Alberta Human Services

CHILD INTERVENTION DEATH REVIEW PROCESS

Human Services leadership and staff are committed to continuously improving our system to support the safety and well-being of children receiving child intervention services.

When there are incidents involving the death of a young person in care or receiving services, a number of steps are taken to ensure the immediate needs of any people involved are supported, and that the incident is thoroughly reviewed externally and internally.

If a child or youth dies while in care or receiving services:

- Child intervention workers offer family members support and if required, referrals for family and/or individual counselling.
- Family members are assisted with arranging the funeral and contacting extended family members. Basic funeral costs are paid for children in care.
- Child intervention workers and caregivers are offered group debriefing as well as assistance in arranging independent individual counselling.
- The ministry provides assistance as needed with any police investigation.

Who investigates and examines deaths of children and youth in care?

Deaths of children in care are examined by a number of external and internal bodies, including:

1. The Office of the Chief Medical Examiner

- The Office of the Chief Medical Examiner must be notified whenever there is a death of a child who was involved with the ministry.
- The Office of the Chief Medical Examiner conducts an investigation whenever a child's death occurs suddenly or cannot be explained, or when the child is in the care or custody of Human Services.
- The investigation is held to determine general circumstances around the child's death.
- Over the last 10 years, causes of death for children in care as determined by the Chief Medical Examiner are:
  - medical (includes congenital anomalies, health conditions and disease) – 49%
  - accidental – 16%
  - undetermined (may include Sudden Infant Death Syndrome) – 13%
  - suicide – 10%
  - homicide – 10%
  - pending – 2%

2. Fatality Review Board

- All deaths of children in care must also be reviewed by the Fatality Review Board for consideration for a public fatality inquiry unless the board is satisfied that the death was due to natural causes.
- The Fatality Review Board may recommend a public fatality inquiry if there is a possibility of preventing similar deaths in the future or if there is a need for public protection or clarification of circumstances surrounding a case.

- The Minister of Justice and Solicitor General calls the fatality inquiry, which is a public process overseen by a judge. The inquiry establishes cause, manner, time, place and circumstances of death, as well as the identity of the deceased.
- Judges may make recommendations to prevent similar occurrences, but are prohibited from making findings of legal responsibility.
- The Fatality Inquiries Act requires that a written report is made available to the public. The ministry provides a written public response to each report.

3. Child and Youth Advocate (CYA)

- The Statutory Director notifies the Child and Youth Advocate whenever there is a serious injury or death involving a child receiving services.
- The CYA may conduct their own investigation if they believe it will be in the best interest of the public.
- A report must be provided to the Legislature. The ministry provides a written public response to each report.

4. Child and Family Services Council for Quality Assurance (CQA)

- The CQA is a multidisciplinary body of experts who work with the Ministry to identify effective practices and make recommendations to the Minister for improving and strengthening child intervention services.
- The Statutory Director notifies the CQA of all serious injuries and deaths of children in care.
- The CQA may recommend that the Minister appoint a panel of experts to review the circumstances surrounding the incident to assist in identifying potential improvements to the system.

5. Internal Examination by Ministry staff

- Whenever there is an injury or death of a child receiving services, an internal examination of the circumstances is conducted to determine if improvements can be made to the child intervention system.
- This could include examining files and talking to staff about the services and supports provided to the child.
- Based on the findings of this process, decisions are made to determine if any immediate changes need to be made in policy or practice that could help prevent a similar incident.
- In addition, case specific actions may be taken to support the immediate safety and well-being of the child or other children.

What happens with the findings and recommendations from the various reviews and investigations?

The ministry is committed to sharing learnings with staff throughout the organization and ensuring that staff are provided with opportunities to learn from real situations.

Learnings can be shared through correspondence and meetings with staff, policy directives, updates to the Enhancement Policy Manual, and/or new or enhanced training.

All recommendations are reviewed and accepted recommendations are tracked for implementation and alignment with Ministry policies, legislation reviews and case practice initiatives.