Findings of the External Expert Panel

Regarding the

Death of a Young Child

Closing the Inter-Systems Gaps
to Keep Alberta's Children Safe

Panel Members: Gayla Rogers (Chair)
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EXECUTIVE SUMMARY

Case Overview

In early May 2010, a young Child of approximately one year of age was taken from a home to the Alberta Children's Hospital (ACH) by Calgary Emergency Medical Services (EMS) and pronounced dead (61 days from the time the Child was first seen at Alberta Children's Hospital).

The Child had been the subject of an assessment by the Calgary and Area Child and Family Services Authority (CFSA) since mid March 2010, when the CFSA Social Services Response Team (SSRT) received a call (Day 13). The referral source had concerns about who was caring for the Child, and reported that the Child had been diagnosed with two broken limbs. During the 49 days that the Child's case was active with CFSA, the Alberta Children's Hospital, through Alberta Health Services (AHS), and the Calgary Police Service (CPS) were involved. Four broken bones on four separate limbs were eventually diagnosed. An initial safety plan first restricted the Child's siblings from caring for the Child, and was later updated to specify that only the primary care-giving Parent (primary Parent) would look after the Child. In review, the panel identified inter-system barriers and gaps, process delays, deficiencies in contextualizing the findings and family history, cumbersome case documenting processes, miscommunications between systems, and inadequate critical thinking.

Recommendations

1. CFSA, AHS and CPS work together to develop protocols, effective relationships and communication pathways, to enhance interdisciplinary and inter-system cooperation and collaboration, and develop a shared mandate for the well-being and safety of vulnerable children.

2. The Alberta Government provide a framework for enhanced inter-ministry and inter-department collaboration among groups including, but not limited to, Alberta Children and Youth Services (ACYS), Alberta Health Services, and Solicitor General and Public Security to share in a vision and mandate to keep Alberta's vulnerable children and families safe.

3. ACYS adopt a critical incident review process conducted by an independent panel of experts.

4. The Alberta Government enact legislation similar to Section 9 of the Alberta Evidence Act that protects information provided in quality improvement reviews conducted for Alberta Health Services.

5. ACYS institute a formal protocol and process when a case is considered ‘complex and challenging’.

6. As a further check and balance, ACYS take steps to identify leading edge, effective, well-researched and accepted child at-risk and family violence risk assessment tools and consider embedding these within the current casework practice model.

7. The Child Abuse Case Conference becomes a pivotal meeting that results in clarity of language around the mechanism of injury and agreed-upon next steps with a written summary that is shared with all participants.

8. ACYS develop and implement a functional electronic file system instead of a combination of handwriting and typing, including forms that are easy to read.

9. ACYS incorporate learning from adverse events and critical incidents through subsequent process and practice reviews, program evaluations and redesign as needed.

10. ACYS implement a critical response protocol for staff when a tragic event occurs.

11. Action on the recommendations of the 2010 Review of the Child Intervention System continue to progress.

SECTION 1: BACKGROUND

1.1 Mandate of the Expert Panel

Honourable Yvonne Fritz, Minister of Children and Youth Services (ACYS), ordered a review in late May 2011 by an independent expert panel into the circumstances around the May 2010 death of the Child.

Minister Fritz appointed the panel to examine the Ministry's involvement with the Child from the time a case file was opened in mid March 2010 until the date of the Child's death 49 days later. The panel also reviewed the related involvement of both the Alberta Children's Hospital and Calgary Police Services Child Abuse Units.

Minister Fritz tasked the panel with a comprehensive review of the case leading up to the Child's death, with the expectation that the panel would identify lessons to be learned and make recommendations.

1.2 Members of the Panel

Dr. Gayla Rogers (Chair) – Professor & Former Dean, Faculty of Social Work, University of Calgary

David Findlay – Lawyer, Findlay Smith

Eric McDonald – Investigator, Calgary Police Service (retired)

Dr. Brent Scott – Director, Alberta Children's Hospital Research Institute for Child and Maternal Health

Donna Wallace – Director, Public Health Nursing, Alberta Health Services

1.3 Approach Used in the Review

From the start, the panel approached its work as a quality improvement process. There was no attempt to single out an individual for blame regarding the Child's death.

The ACYS opened up its files regarding the Child's death to the panel. The panel reviewed all the documents and notes made by the Child and Family Services Authority (CFSA) Assessor and by the supervisor and manager. This included the intake and investigation file, Calgary Police Service reports, the Alberta Children's Hospital Child Abuse Consultation Report, and the CFSA CEO File Review.

In addition, the panel was provided with and reviewed the following documents: Alberta Children and Youth Overview; Closing the Gap Between Vision and Reality, Final Report of the Alberta Child Intervention Review Panel; Government Response to the Child Intervention System Review; Child Youth and Family Enhancement Act; Protection Against Family Violence Act; materials from the Enhancement Act Policy Manual including samples of a Safety Assessment Record, a Detailed Assessment Record, the Screening Aid for Family Violence, a Casework Practice Model – Diagram, Commentary and Process Maps; information, materials and forms regarding Family Violence, Substance Abuse information and Reporting Deaths of Children.

Finally, the panel reviewed a Critical Incident Report draft document, a review of the case compiled by an internal committee of the ACYS Program Quality and Standards Branch.

1.4 Agencies and Principals Involved

The panel interviewed the professionals involved in the Child's case, who were all cooperative and forthcoming in providing information about their dealings with the Child and the family. The panel strove for an informal atmosphere in these interviews so a frank exchange of information could take place. This was not a legal enquiry, but rather a process focused on system and quality improvement.

The panel thanks all those who participated – it was clear that everyone the panel spoke with was impacted by the Child's death and supported the panel's efforts to understand the situation and learn from it.

For the Calgary and Area Family Services Authority, an operating arm of ACYS:

- Assessor
- Team Leader / Supervisor
- Manager, Multi-Service Team
- Manager, Multi-Service Team & Social Services Response Team
- Executive Manager
- Chief Executive Officer

For the Alberta Children's Hospital (ACH)

- Pediatrician

For the Calgary Police Service (CPS):

- Detective
- Staff Sergeant
- Inspector

SECTION 2: TIMELINE

Timeline of Substantive Events

# of Days	Remarks
August 2003 to November 2009	Calgary and Area Child and Family Services Authority (CFSA) document multiple involvements with the family, for a variety of issues primarily related to domestic violence. The majority of these events occurred prior to the birth of "the Child" when that family consisted of two biological parents and three biological children. These parents were not living together at the time of current case situation.
February 2009	The Child is born and is the biological offspring of the primary Parent and a parent unrelated to the other children. The primary Parent has day-to-day care of the Child and the other parent is not in the home.
1 Early March 2010	The primary Parent takes the young Child to the community-based family physician, as the Child is "fussy". Medication is prescribed for an ear infection. No contact with the CFSA at this time.
2-4	One of the Child's baby-sitters expresses concerns to the primary Parent, as the Child seems to be in pain. The baby-sitter asks the primary Parent to take the Child to the hospital for assessment.
5	The primary Parent takes the Child to Alberta Children's Hospital Emergency (ACH) as the Child continues to be "fussy". One of the Child's lower limbs is found to have been recently broken. The injury is described as a "toddler fracture". Treatment is provided and a follow-up orthopedic appointment is set for eight days later. No contact with the CFSA at this time.
13	The primary Parent takes the Child to the ACH for the follow-up appointment with an Orthopedic surgeon. At this time, the other of the Child's lower limbs is found to have been recently broken. No contact with the CFSA at this time.

First day of CFSA involvement in this matter	A baby-sitter of the child contacts the CFSA Social Services Response Team (SSRT) and expresses a concern regarding the un-explained broken bones. The historical CFSA file on the family is reviewed at this time and the case is sent to the CFSA Multi-Service Team for assessment.
14	After reviewing the information, the CFSA Team Leader / Supervisor assigns this referral to the CFSA Assessor as an emergency investigation. The CFSA Assessor conducts an interview with one of the Child's siblings at a school, and makes a home visit to interview another of the Child's siblings and the primary Parent. The CFSA Assessor then makes a visit to the home of another caregiver to the Child, in the company of the primary Parent, one of the Child's siblings and the Child, to observe interactions. The CFSA Assessor develops a safety plan to restrict the Child's caregivers to be adults only.
15	The CFSA Assessor attends a previously scheduled family physician medical appointment with the primary Parent and the Child. Following this appointment, the CSFA Assessor speaks with the S/Sgt of the CPS Child Abuse Unit. No CPS investigation is initiated at this time, absent a complaint of inflicted injury.
20-21	Attempts are made by the CFSA Assessor to have the Child examined by an ACH Pediatric Child Abuse specialist.
22	The CFSA Assessor speaks with an ACH Orthopedic surgeon who then makes a referral to the ACH Pediatric Child Abuse specialist. A follow up appointment is set for six days later.
28	The primary Parent and the Child attend an appointment with an ACH Pediatric Child Abuse specialist and at this time the specialist takes a family history from the primary Parent and orders a full skeletal examination and blood work for the Child. Following the appointment, the Pediatric Child Abuse specialist speaks with the CFSA Assessor by telephone and expresses an opinion that police should also be involved in the investigation of the matter. Following this, the CFSA Assessor contacts the S/Sgt of the CPS Child Abuse Unit and a Detective is assigned to the case.

38	The ACH Pediatric Child Abuse specialist receives the skeletal examination results.
42	The ACH Pediatric Child Abuse specialist contacts the CFSA and advises that the Child was found to have two newly identified broken bones on upper limbs, describing these injuries as “dated”. Following this, the CFSA Assessor meets with the CFSA Team Leader and the Multi-Service Team Manager. The CFSA Assessor contacts the primary Parent. The CFSA Assessor also contacts the CPS Child Abuse Unit Detective and discusses the case.
43	The CFSA Assessor meets with the primary Parent to discuss modifications to the safety plan for the care of the Child, requiring the primary Parent to be the sole caregiver.
45	With the CFSA Assessor observing, the CPS Child Abuse Unit Detective conducts interviews with two of the Child’s siblings and the primary Parent.
48	The CFSA Assessor, the CPS Detective and the Pediatric Child Abuse specialist meet for a Child Abuse Case Conference regarding the Child.
49-58	The CFSA Assessor has three telephone contacts with the primary Parent.
61	The Child, while in the care of the primary Parent and an acquaintance of the primary Parent, is taken to ACH Emergency by ambulance and pronounced dead at 4:41 a.m.

SECTION 3: RECOMMENDATIONS

The expert panel stresses that the following recommendations are offered in a quality improvement context. They are intended to stimulate changes in inter-system and inter-agency collaboration, case management practice, and organizational culture, ideally leading to a reduction of critical incidents.

Furthermore, the panel charges the Ministry with development of a two-year detailed action plan for implementation of these recommendations, including quarterly reports reviewing targets, progress, accomplishments, barriers, evaluation and next steps.

3.1 Inter-System Collaboration

In complex cases such as this, there needs to be an ability to make direct referrals between agencies and to have a high level of cooperation and collaboration among systems. Processes of how to work together effectively must be streamlined and made clear to the workers in the agencies and systems involved.

The panel recommends:

1. **CFSA, AHS and CPS work together to develop protocols, effective relationships and communication pathways, to enhance interdisciplinary and inter-system cooperation and collaboration, and develop a shared mandate for the well-being and safety of vulnerable children.**

For inter-agency work to be effective, relationships among workers are critical. This could include co-location of interdisciplinary teams, shared quality improvement activities, interdisciplinary continuing education, and critical incident reviews. With staff changing frequently, it is difficult to forge a trusting relationship among agency personnel. Joint training sessions between agencies may be useful to bring interdisciplinary workers together for particular topics and to build relationships and enhanced understanding of each other's roles. For example, FOIPP training can be provided in sessions with CFSA, health, educators and police workers together, so questions can be clarified and all agencies and systems are hearing the same information.

The panel supports initiatives currently in the planning and implementation stages under way in Calgary that will result in a more direct working relationship among the agencies and systems that have the same goal of protecting children at-risk. These include plans to co-locate CFSA workers and supervisors with CPS child abuse investigators in the very near future; the building of a co-location Child Abuse investigation centre (planning stage); as well as AVIRT (Alberta Vulnerable Infant Response Team), which has just started taking cases in June 2011.

For inter-system collaboration to be effective at the local level it needs to have a provincial framework, complete with funding and enabling legislation and strong leadership, to break down silos, bridge the gaps and remove the barriers of working together within government to put children first.

The panel recommends:

2. **The Alberta Government provide a framework for enhanced inter-ministry and inter-department collaboration among groups including, but not limited to, Alberta Children and Youth Services (ACYS), Alberta Health Services, and Solicitor General and Public Security to share in a vision and mandate to keep Alberta's vulnerable children and families safe.**

3.2 A Critical Incident Review Process External to Children and Youth Services

Critical incident reviews should lead to process change and systems improvement. Enabling legislation is required to make this work effectively.

The panel recommends:

3. **ACYS adopt a critical incident review process conducted by an independent panel of experts.**

This would be a change from the current practice where personnel from within the Ministry do such reviews. The panel believes there is a higher likelihood that outcomes of such reviews will lead to tangible change especially if there is a reporting requirement for implementing recommendations.

Reviews should include examining inter-system processes and interface; not be limited to process compliance, CFSA file notes and CFSA experience in isolation of the collaborating systems.

This requires enabling legislation, and therefore:

The panel recommends:

4. **The Alberta Government enact legislation similar to Section 9 of the Alberta Evidence Act that protects information provided in quality improvement reviews conducted for Alberta Health Services.**

A combination of independent expert review (transparency) and enabling legislation (quality improvement review) will enable staff from involved agencies and systems to speak frankly and without fear of system reprisal or litigation, about issues, shortcomings and challenges in the current practice environment. Then suggested changes to policies, practices and procedures

can be implemented to improve the quality of service and enhance the safety of children.

The reviews could be done by uniquely constituted panels (like this one) or could be completed under the auspices of a provincial Quality Assurance Council. This would comprise key internal and external experts from all sectors, including the Ministry, Alberta Health Services, Police, Justice, Academia, and possibly a consumer.

The committee's roles could include:

- Review of ACYS files where child safety concerns have been identified or when critical adverse events occur.
- Forward recommendations for implementation to the respective regional operation.
- Oversee the implementation of the accepted recommendations (quarterly reports back from accountable parties).
- Promote a culture where staff feel safe to report and discuss client safety.
- Develop strategies designed to facilitate learning from critical incidents.

A "Section 9" process should also be in place for inter-system quality improvement reviews conducted within the Children and Youth Services system. Section 9 legislation is designed to provide a confidential venue for investigation of critical incidents, whereby a review of structures, procedures and outcomes is conducted to determine if system factors have contributed to the adverse outcome.

The process is not designed to evaluate individual competence or performance. Recommendations for system improvement are made, along with who will be accountable for action on the recommendations. As this is about system effectiveness, individual conversations are not made public – they are protected by Section 9. Instead, the full recommendations are given first to the accountable agencies and then they become public when the investigation is completed.

Without this enabling legislation it will remain challenging to manage the information gleaned from such reviews in a way that promotes a culture of learning for individuals and the organizations involved that is reflective of the spirit of quality improvement.

The legislation will enable a responsible and productive quality improvement process involving various systems and disciplines, including but not limited to, Alberta Children and Youth Services, Alberta Health Services, and Solicitor General and Public Security—and all but the final recommendations should remain privileged.

3.3 Complex Cases Require More Consultation

All individuals who were interviewed by the Panel prefaced their remarks by saying that this was a very complex and challenging case.

The panel recommends:

5. **ACYS institute a formal protocol and process when a case is considered 'complex and challenging'.**

This could mean more frequent and closer supervision and consultation, enhanced critical thinking, more discussion with the professionals from the other systems including inter-disciplinary consultation and conferencing, and more monitoring generally. It is recognized that risk assessment and safety planning are done within dynamic situations; therefore, the plans should be re-evaluated at more frequent intervals.

The system is designed to have Supervisors and Managers who support the Assessor and oversee their work, and either back up their decisions or to over-ride them. Supervisors in turn have Managers to do the same. The Casework Practice Model has the checks and balances embedded in its approach. This recommendation suggests a further step in complex cases along with the necessary training for its effective execution.

Child intervention investigation and case management is challenging work, dealing with emotionally charged and fluid relationship-based situations that can be challenging to the critical thinking process. Actuarial or narrative risk assessment tools are available, and are designed to identify the case specific critical issues and help the user see the broader picture and react most appropriately when safety planning.

The panel recommends:

6. **ACYS takes steps to identify leading edge, effective, well-researched and accepted child at-risk and family violence risk assessment tools and consider embedding these within the current case practice model**.

The effective use of such tools offers a further check and balance strategy to support critical thinking and decision making for Assessors, Team Leaders and Managers.

3.4 The Child Abuse Case Conference: Clear Outcomes and Accountabilities

The panel believes it is important and necessary that each participant of a Child Abuse Case Conference, representing their respective discipline and system, has a professional responsibility to contribute to the recommendations for the child's safety.

The panel recommends:

7. **The Child Abuse Case Conference becomes a pivotal meeting that results in clarity of language around the mechanism of injury and agreed-upon next steps with a written summary that is shared with all participants.**

The panel recommends two people from CFSA, the Assessor and an experienced leader, (manager-level) should attend the Child Abuse Case Conference. The CFSA Manager should chair the conference and have the accountability to clarify objectives for the meeting at the outset, to document agreed upon next steps, and to ensure that all the professionals participating in the case conference receive the written summary document.

Proposed terms of reference for the Child Abuse Case Conference include:

a) A collective responsibility for clearly stating that the mechanism of injury is either reasonably explained, non-accidental/inflicted, or suspicious of abuse;
b) If the injury is inflicted or abuse is suspected, identify the individuals, situations and factors that are perceived to be contributing to the risk profile and critically assess the risk as low, moderate or high;
c) Indicate whether a police investigation is required, or is already underway;
d) Critically review key elements of the CFSA safety plan to determine whether it is perceived to be sufficient.
e) A written summary of the case conference discussion including all decisions, areas of agreement, diverging opinions, next steps and accountabilities are provided to each participant.
f) The written summary of the case conference is provided to and critically discussed with the supervisors of each participating discipline and system.

The panel understands this case conference can be held despite the perceived limitations of *Freedom of Information and Protection of Privacy Act* (FOIPP). There should be no reason for FOIPP or Health Information Act issues to be a barrier to information sharing. All participating professionals must have the information they need to make the best decision for the safety of the child. It may be that education about FOIPP and other like legislations needs to take place within and among the participating systems.

3.5 Electronic Case File Management

With the current case file reporting system, it would be difficult for anyone, including an Assessor, to quickly absorb and assimilate the previous investigation history. For those who have access to the file as it unfolds or for those reviewing the file after the fact, the structure of the electronic forms,

when printed, make them difficult to comprehend. The safety plans are an example. These should be easy to write and to read. In addition to supporting a clear picture of the family and the work that had been previously done, it would also support the Supervisors and Managers when assessing files.

The panel recommends:

8. **ACYS develop and implement a functional electronic file system instead of a combination of handwriting and typing, including forms that are easy to read.**

It might be designed in such a way that cases could not be closed or moved to another level unless certain critical decisions or actions had taken place; or, an indicator might appear if delays were occurring to remind and inform the Assessor, Case Worker, Team Leader / Supervisor and Manager. A summary sheet should also be included in the file for each intervention so Assessors and Team Leaders / Supervisors can easily review a chart with multiple interactions when an emergency investigation is required. This would start a new investigation with a clear understanding of past history.

3.6 Sustaining a Continuous Learning Environment

The panel recommends:

9. **ACYS incorporate learning from adverse events and critical incidents through subsequent process and practice reviews, program evaluations and redesign as needed.**

A variety of mechanisms can be adapted and utilized to create learning within the organization: team debriefings, case reviews, case studies, grand rounds, and other quality improvement exercises intended to adapt practices for continuous improvement in the areas of investigation, risk assessment, safety planning and collaboration.

A critical incident could be turned into a teachable moment with the right internal processes, critical incident reviews, and organizational culture. A new mechanism to incorporate ongoing learning should be embedded into the day-to-day practice and culture of the organization. This will result in improved processes, practices, and relationships between systems and ultimately the safety of children.

The stark reality of intervening in the lives of children and families with complex circumstances and challenging situations is that tragedies occur despite the best of intentions. Such tragedies impact the entire system – from the front line at the local office to senior leaders at the regional and provincial levels. This was evident to the panel as we conducted our review.

Critical incidents and tragic events can cause trauma, stress and strain at the individual level as well as affect the health and functioning of the unit.

The panel recommends:

10. **ACYS implement a critical response protocol for staff when a tragic event occurs.**

3.7 The Alberta Child Intervention Review Panel Report of June 2010

The panel identified some themes similar to those of the Alberta Child Intervention Review Panel Report of June 2010. The key findings from that report relevant to this review are related to quality assurance and capacity to change.

The panel recommends:

11. **Action on the recommendations of the 2010 review of the child intervention system continue to progress.**