9-MONTH-OLD SHARON

An Investigative Review

ocya
OFFICE OF
THE CHILD AND
YOUTH ADVOCATE
ALBERTA

OCTOBER 2016

ocya OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

Under my authority and duty as identified in the *Child and Youth Advocate Act (CYAA)*, I am providing the following Investigative Review regarding the death of a nine-month-old child who had received child intervention services within two years of her passing. Consistent with Section 15 of the *CYAA*, the purpose of this report is to learn from this sad circumstance and recommend ways of improving Alberta's child intervention system.

This is a public report that contains detailed information about children and families. Although my office has taken great care to protect the privacy of the child and her family, I cannot guarantee that interested parties will not be able to identify them. Accordingly, I would request that readers, including the media, respect this privacy and not focus on identifying the individuals and locations involved in this matter.

In accordance with the *CYAA*, Investigative Reviews must be non-identifying. Therefore, the names used in this report are pseudonyms (false names). Finding an appropriate pseudonym for one so young is difficult. However, it is a requirement that my office takes seriously and respectfully. In this situation, her family has chosen the name Sharon.

Sharon was nine months old when she passed away from undetermined causes. She and her five older siblings had recently been returned to their parents' care. We met with her family members and professionals through the course of completing this review. Their thoughts and experiences were critical to our understanding and are incorporated into this report.

This review identified the need for the Ministry of Human Services to provide organizational support to its front-line caseworkers when returning children to their parents' care. This would promote child-focused interventions and safe well-planned transitions for children. It is my sincere hope that the recommendations arising from this review will be acted upon, along with similar recommendations made in other reports, to improve services for Alberta's children and youth.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

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EXECUTIVE SUMMARY

Alberta's Child and Youth Advocate ("the Advocate") is an independent officer reporting directly to the Legislature of Alberta, deriving his authority from the *Child and Youth Advocate Act (CYAA)*. The Advocate has the authority to conduct investigations into systemic issues related to the death of a child who received Child Intervention Services within two years of their death.

Sharon (not her real name)[1] was nine months old when she passed away from undetermined causes. She was in her parents' care when she died. Sharon and her family lived on their First Nation. The Advocate was notified of her death because she had received intervention services approximately two months prior to her passing.

The information gathered through this Investigative Review revealed three issues related to the systems that serve children and families:

1. **Child-Focused Interventions**

   Sharon was impacted by her parents' pattern of substance abuse and relationship issues. Planning was needed that addressed Sharon's attachment disruptions and exposure to trauma.

2. **Transition Planning for Family Reunification**

   Sharon and her five siblings were in care for approximately six months. Child intervention involvement ended shortly after they returned to their parents' care. A purposeful and supported transition is required for successful family reunification.

3. **Organizational Support for Caseworkers**

   Sharon's story reminds us that child intervention is complicated and what works for one family may not work for another. It is important that caseworkers receive support to recognize and address the unique complexity involved in each child's situation.

To help improve the effectiveness of Alberta's services to children, the Advocate makes **two recommendations**:

Recommendation 1

The Ministry of Human Services should require that child intervention caseplans include individual support plans for children that reflect an understanding of the impact of trauma on each stage of child development.

1 All names throughout this report are pseudonyms to ensure the privacy of the child and family.

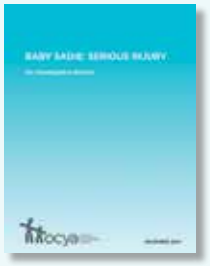
Recommendation 2

The Ministry of Human Services should enhance child intervention policies and procedures to address the complexity involved with family reunification. Planning should be child-centered and address the need for a child's support, safety and stability. These plans must be monitored and adjusted over a period of time.

The following recommendations from previous Investigative Reviews are also relevant in this situation:

Remembering Brian: Investigative Review,[2] the Advocate recommended that a balance be struck between child-focused and family-centered approaches when delivering intervention services. As of September 30, 2015, the Advocate identified that some progress has been made in relation to this recommendation.

Kamil: An Immigrant Youth's Struggle Investigative Review,[3] the Advocate recommended that Human Services should increase opportunities for child intervention staff to work in a more innovative, inclusive and collaborative environment to improve the quality of decision making for vulnerable children and youth. As of September 30, 2015, the Advocate has identified that this recommendation has been met. However, for Sharon, it was not apparent that frontline staff had such opportunities so it is being raised again.



Baby Sadie Serious Injury: An Investigative Review,[4] the Advocate recommended that Alberta Human Services review their training for frontline staff specifically related to critical thinking, risk assessment and case analysis. Training should be strengthened and tailored … to ensure well-informed case analysis and case planning for young people and their families. As of September 30, 2015, the Advocate noted that the Ministry's response partially addressed this recommendation.

The Advocate regularly reports on the progress of recommendations at: www.ocya.alberta.ca/adult/publications/recommendations/

The Ministry of Human Services publicly responds to recommendations at: www.humanservices.alberta.ca/publications/15896.html

2 Office of the Child and Youth Advocate – Alberta, June 2013.

3 Office of the Child and Youth Advocate – Alberta, November 2013.

4 Office of the Child and Youth Advocate – Alberta, November 2014.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act (CYAA)*,[5] which came into force April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*[6] (the *Enhancement Act*), the *Protection of Sexually Exploited Children Act*[7] (*PSECA*), or from the youth justice system.

Investigative Reviews

Section 9(2)(d) of the *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from the death of a child who was receiving child intervention services within two years of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Upon completion of an investigation under this section of the *CYAA*, the Advocate releases a public Investigative Review report. The purpose is to make findings regarding the services that were provided to the young person and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations, which are:

- prepared in such a way that they address systemic issue(s); and,
- specific enough that progress made on recommendations can be evaluated; yet,
- not so prescriptive to direct the practice of Alberta government ministries.

It is expected that ministries will take careful consideration of the recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

5 *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

6 *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

7 *Protection of Sexually Exploited Children Act*, RSA 2000, c. P-30.3.

ABOUT THIS REVIEW

The Advocate was notified that 9-month-old Sharon (not her real name)[8] died of unknown causes while in her mother's care. Sharon was unresponsive when Emergency Medical Services (EMS) responded to her home. A Delegated First Nation Agency (DFNA)[9] had provided services to Sharon and her family that ended approximately two months before her death.

Sharon's child intervention records were thoroughly reviewed by investigative staff from the Office of the Child and Youth Advocate (OCYA). An initial report was completed which identified potential systemic issues and the Advocate determined that an Investigative Review was warranted. The Ministry of Human Services was subsequently notified.

Terms of Reference for the review were established and are provided in Appendix 1. A team gathered information and conducted an analysis of Sharon's circumstances through a review of relevant documentation, interviews and research. Sharon's family met with the investigative team and shared their experiences.

A preliminary report was completed and presented to a committee of subject matter experts who provided advice related to findings and recommendations. The list of committee members is provided in Appendix 2. Committee membership included an Elder and experts in the fields of addictions, attachment, trauma and child intervention best practice.

8 All names throughout this report are pseudonyms to ensure the privacy of the child and family.

9 An agency that delivers on-reserve Child Intervention Services to a First Nation community. DFNA's operate under provincial legislation but are federally funded.

ABOUT SHARON

Sharon was a beautiful baby girl of First Nation heritage. She was the youngest of seven siblings.[10] At nine months old, she was learning to crawl and enjoyed being outside watching the trees as they moved.

Sharon's Family

Sharon's mother, Belinda, was of First Nation heritage. As a young child, she went to live with her grandparents after her father passed away. In her pre-teens she returned to her mother's care.

Belinda's first long-term relationship lasted 13 years and ended when her partner assaulted her; she was hospitalized for two months. Their three young children went to live with relatives while she recovered. Belinda had problems with substance abuse and struggled to care for her children.

Two years later, Belinda became involved with Luke, who was also of First Nation heritage. He was described as handy and worked various jobs. He also abused substances and had trouble following through on commitments.

Belinda and Luke had three children. Their relationship was unstable and they separated a number of times. It was during a temporary separation that Belinda became pregnant with Sharon; her biological father was not involved in Sharon's care. Luke obtained guardianship and was her father figure.

10 Sharon's oldest sibling was primarily raised by a relative through a private family arrangement.

SUMMARY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES PRIOR TO SHARON'S BIRTH

Child Intervention Services was involved with the family prior to Sharon's birth. Luke and Belinda had a volatile relationship and separated often. Whenever he left, Belinda abused substances and had difficulty parenting. It was during one of these times that Sharon's older siblings were first brought into care because Belinda was drinking and unable to care for them. Belinda attended treatment and stayed sober for some time. After almost nine months, the children were returned to her care under a Supervision Order.[11]

Belinda had difficulty caring for her five children who were between one and nine years old. Luke returned home to help, but the couple separated shortly afterwards. About five months later, the children were apprehended[12] because of parental substance abuse and neglect.

Belinda and Luke reunited prior to Sharon's birth and completed addictions treatment. Their caseworker met with them along with their support workers to create a safety plan[13] so that the children could return home. Belinda expressed concerns about her ability to meet her children's needs. Some were aggressive when angry and there were concerns about sexualized behaviors. Two of the children had significant cognitive delays. The children were returned to their parents' care under a Supervision Order.

11 A court order that states supervision of a child and the person they live with to adequately protect the survival, security and development of the child(ren).

12 When the Director has reasonable and probable ground to believe that the child is in need of intervention according to the Enhancement Act and removes the child from the care of the guardian.

13 A safety plan is developed with the family or caregiver to assist in addressing risk and safety concern for the child. The plan should be regularly and consistently monitored.

SHARON'S HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES

Sharon was born approximately two months later. Shortly after her birth, Luke and Belinda separated. When Sharon was two months old, her biological father tried to take her from Belinda. He had been drinking and the children saw him assault their mother.

The children were apprehended and applications were made for Permanent Guardianship Orders.[14] The children were placed separately because of the large size (six) of the sibling group and their individual needs. Sharon was placed in a group home on her First Nation.[15]

During their first five months in care, the children had no visits with each other or with their parents. A new caseworker was assigned. Belinda completed addictions treatment and reunited with Luke. A safety plan was developed which identified that Luke would be the children's primary caregiver. Almost three weeks after starting visits, the six children (between 8 months old and 11 years old) were returned to their parents' care. The children were told about the move the day before.

After returning to her parents' care, Sharon cried a lot, but eventually she settled into a routine. Two weeks after the children returned, Luke obtained Private Guardianship[16] of Sharon. Child intervention involvement ended when the Order was granted.

Approximately one month later, the police responded to the home because Luke was drinking. He left and Belinda became the children's sole caregiver.

Sharon's Death

About five days later, Emergency Medical Services responded to the home because Sharon was in medical distress. She passed away that day. The cause of her death is undetermined; she had bruising and injuries that may have been caused by resuscitative attempts, or may have been the result of a traumatic event. It is also possible that Sharon's death was related to an illness. Despite all inquiries, her cause of death remains undetermined.

Current Circumstances

Sharon's siblings were brought back into care where they remain under Permanent Guardianship Orders.

14 An order in which the court awards guardianship of the child to the Director on a permanent basis. The child is in the care of the Director and remains in an approved placement.

15 A staffed placement that is licensed to provide care for up to six children.

16 An order in which the court awards guardianship of a child(ren) to an individual.

DISCUSSION

The Terms of Reference for this review identified two systemic issues: the collection and documentation of information and the use of tools in decision making. Through the review process these have been incorporated into the following:

1. **Child-Focused Interventions**
2. **Transition Planning for Family Reunification**
3. **Organizational Support for Caseworkers**

Child-Focused Interventions

At nine months old, Sharon was completely dependent. During the short time that she was with her parents, her bond with them was impacted by their substance abuse and their unstable relationship.

Positive bonding experiences in the child's first year is crucial in supporting the development of healthy attachments.[17] Sharon needed a consistent and attentive caregiver to thrive, survive and have a healthy development.[18] Her attachment was compromised by her placement in group care with many caregivers and no familial contact.

It is important to understand how attachment disruptions, neglect, domestic violence and trauma affect children. Difficult childhood experiences affect the brain which influences every aspect of their development.[19] Traumatic experiences in childhood have been linked to increased risk of mental and physical health problems throughout the individuals' lives.[20] The impact of adversity during critical periods of development highlights the need for significant attention to infants.

Child intervention caseworkers work with young children who have challenges and needs that impact their development. Caseworkers need access to expert information to help understand each child's specific needs. There are new programs[21] that provide tools that assist with creating plans for infants and toddlers based on their individual needs.

17 Perry, 2013.

18 Research Brief National Survey of Child and Adolescent Well-Being, 2012.

19 Lieberman, Chu, Van Horn & Harris, 2011.

20 Bellis, Lowey, Leckenby, Hughes and Harrison, 2013.

21 Hospital for Sick Children, 2014.

In previous reports the Child and Youth Advocate has recommended that child intervention practice needs to balance family-centered with child-focused approaches and create case plans that address the effects of trauma on children.[22] [23] Sharon might have benefited if part of the reunification plan identified and addressed her individual needs.

Recommendation 1

The Ministry of Human Services should require that child intervention caseplans include individual support plans for children that reflect an understanding of the impact of trauma on each stage of child development.

Transition Planning for Family Reunification

Sharon was two months old when she was removed from her parents' care. She and her siblings had individual needs but they were all affected by trauma. The children had limited contact with each other and their parents before returning home. Shortly after their return, child intervention involvement ended.

Successfully returning children to parental care is complex. Research[24,25] shows that family reunifications are more likely to succeed if:

- There is evidence that the patterns of abuse and neglect that led to the children coming into care have been addressed;
- The planning for the reunion has been purposeful and included the children;
- The children transition home slowly, over a period of time;
- When there are multiple children the returns are staggered;
- There is a team in place that includes extended family, community and cultural supports; and,
- Parents have access to services.

22 Office of the Child & Youth Advocate – Alberta 2013 – "Remembering Brian".

23 Office of the Child & Youth Advocate – Alberta 2015 – "17 Year Old Makayla: Serious Injury".

24 Wade, Biehal, Farrelly, & Sinclair, 2010.

25 Wilkins, Borg, Farmer & Walker, 2015.

A child's sense of safety comes from their needs being met over an extended period of time.[26] Luke and Belinda were aware of the expectations that their children were not to be exposed to substance abuse and that they were to ensure their daily needs were met. When child intervention involvement ended, Luke and Belinda did not have ongoing supports to help them. There must be a long-term commitment to help families so that they can keep their children safe.

The Enhancement Policy Manual references the need for well-planned transitions to lessen the impact on children.[27] This policy does not speak to the complexity and dynamics involved with returning children to their parents' care. When children return home there needs to be a formal plan that includes connections to culture, community and extended family. Child Intervention Services needs to ensure that these plans are monitored and adjusted after children have returned home.

Recommendation 2

The Ministry of Human Services should enhance child intervention policies and procedures to address the complexity involved with family reunification. Planning should be child-centered and address the need for a child's support, safety and stability. These plans must be monitored and adjusted over a period of time.

Organizational Support for Caseworkers

Sharon's story reminds us that child intervention practice is complex.[28] When caseworkers make decisions, like returning and transitioning children to parental care, it is critical that they have time to gather all relevant information.

Thoroughly reviewing information allows caseworkers time to consider all possible impacts on the children. It is not enough to rely solely on documented information. Policy recommends meeting with previous caseworkers to review information and understand the decisions that were made.[29] Sharon's family had ongoing involvement with Child Intervention Services, previous workers had critical information about Sharon, her siblings and the family's pattern.

26 Turnell, 2012.

27 Alberta Human Services, 2011.

28 Glouberman & Zimmerman, 2002.

29 Alberta Human Services, 2011.

Child Intervention Services has been implementing Signs of Safety (SOS)[30] to promote more innovative, inclusive and collaborative casework. This initiative is in the early stages of implementation and frontline staff require leaders who can create environments that support them in their learning and growth.

It is essential to recognize that caseworkers' feelings and values contribute to their decisions. If time is not made to discuss the impact of working with families, unchecked emotions can contribute to an imbalanced focus on either the parents' or child's needs.[31] Caseworkers require a work environment where they are encouraged to review their thoughts, actions and rationale for decisions with others. Questioning should be seen as central to good practice.[32]

Supervisors play an important role in increasing caseworker motivation, critical thinking, and decision-making by focusing on their actions, responses and decisions.[33] It is critical that child intervention supervisors not only develop the capacity to understand and manage practice, but also to have the skills to help others do the same.[34]

The following recommendations from previous Investigative Reviews are also relevant in this situation:

> *Remembering Brian: Investigative Review*,[35] the Advocate recommended that a balance be struck between child-focused and family-centered approaches when delivering intervention services. As of September 30, 2015, the Advocate identified that some progress has been made in relation to this recommendation.
>
> *Kamil: An Immigrant Youth's Struggle Investigative Review*,[36] the Advocate recommended that Human Services should increase opportunities for child intervention staff to work in a more innovative, inclusive and collaborative environment to improve the quality of decision making for vulnerable children and youth. As of September 30, 2015, the Advocate has identified that this recommendation has been met. However, for Sharon, it was not apparent that frontline staff had such opportunities so it is important to raise again.

30 Signs of Safety is a practice framework that originated in Western Australia by Andrew Turnell and Steve Edwards during work with Aboriginal Communities in the early 1990's. Child Intervention Services in Alberta is implementing signs of safety as a practice framework.

31 Munro, 2011.

32 Munro, 2011.

33 Child Welfare information Gateway, 2015.

34 Castor & Maksymyk, 2014.

35 Office of the Child and Youth Advocate – Alberta - June 2013.

36 Office of the Child and Youth Advocate – Alberta - November 2013.

Baby Sadie Serious Injury: An Investigative Review,[37] the Advocate recommended that Alberta Human Services review their training for frontline staff specifically related to critical thinking, risk assessment and case analysis. Training should be strengthened and tailored … to ensure well-informed case analysis and case planning for young people and their families. As of September 30, 2015, the Advocate noted that the Ministry's response partially addressed this recommendation.

The Advocate regularly reports on the progress of recommendations at:
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The Ministry of Human Services publicly responds to recommendations at:
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37 Office of the Child and Youth Advocate – Alberta - November 2014.

CLOSING REMARKS FROM THE ADVOCATE

Sharon's death is tragic and reminds us that children must be at the center of all decision-making. It is important to look beyond the details of the incident and focus on the underlying issues. This review is not about blame, it is about learning and making improvements so children can be safe. The investigative review is an opportunity to bring awareness to the importance of supporting families to care for their children. When children are returned to their parents' care, supports must be place to meet their child's needs.

Child intervention casework is a challenging responsibility. Caseworkers make complex decisions every day regarding children. Organizational support is required to promote child-focused interventions and safe, well-planned transitions for children.

I want to thank Sharon's family and all those who spoke with us and shared their insights. We must learn from her story so that Alberta's most vulnerable children receive the best supports and services possible.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDICES

APPENDIX 1: TERMS OF REFERENCE

Authority

Alberta's Child and Youth Advocate (the Advocate) is an independent officer reporting directly to the Legislature of Alberta, deriving his authority from the *Child and Youth Advocate Act (CYAA)*. The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act* or from the youth justice system.

Section 9(2)(d) of the *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from the death of a child who received child intervention services within two years of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

The Advocate was notified that 9-month-old Sharon died of unexpected causes while in her mother's care. A Delegated First Nation Agency (DFNA) provided Child Intervention Services to Sharon that ended approximately two months before her death.

The decision to conduct an Investigative Review was made by Del Graff, Child and Youth Advocate.

Objectives of the Investigative Review

To review and examine the supports and services provided to Sharon and her family specifically related to:

- The collection and documentation of information
- The use of tools in child intervention decision making

To comment upon relevant protocols, policies and procedures, standards and legislation.

To prepare and submit a report which includes findings and recommendations arising from the Investigative Review.

Scope/Limitations

An Investigative Review does not assign legal responsibilities, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.

Methodology

The investigative process will include:

- Examination of critical issues
- Review of documentation and reports
- Review Enhancement Act Policy and casework practice
- Review of case history
- Personal interviews
- Consultation with experts

Investigative Review Committee

The membership of the committee will be determined by the Advocate and the OCYA Director of Investigations. The purpose of convening this committee is to review the preliminary Investigative Review report and to provide advice regarding findings and recommendations.

Chair: Del Graff, Child and Youth Advocate

Members: To be determined but may include:

An Elder

A specialist in the area of child welfare best practice

A specialist in the area of Signs of Safety

An expert in the area of trauma specifically in regard to children

Reporting Requirement

The Advocate will release a report when the Investigative Review has been completed.

APPENDIX 2: COMMITTEE MEMBERSHIP

Del Graff, MSW, RSW (Committee Chair)

Mr. Graff is the Child and Youth Advocate for the province of Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in B.C. and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families.

Elder Randy Bottle

Elder Bottle is a member of the Blood Tribe and was a member of Chief and Council for 24 years. He spends a great deal of time in schools with students and with community agencies where he helps young people connect and understand the rich history and valued tradition of Indigenous people.

Caara Goddard

Ms. Goddard is one of six Canadians certified as a Signs of Safety trainer/consultant. She has been using the Signs of Safety approach for just over seven years in all areas of her work at Ktunaxa Kinbasket Child and Family Services Society (KKCFSS – a Delegated Aboriginal Agency in British Columbia). As a child protection and guardianship worker in an Aboriginal community, one of her focus areas has been adapting the Signs of Safety tools to better suit the needs of the Aboriginal community.

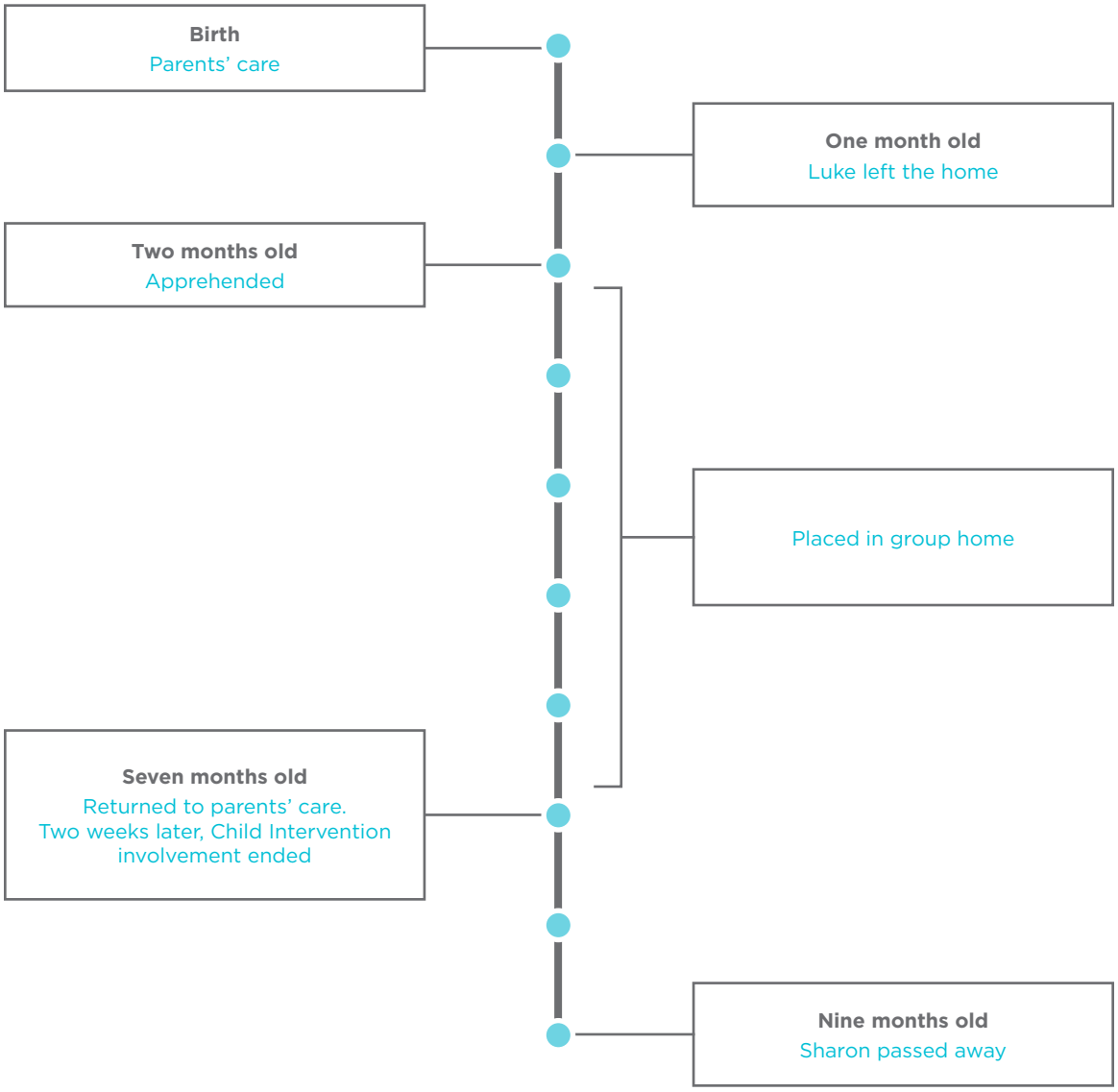
Leona Mountain

Ms. Mountain is a supervisor at the Beaver Lake Treatment Centre. This treatment facility provides services to individuals with drug and alcohol addictions. The Centre provides male and female accommodations, including four self-contained family units. Ms. Mountain has over 20 years of experience in the field of addictions.

Dr. Wanda Polzin, MA, RSW, EdD

Dr. Polzin is the Clinical Director at Child, Adolescent and Family Mental Health Services (CASA) in Edmonton and also has a small private clinical practice. She has presented at many conferences and has facilitated numerous professional development workshops and seminars. She has extensive clinical and programming experience working within the field of child and family mental health as well as child and family services both in the community as well as with inpatient settings with Alberta Health Services. Dr. Polzin has over 20 years of experience working with children and families and has specialized in the areas of trauma and attachment issues as well as FASD.

APPENDIX 3: SUMMARY OF SIGNIFICANT EVENTS



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