10-MONTH-OLD LILY

An Investigative Review
Under my authority and duty as identified in the Child and Youth Advocate Act (CYAA), I am providing the following Investigative Review about the death of a 10-month-old infant who was, at the time, receiving services from the Government of Alberta. Consistent with section 15 of the CYAA, the purpose of this report is to learn from this sad circumstance and recommend ways of improving Alberta’s child intervention system.

While this is a public report, it contains detailed information about children and families. Although my office has taken great care to protect the privacy of the child and her family, I cannot guarantee that interested parties will not be able to identify them. Accordingly, I would request that readers, including the media, respect this privacy and not focus on identifying the individuals and locations involved in this matter.

In accordance with the CYAA, the names used in this report are pseudonyms (false names). Finding an appropriate pseudonym is difficult because a child’s name is part of who they are. However, it is a requirement that my office takes seriously and respectfully. We have called the infant Lily.

When she was 10 months old, Lily drowned in a container of homemade alcohol in her family home. Her family was receiving Child Intervention Services when she passed away.

This review identified the imminent and ongoing impact parental addictions have on children’s safety. It is my sincere hope that the recommendation arising from this review will improve services for Alberta’s children and youth.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate
Alberta’s Office of the Child and Youth Advocate (“the Advocate”) is an independent office reporting directly to the Legislature of Alberta, deriving its authority from the Child and Youth Advocate Act (CYAA). The Advocate has the authority to conduct investigations into systemic issues related to the serious injury or death of a child receiving designated services.

10-month-old Lily (not her real name),\(^1\) drowned in a container of homemade alcohol while in the care of her mother. Lily was taken to the local health centre where she was pronounced deceased. She was a First Nation child who lived in a First Nation community with her parents and siblings. A Delegated First Nation Agency (DFNA)\(^2\) provided Child Intervention Services.

Lily’s mother pled guilty to the charge of criminal negligence causing death for failing to provide adequate care for Lily.

The information gathered through this Investigative Review revealed one issue related to the systems that serve children and families:

1. **Creating safe environments for children exposed to parental addictions**
   Children who are exposed to addictions can experience neglect and uncertainty in their day-to-day lives. Lily was the third generation in her family to suffer from the effects of parental addictions. Although her family wanted to help, they needed guidance to create a safe environment that would protect and support Lily and her siblings.

   To help improve the effectiveness of Alberta’s services to children, the Advocate makes two recommendations.

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**Recommendation 1**

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

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1 All names throughout this report are pseudonyms to ensure the privacy of the child and family.

2 An agency that delivers on-reserve Child Intervention Services to a First Nation community. DFNA’s operate under provincial legislation but are federally funded.
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.
The Office of the Child and Youth Advocate

Alberta’s Office of the Child and Youth Advocate (the “Advocate”) is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives his authority from the *Child and Youth Advocate Act (CYAA)*, which came into force April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act (the Enhancement Act)*, the *Protection of Sexually Exploited Children Act (PSECA)*, or from the youth justice system.

Investigative Reviews

Section 9(2) (d) of the *CYAA* provides the Advocate with the authority to conduct Investigative Reviews. The Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Upon completion of an investigation under this section of the *CYAA*, the Advocate releases a public Investigative Review report. The purpose is to make findings regarding the services that were provided to the young person and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities or draw legal conclusions, nor does it replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations, which are:

- prepared in such a way that they address systemic issue(s); and,
- specific enough that progress made on recommendations can be evaluated; yet,
- not so prescriptive to direct the practice of Alberta government ministries.

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It is expected that ministries will take careful consideration of the recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.
The Advocate received a report that 10-month-old Lily (not her real name) fell into a container of homemade alcohol and drowned while in her mother’s care. At the time, a Delegated First Nation Agency (DFNA) was providing Child Intervention Services through a Safety Phase Assessment. After Lily’s death, her siblings were placed in the care of relatives. Her mother pled guilty to the charge of criminal negligence causing death for failing to provide adequate care for Lily.

The Advocate reviewed file information provided by the Ministry of Human Services. An initial report was completed which identified potential systemic issues. The Ministry was subsequently notified that there would be an Investigative Review.

Terms of Reference for the review were established and are provided in Appendix 1. A team gathered information and conducted an analysis of Lily’s circumstances through a review of relevant documentation, interviews and research. Lily’s mother and other family members met with the investigative team and shared their experiences.

A preliminary report was completed and presented to a committee of subject matter experts who provided advice related to findings and recommendations. The list of committee members is provided in Appendix 2. Committee membership was based on members’ experience and expertise in service provision to First Nation communities and child intervention best practices.

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6 All names throughout this report are pseudonyms to ensure the privacy of the child and family.

7 An agency that delivers on-reserve Child Intervention Services to a First Nation community. DFNA’s operate under provincial legislation but are federally funded.

8 A safety assessment is completed as part of an initial assessment to determine if a child is in need of protective services. Through the gathering of information and investigative interviews of family members, the need for further action is determined.

About Lily

Lily was a 10-month-old First Nation child who lived in a remote First Nation community. She was just learning to walk. She was happy, active and curious about her surroundings. Lily was surrounded by a large extended family who loved her. She was the youngest of a large sibling group; her older brothers and sisters played with her and looked out for her.

About Lily’s Family

Lily’s mother, Victoria, was born in the First Nation, but spent most of her childhood living with extended family in a neighboring community because of her mother’s addiction to alcohol. Victoria began drinking when she was a teenager and soon showed signs of addiction. However, she maintained sobriety during her pregnancies. Victoria said she enjoyed being pregnant. While pregnant, she accessed local programs and felt she brought honour to her husband and extended family.

Lily’s father, Richard, grew up in the First Nation surrounded by extended family. Richard could be violent when he abused alcohol. He worked sporadically and during times of employment his work took him out of the community, leaving Victoria to parent their children alone. Richard’s family have a strong connection to their culture and often had large family gatherings. His parents and siblings often cared for the children.

Victoria and Richard met when they were young and started a family. They both drank which often led to episodes of domestic violence. Their children regularly went to their grandparents when they felt unsafe. The family lived in a community with limited access to alcohol. When legal alcohol could not be purchased, it would be made and stored in containers.
HISTORY OF INVOLVEMENT

One year prior to Lily’s birth, Child Intervention Services received concerns that Victoria and Richard were drinking and not adequately caring for their children. Caseworkers met with their extended family to discuss the concerns. The children’s grandparents agreed to monitor the situation and Child Intervention Services ended their involvement. ¹⁰

Approximately 18 months later, when Lily was almost eight months old, Child Intervention Services received concerns that Richard and Victoria were drinking and the children were not safe. Victoria had injuries from being assaulted by Richard. She was incarcerated for the night because she was intoxicated and uncooperative with the police. Extended family members cared for the children.

A caseworker made numerous attempts to meet with Victoria after her release, eventually contacting her by phone. Victoria had separated from Richard and was staying with her mother. She declined a referral to a treatment program.

Approximately one month later, Victoria and Lily were visiting a friend’s home. Victoria had been drinking and fell asleep when a fire broke out in the residence. A family member ran into the home, removed Lily and woke Victoria. This incident was not reported to Child Intervention Services.

Circumstances of Lily’s Death

Approximately one week after the fire, Victoria was drinking at home when she fell asleep while caring for Lily. Lily’s older brother came home from school and discovered her body in a container of homemade alcohol. He woke Victoria, who rushed Lily to the local health center, where she was pronounced deceased. Richard was not at home at the time of Lily’s death.

Victoria pled guilty to the charge of criminal negligence causing death. ¹¹

After Lily passed away, her siblings were brought into care and placed with their grandparents.

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¹⁰ There was no formalized plan or discussion around the impact of the addictions on the children or how the grandparents would ensure the children’s safety.

¹¹ Criminal Code, 1985 s. 219.
DISCUSSION AND RECOMMENDATIONS

One systemic issue was explored through the Investigative Review:

1. Creating safe environments for children exposed to parental addictions
Creating safe environments for children exposed to parental addictions

Children who are raised in families affected by addictions can experience neglect and uncertainty in their day-to-day lives. This can increase their risk for physical danger and their potential for substance abuse and relationship difficulties.\(^\text{12}\) Addiction is a chronic disease characterized by compulsive use despite harmful consequences.\(^\text{13}\) It is possible for addicts to become so focused on the substance they overlook needs of their children.

When Victoria and Richard were sober they were attentive and caring parents. Their addiction was one factor that interfered in their ability to adequately care for Lily and her siblings.

In a previous Investigative Review, *9-Year-Old Bonita*,\(^\text{14}\) the Advocate identified the need to increase frontline worker’s knowledge of addictions and the impact that parental addictions has on children. When addiction reduces a parent’s ability to meet their children’s physical and emotional needs, a support network that involves extended family and community members can assist.

Child Intervention Services is implementing the Signs of Safety (SOS)\(^\text{15}\) practice model throughout Alberta. This model provides guidance to caseworkers to create networks that increase safety and reduce risk for children by focusing on family strengths and resources. Caseworkers work with families to increase the involvement of support networks to help protect children.\(^\text{16}\) Research indicates that having strong relationships are a protective factor for children.\(^\text{17}\)

When Victoria and Richard drank, relatives took care of their children. Although there were conversations between Child Intervention Services and Lily’s extended family, further work was needed with family members to help them develop a comprehensive understanding of how they could increase the children’s safety.

Child psychiatrist Bruce Perry has said, “If we create environments that are safe and predictable and relationally enriched, then all of the other factors involved in substance abuse and dependence will be so much easier to dissolve away. Our challenge is to figure out how to create these environments.”\(^\text{18}\)

\(^{12}\) Beesley & Stoltenberg, 2002  
\(^{13}\) American Psychiatric Association, 2013  
\(^{14}\) Office of the Child and Youth Advocate – Alberta, 2015  
\(^{15}\) Turnell & Edwards, 1999  
\(^{16}\) Turnell, 2011  
\(^{17}\) Hari, J., 2015  
\(^{18}\) Maté, 2008
Lily’s environment was not predictable. Her parents’ drinking and lack of stable housing were problems that were not easily solved. Family and community members tried to create a safety network but did not have the resources they needed; nor does it appear that they knew what to do when the risk increased.

**Recommendation 1**

The Ministry of Human Services should ensure that ongoing support and mentorship is provided to frontline 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.
The circumstance in which Lily lost her life was tragic. It is my hope that those who read this report will be able to look beyond the details of the incident and focus on the underlying issues. It is important to understand that this review is not about blame, it is about learning and making improvements so that other children and families may benefit from this tragedy. This Investigative Review is an opportunity to bring awareness to the importance of investing in the supports to families that help protect children.

We met Lily’s mother and extended family in the process of conducting this review. It was clear that Lily’s family loved her. We appreciate the time that they spent with us. Our thoughts and sincere condolences are extended to those who knew and loved Lily.

This is the fourth Investigative Review that has identified the impact of parental addictions. I believe that if the recommendations in this report and those from previous reports are acted upon, they will make a difference for children exposed to parental addictions.

[Original signed by Del Graff]

Del Graff
Child and Youth Advocate
APPENDIX 1: TERMS OF REFERENCE

Authority

Alberta’s Child and Youth Advocate (the Advocate) is an independent officer reporting directly to the Legislature of Alberta, deriving his authority from the Child and Youth Advocate Act (CYAA). The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the Child, Youth and Family Enhancement Act, the Protection of Sexually Exploited Children Act or from the youth justice system.

Section 9(2) (d) of the CYAA provides the Advocate with the authority to investigate systemic issues arising from the serious injury or death of a child who was receiving designated services at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest.

Incident Description

The Advocate received a Report of Death regarding 10-month-old Lily who fell into a container of homemade alcohol and drowned. She was receiving Child Intervention Services and in parental care at the time of the incident.

The decision to conduct an investigation was made by Del Graff, Child and Youth Advocate.

Objectives of the Investigative Review

1. To review and examine the supports and services
2. To comment upon relevant protocols, policies and procedures, standards and legislation
3. To prepare and submit a report which includes findings and recommendations arising from the Investigative Review

Scope/Limitations

An Investigative Review does not assign legal responsibilities, nor does it replace other processes that may occur, such as investigations or prosecutions under the Criminal Code of Canada. The intent of an Investigative Review is not to find fault with specific individuals, but to identify and advocate for system improvements that will enhance the overall safety and well-being of children who are receiving designated services.
Methodology
The investigative process will include:

• Examination of critical issues
• Review of documentation and reports
• Review of Enhancement Act Policy and casework practice
• Review of case history
• Personal interviews
• Consultation with experts as required
• Other factors that may arise for consideration during the investigation process

Investigative Review Committee
The membership of the committee will be determined by the Advocate and the OCYA Director of Investigations. The purpose of convening this committee is to review the preliminary Investigative Review report and to provide advice regarding findings and recommendations.

Chair: Del Graff, Child and Youth Advocate

Members: To be determined but may include:

• An expert in the area of service provision to remote First Nation communities
• An expert in the area of addictions
• A specialist in the area of child welfare best practices
• An Elder

Reporting Requirement
The Child and Youth Advocate will release a report when the Investigative Review has been completed.
APPENDIX 2: COMMITTEE MEMBERSHIP

Del Graff, MSW, RSW (Committee Chair)
Mr. Graff is the Child and Youth Advocate for Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in B.C and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment, and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families.

Elder Francis Whiskeyjack
Elder Whiskeyjack is employed by the Edmonton Public School Board. He wears a coat of many colours at Amiskwaciy Academy in his capacity as Elder, traditional art, song and Cree instructor and Community Cultural Resource Advisor. He has been with Amiskwaciy Academy for the past 13 years. Fluent in both English and Cree, he is also an Adjunct Professor and Cultural Advisor at the University of Alberta.

Dr. Vanda Sinha
Dr. Sinha is from McGill University, the Centre for Research on Children and Families. Her research focuses on exploring the ways that minority and marginalized communities support and care for their members in light of resource limitations, restrictions imposed by social policies and other factors that limit members’ quality of life. She is the principal investigator of the First Nation component for the Canadian Incidence Study of Reported Child Abuse and Neglect. She works with a First Nation Advisory Committee to oversee a national level study of First Nation child welfare investigations. She has worked with the Blackfoot community in Alberta. She co-authored *First Nations Child Welfare* in Alberta in 2011.

Crystal Cardinal
Ms. Cardinal supervises the Family Group Conferencing program that provides facilitation services for Alberta Child and Family Services as well as for Delegated First Nation Agencies (DFNAs).

Caara Goddard
Ms. Goddard is one of seven Canadians certified as a Signs of Safety consultant. She has been using the Signs of Safety approach for just over five years in all areas of her work at Ktunaxa Kinbasket Child and Family Services Society (KKCFSS — a Delegated Aboriginal Agency in British Columbia). As a child protection and guardianship worker in an Aboriginal community, one of her focus areas has been adapting the Signs of Safety tools to better suit the needs of the Aboriginal community.
APPENDIX 3: BIBLIOGRAPHY


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