

# Children's Aid Society Reporting: Navigating Complex Decisions in Family Practice


PANELISTS

Kai-Lee Gibeault• Dr. Michelle Ward

WITH

Dr. Carrie Bernard • Dr. Stephanie Zhou


Ontario College of Family Physicians — Thriving Family Physicians in a Healthy Ontario

Family & Community Medicine, University of Toronto | Mental Health and Addictions

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Your name,
Your community,
Your X (Twitter) handle

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Send us an email with your name & topic(s) of interest to
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## Kai-Lee Gibeault

Relationships with financial sponsors (including honoraria):

- Gowling WLG

## Dr. Michelle Ward

Relationships with financial sponsors (including honoraria):

- Happy Roots Foundation via CHEO Foundation
- Nurture Parenting Inc
- BGC (Boys & Girls Club) Ottawa
- CHEO Research Institute

# Disclosures

## Dr. Carrie Bernard

Relationships with financial sponsors (including honoraria):

- Ontario College of Family Physicians
- University of Toronto – Stipend for role in the Division of Mental Health and Addictions
- Ontario College of Family Physicians – Practising Well Scientific Planning Committee
- FPME – Medical Editor
- Membership on Advisory boards or speakers' bureaus:
- College of Family Physicians of Canada – Past President of the Board of Directors

## Dr. Stephanie Zhou @stephanieyzhou

Relationships with financial sponsors (including honoraria):

•Ontario College of Family Physicians – Practising Well Scientific Planning Committee
•Ontario Medical Association – Honoraria for practice management lectures
•Department of Family and Community Medicine (University of Toronto), Dept of Medical Imaging, Dept of Ob/Gyn for practice management lectures
•Toronto Public Health – Board of Directors Member
•McMaster University, Queen's University, McGill University, Toronto Metropolitan University, OntarioMD & Dr. Bill, Canadian Society of Allergy & Immunology, Canadian Fertility & Andrology Society, and Women in Academic Medicine - Honoraria for teaching financial literacy, billing, and practice management.

# Mitigating Bias

**Disclosure of financial support**

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**Potential conflicts**

N/A

**Mitigating potential bias**

The Scientific Planning Committee (SPC) has control over the choice of topics and speakers.

Content has been developed according to the standards and expectations of the Mainpro+ certification program.

The program content was reviewed by the SPC.

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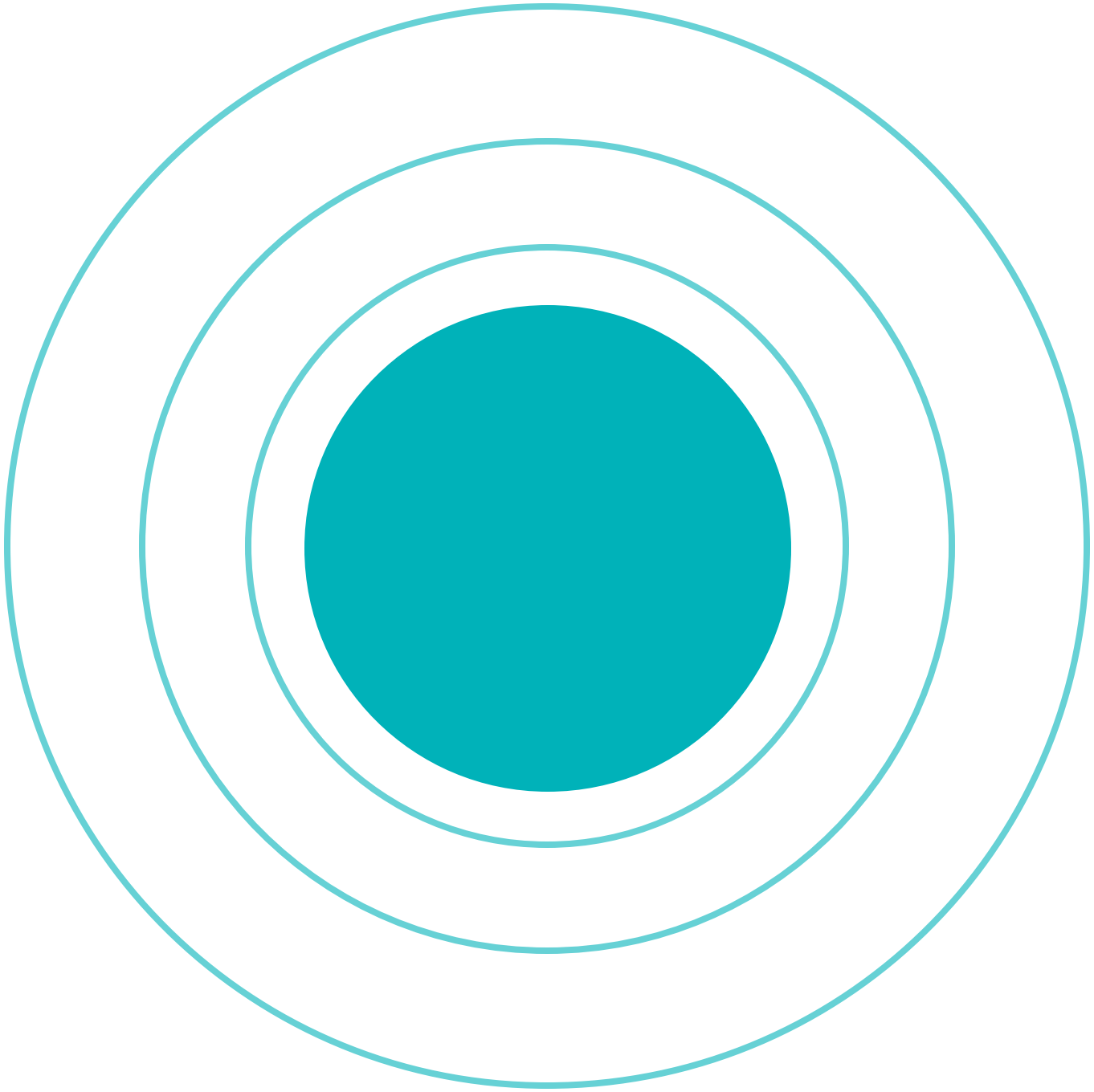
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# Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.



# Your Panelists



Kai-Lee Gibeault

Dr. Michelle Ward

## Children's Aid Society Reporting: Navigating Complex Decisions in Family Practice

# A Physician's Duty to Report to CAS



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# Relevant Legislation

- *Child, Youth and Family Services Act*, 2017, S.O. 2017, c. 14, Sched. 1 (*CYFSA*)

- Section 125 of the *CYFSA* provides that members of the public, including professionals who work with children (including physicians), must immediately report to a children's aid society (CAS) any suspicion that a child is, or may be, in need of protection.



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# Duty to Report

- Mandatory legal reporting requirement: the duty to report overrides duty of confidentiality

- Physicians who fail to meet their responsibility to report suspected child abuse in a timely manner may be at risk of a legal action or College complaint.



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# Legislative Framework on Mandatory Reporting

- Children under the age of 16 “in need of protection”
- Must report immediately and directly to CAS – jurisdiction where the child lives
- Personal and non-delegable duty: cannot rely on anyone else to report on their behalf
- Ongoing obligation

# A “child in need of protection”

- Includes a child who is, or may be, suffering from abuse or neglect under the age of 16
- Discretionary: children aged 16 to 17 years old – permitted, but not required
- The circumstances that trigger a mandatory report can be organized into four groups:
    1. Physical harm;
    2. Sexual harm;
    3. Mental, emotional or developmental harm; and
    4. Neglect

# Threshold for Reporting

***"Reasonable grounds to suspect"***

- Refers to the information that an average person, using normal and honest judgment, would need in order to decide to report
- Ontario courts have interpreted it as a "low threshold for reporting." (*see Ontario (Solicitor General) (Re), 2024 CanLII 15074 ON IPC*)
- No need to be certain that a child is, or may be, in need of protection to make a report: based on belief, not actual proof
- No duty to investigate the accuracy of the information before reporting to a children's aid society

# Time is of the Essence

- Section 125 of the *CYFSA:* "the person shall immediately report the suspicion and the information on which it is based to a society"
- Important to report promptly
- Available 24hrs/365 days



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# Time is of the Essence: case study

***College of Registered Psychotherapists and Registered Mental Health Therapists of Ontario v Raza, 2026 ONRPDT 7***

- A registered psychotherapist delayed reporting to a CAS the suspected sexual abuse of a seven-year-old client by her seventeen-year-old brother until the next day.

- The delay was deemed unprofessional and contrary to public expectations of regulated health professionals

# Duty to Report is Personal and Ongoing

- You must report directly to CAS yourself; you cannot rely on someone else to report on your behalf
- A further report is required if there are additional grounds to believe the child is experiencing, or is at risk of experiencing, abuse or neglect.



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# Confidentiality and Privacy Considerations

- Duty to report under the *CYFSA* overrides duty overrides other provincial statutes, including the Personal Health Information Protection Act (PHIPA)
- PHIPA also permits physicians to disclose personal health information to help the CAS carry out its statutory functions (s. 43(1)(e)).
- Scope of the disclosure: disclose relevant information only

# Good Faith Protection

- Professionals who report in good faith are also protected
- The *CYFSA* provides that "no action for making the report shall be instituted against a person who acts in accordance with this section unless the person acts maliciously or without reasonable grounds for the suspicion"



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# Dual Role of Physicians

- In circumstances where both the parent and the child are patients of the physician
    - Duty to report exists independent of your physician-patient relationship
    - Requires a balance between the duty of confidentiality and reporting obligations



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# Legal Risk

- The most important thing is to act in good faith and prioritize child safety, which is the paramount concern
- If your professional opinion is that the criteria has been met, proceed with a report to CAS
- Any legal risk is lower when you proceed with the report in good faith and with safety considerations. Erring on the side of caution and using your professional judgment is the best way to avoid larger legal repercussions.

# CPSO Policies

- Policy on Reporting Requirements
- CPSO's Guide to Legal Reporting Requirements
- CPSO's Advice to the Profession: Reporting Requirements

# CMPA Resources

- Duty to Report
- “Checklist: Duty to report”
- Protecting Children – Reporting Child Abuse



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# Other Resources

- Information and Privacy Commissioner of Ontario's (IPC) *Dispelling the Myths About Sharing Information with Children's Aid Societies*
- *Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A*
- *Child, Youth and Family Services Act, 2017,* S.O. 2017, c. 14, Sched. 1
- Ontario Association of the Children's Aid Societies' resource on *What is Child Abuse?* – recognizing the signs of child abuse and neglect

# Your Panelists



Kai-Lee Gibeault

Dr. Michelle Ward

## Children's Aid Society Reporting: Navigating Complex Decisions in Family Practice

# OCFP Community of Practice

# Children's Aid Society Reporting: Navigating Complex Decisions in Family Practice

MICHELLE WARD MD FRCPC

DIVISION OF CHILD AND YOUTH PROTECTION (CYP), CHILDREN'S HOSPITAL OF EASTERN ONTARIO

SUSPECTED CHILD ABUSE AND NEGLECT (SCAN) PROGRAM, HOSPITAL FOR SICK CHILDREN

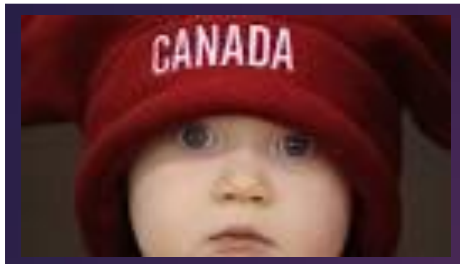
PEER ASSESSOR & QI COACH, COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

ASSOCIATE PROFESSOR, UNIVERSITY OF OTTAWA

OCTOBER 28, 2026

# Clinical perspective

1. Why should I be concerned about this as a family physician?
2. When should I have concerns for child maltreatment (abuse and neglect)?
3. What do I do in my office / ED when I have child maltreatment concerns?
4. How do I communicate these concerns to CAS (+/- Police) and the family?
5. What happens after I make a report?
6. How do I document all of this?
7. How do I manage ongoing patient relationships after a report?
8. What are common pitfalls that I can avoid?




# 1. Why should I be concerned about this?
# Child Maltreatment in Canada



- 32% of adults in Canada report physical abuse, sexual abuse, and/or exposure to domestic violence before the age of 16

- 26% physical abuse
- 10% sexual abuse
- 8% exposure to IPV



- 4% children with CAS Investigation
- 2% substantiated maltreatment

# 1. Why should I be concerned about this?
# Harm

- Mental health consequences
  - All types of maltreatment associated with ↑ risk of all types of MH disorders and suicide risk
  - Dose-response effect with more types of abuse being associated with ↑ odds for MH disorders

- Physical health consequences (long term)[ACE studies]
  - Alcoholism and alcohol abuse
  - Chronic obstructive pulmonary disease (COPD)
  - Depression
  - Fetal death
  - Health-related quality of life
  - Illicit drug use
  - Ischemic heart disease (IHD)
  - Liver disease
  - Risk for intimate partner violence
  - Multiple sexual partners
  - Sexually transmitted diseases (STDs)
  - Smoking
  - Suicide attempts
  - Unintended pregnancies
  - Early initiation of smoking
  - Early initiation of sexual activity
  - Adolescent pregnancy

# 1. Why should I be concerned about this?
# Frequency of Child Maltreatment Presenting To Hospital

- 2-10 % of all pediatric injuries seen in the ED
- >15% of fractures in children < 3yrs seen in ER and orthopedic clinic; higher proportion among infants & toddlers
- 20-30% of children who die from injuries associated with physical abuse were seen prior for injuries likely related to abuse
- 60% of people exposed to human/sex trafficking access care in hospital EDs

## 2. When should I have concerns for child maltreatment ?

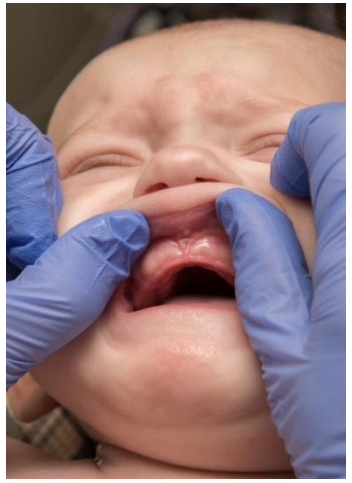
# Common Scenarios in Family Practice / ED Medicine

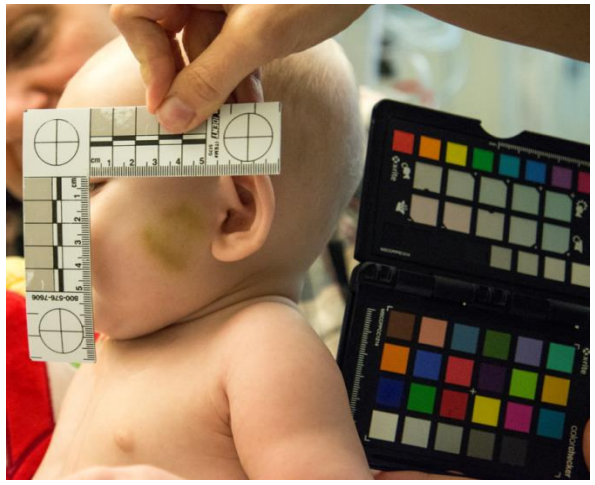
- Neglect
  1. Medical neglect
  2. Other forms of neglect (safety, school, necessities)
- Physical harm
  1. Infant with injury
  2. "Physical discipline"
  3. Youth / Adult altercation
  4. Disclosure by child or parent
- Sexual harm
  1. Teen Acute SA in ED - peer/peer vs adult/youth
  2. Child Acute SA – "disclosure"
  3. Teen Historical SA
  4. Child Historical SA
- Emotional harm
- Children's Exposure to Intimate Partner Violence

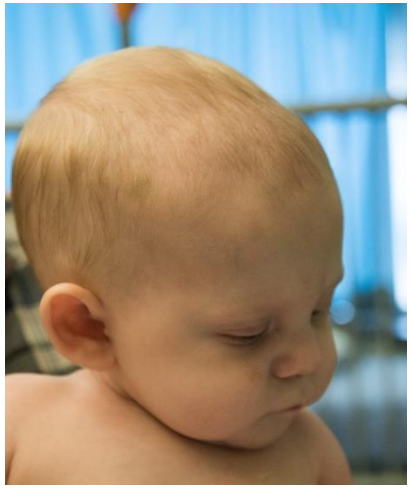
**Does it meet your threshold for reporting?**

## 2. When should I have concerns for child maltreatment?

# Pay attention to minor injuries in infants (sentinel injuries)









- Bruising
- Oral injuries
- Subconjunctival hemorrhages

- Undress infants and toddlers - and look in their mouths!

- Common in abused children, not common in non-abused children

- In infants with severe abusive injuries 27.5% had a preceding sentinel injury and 42% of these were known to a medical provider.

# 3. What do I do in my office / ED when I have child maltreatment concerns?

- When a parent or child shares a concern / disclosure
  - First respond safely
  - Follow your usual approach and use your usual skills
  - Clarify limits of confidentiality

- When you have a concern for maltreatment
  - First follow your usual approach and use your usual skills
  - Find common ground, align around the child's needs

# 3. What do I do in my office / ED when I have child maltreatment concerns?
# Respond safely

- Respond with warmth and support
- Communicate that it is not ok (if child has disclosed)
- Avoid use of stigmatizing terms (eg. violent, abuse, abusive, victim, perpetrator)
- Use objective language and/or use the child's own words when appropriate
- Do not promise that everything will be ok or that there will be a certain outcome
- Only make promises that you can keep eg. to do your best to help

## 3. What do I do in my office / ED when I have child maltreatment concerns?

# Respond safely

***"It took you a lot of courage to tell me about this"***

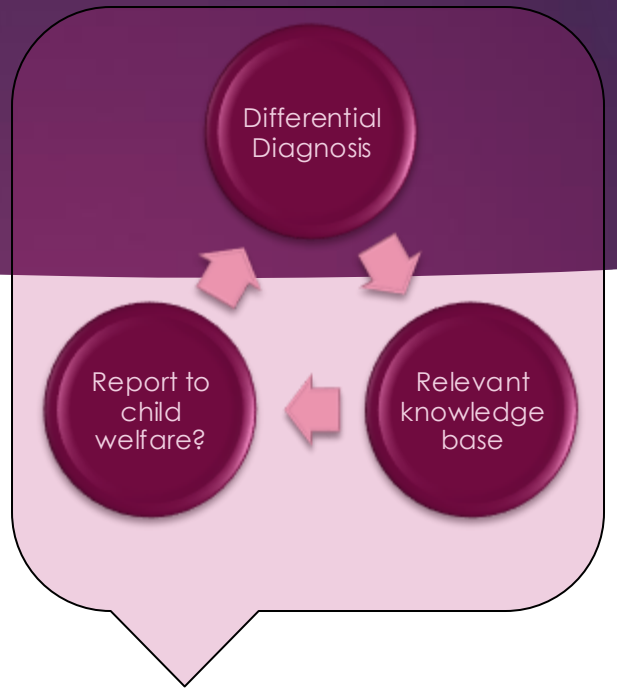
***"That sounds scary, I am glad that you shared this with me"***

***"I'm taking what you have told me seriously. I'm here to help you through this."***

It's okay to communicate that certain behaviours shared by patients, are not okay: ***"It is not okay for your mom to hit"***

# 3. What do I do in my office / ED when I have child maltreatment concerns?

## Stay in your role



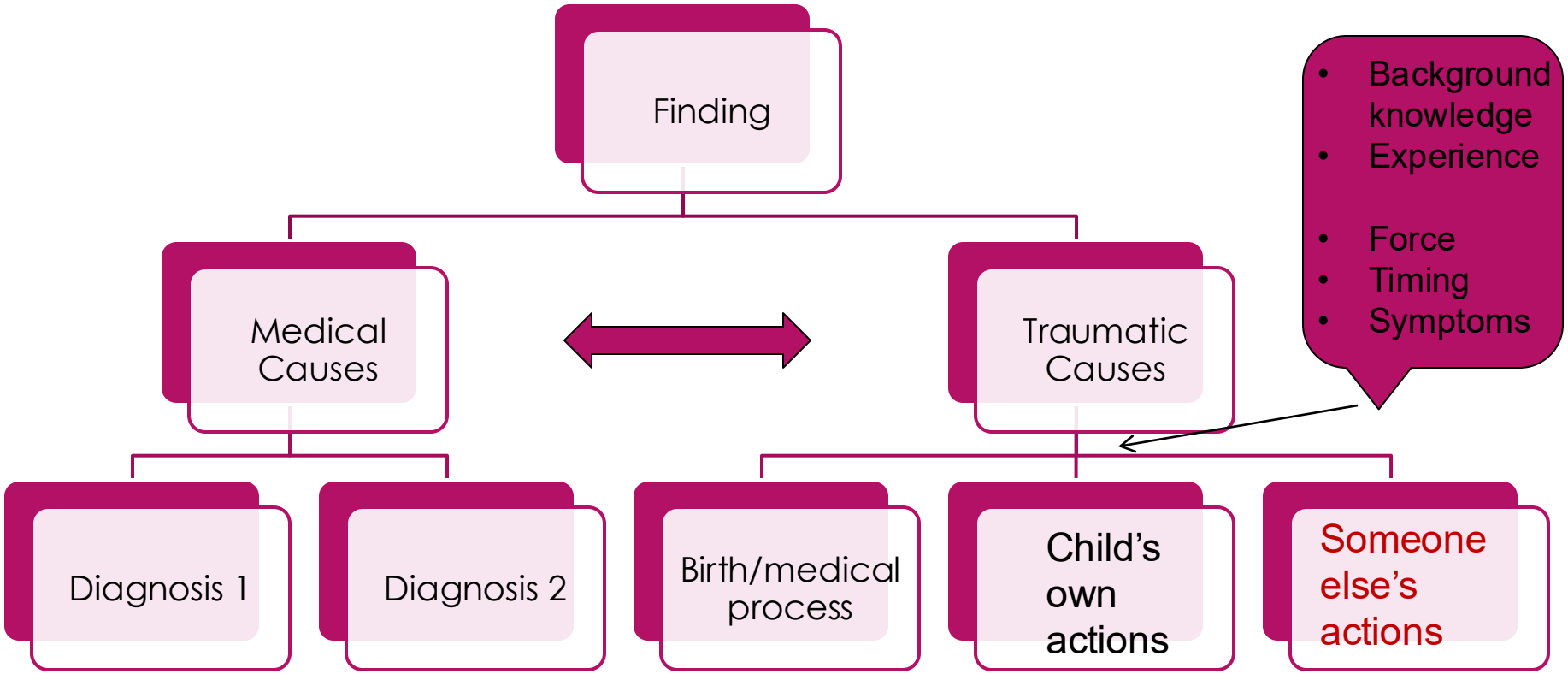



History → Physical Exam → Testing (bloodwork, imaging)

# 3. What do I do in my office / ED when I have child maltreatment concerns?
# History

- Consider who to take history from, consider timing of assessment
- Be aware of your words and how you ask questions
  - Use open ended questions (What happened? TED – Tell, Explain, Describe)
  - Do not offer possible mechanisms for injuries
- Take only enough information as you need to do your job as a physician, including whether the concerns meet your threshold for reporting
- You are not trying to prove or disprove maltreatment
- You are not a forensic interviewer and don't need to know who, what, when, where, why

# Bruise, fracture, burn, head injury, genital finding etc.



# 4. How do I communicate these concerns to CAS (+/- Police) and the family?

- CAS – legal obligation
- Police – not part of the circle of care & no legal obligation for child maltreatment
- Family - duty of care, ethical obligation, also consider safety



4. How do I communicate these concerns to CAS?

# Basics of reporting to CAS



- Report to agency where the child lives
- Demographic information
  - Mother's name, address, child's name, DOB, siblings
- Consider reporting with the youth or parent
- Provide the information that CAS needs to understand and assess risk (ICE)

4. How do I communicate these concerns to CAS?

# Organized approach to reporting to CAS

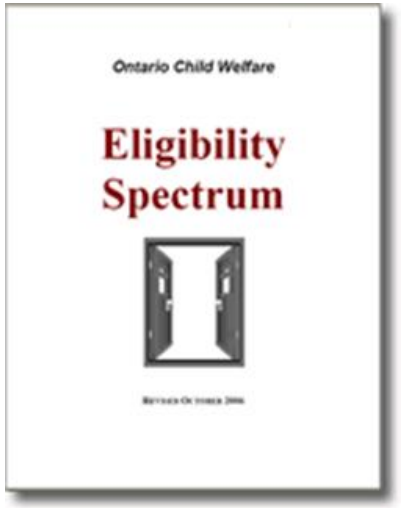
- ICE

| | |
|---|---|
| What is the objective information? | (**i**nformation) |
| Why did this raise your concern? | (**c**oncern) |
| What is the effect on the child? | (**e**ffect) |



# 5. What happens after I make a report?

- The CAS worker listens and determines whether they will investigate the report.
- The CAS has the responsibility and authority to investigate allegations and to protect children (< 5% of cases result in a change of living situation for the child)
- The CAS may involve the police and other community agencies. All CASs provide emergency service 24 hours a day, seven days a week.



# 5. What happens after I make a report?

## What CAS needs from you:

- Demographics, current information, prior history
- Effect on child

## What CAS will do with this information

- Use eligibility spectrum – Legislation translated into action
- Search Child Protection Information Network
- May / may not open investigation (based on current concerns)

# What happens after I make a report?
# How CAS uses your information

*Ontario Child Welfare*

## Eligibility Spectrum



**Revised 2024**

**ELIGIBILITY SPECTRUM (2024)**

| | | Level of Severity | | | |
|---|---|---|---|---|---|
| **SECTION** | **SCALE** | **Extremely** | **Moderately** | **Minimally** | **Not Severe** |
| **SECTION 1 Physical/ Sexual Harm by Commission** | 1. Physical Force and/or Maltreatment | A, B, C, D, E | F, G, H, I, J | K, L | M |
| | 2. Cruel/Inappropriate Treatment | A | B | C | D |
| | 3. Abusive Sexual Activity | A, B, C, D, E,F, G | H, I, J, K, L | M, N | O |
| | 4. Threat of Harm | A | B, C | D | E |
| | 5. Child Fatality | A, B, C, D, E, F | G, H, I, J, K, L | M, N | O, P |
| **SECTION 2 Harm by Omission** | 1. Inadequate Supervision | A | B | C | D |
| | 2. Neglect of Child's Basic Physical Needs | A | B | C | D |
| | 3. Caregiver Response to Child's Physical Health | A, B | C | D | E |
| | 4. Caregiver Response to Child's Mental, Emotional, and Development Condition | A | B | C | D |
| | 5. Caregiver Response to Child Under 12 Who Has Committed a Serious Act | A | B | C | D |
| **SECTION 3 Emotional Harm** | 1. Caregiver Causes and/or Caregiver Response to Child's Emotional Harm or Risk of Emotional Harm | A | B, C | D | E |
| | 2. Child Exposure to Adult Conflict | A, B, C, D | E, F, G | H | I |
| | 3. Child Exposure to Partner Violence | A, B, C, D, E | F, G, H | I | J |
| **SECTION 4 Separation from Parent/ Caregiver** | 1. Orphaned Child or Parent/Caregiver Unavailable | A, B, C | D | E, F | G |
| | 2. Caregiver-Child Conflict/Child Behaviour | A, B | C, D | E | F |
| **SECTION 5 Caregiver Capacity** | 1. Caregiver Has History of Abusing/Neglecting/Exploiting | A, B, C, D, E, F | G, H | I, J | K |
| | 2. Caregiver Inability to Protect | A, B | C | D | E |
| | 3. Caregiver with Problem | A | B | C | D |
| | 4. Caregiving Skills | A | B | C | D |
| **Section** | **Scale** | **Unranked Choices** | | | |
| **SECTION 6 Request for Counselling** | | A, B, C, D, E, F, G | | | |
| **SECTION 7 Request for Adoption Services** | 1. Adoption Services for Potential Adoptive Families | Scale 1: A, B, C, D, E, F, G, H | | | |
| | 2. Adoption Disclosure | Scale 2: A, B, C | | | |
| | 3. Services for Birth Parent(s) Considering Placing Child for Adoption | Scale 3: A, B, C | | | |
| | 4. Adoption Probation Services | Scale 4: A, B, C | | | |
| | 5. Post Adoption Services | Scale 5: A, B, C, D, E, F, G, H | | | |
| **SECTION 8 Family Based Care** | 1. Foster Care Services | Scale 1: A, B, C, D, E, F, | | | |
| | 2. Kinship Service for Child Who Has Been or Will Be Living with Kinship Service Provider(s) | Scale 2: A, B, C, D, E, F, G, H, I | | | |
| | 3. Kinship Service for Children and/or Youth in the Care of a Society | Scale 3: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P | | | |

What happens after I make a report?

# What CAS does when a case is opened

- Safety assessment
- Safety plan
- Continue investigation
- Verification conference
- Closed / on-going services

# 5. How do I communicate with the family?

- Be clear about the information and your role
- Be nonjudgmental and objective
- Keep the focus on the child
- Accept that the parent will be scared, angry or otherwise upset
- Find common ground
- Avoid getting defensive

# 6. How do I document all of this? SOAP note with attention to details

1

## Be objective

- Mother stated that… Child reported that… Parents gave different opinions on… Father expressed concern that…

2

## Be precise

- Use quotes, describe accurately

3

## Explain how you received the information

- Was it spontaneous? Did you ask a question?
- Who was there?

6. How do I document all of this?

# Words to avoid

- Mom / Dad
- Poor historian
- Denies
- Unexplained
- Consistent with
- Evidence
- Accidental / Non-accidental
- Abuse
- Shaken Baby Syndrome
- Investigations
- Impression
- Looks like a handprint / finger prints (avoid being definitive)

# 7. How do I manage ongoing patient relationships after a report?
# Trust and Trustworthiness

"You cannot make someone trust you. What you can do is give people adequate, useful and simple evidence that you are trustworthy."

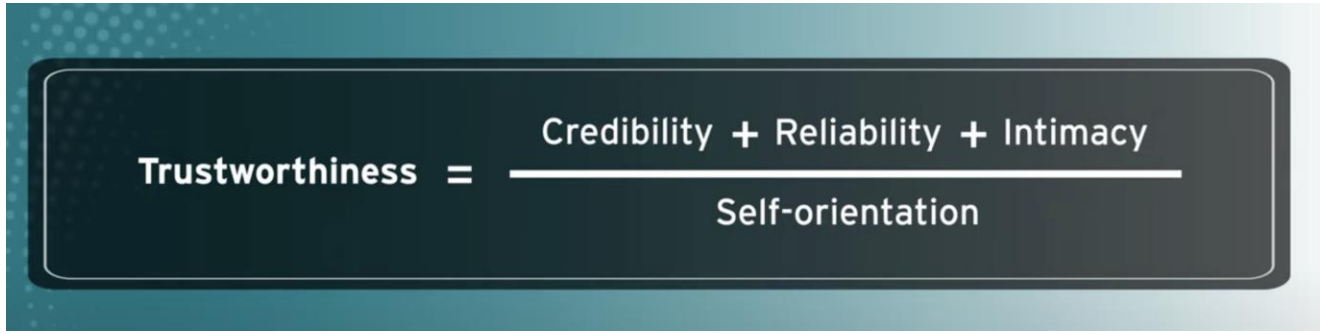



- Baroness Onora O'Neill – British Philosopher and member of the House of Lords

7. How do I manage ongoing patient relationships after a report?

# Communicating Trust

- Communicate Trustworthiness




- Communicate Extending Trust



# 8. What are common pitfalls that I can avoid?



- Trying to be more than an MD (being an investigator)
- Taking the history as truth
- Treating a diagnosis as truth
- Failing to document sufficient detail
- Pattern recognition
- Bias eg. confirmation bias
- Being definitive about something that is not definitive
- Using language that biases the investigation
- Missing important opportunities to help children and families who may be experiencing maltreatment

# Clinical perspective

1. Why should I be concerned about this as a family physician?
2. When should I have concerns for child maltreatment (abuse and neglect)?
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# Thank you.
# Questions?

Resources

# Tools



Links to resources shared today will be sent to participants following the session.

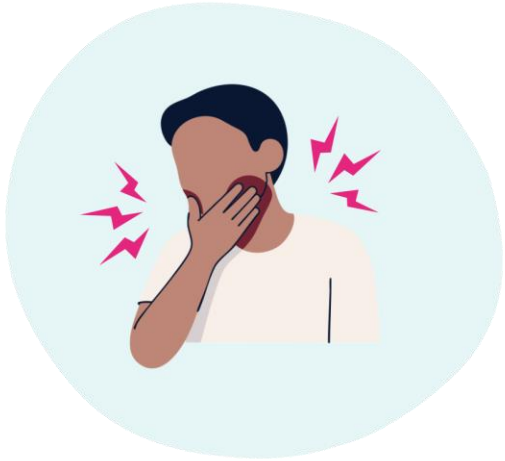
# Tools and Resources

| Resource Type | |
|---|---|
| CPSO Policies | •Policy on Reporting Requirements<br>•CPSO's Guide to Legal Reporting Requirements<br>•CPSO's Advice to the Profession: Reporting Requirements |
| CMPA Resources | •Duty to Report<br>•"Checklist: Duty to report"<br>•Protecting Children – Reporting Child Abuse |
| Other Resources | •Information and Privacy Commissioner of Ontario's (IPC) *Dispelling the Myths About Sharing Information with Children's Aid Societies*<br>•*Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A*<br>•*Child, Youth and Family Services Act, 2017,* S.O. 2017, c. 14, Sched. 1<br>•Ontario Association of the Children's Aid Societies' resource on *What is Child Abuse?* – recognizing the signs of child abuse and neglect<br>• vegaproject.mcmaster.ca<br>• HTTPS://CPS.CA/EN/DOCUMENTS/AUTHORS-AUTEURS/CHILD-AND-YOUTH-MALTREATMENT-SECTION<br>• HTTPS://TREKK.CA/ |

# Tools and Resources

| Resource Type | |
|---|---|
| All Academic Pediatric Centres in Canada have child maltreatment pediatricians, as well as some community hospitals. | • CHEO in Ottawa (CYP)<br>• Sick Kids in Toronto (SCAN)<br>• McMaster Children's Hospital in Hamilton (CAAP)<br>• Children's Hospital at London Health Sciences Centre<br>• (Kingston Health Sciences)<br>• Orillia<br>• Sudbury |

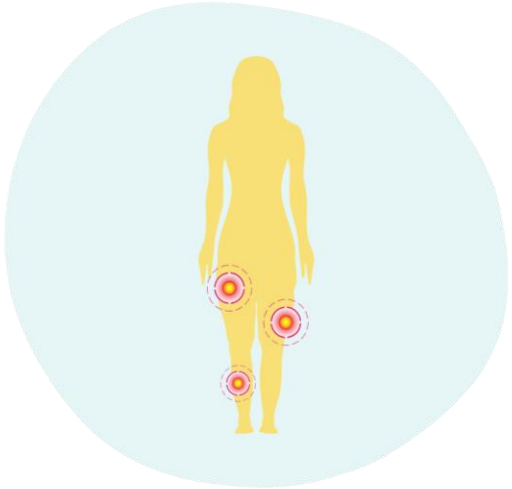
# Upcoming Community of Practice Events



## Practical Assessment & Management of TMJ Pain in Family Medicine

**November 25th, 2026**
**8:00am – 9:00am**

Register Now



## Understanding Fibromyalgia: Practical Strategies for Assessment, Treatment and Patient Support

**December 9, 2026**
**8:00am – 9:00am**

Register Now

# Upcoming Changing the Way We Work Community of Practice

**Infectious Disease & Managing Anaphylaxis**
with Drs. Susy Hota, Mariam Hanna, Samira Jeimy

**Nov 6, 2026**
**8:00am – 9:00am**

**Register Now**



The Changing the Way We Work Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 120 credits.

Ontario College of Family Physicians

ONTARIO Osteoporosis Strategy

# Osteoporosis and Fracture Prevention Workshop



**Participants will:**

✓ **Strengthen** their approach to osteoporosis screening, risk assessment and treatment planning.

✓ **Discover** practical tools, resources and strategies that can be applied immediately in practice.

✓ **Learn** from expert faculty through interactive discussion, case studies and Q&A.

**November 20 , 2026 | 1:00 pm-4:00pm**
**$195 + HST | Virtual**

Earn up to 6 Mainpro+ credits!

**Register Now**

Scan for more info

Ontario College of Family Physicians

Rotman School of Management UNIVERSITY OF TORONTO

# Leadership Academy

**Build the confidence, influence and practical leadership skills to shape the future of primary care.**

An immersive program **designed specifically for family physicians** ready to lead teams, strengthen practices and influence health-system change.

- Practical skills in change leadership, negotiation, coaching and difficult conversations
- Strategies to influence stakeholders and turn ideas into action
- A province-wide network of family physician leaders

**February –September 2027 | Hybrid**
**5 in-person days in Toronto + 4 virtual half-days**

**42 Mainpro+ credits | $3,950 + HST**

**Learn more and apply by November 30, 2026.**

Ontario College of Family Physicians

# The Children's Mental Health Workshop Series

## *NEW* Children's Mental Health: Advanced Cases and Complex Management

Scan QR Code

December 2, 2026 | 1:30PM - 4:30PM | Virtual Workshop | Claim up to **5 credits**!



- Manage youth mental health conditions using evidence-based & age-appropriate approaches
- Recognize potential psychosocial contributors to and interventions for older youth mental health challenges
- Discuss approaches to complex and co-morbid mental health presentations in children & adolescents
- And More

**Price: $250 +HST**

Register now

Ontario College of Family Physicians

# Peer Connect

For Family Physicians and Family Medicine Residents

Connect with a family physician colleague to receive **tailored support on challenges you are facing in your practice.**



## What Peer Learners are saying about their experience....

"After a medical leave from my practice, having a colleague to support me during the transition back has been **invaluable**".

"[Peer Connect] absolutely has helped [with] **building up my confidence and skill set".**

"[My peer guide] has given me a lot of **insight into my own clinical practice** as well as my non-clinical goals. I would highly recommend the Peer Connect program to others".

**Learn at your own pace while earning Mainpro+ Credits!**

**Click here or scan the QR code to learn more and sign up >>**