



Part 1: The investigation

[Fatal Care: Foster care tragedies cloaked in secrecy](#)



In the last 14 years, 145 children have died in government care, nearly triple the number previously reported by the province. Many, like the child this father mourns at a gravesite west of Edmonton, were just infants.

Photograph by: Ed Kaiser , Edmonton Journal

EDMONTON - The Alberta government has dramatically under-reported the number of child welfare deaths over the past decade, undermining public accountability and thwarting efforts at prevention and reform.

A six-month Edmonton Journal-Calgary Herald investigation found 145 foster children have died since 1999, nearly triple the 56 deaths revealed in government annual reports over the same period.

It is the first definitive count of child welfare fatalities in Alberta, based on death records unsealed by the province after a four-year legal battle. The figure includes all of the children who died in government care after child protection workers apprehended them from their families to keep them safe.

Crucially, however, the count is not yet complete: The ministry has not released death records for at-risk children that the government did not yet apprehend, or for children who were returned to their parents after time in care.

Cause of death

How 145 children have died between 1999 and 2013:

Disease/illness	50
Sudden infant death	14
Premature	14
Hanging	14
Cranial trauma	11
Collision	6
Drowning	4
Asphyxiation	3
Pneumonia	3
Sleep arrangement	3
Overdose	3
Hypothermia	3
Fire	2
Stabbing	1
Blunt force trauma	1
Alcohol poisoning	1
Massive trauma	1
Anoxic brain injury	1
Fall	1
Malnutrition	1
CO poisoning	1
Intestinal obstruction	1
Unknown	6

Journalists have identified at least 49 such children. There are likely dozens more.

This startling number of unpublicized deaths highlights the failure of a child death review system blighted by secrecy, disorganization, weak oversight and unmonitored recommendations.

To uncover the number of deaths, the Journal and Herald undertook an unprecedented review of 3,000 pages of ministry death records, historical fatality inquiry reports and lawsuits spanning 14 years.

An exhaustive analysis of those documents revealed alarming trends the government has never identified: A third of children who die in care are babies, another third are teenagers, and the vast majority are aboriginal.

These are their stories.

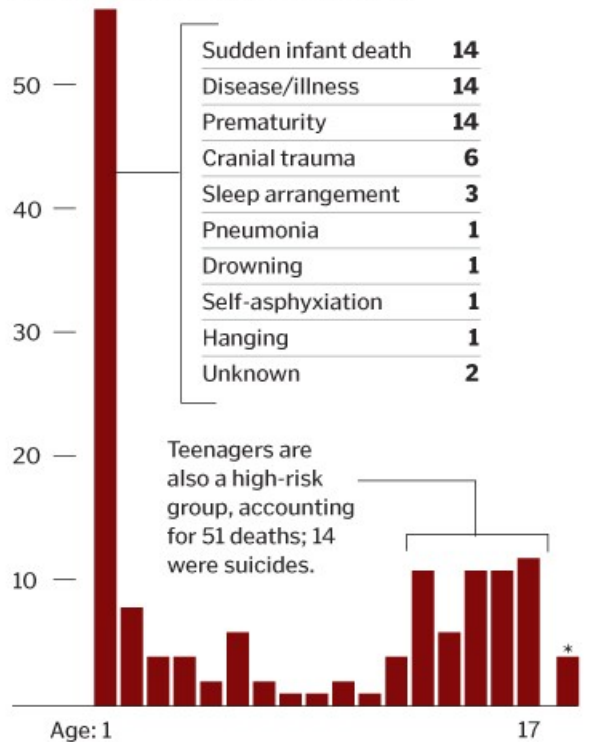
A boy makes a suicide pact with his mother and hangs himself in a group home. A girl is found slain and frozen in a ditch; another drinks herself to death. A mentally ill boy lays down on the railway tracks, his head gets crushed.

More than a dozen babies died inexplicably in their sleep, and many more died from preventable, sleep-related incidents. One died twisted in a foster parent's bedsheets, another suffocated in a collapsed bassinet, a third succumbed to untreated pneumonia while sleeping on the floor.

Among teens, more than two dozen young aboriginals overdosed on drugs, were beaten or stabbed to death, or committed suicide by hanging from basement rafters, playground equipment and closet bar rods.

How old are the children?

A total of 145 children, including 57 babies, died between Jan. 1, 1999 and June 8, 2013.



* Ages in four deaths were not provided by government

Source: Journal/Herald analysis of government records

Three teens were found frozen outside, including two boys who died of hypothermia in a backyard and a public park. When a 14-year-old girl from the Sunchild First Nation was found frozen in a ditch, officials assumed she, too, had died from hypothermia. An autopsy found she had been killed and dumped. The government made no mention of her death.

Alberta child welfare workers apprehended all of these children from their families, in an effort to protect them from harm. Instead, they died.

(To put the number of deaths into context, there are about 8,500 to 9,000 children in care in Alberta at any one time, according to data from the past five years.)

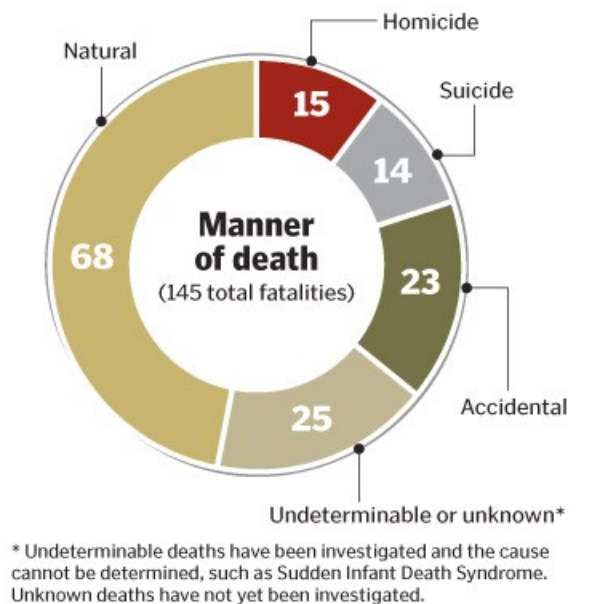
A fraction of the deaths were subject to investigation, and in cases where reviews were completed, recommendations were not tracked or monitored for implementation.

Alberta has no system for studying trends among children who die in provincial care.

“We owe it to the child victims to not only learn from their tragic deaths, but to prevent such tragedies in the future,” says Gord Phaneuf, chief executive of the Child Welfare League of Canada. “We need to commit to this. There really are no more compelling issues than protecting vulnerable babies, toddlers, children and youth from preventable deaths, and from child maltreatment deaths in particular.”

Phaneuf says governments must study individual deaths in the context of all child deaths, looking to identify which children are most at risk, and why.

“When you start to put the data together, and you do it over extended periods of time, you can discern patterns and trends that tell a very important and compelling story. We need that.”



Source: Journal/Herald analysis of government records

The Journal and Herald obtained the internal death records through a freedom of information request submitted by the Journal in 2009, that triggered a four-year legal battle. In June 2013, Alberta’s information and privacy commissioner ruled in the Journal’s favour and ordered the province to release death records dating back to Jan. 1, 1999. The records were to include age, ethnicity and circumstances of death for each child, along with recommendations that resulted from the deaths.

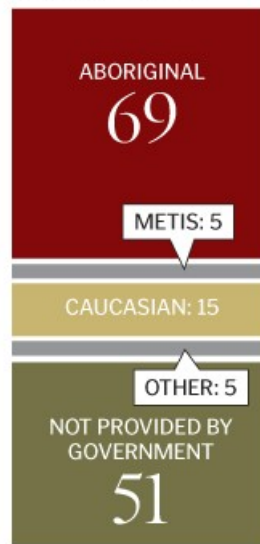
This September, the Ministry of Human Services released the internal death records for children who died while receiving in-care services, which means they were apprehended from their families and placed in group homes, foster or kinship care.

The ministry did not release death records for children who were reported to be at risk but were not apprehended, nor did they release death records for children who had been returned to their parents after time in care.

The Journal and Herald’s investigation into failures of the \$684-million child intervention system also examined Alberta’s child death review process, and found the process is mired in secrecy and bureaucracy. Dozens of elected officials, political appointees and bureaucrats operate in six different bodies under two different ministries and three different laws.

Ethnicity

The ethnic backgrounds of 145 children who have died in Alberta care:



Source: Journal/Herald analysis of government records

Recommendations that emerge from these bodies are not binding on government, they are not tracked or monitored for implementation and are not reviewed to see if changes have been effective in preventing child deaths.

People who work inside the system are barred from speaking publicly about their experiences and even the parents of deceased children cannot utter their dead child’s name, for fear of breaking a law that bans the identification of children in care, even after they die.

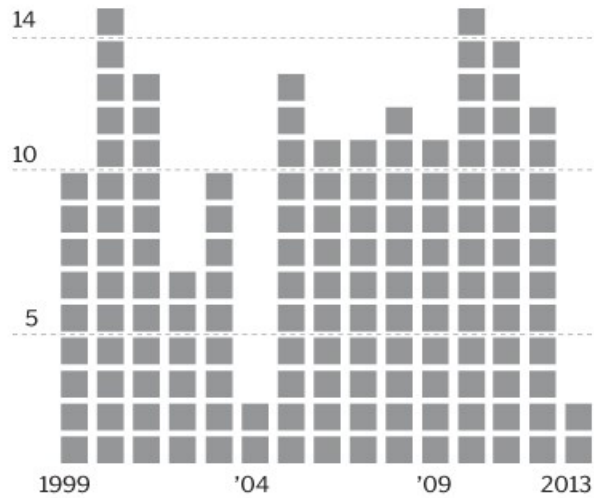
In the end, the fallout from these deaths is widespread: 12 lawsuits totalling more than \$8.7 million, 13 lengthy criminal trials, and the incalculable emotional toll paid by parents, foster parents and child protection workers responsible for children in the care of the state.

Yet in an interview for this series, Human Services Minister Dave Hancock expressed satisfaction with the way the system works. He noted that there are some areas of duplication — and some room for improvement — but overall he concluded that child deaths in Alberta were getting the appropriate amount of investigation and review in the ministry.

“In the death review process,” Hancock said, “we have, I think, a fairly strong organization.”

The loss: 145 deaths in 14 years

Between Jan. 1, 1999 and June 8, 2013, 145 children died while receiving in-care services, which means they had been apprehended from their parents and were living in foster, kinship or group care. The figures do not include children who were receiving out-of-care services from the ministry when they died.



Source: Journal/Herald analysis of government records

Part 2: Trends

Babies account for one-third of all deaths of Alberta foster children



Between January 1999 and June 2013, 18 babies in foster care died in their sleep. In at least six cases, records show the child's foster parents employed "unsafe sleeping practices" such as co-sleeping, sleeping on unsafe surfaces, and having toys and blankets in a crib. These can increase the likelihood of sudden, unexpected infant deaths.

Photograph by: Supplied , photo

Babies account for one-third of all deaths of Alberta foster children

More than half of infants died in their sleep or due to prematurity, yet government has few policies to address these issues

By Karen Kleiss, Edmonton Journal November 26, 2013

The names of the mother and child in this story have been changed to comply with an Alberta law that prohibits identifying children who have received government care.

LAC LA BICHE — This is what the mother of a dead baby remembers.

The police came and said her six-month-old daughter, Angel, had died in her sleep at her foster home. The mother ran into the bathroom and filled her palms with panicked tears. She did not believe it.

"I remember the house being quiet. It felt like the walls were caving in. I could hear my own heartbeat," Jodi said. "It was the worst possible thing you could ever feel."

Her knees buckled at the funeral home when she saw the tiny casket. "I realized then that it was real, that she was going to be in there."

She remembers picking out a white bonnet to hide the bruises on Angel from when her bassinet collapsed on her, and tucking beaded moccasins into the casket.



Photo: In 2009, this six-month-old baby girl died after the bassinet she was sleeping in collapsed. This photo has been altered to comply with Alberta law prohibiting the identification of children in care.

Credit: Supplied.

“When I touched her, she was like a rock,” Jodi said. “It was, just, so cold.”

A fire-keeper tended a fire for two days. Elders passed a pipe. Drummers drummed. As she watched the casket descend into the earth, Jodi thought: “My baby is going in the ground, she is going to be alone.”

“The elder said, in Cree, that your grandmother is here and she is taking Angel with her right now. That brought me comfort,” she said.

“But I was so scared that she was by herself, in the dark.”

One in three children who dies in government care in Alberta is a baby, a startling figure given infants account for one in 10 children in care.

Between January 1999 and June 2013, 145 foster children died in Alberta, and 57 of them were babies, a joint Edmonton Journal-Calgary Herald investigation found.

Eighteen died in their sleep, often after a foster parent employed unsafe sleeping practices. Fourteen died from the consequences of premature birth. Another 14 died from chronic illness.

Eight died by accident or homicide, two died for unknown reasons, and one died from untreated pneumonia.

Experts say many of these deaths were preventable, but government has few rules on where and how foster children sleep, and infant deaths related to sleep and prematurity are rarely subject to review.

Instead, fatality inquiries and ministry investigations focus on high-profile homicides and accidents, including a bathtub drowning, a blind cord hanging, and six cases of cranial trauma.

“I haven’t seen anything come back to say there is a systemic issue with infants,” Human Services Minister Dave Hancock said in a recent interview. “Each case is unique and you have to look at it and learn from those cases, and we do.”

The province has no process to study death trends among children in care. “There are only so many, and the people who are involved can fairly easily determine across them what’s happening,” Hancock said. Angel is one of 18 Alberta foster children who died while sleeping.

At first, police told Jodi that Angel died from Sudden Infant Death Syndrome. She later learned the baby died from “positional asphyxiation” after her bassinet collapsed.

Baby deaths

How 57 babies died while in care:

Sudden infant death	14
Disease/illness	14
Prematurity	14
Cranial trauma	6
Sleep arrangement	3
Pneumonia	1
Drowning	1
Self-asphyxiation	1
Hanging	1
Unknown	2

“It was even worse when they told me that she had suffocated,” Jodi said. “She was awake. ... She suffered.”

In six of the deaths, records show foster parents employed what experts call “unsafe sleeping practices,” which increase the odds of sudden death. Such practices include co-sleeping, sleeping on unsafe surfaces such as sofas, sleeping on the stomach or with blankets in the crib.

In 2009, a baby was found face-down in her crib with a blanket around her head. In 2011, a baby died from “self-asphyxiation.” In 2013, a foster mother brought an infant to bed and found the baby tangled in her bedsheets the next morning.

Three infants died during lengthy, unattended naps. Seven were sick, or had recently visited a doctor. In 2009, a baby died of untreated pneumonia while sleeping on a makeshift bed on the floor. In 2011, another died sleeping in an infant carrier with loose sheets — the autopsy concluded: “The infant’s sleep environment was not completely safe.”

In 2003, a foster mother ignored warnings not to put a baby to sleep on his tummy. After the baby died, his doctor said: “That’s probably what killed him.”

By definition, Sudden Infant Death Syndrome is unpredictable; it is listed as a cause of death when doctors cannot find another explanation.

Yet risk factors are well known.

In 2005, a ministry review of eight SIDS deaths found all of the babies showed at least three of those risk factors, including poor prenatal care, maternal smoking, co-sleeping, aboriginal heritage and male gender. A 2011 medical examiner’s report found co-sleeping was a factor in half of all unexplained infant sleeping deaths between 2005 and 2010. A similar 2005 B.C. study found unsafe sleep practices in 83 per cent of infant deaths over 18 months.

Nobody knows why these factors and practices increase SIDS risk, but University of Calgary pediatrics professor Ian Mitchell said that shouldn’t matter.

An 1854 cholera outbreak ceased after a doctor noticed most of the sick drank from the same well, he said. Scientists didn’t yet know about germs, but taking the handle off the water pump stopped the spread.

“When I tell this story, my message for SIDS is that you can stop it without knowing all the fine details. ... Why does quitting smoking work? Why does sleep position work? I don’t know, but it works,” Mitchell said.

Still, rules that govern sleep practices for foster babies are limited.

The safety checklist used for licensing foster parents contains two lines about safe infant sleep: Each child must have a separate bed with a suitable mattress, and cribs or playpens must meet government standards.

Policy requires caseworkers to tell foster parents a crib must be free of pillows and blankets, and foster parents are not allowed to smoke around foster children. However, a safety assessment does not check for these items.

There are no rules about co-sleeping and sleep position, and foster babies are not assessed for SIDS risk.

“When a child is apprehended, you and I are the parents, along with everybody else,” Mitchell said. “The government is now the parent ... The standards have to be the highest possible standards.”

The province has taken some steps to reduce SIDS deaths.

A new Safe Infant Sleep policy comes into effect in January 2014, when health-care professionals will be required to promote universal safe sleep guidelines for all new Alberta mothers. The policy expands on a campaign launched in 2012.

Alberta is also adopting a B.C. program that trains and supports people caring for babies exposed to drugs and alcohol. In 2013, the program was piloted in Edmonton and Saddle Lake, but a provincewide implementation date has not been set.

On Nov. 8, the government announced foster parents who purchase a crib can be reimbursed up to \$500.

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Jodi was ready for her fourth baby. She set up a crib, bought supplies, saw a doctor and tried to stay sober. She wanted to take her baby home and get her other children back from foster care.

On July 16, 2009, she was on a bus to Edmonton when she realized the baby was coming six weeks early. She walked to the hospital, and Angel came quickly.

“They tested me. I did drink that day, of all days. I drank a six pack to myself,” Jodi said. “They found it in my baby’s system, and my kids before that, that happened, too. So they didn’t even give me a chance to explain.

“I didn’t drink before that, and I decided to drink that day, and then I ended up having her.”

Angel was apprehended at the hospital.

Like 14 babies who died between 1999 and 2013, Angel was premature. It is not clear whether prematurity played a role in her death, but experts say many deaths related to prematurity could be prevented with stronger interventions.

“If you can intervene early enough ... then we really believe we can lower the pre-term birth rate, just through simple behavioural changes,” said David Olson, a professor of obstetrics and gynecology at the University of Alberta who has studied pregnancy and prematurity for more than 30 years.

Death records for two of the 14 premature babies cite inadequate prenatal care as a factor in the child’s death.

Officials say government cannot legally intervene until a child is born, but the ministry offers voluntary prenatal support to expectant mothers. Some women who have had children with fetal alcohol disorder can take part in a three-year, home visitation program shown to reduce substance abuse and increase use of birth control.

A U.S. program that brings at-risk mothers together for monthly meetings on prenatal care resulted in a 33-per-cent reduction in premature births, according to a 2007 study in the *Journal of Obstetrics and Gynecology*, Olson said.



Photo: One in three children who dies in government care in Alberta is a baby, a startling figure given infants account for one in 10 children in care. Here, family members mourn the death of a baby girl who died in foster care in early 2010. Credit: John Lucas, Edmonton Journal.

Alberta government investigations into prematurity and sleep deaths are rare.

A policy in effect until 2009 automatically ruled out an in-depth internal review when a child died for medical reasons; current policies are not documented.

Between 1999 and 2010, no fatality inquiries into sleep deaths occurred. Since then, the province has called six such inquiries. Two are scheduled for 2014, including Angel's.

The internal summary of her case was completed in August 2010. It noted bassinets in Canada were unregulated and the ministry had no policy for their use. Since then, Health Canada has passed stringent regulations. The ministry still has no policy.

The review also revealed Angel slept in the bassinet for six months because she had no crib — a clear violation that went unaddressed.

The report reiterates foster children must have their own bed, and says “this does not include hammocks, bassinets or playpens.” The report was never made public, and this prohibition is not reflected in policy.

Jodi shared her story because she doesn't want other parents to suffer. Her life has unravelled since Angel died. She continues to struggle with alcoholism. The pain and guilt are insurmountable.

This is what she wants to remember:

“She was wise, in her eyes,” she says of Angel. “The last time I saw her, when I put her down to put her stuff on her, she grabbed my pinkies and she wouldn't let go.

“She was saying goodbye to me.”

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About this data analysis

It is impossible to make an apples-to-apples comparison of the mortality rate between infants overall in Alberta and those in provincial care.

This is partly because the infant mortality rate is calculated by using the number of births and deaths over a set period of time; by contrast, the number of infants in care changes from month to month.

It is also because the data that underpins this story is based on incomplete death records released by the provincial government after a four-year legal battle with the Edmonton Journal.

When possible, we extracted key details from the records, including the child's age, but in many cases, the government provided only the years of birth and death. In these cases, we calculated ages based on a birth and death date of Jan. 1, which results in imprecise ages.

With this context, it is worth noting that the mortality rate for Alberta-born infants under one year was 1.6 per 1,000 live births between 2001 and 2010 — the most comparable figures available.

As of September 2013, there were 830 children in care in Alberta under 18 months old. Our data shows that on average, between 1999 and 2012, four infants died in care per year. Taken together, the death rate of infants in care is 4.8 per 1,000 apprehensions.

Part 3: Oversight

Alberta's child death review system lacks accountability, transparency, clear mandate

Alberta's child death review system lacks accountability, transparency, clear mandate

Even when reviews are done, there's no process to track, implement proposals

By Karen Kleiss, Edmonton Journal November 27, 2013



Human Services Minister Dave Hancock acknowledges that there is some overlap in the child death review system, but says that the results meet his 'expectations.'

Photograph by: Shaughn Butts , Edmonton Journal

Alberta's tangled system for investigating the deaths of foster children is secretive, redundant and fails to ensure recommendations to prevent similar deaths are acted upon, an Edmonton Journal-Calgary Herald investigation has found.

The child death review system is governed by two ministries, three different laws, an internal policy document, unwritten conventions and political whim.

At least six groups with divergent mandates review some or all child welfare deaths, depending on the laws that govern them. Communication between organizations is limited and sometimes litigious, conclusions are drawn in isolation, and recommendations can be radically different.

The decision to investigate is made largely in secret, with limited public accountability, despite at least three government-funded reports calling for independent, transparent oversight.

Just two of the six organizations have published guidelines that dictate which deaths must be reviewed, and none is required to tell the public why they decided for or against an investigation.

There is no appeal process for parents or advocates who believe a child's death has not been adequately scrutinized.

In the end, many deaths are never investigated at all. These include the case of a 13-year-old boy who had a seizure and drowned in a bathtub in 2000, the death of a 17-year-old girl from a massive cocaine overdose in 2002, the drowning of 17-year-old boy in a river in 2007, the alcohol poisoning death of a 14-year-old girl in 2008, a 14-year-old boy found frozen to death in 2009, and more than a dozen babies who died in their sleep.

Of the 145 children who died in the care of the Alberta government between 1999 and 2013, 53 cases

merited a public fatality inquiry or a documented in-depth internal review. When those reviews issued recommendations to prevent future deaths, there was no system in place to track them, or to ensure they were implemented.

How it works: Alberta's child death review system

The complicated system is governed by two ministries, three different laws, one internal policy document and unwritten convention. The system involves six bodies and no single person oversees the entire process. Recommendations are neither tracked nor monitored for implementation.

Under Alberta law each body in the system reviews a different group of child welfare deaths.



Children receiving "in-care services," who have been apprehended from their parents and are living in foster or kinship care, or in a group home.



Children receiving "out-of-care" services, who are still living with their parents but are receiving supports from the ministry.



Information passed along



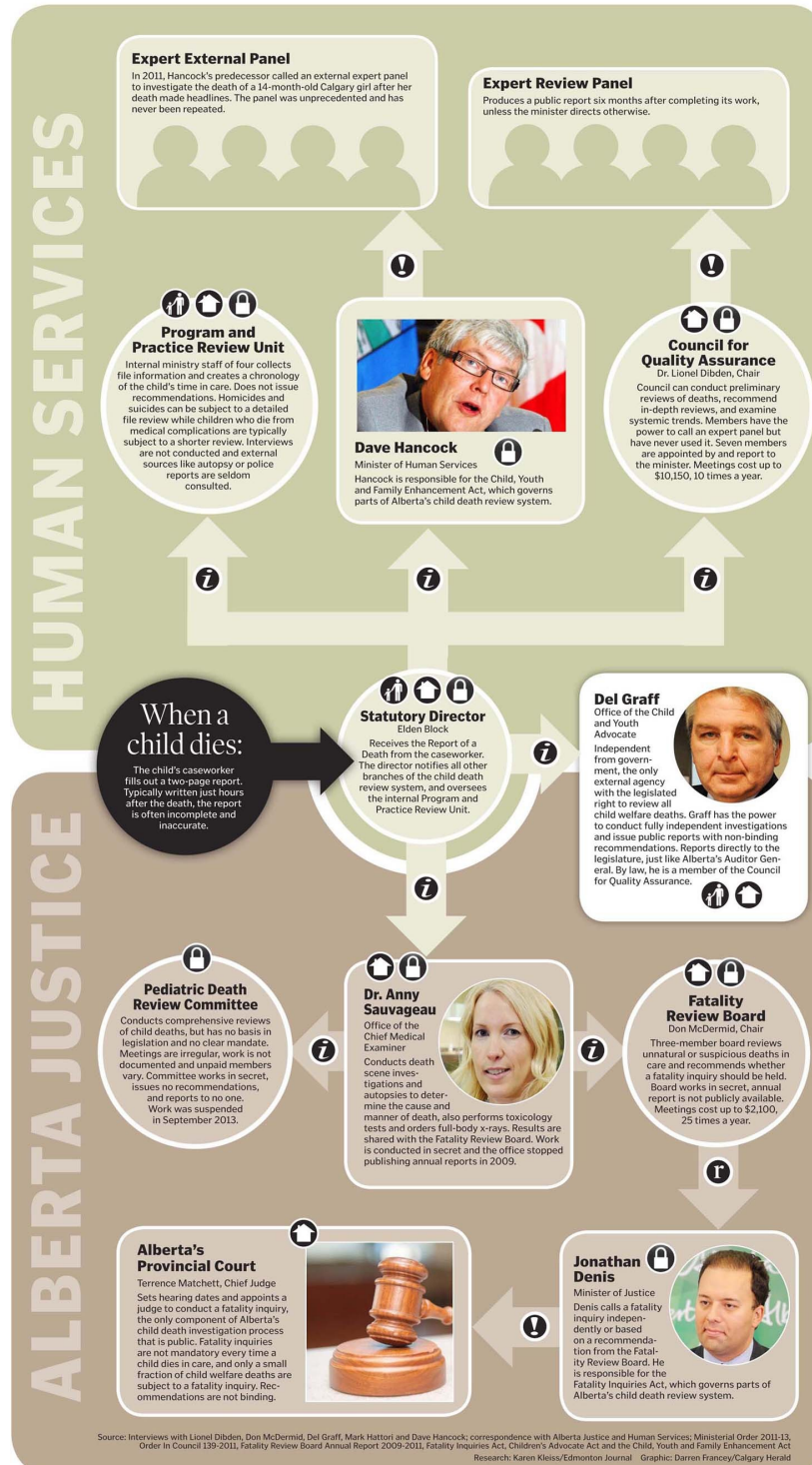
Recommendation made



Order or call issued



Closed to the public, or limited public scrutiny.



SO, HOW DID WE GET HERE?

In June 1977, the province passed the Fatality Inquiries Act, authorizing medical examiners to investigate all sudden deaths, including child welfare deaths. The act also established the fatality review board, whose job would be to recommend which deaths should be the subject of a fatality inquiry led by provincial court judge.

The objective of the law, which remains the cornerstone of Alberta's child death review system, was not to assign blame, but to prevent future deaths.

In the intervening decades, however, new ideas emerged about how to investigate, learn from and prevent child deaths.

Now, many experts say the most effective reviews are conducted by an independent multi-disciplinary group of professionals that includes pediatricians, child welfare experts and police.

They argue the system should be transparent, with clear guidelines about who investigates deaths, and why. Findings should be made public and the resulting changes should be monitored to make sure they are effective.

Such a system would reveal trends that could result in targeted improvements that save children's lives, said Gord Phaneuf, executive director of the Child Welfare League of Canada.

"When we look at (deaths) in isolation, as individual occurrences, the tendency is to miss the larger significance, particularly when we want to think from a prevention perspective," Phaneuf said. "To really get a meaningful understanding of the risk factors ... you have to look at more than one case. You look at many cases."

In response to the changing philosophy, the Alberta government has added to its system, tacking on advocates, panels and committees, but not overhauling it.

First came the child and youth advocate in 1989, a position intended to give a voice to wards of the province. In the mid-1990s, the medical examiner established pediatric death review committees to look at child deaths under 18, including children in care.

By the early 2000s, the ministry was conducting internal special case reviews into child welfare deaths, which were overseen by a panel of department experts, but weren't made public.

In 2005, the government changed the Fatality Inquiries Act to make it "as efficient and effective as possible," by reducing the number of inquiries into child welfare deaths and restricting media access.

In August 2011, the province established the internal council for quality assurance, and months later newly elected Premier Alison Redford made the child and youth advocate an independent officer of the legislature. Both now have the power to order independent investigations into systemic issues arising from a child's death.

Most of these changes were made under political fire, during an election campaign or after a tragedy made headlines.

COMMUNICATION PROBLEMS, OVERLAP

The result is a circuitous child death review system plagued by duplication and poor communication.

Officials at the helm of all six main bodies say their organizations are independent from each other and that they rarely share information; in some cases, agencies employ lawyers before sharing records.

Pediatrician Lionel Dibden, chairman of the council for quality assurance, said the council defers to Del Graff, the child and youth advocate, to investigate systemic issues and doesn't focus on reviewing child welfare deaths; members have the power to do both, but he wants to avoid further duplication.

He notes reviews are already conducted by the advocate, the fatality review board, the medical examiner's office and the pediatric death review committee. In addition, some deaths trigger a fatality inquiry and others are subject to criminal investigation.



Photo: Del Graff, Alberta's child and youth advocate, has released two reports since his office became independent of the legislature in 2012. Both looked at systemic issues surrounding teen suicide. Credit: Larry Wong, Edmonton Journal.

“Many of them relate to the same question,” Dibden said. “What happened? ... What went wrong, or not wrong, and what can we learn from that?”

“Alas, it always seemed to me that there was a lot of overlap. People are doing the same thing, trying to do it at the same time, then there were timelines that you couldn't do one thing before you did the other,” he said. “My position was, whatever we do, we should not make it worse by duplicating what other people are doing.”

Instead, he said the council has set up a spreadsheet to track the “myriad” reviews underway, and focuses on working with government to improve the system in other ways.

Human Services Minister Dave Hancock acknowledges the system retraces its own steps.

“Typically, a fatality review report is about five years after an incident,” he said. “It is almost a retrospective check back to say — and that's not to say that they're not important, they are important — to make sure we caught everything.”

“But by the time it comes out, I hope that my answer would be, yes, we have already dealt with that.”

The system, he said, meets his expectations.

“My expectations would be that first and foremost we would learn everything we possibly could from any incident. ... Out of every circumstance, we should learn,” said Hancock.

“In the death review process, we have, I think, a fairly strong organization.”

Hancock and Justice Minister Jonathan Denis together oversee a child death review system governed by three different laws, each of which uses a different legal definition of what constitutes a reviewable death.

As a result, there is no single person or agency that is accountable for the system, and each body is entitled to information about a different subset of deaths.

The medical examiner and quality assurance council are only legally entitled to information about the deaths of children receiving in-care services — these are children who have been apprehended from their parents.

The fatality review board also reviews deaths in care, but only if the cause of death was unnatural or undetermined, or if the child died under suspicious circumstances.

The law is silent about which deaths the pediatric death review committee examines.

Only the child and youth advocate is entitled to information about all child welfare deaths, including at-risk children who were known to the ministry but not taken into foster care.

FEWER REVIEWS

The changes have also resulted in fewer opportunities to investigate what went wrong in an individual child's case.

While the medical examiner continues to look at individual deaths in care, all other avenues for individual reviews are closed or significantly reduced.

The quality assurance council and the office of the child and youth advocate review child deaths when there are systemic issues at play.

The pediatric death review committee examines individual deaths, but work was suspended in September 2013, pending review. Chief medical examiner Anny Sauvageau declined interview requests, but a spokeswoman said the review is expected to be finished in 2014, after which a new model will put in place. She declined to say what the model would look like.



Photo: Chief medical officer Dr. Anny Sauvageau can review any deaths of children in care. Credit: Shaughn Butts, Edmonton Journal.

Until 2009, the Ministry of Human Services conducted special case reviews into individual child deaths that were unexpected or preventable. These internal reviews included interviews with key people, oversight by an internal panel of experts, and recommendations for change. The process was governed by written guidelines and captured 20 of the 145 in-care deaths between 1999 and 2013.

But the number plummeted in the 2000s — from seven in 2001 to one in 2009 — and they have since been stopped.

Mark Hattori, assistant deputy minister of human services, said such reviews have been replaced with an informal process that doesn't result in written recommendations.

“There might be some conversations between the statutory director and their staff ... but we don't necessarily create reports,” Hattori said. “It wouldn't be documented. ... Some of it might be meetings; there may not be minutes.”

The lone document produced during the new internal review is a chronology of the dead child's time in care, Hattori said.

Today, a fatality inquiry is the only part of Alberta's child death review system that conducts a documented, public review of an individual child's death, but the number of fatality inquiries has fallen dramatically in recent years.

Until 2005, the law required the fatality review board to recommend an inquiry into every death in care, unless the board was convinced the death was both natural and unpreventable.

In 2005, the law was changed, and now, the board can avert an inquiry if it sees “no meaningful connection” between the child’s death and the quality of care. At the time of the law change, critics said the board couldn’t possibly know whether the quality of care played a role in the child’s death without a fatality inquiry, and warned the change would reduce the number of inquiries into deaths in care.

Indeed, in the 15 years that preceded the law change, there was an average of three inquiries a year into the deaths of children in care. In the four years that followed the change, the average was fewer than one. In 2006 and 2008, there were none.

Those statistics were contained in annual reports issued by the medical examiner’s office, but the office stopped publishing such reports in 2009.

RECOMMENDATIONS NOT TRACKED

When reviews are completed, the recommendations that emerge are not collected, tracked or monitored for implementation. None are binding on government, and the province is not required to respond.

Internal and historical recommendations are not accessible to the public.

Since 1999, fatality inquiries and internal reviews have together resulted in 258 recommendations, in addition to those from the child and youth advocate, the auditor general and one-of-a-kind expert panels.

In August, the quality assurance council wrote a letter to Hancock recommending the province collect and monitor recommendations from these reviews.

The ministry refused to release the letter, but Hancock said the government has agreed to “a more formal tracking process” that would be publicly accessible online.

Still, he said he’s confident the ministry has thus far appropriately implemented recommendations and that the government’s “system” would alert him if recommendations were being repeated.

Pressed to explain how, Hancock said: “The people who are involved actually, there are not so many (deaths) that they don’t know each one fairly well. And they would know what’s coming out of them. I am confident that we actually do a pretty good job — I think, an excellent job — of learning from each circumstance and tying them together.”

Part 4: Secrecy

[Restrictive law silences grieving parents](#)

Restrictive law silences grieving parents

Publication ban prohibits naming deceased children, shields Alberta government from scrutiny

By Darcy Henton and Karen Kleiss, Calgary Herald and Edmonton Journal November 28, 2013



Velvet Martin fought to have the publication ban lifted on the case of her daughter Samantha, who died after being in foster care. She argues many parents want to speak about their children's cases, but don't have the knowledge or resources to challenge the ban in court.

Photograph by: John Lucas , Edmonton Journal

Alberta's ban on publicizing the names and photos of children who die in provincial care is one of the most restrictive in the country, robbing grieving families of their ability to raise concerns in public about the deaths and sheltering government officials from scrutiny.

About 10 children die in care in Alberta every year, but because of a law that prevents their names and photographs — and those of parents or guardians — from being publicized, the public is denied the right to know who they are and assess whether their deaths could have been prevented.

Basic information about the 145 children who died in care in Alberta between 1999 and 2013 was only released to the Edmonton Journal and Calgary Herald after a four-year legal battle. Still, we can only tell you the names of two of the 145. That's because their parents applied in court to have the publication ban lifted — a step all parents must take if they wish to speak out about the deaths of their

children.

Velvet Martin, who went through the court process, said the ban is evil and “the nemesis of justice.”

“They have failed the child in the utmost way possible and now they are stealing their identity — the only thing they have left,” said Martin, whose daughter Samantha died after being in care. “It’s bad enough to lose a child, but to have it covered up is just wrong and I won’t stand for it.”

With scant information on child death cases, Albertans are left to trust that the government will investigate and correct any systemic problems, yet often the same people responsible for supervising a case lead the review.

The result of the legislation is a blanket of confidentiality over the child welfare system.

Child welfare agencies won’t talk to the media. Several didn’t respond to repeated requests for information about how they protect children and one, citing the province’s privacy act, referred calls to the Ministry of Human Services.

People who work inside the system are barred from speaking publicly about their experiences; even those who spoke on condition of anonymity were afraid they’d lose their jobs.

Government officials argue the ban is necessary to protect the privacy of children and their families; in some cases, a child who dies might have siblings who are also in government care. Children in care are some of the province’s most vulnerable citizens, and provincial authorities feel strongly about trying to protect them.

“I think there is always a balance of values that you have to take into account,” said Human Services Minister Dave Hancock. “One of the values obviously is an open and transparent process so that people can know and understand what is happening and know that things are being handled in an appropriate fashion. The other value is you don’t want to intrude in the personal lives of families any more than necessary, particularly in circumstances like that where they have already suffered significant tragedy.”

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Photo: Human Services Minister Dave Hancock says Alberta's publication ban on the names of children who have died in care is intended to protect the privacy of families who have already suffered significant tragedy. Credit: Shaughn Butts, Edmonton Journal.

In a press conference on Wednesday, in response to the Journal-Herald investigation, Hancock said that the issue of where that line should be drawn will be discussed at a roundtable of MLAs and experts scheduled for January. Hancock announced the roundtable on Tuesday.

The Alberta College of Social Workers supports the principle of the ban for the benefit of the family and any siblings.

"It could cause some definite hardship for the family," said spokeswoman Lori Sigurdson. "They could be ostracized in the community. It could be a shame thing. Their relationship with the ministry and the worker who is working with them could become antagonistic or more difficult because they feel they have betrayed them."

Hancock said the bodies that review deaths — including the child and youth advocate, the quality assurance council and the fatality inquiry review board — provide the public with appropriate access to information. He said it's "not necessarily useful to publish a name and face just for the prurient interest of the opposition or others."

However, in an interview this month, Hancock admitted he didn't realize the law went so far as to prohibit parents from talking about their children and releasing their names to the media, and said he would look into it.

"I think families for the most part need to be able to heal and need to have the discussions that they need to heal," he said.

That's the argument made by the family of a 21-month-old aboriginal baby who died in a foster home in 2010.

"It is ridiculous. We want to tell our story and we can't," the girl's aunt said. "We're suffering in silence here."

A Morinville foster mother has been charged with second-degree murder, but the case has not yet gone to trial. It could be years before the facts of the case and what went wrong are revealed — if ever.

Choking back tears, the aunt said problems with the system must be scrutinized if similar deaths are to be avoided. "Every couple of years, another child is dying in care, and it is usually a native kid," she said.

Martin, the mother who had the ban lifted on her daughter's name, said almost every family she has met wants to speak out, but they often don't know their rights and can't afford to seek legal advice.

"A lot of people don't have the fortitude, they don't have the education, the ability, to come forward," said Martin, a spokeswoman for a national advocacy group called Protecting Canadian Children.

In her case, she was able to lobby for a fatality inquiry. During that process, she found out that while Samantha's caseworker had assured her that the girl — who had a number of medical conditions — was getting exceptional care, the caseworker hadn't seen her for 14 months, nor had she been examined by a doctor in three years.

"I was naive and under the impression that children's services was doing an internal investigation and were actually going to do something other than cover their ass," she said. "It was a hard lesson for me."

Like Martin, Jamie Sullivan went to court to lift the ban on her daughter Delonna's name — but she's angry she had to. "If you want to arrest me for talking about my daughter, then arrest me," she said. "You can't take anything more from me than you have already. ... And I'm not going to have somebody telling me I can't show her picture. That's just not right."



Photo: Jamie Sullivan, who had the publication ban lifted on her daughter Delonna's case, says parents shouldn't have to fight in court to speak about their deceased children. Credit: Ryan Jackson, Edmonton Journal.

The publication ban law is part of Alberta's Child, Youth and Family Enhancement Act. It stipulates that "no person shall publish the name or a photograph of a child or of the child's parent or guardian in a manner that reveals that the child is receiving or has received intervention services." The penalty is a maximum \$10,000 fine or up to six months in jail.

Prior to legislative changes in 2004, the ban didn't exist. A 13-member task force, chaired by Calgary MLA Harvey Cenaiko and made up entirely of Conservative MLAs and child welfare officials, had recommended the change to government. Cenaiko told MLAs the new provisions were drafted to align with the Freedom of Information and Protection of Privacy Act. No mention was made that the ban remained in place after a child died.

Provincial privacy commissioner Jill Clayton, who wasn't in office when the law was amended, said she can't find any record of the government consulting the office for advice or guidance on the issue.

Across Canada, most provinces ban the publication of names of children who are in care or receiving services from the government, but lift the ban or decline to enforce it when one of those children die. Only Nova Scotia, New Brunswick and Quebec have bans similar to Alberta's, and officials say Quebec currently does not enforce the ban when a child dies.

But in Alberta, despite the minister's promise to review the ban, the government continues to enforce it.

This month, Alberta's children services director refused a request from the Journal and Herald to lift the ban on the name of a Samson Cree baby, opposing an application that was supported with affidavits from both the child's parents.

Being able to publish the names, photographs and personal stories of children who die in care are large factors in bringing about change, experts say. If parents are muzzled, there is no one else to speak for the children, said Robert Fellmeth, executive director of the Children's Advocacy Institute in the U.S.

"These children have no lobby," said Fellmouth, a professor of public interest law at the University of San Diego. "They have no campaign contributions. They don't vote. Their sole asset is democracy, and public sympathy and concern, and disclosure. That's the sole political card they have."

Many laws to protect children are named after child victims, he noted. The Amber Alert system was named for Amber Hagerman, a nine-year-old abducted and murdered in Arlington, Texas, in 1996, while Chelsea's Law in California, which increases penalties and monitoring of sexual offenders, was named after 17-year-old rape-murder victim Chelsea King.

In Canada, there's the Jordan Principle that stipulates that care be provided for children when they need it and decisions about who is responsible for paying for it be made later. It is named after a five-year-old Manitoba Cree child named Jordan River Anderson, who died in hospital while federal and provincial authorities bickered over who was responsible for his home care.

And in other provinces, the deaths of children in care make headlines. In Manitoba, a public inquiry has put the 2005 death of five-year-old Phoenix Sinclair under the microscope; in Saskatchewan, RCMP are investigating the alleged 2013 murder of six-year-old Lee Bonneau by another child under the age of 12; and in Ontario, an inquiry has been probing the case of five-year-old Jeffrey Baldwin, who died in 2002 after years of mistreatment.

By comparison, in Alberta, when the child and youth advocate writes reports about flaws in the system, he has to make up names for the children. In July, he released "Remembering Brian," and just last week he issued "Kamil: An Immigrant Youth's Struggle." Both are pseudonyms.

Even when a death of a child in care is examined at a fatality inquiry in Alberta, the children and parents are identified only by initials. Provincial court Judge Leonard Mandamin balked at this practice

in an August 2007 fatality inquiry report into the suicide of a 16-year-old Tsuu T'ina boy. "The use of initials dehumanizes the tragic death of this young person," he wrote.

University of Manitoba professor Arthur Schafer, director of the Centre for Professional and Applied Ethics, wonders who the publication law is designed to protect.

"My overarching concern is that privacy is being used as a smokescreen to conceal potential wrongdoing and to prevent the public from getting an accurate picture of problems that may turn out to be systemic," he said. "Privacy considerations are important, but they aren't absolute."

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Publication bans by province

British Columbia: The name and photo of a child who dies in care can be published provided information comes from family or other sources.

Alberta: It is illegal to publish names or photos of children who die in care without a court order lifting the ban.

Saskatchewan: The name and photo of a child who dies in care can be published provided information comes from family.

Manitoba: The name and photo of a child who dies in care can be published provided information comes from family.

Ontario: The name and photo of a child who dies in care can be published without restriction.

Quebec: It is illegal to publish the name and photo of a child who dies in care, but the law is not enforced.

New Brunswick: It is illegal to publish the name of a child who dies in care.

Nova Scotia: It is illegal to publish the name of a child who dies in care.

Prince Edward Island: The name and photo of a child who dies in care can be published.

Newfoundland and Labrador: The name and photo of a child who dies in care can be published if information comes from family or other sources.

Original source article: [Restrictive law silences grieving parents](#)

Part 5: Fallout

[The price of a flawed child welfare system? \\$8.7 million in claims](#)

The price of a flawed child welfare system? \$8.7 million in claims

At least 12 families have sued the Alberta government over deaths of children in care

By Karen Kleiss, Edmonton Journal November 29, 2013



A father, who can only be identified as Merle, visits the grave site of his infant daughter at the Paul First Nation. She died while in foster care and the parents are suing the government for \$1 million.

Photograph by: Ed Kaiser , Edmonton Journal

Names in this story have been changed to comply with an Alberta law that prohibits identifying children who have received government care.

PAUL FIRST NATION — In a sudden, sickening instant, Sarah knew they were going to take her baby. She was lying in a hospital bed with her newborn daughter, Amy, just 10 hours old. The baby started fussing and she asked the child protection workers to leave for a moment, so she could breastfeed. They refused.

“The woman said ... ‘I’ll get a nurse to bring her in a bottle’,” Sarah said. “I looked at her and I said, ‘I’m trying to breastfeed my baby, and you want me to give her a bottle?’ By then I was already upset. “They knew they were going to take her.”

Until that moment, she had managed to keep calm.

They had revisited her failures with her five older children, all of whom had been apprehended. They had asked about her estranged, jailed father. They questioned the baby’s father, Merle, too.

Sarah told them she had a room ready for the baby. She pointed to the stuffed diaper bag she brought to

the hospital. She knew drug tests would come back clean — she had pre-emptively tested herself at her doctor's office. "I was thinking I could win, beat them to the battle," she said.

Then they refused to let her breastfeed, and she started to heave with angry, despairing sobs.

They left and returned with apprehension papers, telling her she was too emotionally unstable to care for an infant.

She pleaded with the child protection workers to at least take the diaper bag. They wouldn't. She carried the bag home with her that night, brought it up to the empty baby's room, and wept.

Amy was taken to foster care and then to a respite home, where she died in a playpen on Sept. 23, 2011, two months after she was born. Sarah still doesn't know why.



Photo: This baby, who can only be identified as Amy, died in foster care in 2011. Credit Supplied.

"We are spiritual people. Our belief is if a baby doesn't feel wanted from birth, the Creator will take her home.

"I feel guilty because that's my child. I wanted her. I just couldn't have her."

In October 2013, Sarah and Merle sued the province for \$1 million.

At least 12 Alberta families have sued the government in connection with the death of a child in care since 1999.

The province refused to release details of the lawsuits, and whether any settlements had been paid out, but the Edmonton Journal and Calgary Herald found court records for eight of the 12 lawsuits; those show the claims total at least \$8.7 million.

The lawsuits range from a \$45,000 claim for a baby girl who died of untreated pneumonia, to a \$2.55 million claim for a baby girl found in an infant carrier. The mother of two Edmonton boys sued for just over \$1 million after the children were injected with morphine and smothered to death during an unsupervised, court-ordered visit with their mentally unstable father.

Four of the lawsuits involve babies and toddlers who were dropped, thrown or shaken.

Edmonton lawyer Robert P. Lee says the secrecy surrounding these lawsuits undermines government accountability, and that taxpayers have a right to know how often the government is sued and how much they pay out to the biological parents of children who die in its care.



Photo: Lawyer Robert P. Lee says taxpayers have a right to know how often the government is sued and how much they pay out to the biological parents of children who die in its care. Credit: Bruce Edwards, Edmonton Journal.

“Lawsuits are about changing behaviour,” Lee said. “If the government got sued every time a child died in care, and it was public, and people found out who made mistakes and how bad those mistakes were, then I think there would be more motivation for the government to change their ways.”

Between 1999 and 2013, 145 children died in government care, a Journal-Herald investigation revealed.

Only 12 families have sued.

Lee said parents of children who die in foster care seldom sue because they are already disenfranchised and the death of a child compounds their powerlessness. “They’re not sophisticated enough to launch a lawsuit, or capable emotionally or psychologically,” Lee said. “And then their child dies. ... To go around and find a lawyer to sue the government — it’s just not within their ability.”

The RCMP investigated Amy’s death, no charges were laid. The government conducted no internal investigation and her death did not result in any recommendations for change. The four-page internal report related to her death says she died from a cardiac arrest, but Sarah and Merle were told she died from Sudden Infant Death Syndrome. They have been unable to see copies of the autopsy report or the hospital records. A fatality inquiry has been called, but not scheduled.

In their lawsuit, Sarah and Merle allege the province “carelessly apprehended Amy when she did not need to be apprehended,” and that officials have refused to give them any information about how she died.

“(Officials) are intentionally hiding the information,” the lawsuit reads.

Amy was buried on the Paul First Nation, where her parents were born and raised. In mid-November, Merle trudged through two feet of snow in a driving storm to visit his daughter’s grave. As the snow soaked into his jeans, he crouched to dust off a stuffed monkey holding a big red heart. Snow pelted his back. He said nothing. He returned to the family’s simple, cozy home. Sarah walked out of the bedroom, carrying their new baby girl. Her chubby cheeks were pink and her hair was tousled after a nap. She just celebrated her first birthday. The child was conceived after Amy died, and Sarah contemplated ending the pregnancy. “I didn’t think I could bear to have another child taken away from me,” she said. A friend persuaded her to keep the baby.

When she went to the hospital to give birth, she couldn’t bring herself to pack along a diaper bag.

But this time, she brought their daughter home.

Part 6: Solutions

[Six steps Alberta can take to fix the child welfare system](#)



A woman we can only identify as Ness, tends to the grave of her daughter, Jade, who died of pneumonia while in foster care in 2009. A subsequent fatality inquiry identified numerous deficiencies in the girl's care and repeated breaches of provincial rules.

Photograph by: Greg Southam , Edmonton Journal

Over the past six months, the Edmonton Journal and Calgary Herald produced the province's first definitive count of child welfare fatalities, based on death records unsealed by the Alberta government after a four-year legal battle.

Over the past six months, the Edmonton Journal and Calgary Herald produced the province's first definitive count of child welfare fatalities, based on death records unsealed by the Alberta government after a four-year legal battle.

These documents shed light on a disorganized, secretive child-welfare system in which few deaths are reviewed, trends rarely identified, and recommendations never monitored.

The provincial government can and must take immediate steps to improve the system.

Here are our six recommendations:

1. Overhaul Alberta's child death review process



Photo: Robert Fellmeth, executive director of the Children's Advocacy Institute in the U.S.

The current child death review process is convoluted and redundant, and fails to follow through on recommendations to prevent similar deaths. The provincial government must create a single, independent, multi-disciplinary organization to review all deaths of Alberta children under 18 — not just child welfare deaths — using a consistent, documented process. All deaths must be studied both individually and collectively, and investigators must collect credible data in an effort to identify trends and react to them. The government must respond to all recommendations, and implementation must be monitored. Basic information about the deaths must be publicly reported, including the child’s age, ethnicity, gender, and the location, cause and circumstances of death. The investigation process must be fully transparent — the rationale, recommendations and data must be easily accessible online — and there must be a transparent appeal process for parents and others who want to argue for a more in-depth review. Finally, the Ministry of Human Services must provide families with all the details and records related to their child’s death in care.

“These children have no lobby. They have no campaign contributions. They don’t vote. Their sole asset is democracy, and public sympathy and concern, and disclosure. That’s the sole political card they have. You take that away from them, and there will be consequences. The consequence of course is that more of them will die, and patterns of incompetence, and negligence, and error will not be discovered.”

-Robert Fellmeth, executive director of the Children’s Advocacy Institute in the U.S., which studies deaths in care



2. Repeal the publication ban on children’s names

Photo: Marilyn Buffalo, former president of the Native Woman’s Association of Canada

When children in care die, their biological parents must be free to speak publicly about their deaths. The current law forces parents to go to court to do this. The government needs to amend the Child, Youth and Family Enhancement Act to allow parents to publicly identify themselves and their child who has died in care, to provide much-needed public scrutiny of the system.

“It is a secret society and it is not healthy. We need to talk about how to make it a better healthy relationship with open communication and trust. I know that’s a hard one, but leaders have to take it on.”

-Marilyn Buffalo, former president of the Native Woman’s Association of Canada

3. End the funding disparity for aboriginal child welfare agencies



Photo: Cindy Blackstock, First Nations Child and Family Caring Society of Canada

All Alberta children deserve the same level of support from child welfare agencies, and the same access to programs. The federal government is responsible for First Nations children and provides on-reserve Delegated First Nations Agencies with less funding than the Alberta government provides to off-reserve Child and Family Services Authorities. This has created a discriminatory, two-tiered system. The provincial and federal governments must work to end this disparity.

“If we don’t do anything for this generation of children we are going to see the same impacts of residential schools, but among a greater number of children. It will really call into question the morality of the country, because if we know better, and we can do better, and we choose not to do it for kids, then what does that say about who we are as a country?”

-Cindy Blackstock, First Nations Child and Family Caring Society of Canada, which is challenging the disparity before the Canadian Human Rights Tribunal

4. Focus on prevention, and early intervention



Photo: Jean Lafrance, a former Alberta child advocate and a former children’s services assistant deputy minister.

Most of the children in government care come from high-risk situations, have frequently suffered from neglect or abuse, and are often born to mothers who abused drugs or alcohol. The government needs to focus on preventing these conditions, by funding programs that support families, so their children do not have to be apprehended. The province needs to invest in in-patient facilities for mentally ill and addicted children, including special culture-based facilities for aboriginal children and youth that focus

on suicide prevention. The province must also implement targeted prenatal care programs for high-risk mothers-to-be, to reduce the instances of premature births and congenital birth defects such as Fetal Alcohol Syndrome, which have long-term repercussions for children.

“We really haven’t been able to get into a more preventive mode. It is really still very much a casualty reactive process that waits until things are really bad before doing anything. ... The interventions that we offer, as far as I am concerned, are really no help. It’s more of a way of punishing parents than it is of helping parents.”

-Jean Lafrance, a former Alberta child advocate and a former children’s services assistant deputy minister

5. Undertake a thorough study of infant sleep protocols



Photo: Ian Mitchell, University of Calgary professor of pediatrics.

One-third of babies who died in care did so in their beds, either from unsafe sleeping conditions or Sudden Infant Death Syndrome. The government must review its safe environment assessment for caregivers, as well as its rules concerning co-sleeping and the use of bassinets, playpens and blankets in bed. All infants should be screened for risk of SIDS, and additional training provided to caregivers of infants who are at high risk for sudden, unexpected death. These reviews must be made public.

“When a child is apprehended, you and I are the parents, along with everybody else. The government is now the parent, and the standard has to be different. The standards have to be the highest possible standard.”

-Ian Mitchell, University of Calgary professor of pediatrics

6. Improve work conditions and raise educational standards for front-line caseworkers



Photo: Allan Wade, director of the Centre for Response-based practice, which trains child-protection workers around the world.

In many deaths, mistakes were repeated and policies not followed by caseworkers, many of whom are overworked and under-trained. The government must address recruitment and retention issues with higher salaries, more support and better working conditions. Child protection workers should have a minimum educational requirement of a bachelor of social work degree, a standard already in place in many other provinces.

“For political and funding reasons, we’re putting young people — who get into the field for good reasons — into positions where it is very difficult for them to be successful. ... You have people on the front line who are operating out of fear.”

-Allan Wade, director of the Centre for Response-based practice, which trains child protection workers around the world