THREE YOUNG CHILDREN

An Investigative Review

5-YEAR-OLD SARAH

2-YEAR-OLD ANTHONY

1-YEAR-OLD MIKWAN

ocya
OFFICE OF
THE CHILD AND
YOUTH ADVOCATE
ALBERTA

JULY 2017

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 deaths of three young children of Indigenous heritage.

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 can be difficult, however, it is a requirement that my office takes seriously and respectfully. Where possible, we met with members of the child's family and they chose the child's name.

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

During the Investigative Review process, I made the decision to examine Sarah's, Anthony's and Mikwan's experiences together, as part of a broader collective review. All three children were pre-school age and returned to their parents after significant time in care. They were part of sibling groups from three to seven children. As with any Investigative Review, focused and dedicated attention was given to each child's circumstances.

In October of 2016, I released an Investigative Review about a little girl (Sharon) who was nine months old when she died. She and her five older siblings had recently been returned to their parents when Sharon passed away. The circumstances of the three children discussed in this Review have a number of similarities to those of Sharon.

The tragedies of these children's experiences is heartbreaking and some may find this report difficult to read. However, similar situations can be prevented if the government acts upon the recommendations contained in this report.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

CONTENTS

EXECUTIVE SUMMARY

In October of 2016, the Child and Youth Advocate (the "Advocate") released "*9-Month-Old Sharon: An Investigative Review.*"[1] Sharon had been in care for most of her life and passed away after she and her five siblings were returned to their parents' care. The review into Sharon's circumstances identified that the Ministry of Children's Services must provide more organizational support to front-line caseworkers when returning children to their families to promote child-focused interventions and safe well-planned transitions for children. This is particularly important when returning sibling groups and children who have spent most of their lives in care.

After Sharon's death, the Advocate learned of the passing of five-year-old Sarah, two-year-old Anthony and one-year-old Mikwan.[2] Like Sharon, all three children were returned to their parents after significant time in care. During the Investigative Review process, the Advocate made the decision to examine Sarah's, Anthony's and Mikwan's experiences together, as part of a broader collective review.

Like Sharon, Sarah, Anthony and Mikwan were from First Nation families and they shared a number of experiences and attributes that placed them at risk. They were taken into care when they were very young because their parents struggled with addictions, domestic violence and neglect concerns. Their families ranged in size from three to seven children. When they were returned to their parents, each child had unique needs that required special attention. The services provided when the children were returned to their parents were family-focused and risks that were specific to each child were lost. The children became isolated from relatives and community services that were previously supporting them.

This Investigative Review explores factors that are critical considerations to safely reunify families.

In two previous Investigative Reviews, "*9-Year-Old Bonita*" and "*10-Month-Old Lily*", the Advocate recommended more support to help caseworkers and other front-line service providers help families affected by substance use.[3,4] Implementation of previously made recommendations is in progress and it is imperative that these improvements continue.

1 Office of the Child and Youth Advocate - Alberta, 2016.

2 All names throughout this report are pseudonyms to ensure the privacy of the children and families.

3 Office of the Child and Youth Advocate - Alberta, 2016.

4 Office of the Child and Youth Advocate - Alberta, 2015.

The Advocate's special report "*Voices for Change: Aboriginal Child Welfare in Alberta*"[5] identified a number of systemic issues for Indigenous children and families. There were a number of recommendations that, if implemented, may have made a difference for children like Sarah, Anthony and Mikwan.

The Advocate made two recommendations with respect to Sharon's circumstance which were accepted, but as of July 5, 2017, the Ministry of Children's Services has not provided information regarding how they will be implemented. Child-centered planning is critically important to the well-being of children and families. The Advocate is again recommending that:

Recommendation

The Ministry of Children's 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.

To help improve the effectiveness of Alberta's services to children, the Advocate is making the following new recommendations:

Recommendation 1

The Ministry of Children's Services and community partners should implement intensive, sustained plans to specifically support young children who are returned to family after being in care. Additional care should be taken with children who have disrupted attachments or developmental challenges.

5 Office of the Child and Youth Advocate - Alberta, 2016.

Recommendation 2

The Ministry of Children's Services should implement a research based framework that guides casework through the reunification process with families including ongoing risk assessment and robust after-care plans that provide the level of supports the family requires.

Recommendation 3

The Ministry of Children's Services should ensure that children are returned to their families with a continuity of health, education and social supports comparable to what they received when they were in care.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's 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)*.[6]

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*[7] (the *Enhancement Act*), the *Protection of Sexually Exploited Children Act*[8] (*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 at the time of the injury or death. The advocate may also 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.

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

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

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

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, and making recommendations that result in systemic improvement for young people, when acted upon.

About This Review

In October of 2016, the Advocate released *"9-Month-Old Sharon: An Investigative Review."*[9] Sharon had been in care for most of her life and passed away after she and her five siblings were returned to their parents.

After Sharon's death, the Advocate learned of the passing of three young children of Indigenous descent, who died over a 14 month period:

- 5-year-old Sarah
- 2-year-old Anthony
- 1-year-old Mikwan[10]

Five-year-old Sarah died from serious injuries that included damage to her internal organs, a head injury and multiple bruising. Sarah was in her mother's care when she was injured. She had previously been in care for four years and then returned to her mother under a six-month Supervision Order. She was fatally injured approximately two months after child intervention involvement ended. At the time of her death, Sarah and her siblings were receiving child intervention services through a Safety Phase Assessment. Her mother was subsequently charged in relation to her death.

Two-year-old Anthony died after suffering a cardiac arrest and multiple unexplained injuries that included bruising and serious injuries to his brain and spine. Anthony was taken into care shortly after birth and placed in foster care where he remained for about two years. Although he was the subject of a Permanent Guardianship Order (PGO), Anthony and his siblings had been in their mother's care for approximately three months when he was fatally injured. Anthony's mother was subsequently charged in relation to his death.

One-year-old Mikwan died from complications of acute blunt head trauma. He also had multiple bruising and abrasions on his body. Mikwan was in his mother's care when he was injured. At the time of his death, he was receiving child intervention services through a Safety Phase Assessment. Mikwan had been in foster care for just over one

9 Office of the Child and Youth Advocate - Alberta, 2016.

10 All names used throughout this report are pseudonyms.

year and then returned to his parents' care approximately two months before he passed away. His mother was charged in relation to Mikwan's death.

Sarah's, Anthony's and Mikwan's child intervention records were thoroughly reviewed by investigative staff from the Office of the Child and Youth Advocate (OCYA). Initial reports were completed that identified potential systemic issues and the Advocate determined that Investigative Reviews were warranted. The Ministry of Children's Services was notified.

Terms of Reference were established for each review.[11] A team gathered information and conducted an analysis of the children's circumstances through a review of relevant documentation, interviews and research.

The Advocate subsequently decided that Sarah's, Anthony's and Mikwan's experiences were similar and that the systemic issues should be discussed together. It is critical that more support is provided to children and families before and after they are reunified.

Information about recommendations, responses to recommendations and implementation progress updates can be found at the following links:

Previously released Investigative Reviews are posted at:
http://www.ocya.alberta.ca/adult/publications/investigative-review/

The Ministry of Children's Services publicly responds to recommendations at:
http://www.humanservices.alberta.ca/publications/15896.html

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

11 Terms of References can be found in Appendices 1.C, 2.C, 3.C.

5-YEAR-OLD SARAH

5-YEAR-OLD SARAH

Sarah and her Family

Sarah was a young child of First Nation heritage. Her birth was premature; she was small in stature with straight dark hair and dark brown eyes. She had an older sister, Jamie, and a younger brother, Todd. Sarah was described as initially shy, but over time became more outgoing and affectionate. She had a severe speech delay and was often frustrated because others could not understand her. She received early intervention services while in foster care. She was unsettled at night and woke frequently.

Sarah's parents, Monica and Phillip, separated before her birth. Monica had a supportive relationship with her father and with some of her siblings.

Prior to Sarah's Birth

Child Intervention Services received concerns that Monica's oldest daughter, Jamie, was exposed to substance abuse. Monica attended an addictions treatment program and sought help from relatives to help care for Jamie and child intervention involvement ended.

Sarah from Birth to 2 Years Old

When Sarah was two months old, she went to live with her father, Phillip.[12] When Sarah was nine months old, Child Intervention Services received concerns and became involved with the family. Sarah was significantly underweight and had missed medical appointments. Sarah frequently moved between her parents and relatives. Monica did not have stable housing and was abusing substances.

Monica was pregnant and told her caseworker that she was not able to take care of her children. Jamie stayed with her maternal grandfather, while 10-month-old Sarah was placed in foster care.[13] In the foster home, she cried constantly and could not be soothed. After three days, she was moved to a group home where she stayed for approximately two months. Just before her first birthday, Sarah was moved to a second foster home.

Over the next five months, Monica worked with a Family Support Worker, obtained housing and completed a parenting program. Monica had supervised visits with Sarah and Jamie was returned to her care. Child intervention received a report that Jamie

12 Monica's older daughter, five-year-old Jamie, was living with Monica's father.

13 There was no family identified who could take Sarah.

had a swollen lip and that she said her mother hit her. A caseworker interviewed Jamie and she did not disclose how she was injured. Monica was provided with support to help her care for Jamie.

Shortly after Todd's birth, Child Intervention Services received concerns that Monica was drinking, abusing drugs and was in a violent relationship. Jamie and Todd were apprehended. Todd was placed in the same foster home with Sarah while Jamie was placed in another foster home.

Monica completed a parenting assessment that indicated she was quick to anger and had the potential to be abusive when stressed. It was recommended that although she was capable of learning, her supports needed be adapted. Monica voiced that she felt overwhelmed when she visited with Sarah; the psychologist recommended that Monica first needed to demonstrate that she could care for Jamie and Todd. Monica was connected to a family support worker and agreed to attend parenting classes in the community.

When Sarah was almost two years old, she was assessed and found to have a language delay. Speech therapy was recommended. Her foster parents contacted Early Intervention Services because of her behaviours. She screamed at a high pitch five to six times per week, had trouble sleeping and required a high level of supervision. A Temporary Guardianship Order was granted for Sarah, Jamie and Todd.

Sarah was accepted into an early intervention program where she received occupational and speech therapy. Sarah's foster parents were provided with strategies to manage her behaviours. A few months later, they reported that Sarah's speech was improving and her tantrums were diminishing.

Sarah and Todd's foster parents quit fostering after the children had been there for just over a year and they were moved. Their new foster mother[14] continued with early intervention services and reported that Sarah was a busy child, easily frustrated and hard to understand. Their older sister, Jamie frequently had overnight visits with Sarah and Todd in their foster home.

Sarah's father (Phillip) visited the children but was unable to care for them. Monica continued to struggle with addictions and did not have her own residence. However, she completed an anger management program and went to counseling. Documentation noted that Sarah's needs might be too overwhelming for Monica.

14 This was Sarah's third foster home and fourth placement.

Sarah from 3 to 4 Years Old

When Sarah was almost three years old, the caseworker applied for a Permanent Guardianship Order (PGO) for the three children.

After the application was made, Monica completed addictions treatment, anger management and parenting programs. She went to her children's medical appointments and met with a family support worker to help her with parenting strategies. Monica completed a second parenting assessment which indicated that she had symptoms of depression and her relationship with Sarah was not close. She had difficulty understanding Sarah's developmental needs and appeared to be the most responsive to her oldest child, Jamie.

Sarah qualified for special needs funding for pre-school and underwent further assessments. Although Sarah's speech was improving, she was still hard to understand. Her foster parent was provided with communication strategies to help reduce Sarah's frustration and it was recommended that she attend pre-school. Sarah continued to have trouble sleeping.

When Sarah was four years old, the children started to have overnight visits with their mother. Monica communicated with their foster parents so that she could implement their routines in her home. No concerns were identified during the visits.

Monica achieved almost one year of sobriety, had stable employment, maintained her residence and went to counseling. Shortly afterwards, four-year-old Sarah said that her "mother" hit her. The foster home was investigated; however, it was unclear if Sarah was talking about her foster mother or her biological mother. The concerns were not substantiated and the matter was closed.

Sarah at 5 Years Old

Before the investigation was completed, Monica's three children were returned to her. The PGO application was withdrawn and a six-month Supervision Order was granted.

Monica left her job so that she could focus on being a parent. Shortly after the children's return, she expressed that she needed to go back to work. She felt that Sarah's behaviours were more challenging now that she was with her full-time. Sarah often woke in the middle of the night and had tantrums, and Todd was very active. Monica shared that it was difficult for her because the children missed their foster mother.

Sarah and Todd wanted to go to school, but Monica could not afford the fees. She was unaware that Sarah had funding to attend early intervention programs. Monica secured a family physician and kept all of her children's medical appointments. She saw a counselor and the family support worker helped her access resources in the community.

Approximately one month later, Monica wanted Todd and Sarah to go on a visit to their former foster home so she could have a break. The foster parent was agreeable and Monica was prompted by the caseworker to contact her directly, but a respite arrangement was not set up.

Over the next month, Monica shared that Sarah and Todd's behaviours improved; Sarah had fewer tantrums and was coming to her for help. Monica still wanted to connect with their former foster parent to discuss how to manage their behaviours and was again encouraged to contact her. Monica planned to re-enroll Sarah into the early intervention school program.[15]

During the last three months of the Supervision Order, there were three incidents in which Sarah was injured that were reported to Child Intervention Services. The caseworker interviewed Sarah after the first incident and she did not disclose any abuse. Monica reported the following two injuries and said that she took Sarah to the doctor each time. Monica's subsequent explanations were accepted without further follow-up.

The family support worker was discontinued at Monica's request. She had arranged to attend an anger management program, a parenting program and counseling on her own. She felt that this provided her with adequate support. Monica was resistant to the caseworker's attempts to contact her service providers.

Near the end of the Supervision Order, Monica connected with a community-based family support program that could help her after child intervention involvement ended. Monica began working part-time and her father was a support to her, but he lived outside her community.

Child intervention involvement ended when the Supervision Order concluded.

The family support worker from the community agency visited the family. Five-year-old Sarah was sick with a cold but the worker observed no concerns. A second visit was arranged but Monica cancelled.

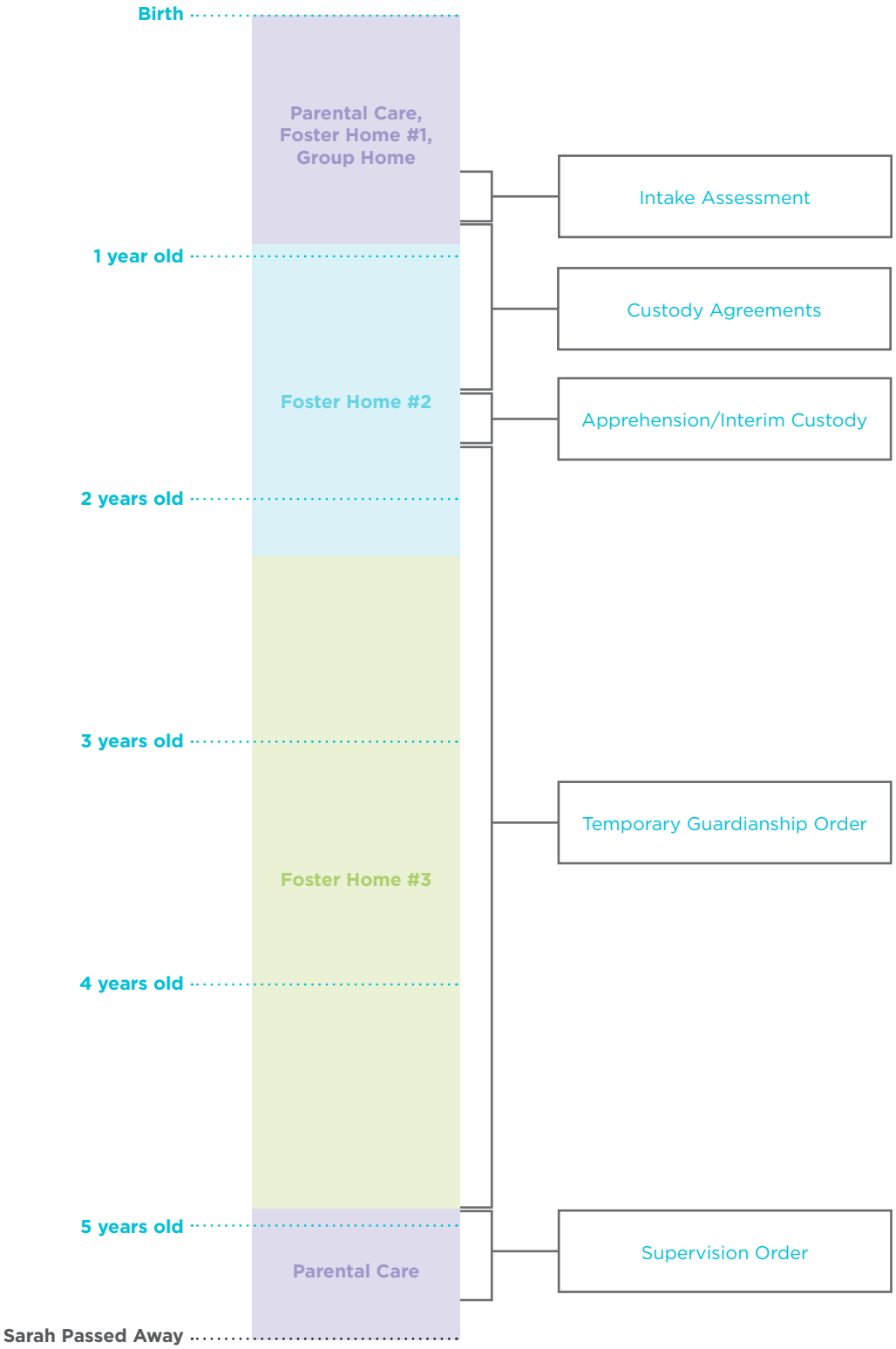
Circumstances Surrounding Sarah's Death

Approximately six weeks after child intervention involvement ended, Emergency Medical Services responded to the family home because Sarah was in medical distress. She was hospitalized with a serious head injury, injuries to her internal organs and bruising on her body. Sarah was placed on life supports and passed away a few days later.

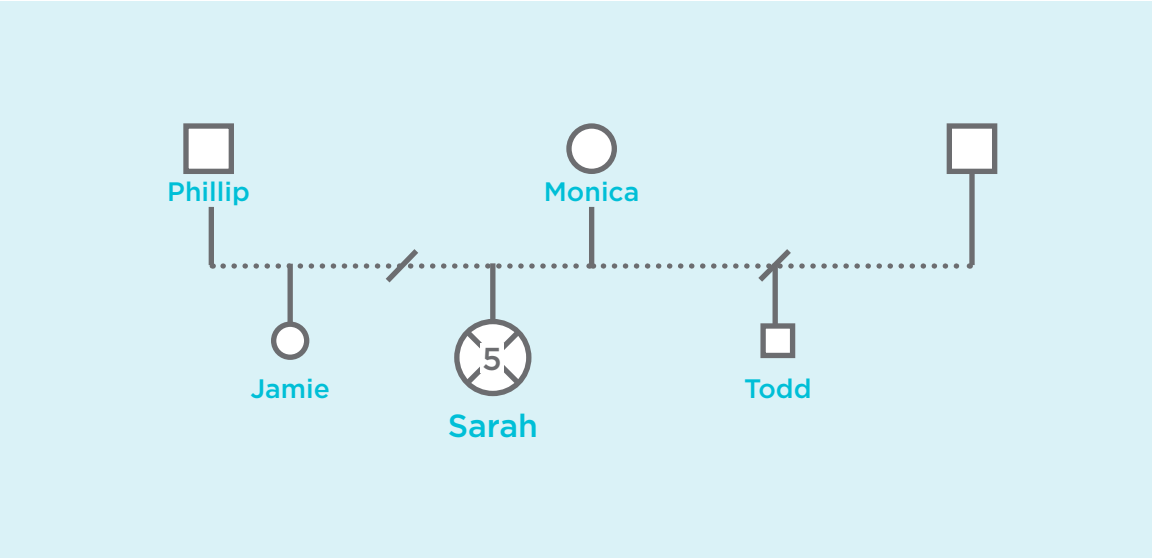
Monica was subsequently charged in relation to Sarah's death.

15 Sarah's former school program was not included in planning to determine if Sarah could attend a program in her new neighbourhood.

APPENDIX 1.A: SARAH—SUMMARY OF SIGNIFICANT EVENTS



APPENDIX 1.B: SARAH—GENOGRAM



LEGEND

Male Female Death

APPENDIX 1.C: SARAH—TERMS OF REFERENCE

Authority

Alberta's 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)*. 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 (CYFEA)*, the *Protection of Sexually Exploited Children Act (PSECA)* or from the youth justice system.

The *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving child intervention services at the time of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

Sarah was taken to hospital after being found unresponsive at home. She had significant injuries and passed away after life supports were removed.

Due to the suspicious nature of Sarah's injuries, Child Intervention Services became involved and there was an open Assessment at the time of her death. Sarah's mother was subsequently charged.

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

Objectives of the Investigative Review

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

- Early intervention services
- Supporting special needs parents in parenting special needs children

To comment on 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 or draw legal conclusions, 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
- Interviews
- Consultation with experts
- Research
- Other factors that may arise for consideration during the investigative process

Investigative Review Committee

The membership of the committee will be determined by the OCYA Director of Investigations and the Advocate. 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
- An expert in the area of early childhood intervention
- An expert in the area of speech and language delays
- An expert in the area of service provision to special needs parents

Reporting Requirement

The Child and Youth Advocate will release a report when the Investigative Review is completed.

2-YEAR-OLD ANTHONY

2-YEAR-OLD ANTHONY

Anthony and his Family

Anthony was a two-year-old toddler of First Nation heritage. He was born prematurely with symptoms of prenatal exposure to drugs. Anthony was a playful, active and content little boy. He was the youngest of five children.

Anthony's mother, Judy, was raised with strict rules, played sports and participated in traditional activities. She resided in her home community close to her extended family. Anthony's father, Quentin, was also of First Nation heritage. He spent a number of years in foster care away from his family and community when he was young.

Judy and Quentin separated shortly after Anthony's birth. Quentin had little involvement with Anthony.

Prior to Anthony's Birth

Child Intervention Services responded to concerns that Anthony's three oldest siblings (Lisa, Ross and David) were neglected and exposed to domestic violence. They were taken into care for a short time. Their parents entered into a Family Enhancement Agreement when the children were returned.

Lisa, Ross and David were taken into care a second time when concerns were received that Judy and Quentin's newborn daughter (Brittany) had symptoms of prenatal exposure to drugs. Caseworkers found that the children were neglected and needed medical treatment. The four children were placed in foster homes and kinship homes and became subjects of Temporary Guardianship Orders.

Judy completed addictions treatment and a parenting assessment. The assessment indicated she did not have a secure attachment to her children. It was recommended that Judy needed help understanding her children's developmental needs and continued support for her addictions. Judy was unable to maintain sobriety and Quentin did not engage with services. After two years, the children became subjects of Permanent Guardianship Orders. One child was placed in a kinship home while the other three were placed in foster homes outside of their community.

Anthony from Birth to 1 Year

Anthony was apprehended when he was a newborn. He was premature and had symptoms consistent with drug withdrawal.[16] He received treatment in the Neonatal Intensive Care Unit and was then placed in the same foster home with David and Brittany. About one year later, the children were moved to a foster home closer to their First Nation.

Judy agreed to drug tests so that she could have weekly supervised visits with her children. There were no concerns about the visits, but sometimes Judy seemed overwhelmed because the children were very active, fought with each other and did not listen.

Anthony from 1 to 2 Years Old

Judy participated in addictions counseling and went to parenting and domestic violence programs. The visits with her children became longer and more frequent. A support worker assisted her with parenting.

The two oldest children (Lisa and Ross) were placed with relatives. They usually visited with Judy separately from David, Brittany and Anthony. On a few occasions, all five children visited and Judy shared that she found this stressful. The family support worker was asked to work with Judy to enhance her parenting skills.

When Anthony was 18 months old, a Permanent Guardianship Order (PGO) was granted.[17] Judy consented because the case plan was that the children would be returned to her and the PGO could be terminated. It was recommended that Judy complete another parenting assessment and attend therapy in preparation for their return.

Approximately two months later, the caseworker met with Judy, her support worker and family members to discuss longer visits. Judy had a brief relapse using alcohol, but overall was making positive progress. In planning for the children's eventual return, relatives were asked to help babysit so that Judy could continue attending programs to support her sobriety.

16 Tremors, low food intake, high body temperature, agitated and unable to sleep.

17 Although Anthony's mother was doing better, the Permanent Guardianship Order was pursued because of the length of time Anthony had been in care, as required by the *Child, Youth and Family Enhancement Act*. The older children were already subjects of PGO's.

Anthony at 2 Years Old

Shortly after Anthony's second birthday, he and his two younger siblings (Brittany and David) spent the weekend with their mother. Near the end of the visit, Judy reported bruising on Anthony's back. He was examined at the hospital and discharged. The children remained with Judy while an investigation into their foster home was undertaken.[18] The investigators had difficulty meeting with Judy to talk about Anthony's injuries. They asked her caseworker to help them arrange a meeting, but after several weeks of keeping appointments,[19] child intervention workers started having difficulty connecting with Judy.

About two months after the children were left with their mother, Anthony had a serious head injury that required hospitalization. Four of her five children were with Judy when Anthony was injured. His injuries were investigated by Child Intervention Services and police.[20] Judy said that she was having difficulties with her children's behaviours and that she did not have the supports she needed. Through the investigation, it was discovered that Judy's oldest children (Lisa and David) were often left in her care. In addition, there were adult relatives who stayed with her.

While Anthony was in the hospital, child intervention staff met with physicians[21] and police. The cause of Anthony's head injury could not be determined. It was decided that he would be discharged to his mother. Intensive supervision and supports were recommended to ensure Anthony's safety.

Anthony stayed in hospital for about one week. When he was discharged, arrangements were made for a support worker to be in Judy's home 24 hours a day, seven days a week. After six days, Judy refused to continue with 24-hour support workers so their hours were decreased. The support worker was in the home for up to eight hours a day. Judy took Anthony to follow-up medical appointments and accessed services from a family resource center.

Approximately three weeks after Anthony's discharge, child intervention staff met with the police to discuss their investigation. There were concerns about the inconsistent explanations regarding the cause of Anthony's injuries and the supervision in Judy's home. Relatives were contacted to explore whether they could care for the children.

18 The foster home investigation was conducted by the child intervention region where the foster parents resided and concluded after Anthony's death. There was no information gathered during the investigation to suggest that his foster parents caused his injuries.

19 Judy met regularly with her caseworker and family support worker for approximately six weeks and then started to miss appointments.

20 Because the head injury happened on the First Nation, it was investigated by the First Nation police service and the Delegated First Nation Agency (DFNA), which is an agency that delivers On-Reserve Child Intervention Services to a First Nation.

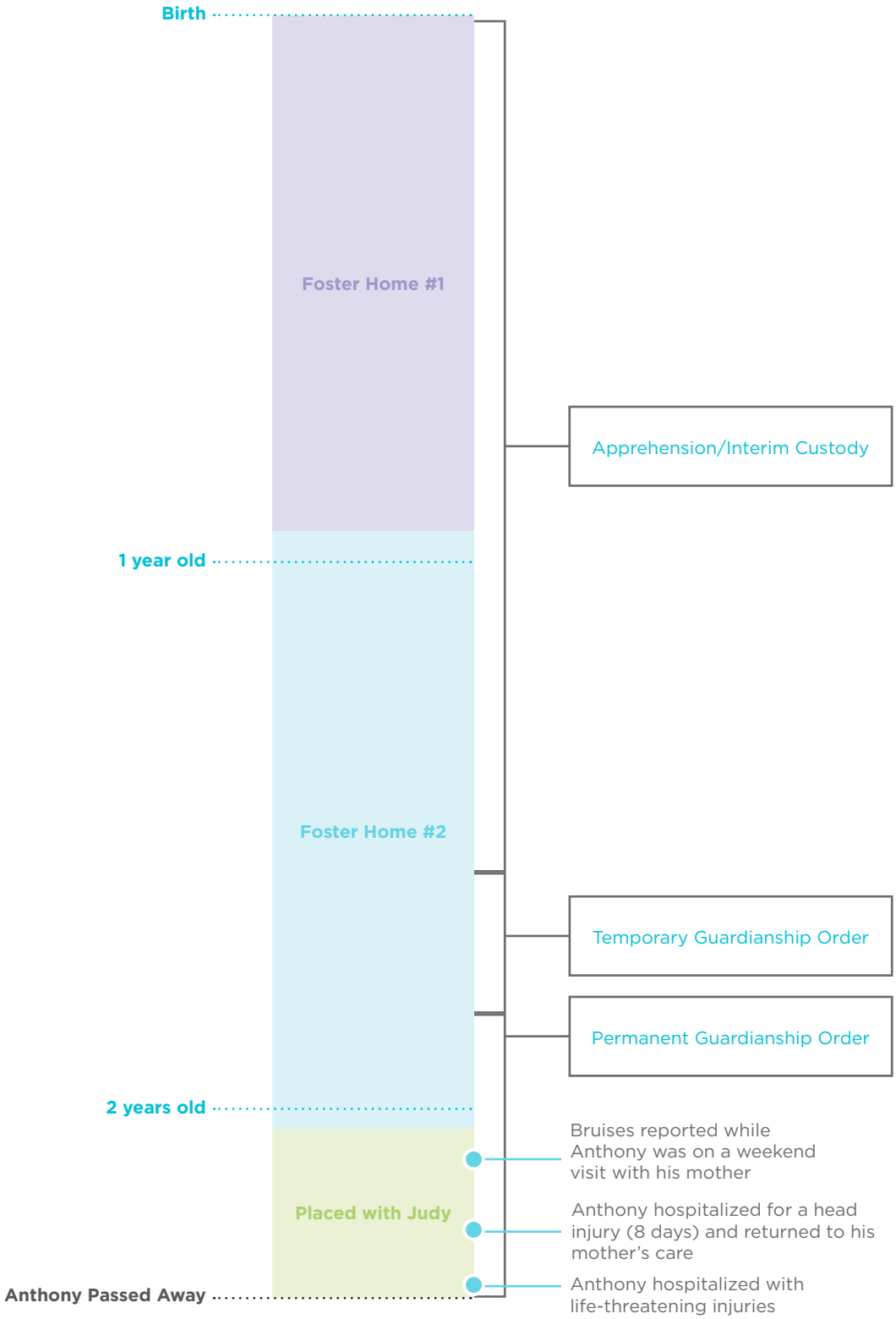
21 Including physicians specialized in diagnosing and treating child abuse injury.

Circumstances Surrounding Anthony's Death

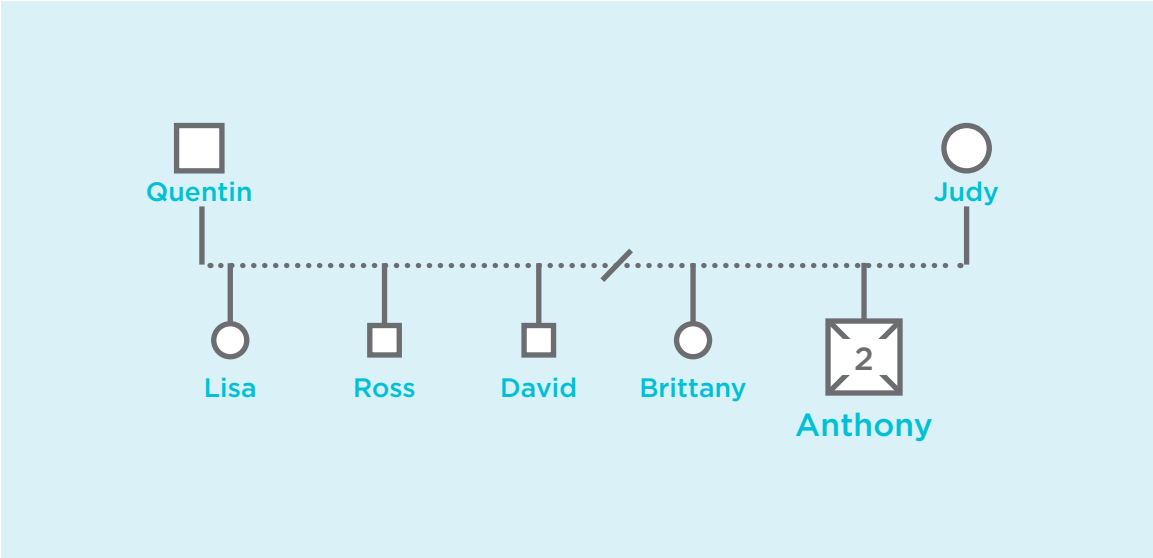
Approximately one month after Anthony's discharge from hospital, Emergency Medical Services were called to the family home after he was found unresponsive. Anthony was admitted to the Intensive Care Unit in critical condition after suffering a cardiac arrest. He had serious injuries to his brain and spine along with bruising on his body. Anthony was placed on life supports and passed away a few days later.

The Office of the Chief Medical Examiner attributed Anthony's death to multiple blunt force injuries. His mother was charged in relation to Anthony's death.

APPENDIX 2.A: ANTHONY—SUMMARY OF SIGNIFICANT EVENTS



APPENDIX 2.B: ANTHONY—GENOGRAM



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The *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving child intervention services at the time of their death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

Anthony was admitted to the hospital in critical condition after suffering a cardiac arrest and multiple unexplained injuries. A few days later, he was removed from life supports and passed away. At the time of his fatal injury, Anthony was the subject of a Permanent Guardianship Order (PGO) and staying with his mother.

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

Objectives of the Investigative Review

To review and examine service and supports provided to Anthony and his family specifically related to:

- Parental placement of children who are under Permanent Guardianship Orders
- Information used in decision making when assessing risk
- Follow through of safety plans
- Relevant protocols, policies, procedures, standards and legislation

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

Scope/Limitations

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- Consultation with experts
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- Other factors that may arise for consideration during the investigative process

Investigative Review Committee

The Advocate and the OCYA Director of Investigations will determine committee membership. 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 medical doctor specializing in child abuse
- An expert in the area of safety planning and risk assessment
- An Elder
- A specialist in the area of child intervention best practices

Reporting Requirement

The Child and Youth Advocate will release a report when the Investigative Review is complete.

1-YEAR-OLD MIKWAN

1-YEAR-OLD MIKWAN

Mikwan and his Family

Mikwan was a toddler of First Nation heritage. He was the second youngest of seven children. He was a healthy, content baby who loved to cuddle and fall asleep while being held.

Mikwan's parents, Fiona and Justin, were members of the same First Nation. Justin and Fiona met when they were teenagers; their relationship was impacted by violence and substance abuse. They sometimes separated and Fiona found it overwhelming to care for the children on her own.

When Justin was a child, he was exposed to family violence and substance abuse. Both Fiona and Justin started using drugs and alcohol when they were teenagers.

Prior to Mikwan's Birth

Child Intervention Services received concerns that Fiona and Justin were using substances while caring for their five children (Dan, James, Kyle, Dina and Ellen). The family could not be located. They lived outside of Alberta for over a year. Fiona became pregnant with Mikwan and tested positive for illegal drugs during a pre-natal check-up. The child welfare agency in that area investigated and had a plan to address the concerns, but the family moved back to Alberta before that occurred.

Mikwan from Birth to 1 Year

The family was involved in a car accident and Fiona was hospitalized for her injuries. Her labour was induced and she had Mikwan. He tested positive for benzodiazepines and opiates.[22] Fiona was discharged while Mikwan remained in the hospital. Fiona and Justin appeared to be intoxicated when they visited him.

Regional Child Intervention Services (CFS) received concerns about the family and spoke with staff from the Delegated First Nation Agency (DFNA) from the family's community. The family did not have a residence on their First Nation so the DFNA did not have jurisdiction to provide services.

When Mikwan was four days old, he was discharged from hospital and placed in a foster home. Fiona and Justin's five older children were taken into care. They were placed among three foster homes outside of their First Nation. Mikwan and his brother,

22 The opiates were prescribed to Fiona to treat her injuries but the benzodiazepines were not prescribed.

Kyle, were placed together. Justin and Fiona agreed to visit their children and attend addictions treatment.

Over the following nine months, Justin and Fiona frequently missed visits and did not attend addictions treatment. When Mikwan was ten months old, a six-month Temporary Guardianship Order (TGO) was obtained. He was settled in his foster home and was described as a calm baby who liked to be around people. He seldom cried so it was sometimes difficult to know if he was in distress. A pediatrician questioned whether Mikwan might have Fetal Alcohol Spectrum Disorder (FASD) and noted that he had gross motor delays.

When Mikwan was about one year old, Justin and Fiona completed an outpatient addictions program and regularly visited with their children. They had moved into a home on their First Nation, but it was in need of repairs before it would be suitable for their family. Both parents were attentive and caring during visits and were meeting the goals of their case plan.

Child intervention staff met frequently with Fiona, Justin and their extended family members. Justin and Fiona agreed to live with relatives who would support them as their children were returned to their care. Mikwan's sisters would live with their grandmother (Diane), while Mikwan and his three brothers would live with their maternal aunt (Cheryl). A visit schedule was established to transition the children and relatives agreed to monitor Justin and Fiona's progress.

Mikwan at 1 Year Old

After their first weekend visit, the children returned to their respective foster homes hungry and tired. The caseworker from the CFS met individually with the older children who did not indicate any concerns about the visit, but shared that they had a new baby brother, Derek.[23] A Safety Phase Assessment was initiated by the DFNA to ensure Derek's safety. The plan to transition Mikwan and his siblings back to their family continued.

The six-month TGO for the six oldest children was terminated after four months and was replaced with an Enhancement Agreement. Mikwan, Dan, James and Kyle moved into Aunt Cheryl's home with Fiona and Derek, while Dina and Ellen went to live with Diane. Within one week, child intervention staff learned that Justin was arrested for drug activity.

Aunt Cheryl's home was crowded and the situation was stressful for everyone. Within three weeks, Fiona took the children and went to stay at her house which was undergoing repairs. Mikwan's sisters were frequently with Justin and Fiona, despite the agreement that they would live with Diane. Family members felt that they could not prevent Fiona from taking her children and suspected that she was using drugs.

23 Child Intervention Services was not aware that Fiona was pregnant.

Approximately one month after the children returned to their First Nation, staff from the CFS and the DFNA met and discussed the family's circumstances. The DFNA agreed to provide services and the CFS ended their involvement.

Justin and Fiona completed drug screens and tested positive for substances. Their caseworker quickly met with the family to discuss alternatives to placing the children in foster care. Aunt Cheryl agreed to have all seven children, along with Fiona, return to her home but it was crowded. Mikwan often went to his aunt and uncle for comfort. A family support worker was arranged to help Fiona with parenting and to take the children on outings. Additional financial support to cover necessities was also provided.

About three weeks later, Justin and Fiona's house was ready. The caseworker visited and felt that the home was safe for the children. Justin and Fiona were asked to attend an outpatient treatment program and were told that child care would be provided. They did not register for the program. The following week, the caseworker met with Fiona and discussed the importance of addictions treatment. During the visit, all of the children were home and appeared happy.

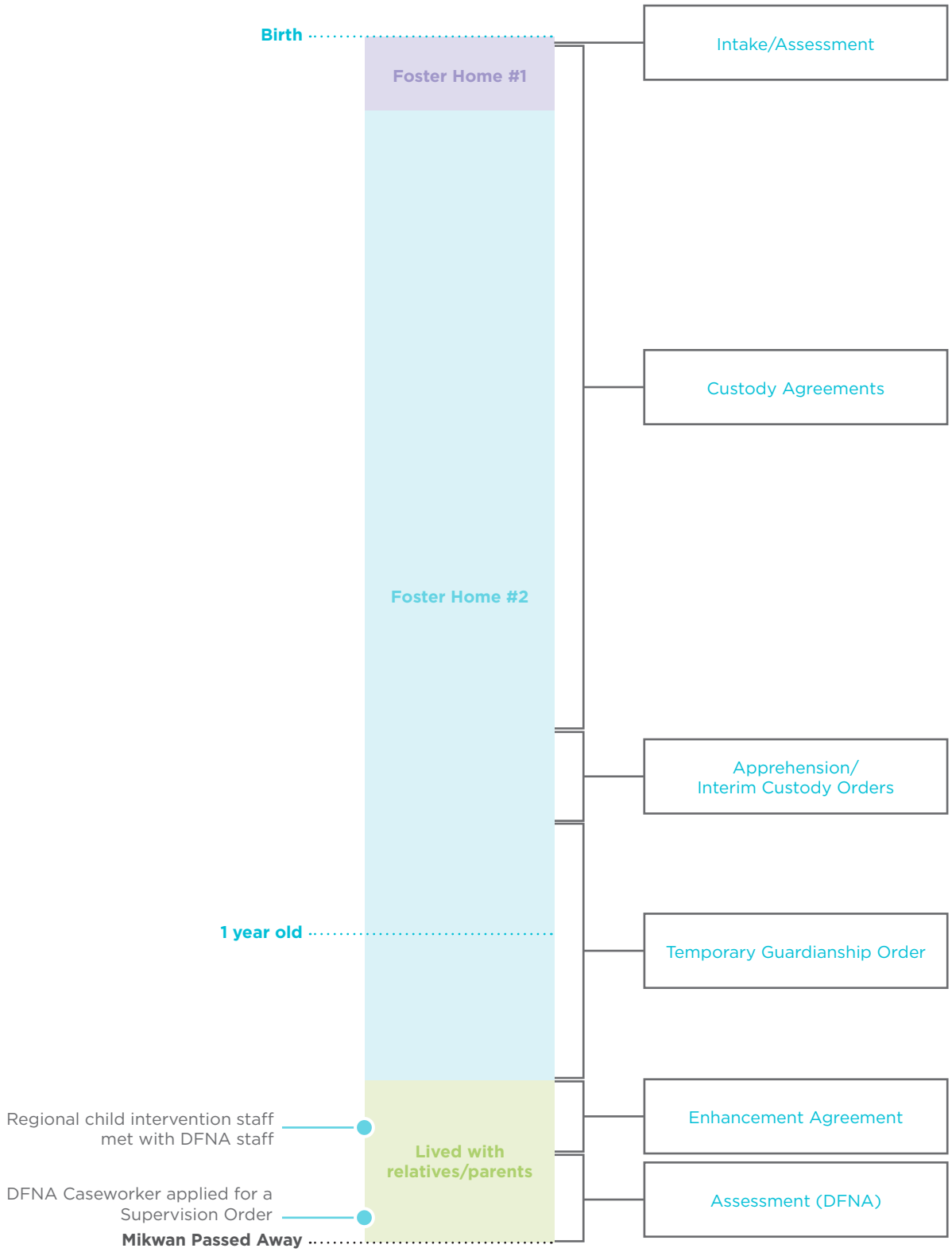
One week later, the caseworker met again with Fiona and the children. Fiona said that she and Justin had separated. An application for a Supervision Order was discussed and Fiona indicated that she would consent.

Circumstances Surrounding Mikwan's Death

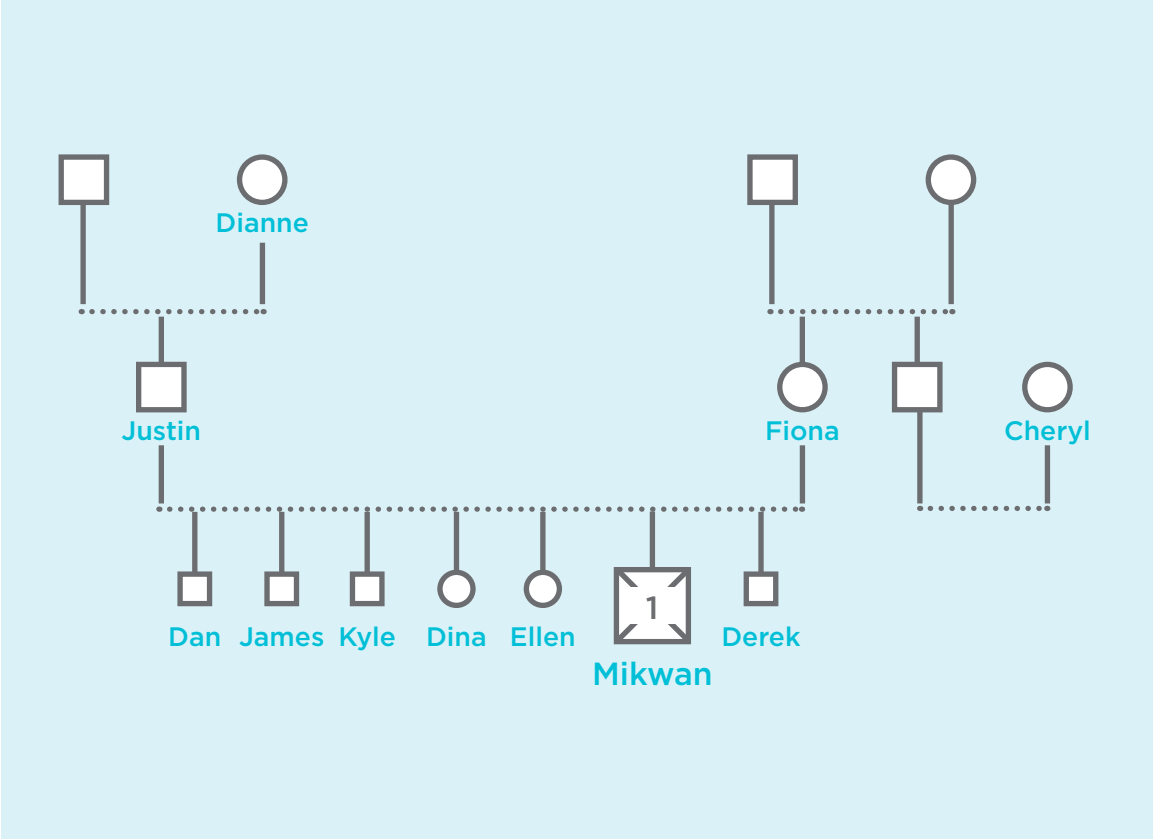
Two days later, the family support worker took Fiona and the children on an outing and returned them home in the early evening. About three hours later, Emergency Medical Services were called to the home and found Mikwan deceased. Police determined that Mikwan's death was suspicious.

The Office of the Chief Medical Examiner attributed Mikwan's death to acute head trauma. He also had multiple bruising and abrasions on his body. Fiona was charged in relation to Mikwan's death.

APPENDIX 3.A: MIKWAN—SUMMARY OF SIGNIFICANT EVENTS



APPENDIX 3.B: MIKWAN—GENOGRAM



LEGEND

Male Female Death

APPENDIX 3.C: MIKWAN—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.

The *CYAA* provides the Advocate with the authority to conduct Investigative Reviews arising from the death of a child who was receiving designated services at the time of death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

The Office of the Child and Youth Advocate received a report that one-year-old Mikwan passed away from non-accidental injuries. He was living on his First Nation with his mother and six siblings at the time of his death. The children had returned to their parents two months earlier after spending over a year in foster care.

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

Objectives of the Investigative Review

To review and examine service and supports provided to Mikwan and his family specifically related to:

- Transitioning children back to parental care
- Reliance on family members to ensure children's safety
- Cross jurisdictional services to families
- Parental substance abuse

To comment on 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 or draw legal conclusions, 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
- Interviews
- Consultation with experts
- Research
- Other factors that may arise for consideration during the investigative process

Investigative Review Committee

The membership of the committee will be determined by the OCYA Director of Investigations and the Advocate. 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
- An expert in the area of addictions
- A specialist in the area of child intervention best practices
- An expert in the area of childhood trauma and/or attachment

Reporting Requirement

The Child and Youth Advocate will release a report when the Investigative Review is completed.

DISCUSSION AND RECOMMENDATIONS

Sarah, Anthony and Mikwan cannot be discussed together without also remembering Sharon. The Advocate released an Investigative Review about Sharon in October of 2016. She was the youngest of seven siblings who was taken into care when she was two months old. Her parents struggled with addictions, the children witnessed family violence and there were concerns about neglect. Sharon had been in care for five months when she and her siblings were returned to their parents. Her mother had just completed addictions treatment. Sharon passed away from traumatic injuries about six weeks later.

All four children were from First Nation families and they shared experiences that we must learn from, to better serve all children and families. They were taken into care when they were very young because their parents struggled with addictions, family violence and neglect concerns. When they were returned to their parents, each child was extremely vulnerable because of their young age. Their families ranged from three to seven children and they each had unique needs that further increased their risk of being maltreated.

Supporting Capacity in Indigenous Families and Communities

Indigenous communities in Canada are recovering from the damage brought by the *Indian Act*; the confinement and segregation of people to Reserves; the residential school era; the 60's scoop; and, the current child welfare system. In July of 2016, the Advocate[24] and the Alberta Auditor General[25] released reports in response to the over-representation of Indigenous children involved with Child Intervention Services. Considering historic and current systemic issues, special attention must be paid to how Indigenous children are returned to their families.

Interventions typically focus on parents and their children, while paying little attention to important factors in the family's environment. Systemic issues of inadequate housing, poverty, addictions and intergenerational trauma impact many Indigenous families on a daily basis. These are structural challenges that child welfare agencies are not mandated or funded for,[26,27] but are critical factors to the health and well-being of children and families.

24 Office of the Child and Youth Advocate – *Voices for Change*, 2016.

25 Auditor General of Alberta, 2016.

26 Blackstock, Brown & Bennett, 2007.

27 Aboriginal Healing Foundation, 2010.

Definitions of family, parenting, and child development need to take into consideration traditional knowledge and practices within Indigenous communities. This will depend on the beliefs and wishes of each family. For some Indigenous families who are struggling, the restoration of traditional knowledge and practices[28] may be beneficial. In recent years, programs have successfully revitalized Indigenous child-rearing practices and traditional kinship connections to support parents.

Child Intervention Services has adopted practices that engage inherent strengths within Indigenous communities. Family Group Conferencing and Signs of Safety are tools that bring concerned relatives and community members together to create plans to keep their children safe. At different points, caseworkers for Sarah, Anthony and Mikwan met with relatives to explore how they could support the children's return to their parents. After the children were returned, child intervention staff and relatives needed to regularly communicate to assess if the plans for the children were working. Successful reunification of children with their parents must involve intensive work to nurture the support in the larger family and community around them.

Mikwan and his siblings were taken into care by a Child and Family Services region (CFS) and returned to family on their First Nation. After the children were returned, a Delegated First Nation Agency (DFNA) took on responsibility. Jurisdictional differences in Alberta contribute to inequitable funding for programs that serve children and families on First Nations. In 2010, leaders from government, DFNA's and CFS's attended a forum to improve their collaboration and enhance the capacity of First Nations to care for their children.[29] The Inter-Regional/DFNA policy[30] was revised to reflect a commitment to work together for seamless, timely, effective and culturally appropriate services to families. Although the policy is in place, it does not appear that it is consistently applied.

28 Simard, 2009.

29 Government of Alberta, 2010.

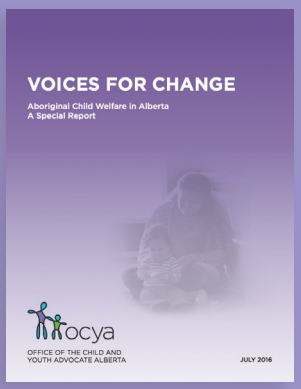
30 Enhancement Policy Manual, 2011 Section 10.5.

The Advocate's special report "*Voices for Change: Aboriginal Child Welfare in Alberta*"[31] identified a number of systemic issues for Indigenous children and families. Although there were a number of recommendations that, if implemented, would make a difference for children like Sarah, Anthony and Mikwan, one stands out:

Recommendation

The Ministry of Human Services should provide the resources and supports for Aboriginal communities to ensure delivery of child welfare services to their children and families by:

Establishing a range of services from prevention, through intervention and aftercare for Aboriginal children and families who come into contact with the child welfare system.



It is critical that the above recommendation be implemented so that children like Sharon, Sarah, Anthony and Mikwan have greater potential for their needs to be matched to appropriate supports and services; resulting in better outcomes for them.

Multiple Risk Factors

Addictions

When children are taken into care, the primary goal is to reunite them with their parents.[32] The Enhancement Policy Manual states, "*When a child leaves the care and custody of the Director, ensure that planning has occurred for the care of the child and to assist with the transition to the new living arrangement and after care services that will meet the child's needs and ensure their safety.*"[33]

Sarah's, Anthony's and Mikwan's parents took steps to improve their lives so that their children could be returned to them. Counseling, addictions treatment, and parenting programs are important, but parents must demonstrate their ability to consistently meet their children's needs.[34] Visits are not the same as full-time parenting. Even when

31 Office of the Child and Youth Advocate - Alberta, 2016.

32 Enhancement Policy Manual 2014 Section 4.2.3 (Concurrent Plan).

33 Enhancement Policy Manual, 2011 Section 3.2.4 (Leaving the Custody of the Director).

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

children return to their families through a carefully planned process, the change is likely to increase stress within the family and heighten risk.[35]

Substance abuse is strongly associated with higher rates of child maltreatment[36] and Sarah's, Anthony's, Mikwan's and Sharon's parents all had addictions. Addressing substance abuse is complex and should not be based solely on the cessation of use. Parents who resume caring for their children may struggle with balancing their own wellness with the day-to-day demands of parenting.[37] Supporting parents' recovery after their children are returned must address co-occurring issues such as child-care, housing and poverty.[38] Recovery and relapse are closely tied to supports and stressors that constantly change.

Sarah's mother, Monica, had been sober for almost one year before her children were returned to her. Within two weeks of being returned, Monica felt Sarah's behaviours were more challenging now that she was with her full-time.

Anthony's mother, Judy, had a longer period of sobriety and had a relapse approximately six months before the children were returned. After Anthony's second injury, Judy said that she was overwhelmed and didn't have the supports she needed.

Mikwan and his siblings were returned home five weeks after their parents completed addictions treatment. During this time Fiona had her seventh child. Fiona and Justin separated approximately two months after the children were returned.

Serious Case Reviews in the United Kingdom revealed deficits in the knowledge and skills of professionals serving families who struggle with substance use. Babies of parents with addictions are especially vulnerable and services must support the parents' recovery while strengthening the connection between parents and infants.[39] In two previous Investigative Reviews, "*9-Year-Old Bonita*" and "*10-Month-Old Lily*", the Advocate recommended more support to help caseworkers and other front-line service providers help families affected by substance use.[40,41]

35 Fernandez & Lee, 2013.

36 Dawe, Harnett & Frye, 2008.

37 Neger & Prinz, 2015.

38 Dawe & Harnett, 2007.

39 Rayns, Dawe & Cuthbert, 2013.

40 Office of the Child and Youth Advocate - Alberta, 2016.

41 Office of the Child and Youth Advocate - Alberta, 2015.

The Advocate is not making any new recommendations on the issue of addressing parental substance abuse. Implementation of previously made recommendations is in progress and it is imperative that these improvements continue. Previous recommendations and Ministry responses can be found in Appendix 4.

Child-Parent Relationships

Child-parent relationships are a critical factor to consider when children are being returned to family. Sarah, Anthony and Mikwan spent most of their lives in care and did not have the opportunity to form strong connections with their mothers.

When she was newborn, Sarah was moved among her parents and relatives, and then was taken into care. She was in her third placement by her first birthday. Sarah was difficult to soothe and she required exceptional parenting supported by services in the community. Sarah had been in care for almost four years before she was returned to her mother.

Anthony and Mikwan were taken into care shortly after their birth. When they were newborns, they bonded with their foster parents. Both were in foster care for just over one year when they were returned to their parents.

When young children are returned to family, they may miss their foster parents and express this. Children under two years old may cry excessively and be difficult to console; children between two and five years old may regress with feeding and toileting, have bad dreams and temper tantrums.[42] Depending on the parent's capacity and supports, they may become overwhelmed, increasing the risk for abuse.[43] Foster parents can ease the transition by working with birth parents before and after children return home.[44]

Children's Unique Needs

Some children may have attributes that place them more at risk than others and a thorough assessment of each child's unique needs and role in the family is essential. In these circumstances, Sarah, Anthony and Mikwan had exceptional needs that required patient caregivers. Challenges were identified indicating that their parents required intensive support so that they could feel confident and successful caring for their

42 Ann & Robert H. Lurie Children's Hospital of Chicago, Berrier (as cited in the Office of the Children's Advocate – Manitoba, 2016).

43 Thoburn, Robinson & Anderson, 2012.

44 Thoburn, 2009.

children. Appropriate post-return supports must be provided and tailored to each child's unique needs.

Children who are underweight at birth, who require special care or who are affected by maternal substance use are at highest risk for maltreatment. [45]

> Sarah was born prematurely and had language delays that caused her to act out in frustration. Her foster parents accessed services and used strategies to help her through her difficulties. In the months after Sarah returned to her mother, child specific supports were discontinued. The focus shifted to programs that her mother had enrolled herself in and Sarah was isolated with no connections to services and supports.
>
> Anthony and Mikwan had pre-natal exposure to drugs. Both received specialized care from their foster parents that helped them meet developmental milestones. After they returned to family, Anthony and Mikwan were not involved with any specialized supports.

In addition to child-specific information, both Anthony's and Sarah's mothers completed parenting assessments which provided insight into their ability to meet their children's needs.

> Sarah's mother completed two parenting assessments that identified difficulties in her relationship with Sarah and her tendency to become angry when she was stressed.
>
> Anthony's mother completed a parenting assessment that indicated that she did not have a secure attachment to her children. She had rigid expectations of their behaviours and tended to isolate herself.

Research supports that children should be returned through a gradual, staged process. Families with three or more children are at higher risk to have their reunification fail, and they require a more phased transition with outside child-care support for the parents.[46] After the children are reunified with their families, supports and monitoring should ideally continue for a year.[47]

45 Sidebotham, et al, 2016.

46 Barth, Weigensberg. Fisher, Fetrow & Green, 2007.

47 National Society for the Prevention of Cruelty to Children, 2012.

It can be challenging for child intervention workers to focus on ongoing risk assessment after children have returned to their parents.[48] Child welfare systems are typically driven by goals to reduce the number of children in their care so the decision to take children back into care may cause hesitation. Parents may feel caught between needing ongoing support and wanting child welfare out of their lives. Information about a child's risk or safety may not be shared or it may be minimized until, in extreme circumstances, a harmful event happens.

In order to prevent an "all or nothing" approach to returning children, caseworkers must be supported to build strong relationships with parents and have meaningful conversations about what is working. As families go through the transition of being reunified, parents might be having difficulty caring for some children over others. The relationship with their caseworker can make the difference between sharing their vulnerability and reaching out for help or concealing it while matters get worse.

Connections must also be in place for each child with relatives, school programs and other services outside of their home to inform caseworkers about how they are doing beyond the information that is provided by parents.

Practice frameworks guide caseworkers to make decisions for children in circumstances that are often complex and emotionally charged. In the United Kingdom, there is a framework to help caseworkers safely return children home. Evidence based research drawn from reunification successes and failures is being used to assess the attributes of each child and caregiver in the family. Parents with alcohol or drug problems are at high risk to harm or neglect their children after they are returned. Children who are very young or who have special developmental needs are vulnerable to future maltreatment and need more intensive supports when they are returned to their parents.[49]

In October of 2016, the Advocate released *"9-Month-Old Sharon: An Investigative Review."*[50] Sharon was in care for most of her short life and passed away after she and her five siblings were returned to their parents. The review identified the need for the Ministry of Children's 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.

48 National Society for the Prevention of Cruelty to Children, 2012.

49 Wilkins & Farmer, 2015.

50 Office of the Child and Youth Advocate - Alberta, 2016.

The recommendations were accepted, but as of July 5, 2017, the Ministry of Children's Services has not provided information regarding how they will be implemented. Given the relevance of the second recommendation from Sharon's report to the circumstances of Sarah, Anthony and Mikwan, the Advocate is again recommending:

Recommendation

The Ministry of Children's 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.

When young children are returned to family after spending their early years in care special attention must be paid, over a sustained period of time, to support the child-parent relationships and other unique needs.[51]

To help improve the effectiveness of Alberta's services to children, the Advocate is making the following new recommendations:

Recommendation 1

The Ministry of Children's Services and community partners should implement intensive, sustained plans to specifically support young children who are returned to family after being in care. Additional care should be taken with children who have disrupted attachments or developmental challenges.

Recommendation 2

The Ministry of Children's Services should implement a research based framework that guides casework through the reunification process with families including ongoing risk assessment and robust after-care plans that provide the level of supports the family requires.

51 National Society for the Prevention of Cruelty to Children, 2012.

Recommendation 3

The Ministry of Children's Services should ensure that children are returned to their families with a continuity of health, education and social supports comparable to what they received when they were in care.

CLOSING REMARKS

The loss of children to such tragic circumstances is incomprehensible. My condolences go out to those who loved them. These children had families and foster families who cared deeply about them and my thoughts are with them.

The situations that come to my attention unequivocally show that children are particularly vulnerable during periods of transition. Reunifying children with their parents is a new phase of involvement, not an ending.

Sarah's, Anthony's, Mikwan's and Sharon's parents worked hard to have their children returned to them. In all of these circumstances, there were risk factors that became apparent after the children were returned. The unique needs of each child must not be forgotten after they are returned to family. Ongoing assessment of safety and risk and the necessary supports the family requires must be looked at carefully.

I believe that children belong with family; and, I am concerned that the tendency following tragic situations such as these can lead to fewer children being reunited with family. The priority must be to work towards family health in a meaningful and sustained way. For this to happen, child intervention workers and their organizations must have the time, support, resources and capacity to work in a more relational manner with the children and families they serve.

Our government must take action on the many recommendations made to improve the lives of children and prevent these tragedies.

Finally, I hope that Albertans will honour these children and their families by having respectful and thoughtful dialogue about how to improve the ways that we attend to the safety and well-being of our most vulnerable citizens—our children.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate

APPENDICES

APPENDIX 4: PREVIOUS INVESTIGATIVE REVIEW RECOMMENDATIONS RELEVANT TO SARAH, ANTHONY AND MIKWAN

Voices for Change: Aboriginal Child Welfare in Alberta, A Special Report (July 2016)

Recommendation 3

The Ministry of Human Services should provide the resources and supports for Aboriginal communities to ensure delivery of child welfare services to their children and families by:

Establishing a range of services from prevention, through intervention and aftercare for Aboriginal children and families who come into contact with the child welfare system.

Ministry Response: As of July 5, 2017, the ministry has not responded the report.

Progress Identified by the Advocate: Progress has not been reported.

10-Month-Old Lily: An Investigative Review (March 2016)

Recommendation 1

The Ministry of Human Services should ensure that ongoing support and mentorship is provided to frontline workers to assist in the creation and planning of protective support networks for children living with parents who have addictions.

Ministry Response (June 2016): The ministry accepts the recommendation. Actions are underway to support the implementation of the recommendations and their expected outcomes to improve service delivery and support positive outcomes for children, youth, families and their communities.

The Child Intervention Practice Framework (CIPF), associated practice strategies, tools, Signs of Safety and collaborative service delivery support front-line service delivery staff in gathering information, thinking critically, and reviewing and responding to

the needs of children and families. This includes the tools and resources necessary to develop collaborative, inclusive safety plans with children, families, extended family members and other natural supports and community stakeholders. These plans must address the safety needs of the child and build a support network to increase the family's capacity to meet their child's needs on an ongoing basis.

Safety plans focus on maintaining the child's safety and well-being and include actions to mitigate risk. The plans identify persons responsible for taking specific actions should the risk for a child increase or harm occur. Safety plans are strengths-based and focus on the needs of the child, including, but not limited to, the exposure to and impacts of parental mental health and addictions, domestic violence, and access to or availability of basic needs, including food, clothing and housing.

The CIPF is in year two of a five-year implementation plan to support provincial integration. The CIPF and associated practice strategies training have been delivered across the province and are now integrated into required training for new staff. Additionally, over 80 per cent of the province has minimally completed the two-day basic Signs of Safety training. Enhanced training, including the use of safety mapping tools and the provision of supervisory supports and ongoing mentoring opportunities, will continue over the 2016/2017 fiscal year.

Progress Identified by the Advocate: Progress as of March 31, 2017, has not been reported.

9-Year-Old Bonita: Serious Injury, An Investigative Review (May 2015)

Recommendation 3:

A) The Ministry of Human Services, with its service delivery partners, should develop a Memorandum of Understanding (MOU) and/or protocol to work together so addictions expertise and consultation is provided to frontline child intervention workers who are working with families where addictions concerns are present; and

B) The Ministry of Human Services should dedicate resources to increase frontline workers' knowledge of addictions and the impact parental addictions has on children.

Ministry Response (December 2015): The ministry accepts the recommendation. A similar recommendation was previously made and accepted in the Advocate's *Remembering Brian* report (June 2013). Human Services is an active participant with Health in the Addictions and Mental Health Strategy and continues with the comprehensive review of staff training including material, training and tools to support staff to meet the needs of the children, youth and families they serve.

March 2016 Update: A Youth Addiction and Mental Health Web Portal is being developed with the intent to launch phase 1 in May 2016. The Children's Mental Health Series is available on the Children's Services public website for front-line service delivery staff, families, caregivers and professionals and was televised on SHAW cable in Edmonton, Red Deer and Fort McMurray.

A Foundations of Caregiver Support (FCS) document will provide vision and purpose in supporting the interactions of a wide-range of caregivers with infants, children and youth. The FCS will be incorporated into caregiver training (the core story, grief and loss, child development and trauma) and will support healthy child development, create connections for infants, children and youth receiving child intervention services, and assist them through the grieving process—all of which are relevant to understanding and supporting families impacted by additions and children exposed to parental addictions. Developing case plans, and negotiating services and supports based on an understanding trauma, grief and loss is integral to supporting children receiving services and where their safety and well-being has been compromised through parental addictions.

Progress Identified by the Advocate: There is some progress on this recommendation with the planned development of the Youth Addiction and Mental Health Web Portal.

Information about recommendations, responses to recommendations and implementation progress updates can be found at the following links:

Previously released Investigative Reviews are posted at:
http://www.ocya.alberta.ca/adult/publications/investigative-review/

The Ministry of Children's Services publicly responds to recommendations at:
http://www.humanservices.alberta.ca/publications/15896.html

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

APPENDIX 5: 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 British Columbia 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 (Anthony's Committee)

Elder Bottle is a member of the Blood Tribe where he was a member of Chief and Council for 24 consecutive years. Elder Bottle 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.

Elder Charles Wood (Sarah's and Mikwan's Committees)

Elder Wood is a Cree Elder from Saddle Lake Cree Nation. He is on the Board of Governors for the Blue Quills University and has been an advocate for First Nations education for many decades. He is a former Chief of the Saddle Lake Cree Nation and is Chair of the Remembering the Children Society, that works to identify children in unmarked cemeteries who died while attending residential school as well as memorializing these sites.

Dr. Maggie Hodgson (Hon) (Sarah's and Mikwan's Committees)

Dr. Hodgson is the Founder of Healing Our Spirit Worldwide and National Addictions Week/Keep the Circle Strong. She grew Nechi Alcohol and Drug Training Centre into a world class Indigenous health promotions, family wellness and addictions Institute. She is a member of the Nadleh Whut'en First Nation. She has worked in the area of addictions for 36 years as well as working with families, young offenders, criminal courts and civil court. She has a deep understanding of traditional knowledge, ceremony and identity. She helps re-connect community members to resources to walk with them as they strengthen their road forward.

Rhonda Barraclough, BSW, M.Ed (Anthony's Committee)

Ms. Barraclough is the Executive Director of ALIGN Association of Community Services. She has a Bachelor of Social Work degree from the University of Calgary and a Masters of Adult Education in Public Policy from the University of Alberta. She has experience in planning, strategic direction and facilitation and encourages agencies and government to work toward excellence in child welfare.

Lionel Dibden, MB BCh, FRCP(C) (Sarah's, Mikwan's and Anthony's Committees)

Dr. Dibden is an expert in the field of child maltreatment and is currently an Associate Professor at the University of Alberta in the Department of Paediatrics. He participated in the development and implementation of the Child and Adolescent Protection Centre (CAP Centre) at the Stollery Children's Hospital. He served for three years as the Chair of the Child and Family Services Council for Quality Assurance with the Ministry of Human Services.

Donna Jamieson, M.Ed., CCYC (Anthony's Committee)

Ms. Jamieson is an Assistant Professor and Chair of the Bachelor of Child and Youth Care Program at MacEwan University. She supervised an Alberta government program that provided assessment and intervention for "high risk" families and developed and delivered a variety of treatment groups for families where abuse or neglect was a concern. She managed a multi-disciplinary team that provided consultation and parenting capacity assessments of complex families involved with the Ministry of Children's Services.

David McConnell, PhD (Sarah's Committee)

Dr. McConnell is a Professor and the Director of the Family and Disability Studies Research Initiative at the University of Alberta. His research focuses on the nexus between family, life-long disability and human service systems. He is Chair of the International Association for the Scientific Study of Intellectual and Developmental Disability Special Interest Research Group on Parents and Parenting. He has conducted research on decision-making in child welfare matters and co-authored numerous scientific papers.

Tanya Pace-Crosschild, B.Sc., MPA (Sarah's Committee)

Ms. Pace-Crosschild is a member of the Kainai Nation of the Blackfoot Confederacy. She is an advocate for Indigenous children and families and has been a dedicated leader of Opokaa'sin Early Intervention Society, which is a strength-based service agency that incorporates child and family services approaches through a cultural lens. She has a dedicated passion for community that includes many community board memberships and advisory committees.

Sharon Steinhauer, MSW RSW (Sarah's and Mikwan's Committees)

Ms. Steinhauer is the program lead for Social Work at the University nuhelot'įne thaiyots'į nistameyimâkanak Blue Quills. Blue Quills is committed to reclaiming Indigenous knowledge and practice and has established programs that students of all cultures describe as transformative; influenced significantly by the relational practice of engaging in circles to build common ground. She has proven leadership in prevention programs and asset-based community development and has completed work in the area of restoring families and communities to health.

Cheryl Whiskeyjack, CYC (Anthony's Committee)

Ms. Whiskeyjack is the Executive Director of the Bent Arrow Traditional Healing Society. She has a Diploma in Child and Youth Care from Grant MacEwan University, and a Certificate in Indigenous Leadership & Governance from the Banff Centre. She was a participant at the Aboriginal Round Table for the Mayor's Taskforce on Poverty Elimination, participated in training with the Edmonton Police Service in preparation for the Truth & Reconciliation National Event and presented at the National St Vincent de Paul Conference on "Making Successful Transitions."

Dr. Sonya Vellet (Mikwan's Committee)

Dr. Vellet a is Registered Psychologist who specializes in the areas of child psychology, infant and early childhood mental health, and caregiver-infant/child attachment. She provides assessment and therapy to parents (including foster and adoptive parents) whose infants/children have challenges with behaviour, development, and attachment. She also offers training and supervision to professionals in infant and early childhood mental health and parent-child attachment.

APPENDIX 6: GLOSSARY OF TERMS

Caseworker	A child intervention worker—for the purposes of this report, this term describes all front-line child intervention workers (includes assessors, intake workers, caseworkers; anyone who performs tasks addressed in the Enhancement Policy).
Child Intervention Services	Any services provided to a child or family in accordance with the *Enhancement Act*, excluding Part 2 (adoptions) or Part 3 (licensing of residential facilities).
Child Maltreatment	Sometimes referred to as child abuse and neglect, includes all forms of physical and emotional ill-treatment that results in actual or potential harm to the child's health, development or dignity.
Depression	A mood disorder that causes a persistent feeling of sadness and loss of interest. Also called major depressive disorder or clinical depression, it affects how a person feels, thinks and behaves and can lead to a variety of emotional and physical problems.
Drug Test/Screen	A toxicology screening on a sample (usually urine or hair) to determine if an individual has used a substance.
Early Intervention Services	Programs that provide support, education and information to families with children who are three to five years old and have two or more developmental concerns or disabilities.
Family Enhancement Agreement or Enhancement Agreement	A voluntary agreement with Child Intervention Services to provide supports, and intended to address protection concerns, while the child remains with their guardian or lives independently. The Agreement can be with a guardian or a young person between the ages of 16 and 18 years. Prior to the *Enhancement Act*, this was referred to as a Support Agreement.

Family Group Conference	A formal meeting between family members and caseworkers regarding the care and protection of a child.
Foster Home	A family home (facility) licensed in accordance with the *Enhancement Act* that provides an approved placement for a child or youth in the care of the Director. Foster parents must complete formal training.
Group Home	A residential placement staffed by childcare workers that provides an approved placement for the child or youth in the care of the Director.
In Care	The Director has custody and/or guardianship of a child and the child is placed outside their parents' care in Delegated First Nation Agency and Child and Family Services approved placements.
Indigenous	Originating in and characteristic of a particular region or country; pertaining to, or concerned with the Aboriginal inhabitants of a region. Includes Treaty Status, potential to be registered, non-status, Métis and Inuit.
Investigation	Currently referred to as an Assessment. This was the language used in the child welfare legislation prior to the *Enhancement Act*.
Kinship Care	A placement outside of the parental home with relatives or members from a child's community who are approved by Child Intervention Services to care for a specified child(ren).
Permanent Guardianship Order	The Director is the sole guardian of the child. This order is sought when it is believed that the child cannot be safely returned to their guardian within a specified period of time.

Safety Phase Assessment	The gathering and analysis of information (investigation) to determine if a child is in need of intervention in accordance with the *Enhancement Act*. This phase follows the Intake or Screening.
Signs of Safety	A strengths-based, safety-organized approach to child protection casework focusing upon risk assessment and the integration of professional knowledge with local family and cultural knowledge. The goal is to form partnerships with families in order to enhance safety and reduce risk.
Supervision Order	The court grants mandatory supervision of a child to the Director. Guardianship and custody of the child remains with the family/guardian.
Temporary Guardianship Order	An Order in which the court awards custody and guardianship to the Director for a specified period of time. This order is sought when it is believed that the child can be safely returned to their guardian.

APPENDIX 7: BIBLIOGRAPHY

Alberta Human Services. (2011). Intervention Section, Chapter 3: Casework Practice, Subsection 3.2.4: Leaving the Care and Custody of the Director. *Enhancement Act Policy Manual*. Edmonton, AB: Author. Retrieved from: http://www.humanservices.alberta.ca/documents/Enhancement-Act-Policy-Manual.pdf

Alberta Human Services. (2011). Intervention Section, Chapter 4: Assessment and Planning Tools, Subsection 4.2.3: Concurrent Plan. *Enhancement Act Policy Manual.* Edmonton, AB: Author. Retrieved from: http://www.humanservices.alberta.ca/documents/Enhancement-Act-Policy-Manual.pdf

Algood, C.L., Hong, J.S., Gourdine, R.M., & Williams, A. (2011). Maltreatment of children with developmental disabilities: An ecological system analysis. *Children and Youth Services Review, 33*(7), 1142-1148. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0190740911000387

Auditor General of Alberta. (2016). *Report of the Auditor General of Alberta: Human Services – Systems to Deliver Child and Family Services to Indigenous Children in Alberta.* Retrieved from: http://www.oag.ab.ca/webfiles/reports/July2016HSReport.pdf

Barth, R.P., Weigensberg, E.C., Fisher, P.A., Fetrow, B., & Green, R.L. (2008). Reentry of elementary aged children following reunification from foster care. *Children and Youth Services Review, 30*(4), 353-364. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134969/

Benoit, D. & Madigan, S. (2010). *Attachment Part One: The dance of relationship.* AboutKidsHealth. Retrieved from: http://www.aboutkidshealth.ca/En/News/Series/Attachment/Pages/Attachment-Part-One-The-dance-of-relationship.aspx

Bernheimer, L.P. & Weisner, T.S. (2007). "Let me just tell you what I do all day…": The family story at the center of intervention research and practice. *Infants & Young Children, 20*(3), 192-201. Retrieved from: https://depts.washington.edu/isei/iyc/20.3_bernheimer.pdf

Carlson, B., Smith, C., Matto, H., & Eversman, M. (2008). Reunification with children in the context of maternal recovery from drug abuse. *Families in Society: The Journal of Contemporary Social Services, 89*(2), 253-263. Retrieved from: http://familiesinsocietyjournal.org/doi/abs/10.1606/1044-3894.3741?code=afcf-site

Child, Youth and Family Enhancement Act, Revised Statues of Alberta 2000, Chapter C-12; current as of January 1, 2017. Alberta Queen's Printer. Retrieved from: http://www.qp.alberta.ca/documents/Acts/c12.pdf

Dawe, S. & Harnett, P. (2007). Reducing potential for child abuse among methadone-maintained parents: Results from a randomized control trial. *Journal of Substance Abuse Treatment, 32*(4), 381-390. Retrieved from: http://www.sciencedirect.com/science/article/pii/S0740547206003357

Dawe, S., Harnett, P., & Frye, S. (2008). Improving outcomes for children living in families with substance misuse: What do we know and what should we do. *Australian Institute of Family Studies, 29*. Retrieved from: https://aifs.gov.au/cfca/publications/improving-outcomes-children-living-families-pare

Farmer, E. & Wijedasa, D. (2013). The reunification of looked after children with their parents: What contributes to return stability. *British Journal of Social Work, 43*(8), 1611-1629. Retrieved from: https://academic.oup.com/bjsw/article-lookup/doi/10.1093/bjsw/bcs066

Fernandez, E. & Lee, J-S. (2013). Accomplishing family reunification for children in care: An Australian study. *Children and Youth Services Review, 35*(9),1374-1384. Retrieved from: https://www.researchgate.net/publication/257042985_Accomplishing_family_reunification_for_children_in_care_An_Australian_study

Johnson, C.P. & Blasco, P.A. (1997). Infant growth and development. *Pediatrics in Review, 18*(7), 224-242. Retrieved from: http://www.uthsc.edu/pediatrics/clerkship/docs/Infant_Growth_and_Development.pdf

Miller, K.A., Fisher, P.A., Fetrow, B., & Jordan, K. (2006). Trouble on the journey home: Reunification failures in foster care. *Children and Youth Services Review, 28*(3), 260-274. Retrieved from: http://www.sciencedirect.com/science/article/pii/S019074090500099X

Neger, E. & Prinz, R. (2015). Interventions to address parenting and parental substance abuse: Conceptual and methodological considerations. *Clinical Psychology Review, 39*, 71-82. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4464898/

NSPCC. (2012). *Returning home from care: What's best for children*. National Society for the Prevention of Cruelty to Children. Retrieved from: https://www.nspcc.org.uk/services-and-resources/research-and-resources/pre-2013/returning-home-from-care/

Office of the Children's Advocate – Manitoba. (2016). *Don't Call Me Resilient: What Loss & Grief Look Like for Children and Youth In Care*. Retrieved from: http://www.childrensadvocate.mb.ca/wp-content/uploads/Loss-and-Grief-FINAL-web.pdf

Office of the Child and Youth Advocate – Alberta. (2015). *9-Year-Old Bonita: Serious Injury. An Investigative Review*. Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_9-Year-Old-Bonita_2015May27.pdf

Office of the Child and Youth Advocate – Alberta. (2016). *9-Month-Old Sharon: An Investigative Review.* Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wpcontent/uploads/2014/08/InvRev_9-Month-Old-Sharon_2016November.pdf

Office of the Child and Youth Advocate – Alberta. (2016). *10-Month-Old Lily: An Investigative Review*. Edmonton, AB: Author. Retrievable from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/InvRev_10-Month-Old-Lily_2016March.pdf

Office of the Child and Youth Advocate – Alberta. (2016). *Voices for Change: Aboriginal Child Welfare in Alberta – A Special Report*. Edmonton, AB. Retrieved from: http://www.ocya.alberta.ca/wp-content/uploads/2014/08/SpRpt_2016July_VoicesForChange_v2.pdf

Rayns, G., Dawe, S., & Cuthbert, C. (2013). *All babies count: Spotlight on drugs and alcohol*. National Society for the Prevention of Cruelty to Children. Retrieved from: https://www.nspcc.org.uk/services-and-resources/research-and-resources/2013/all-babies-count-drug-alcohol/

Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Garstang, J., Harrison, E.,... Sorensen. P. (2016). *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014*. London: Department for Education. Retrieved from: http://wrap.warwick.ac.uk/84285/3/WRAP_Triennial%20Analysis%20of%20SCRs%202011-2014%20-%20%20Pathways%20to%20harm%20and%20protection.pdf

Thoburn, J. (2009). *Reunification of children in out-of-home care to birth parents or relatives: A synthesis of the evidence on processes, practice, and outcomes*. Report for the German Youth Institute. Retrieved from: http://www.dji.de/fileadmin/user_upload/pkh/expertise_dji_thoburn_reunification.pdf

Thoburn, J., Robinson, J., & Anderson, B. (2012). *Returning children home from public care*. Social Care Institute for Excellence. Retrieved from: http://www.scie.org.uk/publications/briefings/briefing42/

University of Minnesota. (2013). *CW 360°: A comprehensive look at a prevalent child welfare issue*. The Intersection of Child Welfare and Disability: Focus on Children. Center for Advanced Studies in Child Welfare. Retrieved from: http://cascw.umn.edu/wp-content/uploads/2013/12/Spring2013_360_web-FINAL.pdf

Wade, J., Biehal, N., Farrelly, N., & Sinclair, I. (2010). *Maltreated children in the looked after system: A comparison of outcomes for those who go home and those who do not.* Social Policy Research Unit: University of York. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/267061/DFE-RBX-10-06-1.pdf

Weisner, T.S., Matheson, C., Coots, J., & Bernheimer, L.P. (2005). Sustainability of daily routines as a family outcome. In A.E. Maynard & M.I. Martini (Ed.), *Learning in cultural context: Family, peers, and school* (pp. 41-73). New York, NY: Kluwer Academic/Plenum Publishers. Retrieved from: https://www.researchgate.net/profile/Thomas_Weisner/publication/227222967_Sustainability_of_Daily_Routines_as_a_Family_Outcome/links/09e4150e3bf966951c000000.pdf

Wilkins, M. & Farmer, E. (2015). *Reunification: An evidence-informed framework for return home practice*. NSPCC. Retrieved from: https://www.nspcc.org.uk/globalassets/documents/research-reports/reunification-practice-framework-guidance.pdf

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2-YEAR-OLD ANTHONY
1-YEAR-OLD MIKWAN

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