Ministry of Children's Services Response to the T.R. Fatality Inquiry Report

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Alberta
Children's Services

Table of Contents

Background

The Ministry of Children's Services has carefully reviewed the Fatality Inquiry Report into the October 23, 2012 death of 15-year-old T.R., released on February 9, 2017.

The inquiry found that the cause of death was hanging and the manner of death was suicide. The child was in provincial government care at the time of death.

Fatality inquiries provide a valuable opportunity for an external review of tragic incidents involving individuals receiving services and supports from the ministry. The information in the fatality inquiry report has been reviewed and considered, and any learning has been shared with staff who support children and youth in care. The ministry response includes information gathered from a review of existing policies and current ministry initiatives related to issues identified in the report.

Response to Recommendations

The Fatality Inquiry Report makes two recommendations to support the prevention of similar deaths. The recommendations are aimed at improving information sharing between children, caregivers, and front-line staff.

Recommendation #1:

It is recommended that policies and practices be adopted to regularly remind children of the importance of sharing information with their caregivers about suicidal threats or comments by other children. It is recommended that children be offered a means by which they can communicate information anonymously.

Ministry Response: The ministry accepts this recommendation.

The ministry is committed to increasing awareness and reducing the stigma surrounding suicide and suicidal ideation so children are more likely to speak freely.
Children's Services and the Ministry of Health are co-leading the development of a provincial youth suicide prevention strategy to support children, youth, caregivers, and communities to help themselves and each other when addressing issues of suicide.

The ministry further supports caregivers and front-line staff to understand the impacts on children of grief, loss, and trauma by providing ongoing training and development.
This supports caregivers and front-line staff to have the skills and strategies needed to talk about important but sensitive topics.

Recommendation #2:

It is recommended that no child be admitted to a placement or moved from one placement to another without a direct, specific and detailed discussion by the caregivers about suicide as it relates to that child. It is recommended that a concise, detailed and current suicide profile accompany every child in care to and between every placement.

Ministry Response: The ministry accepts this recommendation.

The ministry continues to implement the Child Intervention Practice Framework (CIPF) and associated practice strategies to support principled practice. The Lifelong Connections practice strategy is a tool for front-line service delivery staff that will enable them to support children and youth through transitions, including between placements, to increase caregiver awareness of the unique needs of the children placed in their care. Operational policy revisions are being completed to support CIPF implementation, which will reinforce the need to clearly document and share information about the child, including trauma, grief, and loss and the supports available to the child and the caregiver.

Conclusion

The recommendations provided in this fatality inquiry are intended to protect the most vulnerable members of our society. This report highlights the importance of open and ongoing communication with children, youth, and caregivers, particularly as it relates to trauma, grief, and loss.

The ministry recognizes the work that caregivers do to support vulnerable children and youth and is committed to improving communication, particularly at times of transition, to improve outcomes for children and youth.