JAMAICANS FOR JUSTICE

Report
on
The Situation of Children
in
The Care
of
The Jamaican State

Presented to: The Inter American Commission on Human Rights

October 2006

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Introduction

This request to be allowed to provide a report to the honourable Inter American Commission on Human Rights arises because of continued concern on the part of Jamaicans For Justice (JFJ) about the situation facing children in the care of the Jamaican state domiciled in Children's homes or places of safety or in foster care. In June, 2003 JFJ presented a report to Sra. Susana Villaran, the Inter American Commission on Human Rights (hereinafter called the Commission) Special Rapporteur on the Rights of the Child. In that report of 2003 we detailed the facts as to the abuse of a particular child in the care of the state and provided allegations of other cases of abuse of children in the care of the state. This report formed the basis for a request for precautionary measures for the particular child, which request was granted by the Commission on September 22, 2003, continued in November 2003 and lifted in April, 2004.

In March, 2004, with the assistance of the International Human Rights Clinic, Washington College of Law of American University, a request for Precautionary Measures as to all Juvenile Homes in Jamaica was presented to the Inter American Commission on Human Rights. While this request for Precautionary Measures was denied, since that time Jamaicans For Justice and the Government of Jamaica through the Child Development Agency (CDA) have been providing periodic (six monthly) reports to the Commission on the status of children in the care of the State and the concerns of civil society.

JFJ has done both on-the-ground investigations of the situation of the children in the care of the State as well as an analysis of the monitoring reports of the regional officers of the CDA. The analysis of the monitoring reports was done on two separate sets of reports that were obtained under the Access to Information Act 2002 in 2005 and 2006. The analysis of the data and on-site reports from the Children's Homes served to reinforce the grave concerns of JFJ that more than three years after the Keating Report was written, more than two years after the passage of the Jamaican Child Care and Protection Act (CCPA) and more than two years after the establishment of the CDA, very little, if anything, has changed in the horrific situation of children in care

documented so eloquently in the Keating Report. JFJ remains deeply concerned that the Government's seeming inability to translate bureaucratic shuffling into a safe, nurturing condition for children in state care has left the children under its care in need of urgent protection.

Data Analysis

Summary

Jamaicans for Justice has conducted an evaluation of monthly monitoring reports of children's homes across the island for the years 2005 and 2006. This review is an addendum to the Summary Report on the Status of Children's Homes presented to the Commission in February 2006. This review was initiated by way of applications under the Access to Information Act, providing us with the opportunity to follow up on the implementation of the Keating Report and the provisions of the Child Care and Protection Act, 2004.

Jamaicans for Justice believes that the process of evaluation and the monitoring reports developed by the Child Development Agency [CDA] to ensure the safety and well being of the children in the custody of the Jamaican government, are not sufficiently guaranteeing that the children in care are being provided with the highest quality of care and treatment. Our findings have shown inefficiency and inadequacy of the monitoring system that ultimately lends to a lack of follow-up or corrective action for issues being faced within the homes. Also, there are inherent problems with the reporting process that derives from the lack of depth and breadth accompanying the prescribed monitoring report and process. Though the CDA has made great strides to improve the process in which the monitoring of Children's Homes in Jamaica is administered, much improvement is needed in terms of the evaluation of the safety and well being of all of the children in the care of the government.

This data analysis will be reported as a summary of the findings from the monthly monitoring reports of the regional monitoring officers employed to the CDA. The analysis in regards to the problems being found within the monitoring system outlines:

- Problems inherent in the reporting process
- Negligence of ward contentment in the reporting process

- Unprofessional treatment of report forms
- Evidence of inefficiency of the monitoring process
- Specific cases of inadequacy of the monitoring system

Problems Inherent in the Reporting Process

The Monitoring Report designed for on-site visits allows for a skeletal assessment of the facilities. The report outlines basic details for each facility such as: the focal point of the visit; the number of new admissions; current number of children in the home; number of new entries in the critical incident log book (though no call for an explanation of said critical incidents). However, there are certain areas of improvement necessary in order to ensure that the Monitoring Officer is accurately assessing the safety and well being of the children in care. Within the format of the survey, the evaluation of key areas of potential abuse is afforded little space. There are:

- No requirements to detail accounts of the nature of critical incidents
- No requirements to interview all involved in critical incidents
- No requirements to interview absconders as to determine the reason why the ward absconded
- Little to no space available to detail any reactive "Actions taken by Monitoring Officer" in response to neglect and abuses observed
- No requirements to interview the staff as to what attempts and efforts are being made to help or control the behaviour of the children
- No requirements to target specific documentation of the ineffectiveness of the staff's methods of ensuring the safety and well being of the children

The structure of the reports limits the ability of the monitoring officer to understand the general well being of the wards.

Negligence of child contentment in the reporting process

There are sections of the report that require the description of observable signs of neglect or abuse, complaints received from clients and entries in the punishment log. Nevertheless, sections that give the wards a greater opportunity to express their true

opinions on the homes are lacking in depth. Our reviews have specifically observed that:

- No requirements for interviews with the wards thus no extensive contact with the children is necessitated
- The report forms do not sufficiently cater to the opinions of the children
- Children are only given one line on the report to raise issues they face
- The report does not prompt the Monitoring Officer to reference previous complaints by the children nor to indicate whether or not those concerns have been addressed

Unless the monitoring officers know the extent to which issues are affecting the children and take action to address the children's concerns, these same issues perpetuate visit after visit as is evidenced in a number of reports. Consequently, the monitoring officers do not examine the homes from the reference point of the children's satisfaction, and hence fail to completely and thoroughly examine their welfare.

Unprofessional Treatment of Report Forms

More effort is needed in reporting with accuracy and organization. Incomplete, irrelevant and non-existent responses make it impossible to gain even the most fundamental information needed. The form is comprised of "yes" or "no" questions, short answer questions and an overall comments section. According to our findings, there is a tendency towards lack of thoroughness on the Monitoring Reports including:

- Several questions on a single report go unanswered, including "yes" or "no" questions.
- Unanswered questions often will nullify the answers of other related questions.
- In some instances, incomplete, irrelevant answers are given. For example, questions like "number of children not at school, in training or other programme at time of visit" are answered with "some" and "not all."
- Often times, the general comments outlined are brief and not very descriptive.

Basic information is often omitted and evidence of inattention is outright on many Monitoring Reports. The purpose of the reports is to assess completely and thoroughly the welfare of the children and it is obvious that pertinent information is not adequately provided; therefore the needs of the children are not being completely scrutinized and evaluated.

Evidence of the Inefficiency of Monitoring Process

Although it is expected for any institution to face problems of various kinds, some which exist within the children's homes are exceptional cases, both in terms of the gravity of the situation and the lack of gravity of its treatment. Our reviews have flagged specific problems within homes that raise doubt upon the efficacy of the monitoring process in place currently. To summarize our findings, the monitoring system continues to be affected by:

- Insufficient and inadequate reporting of serious and critical incidents – upon investigation into critical incidents the Monitoring Report does not allow for extensive detailing of the incident or necessary corrective action

- Insufficient response to recurring concerns – there are several cases of hygiene concerns and treatment of the children that re-occur on certain homes' Monitoring Reports and the fact that the same issues keep being reported is proof that there is insufficient response to recurring concerns.

- Insufficient reporting of corrective & follow up actions for previous issues – there is no description of the specific corrective measures being taken to address issues at hand; therefore it is uncertain whether any corrective actions are in fact taken in response to issues confronted in the homes.

- Inattention to children during monitoring visit – there is little contact with the children during the assessment

- Breaches of the Child Care and Protection Act, the CDA Guidance and Standards of Care for Residential Childcare Facilities, and the recommendations of the Keating Report (evidence outlined in Appendix 1).

Specific Cases of Inadequacy of Monitoring System

Muirton Boys' Home: The monitoring reports consistently show inadequate investigation and reporting of serious incidents and there is no evidence of appropriate action being taken in the interests of the children. On 6 January, 2006 a monitoring report was taken to investigate a critical incident:

- Q-27. Are any children in isolation facility? Yes. Q-28. Yes- give reason and outline issues involved (client and staff): N/A
- Q-29. Did you observe any signs of neglect, abuse? Yes. Q-30. Name(s) and age(s) of children. N/A. Q-31. Nature and extent of injury and neglect. N/A Q-32. Action taken by MO. Nil

There is obvious negligence of the monitoring officer: there is no detail as to why there are children in isolation, there is no details regarding the observed signs of neglect or abuse and there is no obvious action taken in response to these findings. During this same visit, the monitoring officer collected three specific complaints from the children:

1. That the manager does not have time for them.
2. One ward stated that he went to the manager and requested School-Based Assessment items for his exams, she did not respond, on seeing her leaving for the day he went to her and again request these items, he said she replied that she was on her way home and could not deal with the matter at that time.
3. Some said that they are not seeing the manager as when they leave for school she is not there and when they return she is not there.

The action taken and response to these complaints by the Monitoring Officer was as follows: "Due to the time this discussion was concluded with the wards there was not enough time to adequately discuss these issues. However, it was decided that at my next visit these will be discussed." There is no evidence of a follow up or corrective action in response to these complaints recorded in the next report. Additionally, many issues were raised repeatedly that also have no documentation of corrective action or follow up investigation being made: hygienic integrity of the facility (cleanliness of the kitchen, bathrooms and boys' rooms), indiscipline of boys, and the lack of presence of the manager.

Granville Place of Safety: Monitoring reports show evidence of inaction when dealing with the children's requests and insufficient details concerning critical incidents. The home was visited on 11 January 2006 and it was documented that requests have been made by the children to be placed elsewhere yet the requests have been sitting in-house "for a long time." During this same visit, it was noted that the children have even sought the intervention of other officials to address their requests for family visitation. Neither of these requests shows evidence of action to rectify the situation by the monitoring officer.

During the visit on March 15th 2006, the focal point of the visit is noted as a critical incident yet almost half of the report, with pertinent questions regarding critical incidence documentation, investigation and counter-action, is left blank. There is no detail, description or reference made to the critical incident in the report.

Windsor Child Care Facility: Obvious inaction and insufficient response to the same recurring concerns is evident in the reporting process. The issue of security is raised in many reports with no evidence of this issue being addressed. Children and staff members repeatedly expressed concerns about the men and boys around the circumference of the property. The children and staff members also expressed concerns about the holes in the fencing (which pose a serious security problem) yet there is no evidence of follow up or action being taken. Repeated reports of the misbehaviour of the children are also documented. Details of the disrespect and disreputable behaviour of the children is described in multiple reports. It was noted that the in-house psychologist visits the home once a month. However, no intervention or action was evident to increase the frequency and amount of counselling that is administered to the children.

The children issued specific complaints about the staff members on January 3rd 2006. It was noted, "That some staff are begging them things when relatives visit." Also that, "There are staff who when the girls ask for things, they were told to let your man give it to you." The action taken was cited as "…will be addressed at the next staff meeting on the First Monday in February, 2006." The meeting was scheduled for one full month after these complaints had been submitted.

Summerfield Boys Home: There is evidence of an inadequate investigation regarding the death of a child. On 1 November, 2005,

> "Interviews were conducted with staff on the death of 'Kemar' Channer. Statements were written and collected. Staff seemed to be adverse in writing the statements as they are of the feeling that they will be charged by the police if persons were found not to have performed their duties."

There was no follow up or further investigation as to why the staff members might feel that their duties were not being performed, thus possibly resulting in the death of the ward. There is also no documentation of a follow up to determining the cause of death of the child.

Pringle Home for Children: There is evidence of insufficient response to the recurrent concerns of corporal punishment.

> "On a routine monitoring visit to Pringle Child Care Facility in January 11, 2006, ward, Jhavour Douce, complained that a staff Ms. Lord punched him several times and box him in his face. There were other wards present and saw what took place… The staff appears as if they are frustrated because they cannot apply corporal punishment, when they are faced by abuse by the wards."

Training is suggested to curtail the use of force and corporal punishment. However, there is no documentation of a training session given to the staff pertaining to this matter. Moreover, there is no evidence of consequences issued to the staff for the use of force on the children.

Other Issues Documented

Lack of assessment of needs of wards of State

At a meeting held in April, 2006 with various Children's Interests groups and the CDA, the head of the CDA acknowledged that up to that date a comprehensive assessment of each and every child in care had yet to be carried out. In the absence of this assessment the children have not been provided with individualized, specific care plans. It remains impossible for JFJ to conceptualize how one can put in place plans, budgets and processes for the wards of the state if one has not done an assessment of their needs and developed comprehensive care plans for each child.

At this meeting commitment was given to work with CDA to try and urgently put the requisite team in place but attempts to get the CDA to define specifics of skill sets and personnel needed have to date proved futile.

To the best of our knowledge as of October, 2006 the CDA remains unaware of how many children in its care are challenged visually, audibly, physically, mentally, psychologically or educationally, and how many need special assistance and attention as well as the nature of the assistance needed. Two years and six months after the CDA was given the responsibility for childcare and protection this is an unacceptable situation which leaves the most vulnerable in our society receiving inadequate care and at continuing risk of abuse. This situation cannot be allowed to continue and constitutes the first obstacle to improving the conditions of the wards of the state and ensuring full enjoyment of rights for the children in care.

Lack of Categorization of Homes

There is very little effort to separate children in need of care because of failures on the part of their primary caregivers, from children who are in the care of the state because of their own behavioural problems including those awaiting trial on criminal charges. Similarly children with special needs (even when these needs are known) are not separated from 'normal' children nor, for the most part, are they provided with special services or facilities. This situation is intolerable and results in children being put in danger from other children, abused or molested by their peers and not receiving the specialized services to which they are entitled.

Lack of Regulations to govern CCPA

More than two years after the passage of the Child Care and Protection Act (CCPA) in March 2004, the regulations necessary to govern the operations of the Children's Homes and the Child Abuse Registry are yet to be passed. The absence of these regulations leaves the CDA unable to enforce standards for the conditions and operations of the Children's Homes (many of which are privately owned and operated) and unable to insist on the provision of audited accounts by these private homes. The absence of regulations has left monitoring officers unclear on the standards that they

are monitoring against, and unclear as to what powers they have for enforcement of standards for conditions and operations.

The absence of regulations to govern the operations of the Children's Homes leaves the children in care at risk of further and continuing abuse of their rights and in need of protection.

Child Abuse Registry and Regulations

The absence of regulations to govern the Child Abuse Registry has meant that in fact no Registry has been established and the public, and interested persons who deal with children and/or know of cases of abuse, are left unclear as to where and how to report what they know, what are the safeguards which will be applied to the information they report, and how the information will be handled.

The absence of these regulations and the lack of establishment of the Registry means that the CCP Act is not functioning as effectively as it could or should and leaves the children in need of care from the State vulnerable to continuing and further abuse.

Breaches Of Rights Under The American Convention

Article 19

This article states that "Every minor child has the right to the measures of protection required by his condition as a minor on the part of his family society and the state."

The Government of Jamaica is the primary executor of the rights of the children in care. It is the duty of the Jamaican Government by way of the CDA, to ensure that the fundamental needs, the safety, the emotional well being and welfare of these children are appropriately attended to.

The State has an obligation to ensure that discrimination and violations of these rights do not persist, irrespective of the costs. As is evidenced in the specific case studies [Granville Place of Safety, Windsor Child Care Facility], the children are being

dehumanized and their rights are being violated. At the Muirton Boys Home, there was an instance of reported neglect/abuse, yet there was no protective or corrective action evidenced within the Monitoring Report. Complaints are going unresolved, personal safety is being compromised and the sanitary conditions for some of these children and their "rights and freedom" are not being respected. The monitoring process is not sufficiently addressing the problems that arise within the context of the children's homes thus compromising the very rights of the inhabitants of said homes. These breaches are occurring to the most vulnerable in the society without corrective action being taken by the state in whose care they are abused, and who has the duty to ensure the protection of these rights.

Article 3

Article 3 of the American Convention on Human Rights guarantees that "Every person has the right to recognition as a person before the law." As the monitoring reports clearly demonstrate the voice of the children, in all of the cases, is missing. There is a clear lack of recognition of these children in many of these homes as 'persons before the law'. Failure to do an assessment of all the children in the care of the State and to develop individual care plans for each child also constitutes a breach of the guarantee of "recognition as a person before the law". It is the individual personhood and needs of the children in care that must be addressed to provide them with this guarantee. Failure also of the authorities to ensure that breaches of these children's rights are prevented and, when they occur, legally corrected constitutes a breach of the right to recognition as a person before the law.

Article 5

"(1) Every person has the right to have his physical, mental, and moral integrity respected

(2) No one shall be subjected to torture or to cruel, inhuman, or degrading punishment or treatment."

There is documentation in the monitoring reports as well as there have been reports in the local newspapers (including pictures) of children being beaten by 'caregivers' at the Children's Homes. There are also numerous stories from the children, documented

in the monitoring reports, of children being beaten, removed from school, transferred from home to home without explanation or recourse, made to do heavy work (reportedly on occasion outside in the rain) and left vulnerable to sexual exploitation. All these are threats to the physical, mental and moral integrity of the children.

Article 25

"Everyone has the right to simple and prompt recourse, or any other effective recourse, to a competent court or tribunal for protection against acts that violate his fundamental rights recognized by the constitution or laws of the state concerned or by this Convention, even though such violation may have been committed by persons acting in the course of their official duties."

The monitoring reports afford little space for the children residing within the homes to broach issues regarding their living conditions to the Monitoring Officers. Moreover, the children are limited in the accessibility to appeal to those outside of the facility's staff for help regarding their welfare. At the Granville Place of Safety, it was noted that:

> "The home was visited on 11 January 2006 and it was documented that requests have been made by the children to be placed else where yet the requests have been sitting in-house "for a long time." During this same visit, it was noted that the children have even sought the intervention of other officials to address their requests for family visitation."

Though these instances are aptly documented, there is no evidence of resolving the complaints by the Monitoring Officer, there is no corrective actions elucidated and no documentation of suggested follow up measures.

The children are left without recourse and thus their rights under article 25 are being breached by the state.

Article 26

"…[T]he full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth…"

The monitoring reports document more than one instance where children in the Children's Homes are punished for inappropriate behaviour by being suspended from going to school (whether the school within the compound of the home or the school external to the home) . This is a breach of the Jamaican Education Act and the CCPA as well as a breach of Article 26 by denying the children opportunities for full realization of the "rights implicit in the economic, social, educational, scientific and cultural standards set forth".

Article 1

This article imposes on the State Parties to the Convention a requirement to "undertake to respect the rights and freedoms recognized herein and to ensure to all persons….the free and full exercise of those rights and freedoms, without any discrimination". It is clear from an analysis of the monitoring reports, as detailed above, that breaches of the rights guaranteed under the convention are occurring and are not being ensured simply because these children are in care of the State. These children are being discriminated against and their rights abused simply because of their status as wards of the State. The State is failing in its duty to provide for the exercise of 'rights and freedoms' without discrimination. This is a clear breach of Article 1 of the Convention.

Recommendations

International standard practice by states in carrying out their responsibilities for the care of children who are wards of the state require that safety, protection, stimulation and care for each and every child are the basic standards to be monitored against. The imposition of these standards require certain basics to be put in place. These include:

1. The development (by way of comprehensive assessment) and periodic review of care plans for each and every child in care of the state. This is critical to the process of ensuring proper care is given to each child in keeping with the responsibility of the state. These care plans must include comments on educational, health and social issues, as well as comments on any disabilities and special challenges faced by the child as well as specific recommendations

on who the child may be in contact with, as well as recommendations to deal with specific challenges or problems documented.

2. It is crucial that there be clearly established categories of homes for different categories of needs of the wards of the state. There needs to be urgent separation of children in need of care and protection from those who are in care because of behavioural problems, or who are on remand awaiting a trial on a criminal charge, or who are in care as part of a custodial sentence. Similarly, children with disabilities or specific difficulties need to be placed in homes where their above normal needs may be best met. We cannot protect the rights of our children adequately if we do provide appropriate facilities to cater to their particular needs. The full categorization of the homes and appropriate placement of the children in the appropriate homes must be undertaken as a matter of urgency.

3. Clear separation of monitoring responsibilities for homes and places of safety from child protection and care responsibilities. It should be evident to the monitoring officers, staff of the homes and the children themselves who has the responsibility for monitoring and improving the conditions of the place where they are kept and who has responsibility for ensuring the individual welfare of the child. It is equally apparent from the monitoring reports that there is no clear definition of the very different responsibilities outlined.

4. Monitoring cannot take place in a vacuum but must occur against specific standards and guidelines. There appear to be no enforceable standards and guidelines against which the monitoring occurs and this highlights the urgent need for regulations to govern Children's Homes operations and standards under the CCPA to be passed.

5. The Monitoring form needs urgent revamping and must provide in depth commentary; particularly they must show comprehensively what is on offer in the homes and document in detail health and safety issues in the homes.

6. Enforceable standards for Monitoring reports are needed. As is evidenced in the monitoring techniques at such facilities as Mount Olivet Boys Home, New Vision Child Care Centre and Elsie Bernard Home, efficient and detailed reports are possible. There is evidence of adequate monitoring and response at these three facilities, even given the above lack of enforceable standards and guidelines. The questions are fully answered and the general commentary is thorough and descriptive. The follow up and corrective action taken for issues addressed in previous visits is clear and explicit details of the follow up measures are clearly outlined. Attention to the entire environment and well being of the wards is exhibited. It is clear that the monitoring officers overseeing these facilities are adequately assessing the facilities, administering corrective action and looking out for the best interest of the children in care. This should be the norm throughout and so it is recommended that CDA insist that all monitoring officers:
    - Answer every question thoroughly on monitoring reports
    - Detail all commentary: general comment, focal points, issues raised (by staff and wards)
    - Document all corrective and follow up actions by detailing the extent which each corrective action has been implemented
    - Document negligence of the facility in terms of compliance to health codes and children's rights
    - Interview and interact with the children to get more detailed information about the condition of the facilities

7. It is clear from the data analysis that the duty of the monitoring officer or his superiors at the CDA to take action on documented deficiencies is unclear to either the Monitoring Officers or their superiors at the CDA. If this duty to take action were clear, then deficiencies and problems highlighted in the monitoring reports would result in documented action lists with follow up responsibilities and time scales. However, for the most part, the monitoring reports lack such actions and documentation. It is recommended that there must be clear and legally enforceable duty of the monitoring officer and his/her superiors to take action on all documented deficiencies in the reports. This legally enforceable duty would be made clearer and easier by the passage

of regulations to govern the CCP Act and this must be given urgent priority by the relevant agents of the State.

8. A complaints policy and procedure for the children must be put in place and the children in care must be made aware of it, given the names of the responsible officers to whom they can complain (and these must be persons outside the homes), the names and contact information for the specific social workers assigned to their case, as well as the numbers for the superiors of those case workers. Similarly the staff in the homes must be aware of where and to whom they can direct their concerns and complaints at the level of the monitoring officer and his/her superiors.

Conclusion

The problems of the care of children who are wards of the state are well studied and well documented and many recommendations have been made over many years. Though the government must be commended for its openness, willingness to dialogue and some improvements in the supervision of children's homes, JFJ is deeply concerned that all the efforts of the Government to change the situation have resulted in little more than mere bureaucratic shuffling and paper pushing. JFJ is convinced that there is much room for improvement and that the situation must be addressed urgently if we are to improve the lives of the children in care. The various problems that still plague these homes are mere manifestations of a deeper, rooted problem of negligence in addressing the concerns of the wards. It is imperative that the recommendations offered in this report be established and enacted. For too long and in far too many areas, the government of Jamaica has tolerated unforgivable levels of delinquency, unaccountability and inefficiency. We ask the Commission to acknowledge our deep concern that the Government of Jamaica is failing in its responsibility under the Convention on the Rights of the Child, and the Charter of the Organization of American States, to protect the rights of Jamaica's children and to ensure accountability for their safety and well being.

Appendix 1: Summary of Breaches Identified in Monitoring Reports, 2004-05

ISSUES IDENTIFIED		LAW OR POLICY STANDARDS BREACHED		
Summary	***Example***	***CCPA***	***Keating***	***Standards of Care***
Failure to use requisite logs and maintain children's records	This was a prevalent complaint for many homes.		Rec. 21: Educational, physical, psychological evaluations on entry; medical history, examination and records	Art.3: Keep records reflecting all relevant information, decisions and actions Art. 4: Critical Incident file Art. 62: Ensure maintenance of individual files, recording all information, activities and occurrences Art. 63: Maintain discipline log
Lack of security	Absconding Windsor – neighbourhood boys camp at the gate to harass or lure girls. Poor fencing reported at homes.	s. 2(3)(a) Child entitled to protection from abuse, neglect harm or threat of harm		Art. 28: Clear and positive steps to protect children from all forms of abuse
Lack of treatment for psychological or behavioural problems	Violence and excessive aggression among children Sexual abuse perpetrated by children Absconding	s. 62 (f) child in a home has a right to receive psychological care when required.	Rec. 11: Team of professionals – including mental health and social work professionals – in each health region should conduct evaluations	Art. 29: Provide counseling to children and families

	Attempted suicide		Rec. 21: Every child should have (inter alia) a psychological evaluation Rec. 22: Individual care plan to be developed for each child, and repeated assessments done	
Inadequacy of facilities	Poor, dirty bedding Poor storage and disposal of waste	s. 26-27 Person given care of child by order of the court has a duty to provide appropriate food, clothing, lodging.		Art. 17: Compliance with Public Health and related codes Art.18: Clean, safe and vermin-free environment Art.23: Clean mattresses between use. Art. 26: Closed storage of waste; regular removal
Inadequate levels of supervision	Sexual activity among children Absconding Insufficient quota of staff		Rec.13&30: Implement standard ratio of 10 wards per staff member; 3:1 in relation to children with disabilities	Art. 15 & 16: Staff numbers and duty roster should reflect adequate supervision, night and day Art. 28: Clear and positive steps to protect children from all forms of abuse Art. 35: Staff disciplinary procedures for dereliction of duty
Allegations of corporal punishment	Pringle Home (January-March 2006)	s. 62 Child in a home has a right to be free from corporal		Art. 12: Train staff in child care, avoiding methods injurious to

		punishment		child
Inappropriate behaviour management systems	Use of profanity by staff Reluctance by staff to adhere to new standards/ban on corporal punishment			Art. 36: Disciplinary policy and procedure for each home
Inadequate medical attention and health care	Medical files not kept. Children not given a medical check-up on arrival Prescriptions not filled Poor dental health	s. 62 (f) Child in a home has a right to receive medical and dental care when required s. 26-27 Person given care of child by order of the court has a duty to provide appropriate health care.	Rec. 11: Team of doctors and health-care professionals in each health region should conduct evaluations Rec. 21: Every child should have (inter alia) a physical evaluation Rec.22: Care plans should involve reference to medical records.	Art. 44: Keep medications locked away; maintain treatment administration charts. Art. 45: Keep first-aid materials out of children's reach Art. 47: Medical exams on entry, on discharge and annually in between. Art.49: Doctor to be assigned to each facility
Inadequate monitoring systems and practices	Each home not visited monthly No evidence of child participation No independent monitoring	s. 62 Child in home has rights: (b) to be consulted on major decisions (e) to be informed of standards of behaviour expected of caregivers and consequences of failing to meet these standards (k) to be informed about and to be assisted in contacting the Children's Advocate (l) to be informed of his rights and procedures for enforcement	Rec. 20: Assessment Team to visit and monitor child welfare Rec. 38&40: Boards of Visitors to monitor performance and hear complaints	Art. 37: Ensure child participation in reviews and decision-making Art.42: Implement complaints procedure for children and parents Art.43: Ensure that children know how to make complaints