relates to advocacy respecting services dispensed under the *Child, Youth and Family Services Act*.[53] That *Act* focuses not only on children and youth but also the families of children and youth. The short title of that *Act* says as much. The provisions of that *Act* are replete with references to the family and to members of a family; not least, a caregiver and a parent.

Elsewhere in Canada, the language of child and youth advocacy legislation is often framed in terms of children, youth and families. The equivalent in Ontario of Newfoundland's *Child and Youth Advocate Act* is the "Office

of Child and Family Service Advocacy."[54] The Preamble to *The Child and Family Services Act* of Manitoba which provides for appointment of a Children's Advocate includes a statement that[55]

> **[f]amilies and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.**

Section 3(1)(d) of Alberta's *Child, Youth and Family Enhancement Act*[56] which creates the Office of Child and Youth Advocate obligates that Office

> **to facilitate the involvement of family or community members in assisting in advocating for a child who is receiving services**

from the Province of Alberta.

All children and most youths who engage the *Child and Youth Advocate Act*[57] are members of families residing in the care and control of parents or other caregivers.

Recommendation 12.9

THAT the *Act* be amended throughout to express the mandate, powers and duties of the Advocate in terms of

children, youth and families, including parents and other caregivers.

4. Disputes about Jurisdiction

Although I did not encounter any obstacle relating to jurisdiction in the conduct of my Review, I envisage circumstances where the Advocate may be brought to a standstill by jurisdictional objections to performance by the Advocate of a review or investigation.

Readily coming to mind are matters in which objection is taken to a review or to a review and investigation that the Advocate chooses or is required to perform because a criminal investigation or prosecution is underway, or because a Human Rights Commission[58] review, inquiry or proceeding is being conducted or the Commission claims exclusive jurisdiction to do so.

A mechanism is desirable to resolve challenges to the Advocate's jurisdiction.

Recommendation 12.10

THAT the *Act* be amended to provide that any question respecting the Advocate's jurisdiction to review or investigate any matter under the *Act* may be resolved by the Advocate's application to a judge of the Provincial Court of Newfoundland for a declaratory order determining the question of jurisdiction.

5. Investigations

By expecting the Advocate under section 15(1)(c) of the *Act*[59] as a pre-condition of an investigation to first undertake "advocacy," "mediation" or "another dispute resolution process" may delay the Advocate in commencing an investigation, especially in circumstances where delay would or could prejudice the investigation. If the Advocate is requested by the Provincial Government under section 16 of the *Act* to investigate, no such pre-condition exists.

Recommendation 12.11

THAT section 15(1)(c) of the *Act* be amended to enable the Advocate to dispense with advocacy, mediation or other dispute resolution process, and any other precursor to

investigating a matter where, in the Advocate's opinion, those mechanisms are impracticable.

6. Proposed Action by Office of Child and Youth Advocate

The types of proposed steps the Advocate may recommend to a department or scheduled agency of the Provincial Government following conduct by the Advocate of a review or a review and investigation under section 15(1) or section 16 of the *Act*[60] are not described in any detail under the principal remedies provision (section 24) of the *Act*.[61]

I would have benefited from provisions being included in the *Act* which designated specific types of measures available to the Advocate. Recourses available to the Advocate are driven by conclusions the Advocate reaches from evidence examined during a review, or from evidence accumulated during an investigation. Having a fuller indication from the *Act* of the Advocate's options would have assisted me, as the Advocate's Delegate, in identifying and developing the scope of my Review. And, during conduct of the Review, in turn, I could have crafted more specific proposals for the Advocate who ultimately must decide what

recommendations (if any) from these Findings to make to Provincial Government departments and/or scheduled agencies.

I am not proposing a definitive statutory list of the Advocate's options for making recommendations to Provincial Government departments and scheduled agencies. Rather, I have in mind a list which illustrates the types of steps the Advocate may recommend.

Recommendation 12.12

THAT section 24 of the *Act* be amended to state that the types of steps the Advocate may propose include, although not be confined to:

(a) enactment of new legislation and amendment of existing legislation;

(b) development of policies, standards and practices, and alterations to existing policies, standards and practices;

(c) development of new programs and reform of existing programs;

(d) review, modification and reversal of particular program services delivery decisions;

(e) rectification of omissions in program services delivery;

(f) provision of reasons for decisions;

(g) allocation and reallocation of program service centres and providers;

(h) development of professional and non-professional employee training, and modification of existing training;

(i) conduct of additional investigations;

(j) "no name/no blame" monitoring and auditing of professional and non-professional program services delivery personnel; and

(k) resolution of circumstances which are unreasonable, unjust, oppressive or discriminatory.

7. Youth Criminal Justice Act

And finally, a "housekeeping" amendment is required to section 17(1) of the *Act*[62] considering that the *Young Offenders Act*[63] there mentioned was replaced on 01 April 2003 by the *Youth Criminal Justice Act*.[64]

Recommendation 12.13

THAT section 17(1) of the *Act* be amended by deleting "*Young Offenders Act*" and substituting "*Youth Criminal Justice Act.*"

[Notes to Chapter 12]

[1] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[2] *Child and Youth Advocate Act*, Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[3] Ibid., Section 21, Appendix 4, p.A.17.

[4] Statutes of British Columbia, 2006, Chapter 33, not yet in force. When in force, will replace *The Office for Children and Youth Act*, Statutes of British Columbia, 2002, Chapter 50.

[5] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.14.

[6] Ibid., p.A.15.

[7] Statutes of Newfoundland and Labrador 1998, chapter C-12.1 (as amended), Appendix 5, p.A.25.

[8] Statutes of Newfoundland and Labrador, 1995, Chapter E-16.1.

[9] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.8.

[10] Ibid., p.A.23.

[11] Ibid., p.A.7.

[12] Ibid., p.A.17.

[13] Newfoundland Labrador Regulation 48/98.

[14] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[15] Newfoundland and Labrador Regulation 18/05.

[16] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.17.

[17] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[18] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[19] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[20] Ibid.

[21] Ibid.

[22] Ibid.

[23] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.9.

[24] Statutes of Newfoundland and Labrador, 1995, Chapter F-6.1.

[25] Ibid.

[26] Ibid.

[27] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.17.

[28] *Regional Integrated Health Authorities Order*, Newfoundland and Labrador Regulation 18/05 filed 04 March 2005.

[29] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.17.

[30] Ibid., p.A.7.

[31] Ibid.

[32] Ibid.

[33] Ibid., p.A.17.

[34] Ibid., p.A.7.

[35] *Medical Act*, 2005, Statutes of Newfoundland and Labrador 2005, Chapter M-4.01.

[36] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, pp.A.17-A.18.

[37] Ibid., Appendix 1, p.A.1.

[38] Ibid., Appendix 4, pp.A.17-A.18.

[39] Ibid., p.A.7.

[40] Ibid.

[41] Rules of The Supreme Court, 1986, Rule 30.

[42] *Citizens' Representative Act*, Statutes of Newfoundland and Labrador 2001, Chapter C-14.1, Section 31.

[43] Statutes of Newfoundland and Labrador, Chapter C-12.01, Appendix 5, pp.A.42-A.32.

[44] Statistics Canada. Table 051-0001 (Ottawa: 2005).

[45] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[46] Revised Statutes of Newfoundland and Labrador 1990, Chapter P-39.

[47] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.17.

[48] Ibid., p.A.7.

[49] Ibid.

[50] Ibid.

[51] Ibid.

[52] Ibid.

[53] Statutes of Newfoundland and Labrador, Chapter C-12.01, Appendix 5.

[54] *Child and Family Services Act*, Revised Statutes of Ontario, 1990, Chapter C-11, Section 102.

[55] Continuing Consolidation of Statutes of Manitoba, Chapter C-80.

[56] Revised Statutes of Alberta, 2000, Chapter C-12.

[57] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[58] Human Rights Code, Revised Statutes of Newfoundland and Labrador, 1990, Chapter H-14.

[59] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.14.

[60] Ibid.

[61] Ibid., p.A.19.

[62] Ibid., p.A.15.

[63] Revised Statutes of Canada, 1985, Chapter Y-1.

[64] Statutes of Canada, 2002, Chapter 1.

Chapter 13

Recommendations

1. Introduction

After completing a Review or a Review and Investigation under the *Child and Youth Advocate Act*, the Advocate may, under section 15(1)(g) of the *Act*,[1]

> **make recommendations to the government, an agency of the government or communities about legislation, policies and practices respecting services to or the rights of children and youth.**

To ensure the Advocate's recommendations do not fall on fallow earth, the *Act* further provides under section 24(1) of the *Act*[2] that the Advocate may, if recommendations relate to services of a Provincial Government department or an agency of the Provincial Government listed in the Schedule to the *Act*,

> **request the department or agency of the government to whom the recommendation is made to notify him or her within a specified time of the steps that it has taken or proposes to take to give effect to his or her recommendations.**

And, under section 24(2) of the *Act*,

> **[w]here, within a reasonable time after a request respecting recommendations is made under this section, no action is taken which seems to the advocate to be adequate and appropriate, the advocate, in his or her**

> **discretion, after considering the comments made by or on behalf of the department or agency of the government affected, may report the matter, including a copy of the report containing the recommendations, to the Lieutenant-Governor-in-Council and may mention the report in the advocate's next annual report to the House of Assembly.**

Throughout these Findings, resulting from my Review and Investigation as Advocate's Delegate, I have made recommendations which I advise the Advocate to adopt and propose to affected Provincial Government departments and agencies.

In summary, the recommendations referenced to the chapters of these Findings in which they are made are as follows.

2. Summary Of Recommendations

2.1 Chapter 6

Recommendation 6.1

THAT either by legislation or directive from the Minister of Justice for Newfoundland, provision be made for informing potential sureties of their obligations should they enter into a

Recognizance, and for qualifying them to serve as sureties (including provision of documentation verifying their financial capacity to serve as sureties); and that the legislation or Ministerial directive designate who will be responsible for discharging these duties.

Recommendation 6.2

THAT before legislation is enacted or a Ministerial directive is issued, the Province shall consult with all Newfoundland Courts and obtain their views on the processes which will most probably facilitate informing potential sureties of their obligations under, and qualifying them to enter into, a Recognizance.

Recommendation 6:3

THAT the Child and Youth Advocate, after having determined who is legally entitled to conduct a Judicial Review (acting along with the authority of the Federal Government), do so in order to fully examine how the justice system functioned in relation to Dr. Shirley Turner and hence affected the rights and interests of Zachary Turner.

Recommendation 6:4

THAT the Child and Youth Advocate report her findings to the House of Assembly and the Newfoundland public.

2.2 Chapter 7

Recommendation 7.1

THAT Section 14 of the *Child, Youth and Family Services Act* be amended, in order to ensure better protection of the child, by providing:

> A child is in need of protective intervention where the child[3] is, or is at risk of being
>
> (a) physically harmed by the action or lack of appropriate action by the parent of a child;[4]
>
> (b) sexually abused or exploited either by the child's parent, or through lack of appropriate action by the parent of a child;
>
> (c) emotionally harmed by the conduct of a parent of a child;
>
> (d) physically harmed by a person and the parent of a child does not protect the child;
>
> (e) sexually abused or exploited by a person and the parent of a child does not protect the

child;

(f) emotionally harmed by a person and the parent of a child does not protect the child;

(g) in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;

(h) abandoned;

(i) left with no living parent or a parent is unavailable to care for the child;

(j) exposed to domestic or other violence; or,

(k) where the child

(i) has been left without adequate supervision appropriate to the child's developmental level; or

(ii) has allegedly, or whose parent has allegedly, killed or seriously injured another person or has caused serious damage to another person's property; or

(iii) on more than one occasion caused, or whose parent has caused, injury to another person or other living thing or

threatened, either with or without weapons, to cause injury to another person or other living thing;

(l) the child is living in circumstances in which the child's safety, health or well-being otherwise is, or is at risk of, being endangered."

Recommendation 7.2

THAT Section 15(4) be amended to add "to suspect or believe that a child is, or may be, in need of protective intervention."

Recommendation 7.3

THAT where the Advocate's Office is contacted by someone already receiving services under the *Child, Youth and Family Services Act*, the Advocate shall consider initiating a case conference with those mandated under the *Act*.

Recommendation 7.4

THAT the policy manual be amended to include clear directions with respect to interpretation of "least intrusion" within the context that the best interests of the child are the paramount consideration under the *Act*. The amendments must provide clarification as to when the practice becomes a form of

negligence and contributes to a child being "in need of protective intervention."

Recommendation 7.5

THAT policy with respect to Section 10 Family Services be drafted and disseminated through in-service training to all personnel.

Recommendation 7.6

THAT the Province develop and deliver mandatory, multi-disciplinary education and training (including but not limited to) from police, health care professionals, educators, lawyers and caregivers,[5] the focus of which is investigation and assessment of the need for protective intervention on behalf of the child or children.

Recommendation 7.7

THAT the investigation and assessment of the need for protective intervention, at all times, only be carried out by someone who has successfully completed the education and training proposed in Recommendation 7.6.

Recommendation 7.8

THAT the definition of parental social history be expanded and the collection of a full social history, as outlined above, be mandatory not only for all child protection investigations and assessments, but also in long-term family services cases.

Recommendation 7.9

THAT whenever a child comes to the attention of CYFS, if and when it is discovered that the child and/or family are involved with more than one professional or agency, a case conference involving all parties be a regular part of policy.

Recommendation 7.10

THAT Social Work education and in-service training include coverage of the ability to override confidentiality, where a child's safety is at issue.

Recommendation 7.11

THAT the Director in Region of Child, Youth and Family Services be responsible for both line and legislated authorities, to ensure effective and efficient formal lines of accountability and communication.

Recommendation 7.12

THAT where there is an open file related to a matter under the *Child, Youth and Family Services Act*, all activities and/or discussions pertaining to it shall be recorded on that file, no matter at which level they occur.

Recommendation 7.13

THAT when a child comes to the attention of CYFS as possibly in need of protection, the responsible worker be proactive in thoroughly and expeditiously seeking out and documenting all relevant sources of information.

Recommendation 7.14

THAT policy be clearly established that part of the manager/supervisor's mandate and responsibility is to assist the worker carrying a file to establish long-term as well as short-term goals. The goals must be translated into specific tasks, with projected time lines attached, to enable periodic reviews of outcomes.

Recommendation 7.15

THAT when a worker responsible for a child entitled to any service under the *Child, Youth And Family Services Act* is on

leave, or absent for whatever reason, another worker must be assigned and the persons responsible for the child's care be informed of the name of that person to ensure constant monitoring of the child's safety and security.

Recommendation 7.16

THAT mandatory in-service training which incorporates skills in caseload management and time management be developed and delivered to supervisory and direct service personnel.

Recommendation 7.17

THAT all assessment workers be provided with ongoing and regularly scheduled in-service training on the meaning, the importance and the implementation of Policy Reference No. 02-02-03 (Coordinated Response).

Recommendation 7.18

THAT all prior records of child abuse and neglect, currently held on card indexes, be transferred to CRMS as soon as possible and be easily accessible to all CYFS staff.

Recommendation 7.19

THAT all child abuse and neglect records include sufficient identifying information such that a name change will not result in their being overlooked.

Recommendation 7.20

THAT all reports be founded on fact to promote evidence-based practice.

Recommendation 7.21

THAT a multi-disciplinary committee be struck, including representation from NLASW and the Province, to consult with the Memorial University School of Social Work (within three months of the release of these Findings) to investigate the feasibility of establishing a postgraduate diploma in child welfare and child protection.

Recommendation 7.22

THAT the Memorial University School of Social Work give a seat on its Academic Council to the Province.

Recommendation 7.23

THAT caseload management and time management be included in course work at the Memorial University School of Social Work.

Recommendation 7.24

THAT training on legislation, policy and procedures, and other appropriate in-servicing be updated semi-annually, and be the responsibility of the Provincial Director to ensure province-wide equity of opportunity.

Recommendation 7.25

THAT regular performance evaluations be provided to all personnel using child-centred criteria to fit with the monitoring duties of the Provincial Director under section 5 of the *Child, Youth and Family Services Act*.

Recommendation 7.26

THAT record keeping, beyond what may already be required by law or policy, be a fundamental obligation at all levels. Records to include purpose of the event, strategies used to achieve objectives, decisions made, directions given, those responsible for implementing actions, time lines, plans for

follow-up and evaluation, and whether objectives have been achieved.

Recommendation 7.27

THAT mandatory in-service training be developed in the theory and practice of documentation and record keeping.

Recommendation 7.28

THAT there be group supervision as well as individual supervision beyond what is already required by law or policy.

Recommendation 7.29

THAT the *Child, Youth and Family Services Act* be amended to authorize the Supreme Court of Newfoundland and the Provincial Court of Newfoundland to receive, hear, decide and make orders resulting from applications for psychological and psychiatric assessments, and for health care treatment of persons having, or being considered by CYFS or the Court to have, custody of or access to children, as well as children themselves, where established to be relevant from the perspective of a child's best interests in either a CYFS investigation or in a proceeding under the *Act*.

Recommendation 7.30

THAT reports of the course and results of assessment or treatment be provided to CYFS, the ordering Court and the persons assessed or treated, or their caregivers.

2.3 Chapter 8

Recommendation 8.1

THAT the Departments of Psychology and/or Psychiatry at Memorial University of Newfoundland (MUN) complete a psychological autopsy on Dr. Shirley Jane Turner.

Recommendation 8.2

THAT issues in Forensic Psychiatry be addressed not only in the education and training of general psychiatrists, but also be part of a continuing medical education program.

Recommendation 8.3

THAT lectures in "Physicians and the Law" be offered at Memorial University's Faculty of Medicine, both at the undergraduate and postgraduate levels, such lectures to include coverage of child protection issues.

2.4 Chapter 10

Recommendation 10.1

THAT the decision to call a Medical Examiner's inquest in Newfoundland - a public inquiry into any death under its jurisdiction - lie with the Chief Medical Examiner and, when made, shall not be countermanded by the Provincial Government.

Recommendation 10.2

THAT the Chief Medical Examiner be appointed at arm's length from the Government of the Province and only be dismissed "for cause."

Recommendation 10.3

THAT an investigation be conducted to determine the feasibility of appointing the Chief Medical Examiner with a non-tenured position at Memorial University, partially or wholly funded by the University; for which purpose, the portion of the budget of Memorial University provided by the Provincial Government would include funding adequate - in the judgement of the Department of Justice and Memorial

University - for the operation of the Office of the Medical Examiner.

Recommendation 10.4

THAT the Office of the Medical Examiner conduct an investigation into the death of all children under two years old.

Recommendation 10.5

THAT, in order to reduce or eliminate any further speculation surrounding the circumstances of both Dr. Turner's and Zachary's deaths, full toxicological analyses be done on all the still preserved body fluids of both decedents.

Recommendation 10.6

THAT the Medical Examiner's Office establish and conduct Child Death Reviews, chaired by the Chief Medical Examiner, with multi-disciplinary membership including the Child and Youth Advocate.

Recommendation 10.7

THAT the Chief Medical Examiner be given the legislative authority to make recommendations to respective Ministers of

the Crown (with opportunities to follow-up on these recommendations).[6]

Recommendation 10.8

THAT the Office of the Chief Medical Examiner seek accreditation by the National Association of Medical Examiners.

2.5 Chapter 12

Recommendation 12.1

THAT the four regional integrated health authorities created by the *Regional Integrated Health Authorities Order* be specifically listed in the Schedule to the *Act*.

Recommendation 12.2

THAT an amendment of the Schedule to the *Act*[7] include the Chief Medical Examiner and any other agency of the Provincial Government likely to possess information relevant to the Advocate's responsibilities under the *Act.*

Recommendation 12.3

THAT an amendment of the *Act*[8] provide that the Chief Medical Examiner be obligated to perform, or cause to be performed, any feasible medical or laboratory analysis or other scientific procedure requested by the Advocate which the Advocate determines to be relevant to the Advocate's mandate under the *Act.*[9]

Recommendation 12.4

THAT section 21 of the *Act* be amended to authorize the Advocate to require information by written interview instead of depending on voluntary participation.

Recommendation 12.5

THAT the *Act*[10] be amended to provide for addition of the following section:

(1) For the purposes of a review or an investigation, or a review and investigation, subject to subsection (4), the Child and Youth Advocate may

(a) summon by subpoena and enforce attendance of any witnesses;

(b) summon by subpoena and enforce production by witnesses of any records and other things, and provisions of answers to written questions.

(2) Where the Advocate exercises a subpoena power under subsection (1), a person or other legal entity who fails or refuses to

(a) attend;

(b) answer questions;

(c) produce the records or other things in the person's custody or possession, or provide answers to written questions requested by subpoena;

is liable, on application by the Advocate or his or her Delegate to a Judge of the Trial Division of the Supreme Court of Newfoundland and Labrador, to be committed for contempt as if in breach of an order, judgement or other process of the Supreme Court of Newfoundland and Labrador.

(3) The Advocate shall issue a subpoena provided for in subsection (1) in the manner authorized by the *Public Investigations Evidence Act*.[11]

(4) The Advocate shall not exercise the powers prescribed by subsection (1) unless the Advocate is unable, under section 21 or voluntarily, to obtain evidence, records and other things that the Advocate determines to be necessary to a review or investigation.

Recommendation 12.6

THAT amendment of section 21 of the *Act* provide that, should the Advocate encounter any refusal or delay in response to an information request for documents or other things, verbal testimony, or written answers, the Advocate may apply for an information disclosure order from a Judge of the Provincial Court of Newfoundland on not less than seven days written notice of the application to the information source. And, that the Judge be given discretion to order payment by respondents to an application of some or all of the actual fees and disbursements incurred by the Advocate in making the application (depending on the outcome of the application).

Recommendation 12.7

THAT amendment of the *Act*[12] provide that during a review or investigation by the Advocate, all information (oral and written) on which the Advocate relies for reports the Advocate may or must make under the *Act*[13] to any department or scheduled agency of the Provincial Government or a community or community member, be received under oath or on affirmation.

Recommendation 12.8

THAT regulations be enacted under the *Act* which prescribe forms to be employed by the Advocate in requesting and receiving information, e.g., documents and written interview answers.

Recommendation 12.9

THAT the *Act* be amended throughout to express the mandate, powers and duties of the Advocate in terms of children, youth and families, including parents and other caregivers.

Recommendation 12.10

THAT the *Act* be amended to provide that any question respecting the Advocate's jurisdiction to review or investigate

any matter under the *Act* may be resolved by the Advocate's application to a judge of the Provincial Court of Newfoundland for a declaratory order determining the question of jurisdiction.

Recommendation 12.11

THAT section 15(1)(c) of the *Act* be amended to enable the Advocate to dispense with advocacy, mediation or other dispute resolution process, and any other precursor to investigating a matter where, in the Advocate's opinion, those mechanisms are impracticable.

Recommendation 12.12

THAT section 24 of the *Act* be amended to state that the types of steps the Advocate may propose include, although not be confined to:

(a) enactment of new legislation and amendment of existing legislation;

(b) development of policies, standards and practices, and alterations to existing policies, standards and practices;

(c) development of new programs and reform of existing programs;

(d) review, modification and reversal of particular program services delivery decisions;

(e) rectification of omissions in program services delivery;

(f) provision of reasons for decisions;

(g) allocation and reallocation of program service centres and providers;

(h) development of professional and non-professional employee training, and modification of existing training;

(i) conduct of additional investigations;

(j) "no name/no blame" monitoring and auditing of professional and non-professional program services delivery personnel; and

(k) resolution of circumstances which are unreasonable, unjust, oppressive or discriminatory.

Recommendation 12.13

THAT section 17(1) of the *Act* be amended by deleting "*Young Offenders Act*" and substituting "*Youth Criminal Justice Act*."

[Notes to Chapter 13]

[1] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.15.

[2] *Child and Youth Advocate Act*, Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.19.

[3] Child is defined by the *Child, Youth and Family Services Act*, Section 2(1)(d).

[4] Parent of a child is defined by the *Child, Youth and Family Services Act*, Section 2(j).

[5] Caregiver is defined by the *Child, Youth and Family Services Act*, Section 2(1)(c).

[6] In Manitoba, the Ombudsman's Office (the People's Representative's Office), having the authority and the resources to do so, took it upon itself to fulfil that role.

[7] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[8] Ibid.

[9] Ibid.

[10] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[11] Revised Statutes of Newfoundland and Labrador 1990, Chapter P-39.

[12] Statutes of Newfoundland and Labrador, 2001, Chapter C-12.01, Appendix 4, p.A.7.

[13] Ibid.