Ministry of Human Services' Response to the Office of the Child and Youth Advocate "10-Month-Old Lily: An Investigative Review"

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Background

In 2013, a 10-month-old infant in parental care passed away. The Office of the Chief Medical Examiner determined that the manner of death was accidental and the cause of death was drowning. The family was receiving services under assessment at the time of the death. Our thoughts are with this young child's immediate and extended family and community.

As described in the Advocate's report, this young child drowned in a container of homemade alcohol while in parental care. At the time of her death, Human Services was engaged in an assessment to determine the needs of the child, her siblings and the family to maintain the safety and well-being of the children in the home. Prior to this assessment, the family had limited involvement with intervention services. The family was willing to access resources within their community and had supports from both the maternal and paternal extended families.

The Child and Youth Advocate Act provides the Child and Youth Advocate with the authority to investigate systemic issues arising from a serious injury or death of a child who was receiving child intervention services at the time of injury or death. Receiving services includes intake/screening and assessment at the front-end of service delivery through to voluntary and court order services and a child being in the care and/or guardianship of the Director under the Child, Youth and Family Enhancement Act.

On March 21, 2016, the Advocate released an investigative review entitled 10-Month-Old Lily: An Investigative Review. This report makes two recommendations regarding planning and engaging support networks.

The ministry's response includes information gathered from the following sources:

- A review of existing policies in comparison to issues identified in the report;
- A review of current ministry initiatives, practice and program directions related to issues identified in the report; and
- Engagement with our ministry partners, including other divisions, regional service delivery partners and other ministries.

Evidence-informed intervention casework practice in Alberta continues to evolve and incorporate new learnings, feedback and inputs from a variety of sources, including external reviews; research into leading practices; experiences of service delivery staff; and analysis of outcomes for children, youth and families receiving services.

When a serious incident occurs, we examine the circumstances and our practice, and we identify areas of strength and opportunities for improvement. The Office of the Child and Youth Advocate plays a role in identifying systemic issues for vulnerable children and youth, through the course of day-to-day service provision or through the investigation of a single case. We welcome the recommendations from the Advocate to support the improvement of outcomes for vulnerable Albertans.

Response to Recommendations

Recommendation #1:

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

Recommendation #2:

The Ministry of Human Services should ensure that those involved in support networks know what to do and who to notify when risk increases for a child.

Ministry response: The ministry accepts both recommendations, which are similar to previous Advocate recommendations that have been accepted. 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.

Conclusion

Human Services thanks the Advocate for his review and recommendations. We will continue to implement evidence-informed practice strategies and collaborative and innovative solutions to meet the needs of vulnerable Albertans. Through our ongoing evolution, we are striving for the development and sustainment of a system responsive to the needs of children, youth and families, now and in the future. We recognize that we have a shared responsibility, along with communities and families, to support the safety and well-being of Alberta's children.