4-MONTH-OLD CORAL

AN INVESTIGATIVE REVIEW

Office of the Child and Youth Advocate, Alberta

March 2026

LEGISLATIVE AUTHORITY

Under my authority and duty as identified in Section 9(2)(d) of the *Child and Youth Advocate Act* (*CYAA*), the following is an individual investigative review regarding Coral. Her circumstances meet the criteria for a **systemic review**. Coral and her family had received Child Intervention through an Intake within two years of her passing.

Investigative reviews are designed to improve the lives of young people by identifying ways to enhance services and supports, leading to system improvements and better outcomes for young people and their families. Releasing individual reviews ensures that each young person's circumstance is reported in a consistent manner and provides increased transparency and public accountability. I believe that this is in the public interest. I will review and report annually on themes identified across the investigative reviews and include recommendations.

The investigation process includes:

- Examination of critical issues
- Review of documentation and reports
- Review of policy and casework practice
- Personal interviews
- Other factors that may arise for consideration
- Notification and involvement of the young person's family, Band, Delegated First Nation Agency, community or cultural group, relevant Ministry, law enforcement agency, Office of the Chief Medical Examiner, Alberta Health Services, and any other person the Advocate considers appropriate.

In accordance with the *CYAA*, investigative reviews must be non-identifying. Therefore, the names used in these reports are pseudonyms (false names). Great care has been taken to protect their privacy; however, there is no guarantee that interested parties will be unable to identify them. Accordingly, readers and interested parties, including the media, should respect this privacy and not focus on identifying the individuals and locations involved in these matters.

Investigative reviews do not contain findings of legal responsibility or conclusions of law nor replace other processes that may occur, such as investigations or prosecutions under the *Criminal Code* of Canada. The intent of a review is not to find fault with specific individuals but to identify key issues and meaningful findings.

Coral's experiences were unique, and she left a lasting impression on those who knew and loved her. My heartfelt condolences go out to her family and those who cared about Coral.

Respectfully,

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

ABOUT CORAL AND HER FAMILY

Coral[1] was four months old when she was found unresponsive in her bassinet. The Office of the Chief Medical Examiner concluded that she died from undetermined causes. Coral and her family had received Child Intervention through an **Intake**[2] within two years of her passing.

Coral was a happy and alert baby who smiled at everyone. She was part of a blended family and was Chad and Ruth's only child.

SUMMARY OF CORAL'S EXPERIENCES WITH GOVERNMENT SYSTEMS

Coral from Birth to 4 Months Old

Child Intervention received a report related to physical injury of Coral's step-siblings months before she was born. Involvement ended after a safety plan was developed and a support network was put in place.

Coral was born six weeks premature and was hospitalized for one month because of complications related to her breathing, feeding, and blood pressure. Ruth and Chad were regularly at the hospital and said that they had challenges caring for their other children while being with Coral. They were provided with transportation and referred to community-based services.

Coral's health stabilized, and she was discharged home with oxygen support. Her parents received teaching and information about caring for a premature baby, including feeding, safe sleep and risks associated with sudden infant death. Coral was seen by a home visitation nurse who monitored her health over the next month. She had follow-up appointments with the breathing clinic and with her pediatrician.

When Coral was two months old, Child Intervention received a report about emotional injury related to family violence. Chad was intoxicated and had an argument with Ruth that escalated and resulted in a police response. Ruth disclosed additional assaults in the previous two months. Chad was charged, incarcerated, and a No-Contact Order (NCO) was obtained. Intervention involvement ended at Intake, indicating that the previous safety plan and NCO were in place. The family's identified supports were not contacted to confirm that they were aware of the new concerns and their roles and responsibilities as part of the safety plan. Chad's substance use was not addressed before involvement ended.

The following week, Coral was seen at the breathing clinic, and it was determined that she did not require oxygen support. Her pediatrician noted that she had gained weight and overall was healthy. Regular follow-up appointments were scheduled.

Two months later, four-month-old Coral was found unresponsive in her bassinet. The Office of the Chief Medical Examiner concluded that she died from undetermined causes. Coral is deeply missed by those who loved her.

1. All names in the report are pseudonyms.
2. Bolded terms are defined in Appendix A.

TIMELINE OF SIGNIFICANT EVENTS

Birth to 4 Months Old

- **Born premature**
  - Respiratory and feeding concerns
- **1 Month Old**
  - Discharged home
    - Home visitation nurse, breathing clinic, pediatrician supports
- **2 Months Old**
  - Child Intervention involvement
  - Medical follow-up
    - Health improved

4-month-old Coral passed away

FINDINGS

Children and Family Services

Child Intervention received a report about emotional injury when Coral was two months old because of her father's substance use and family violence between her parents. It was determined that the previous supports in place and a No-Contact Order were sufficient to end involvement at Intake. The family's identified support network was not contacted to re-assess their role and Chad's substance use was not addressed. Coral may have benefited from further assessment of her family's circumstances and confirmation that the safety plan in place was adequate.

Health

Coral was born premature and was hospitalized for one month. She received timely and appropriate health services to meet her needs. Before her discharge, her parents were given information about caring for a premature baby, safe sleep and risks associated with sudden infant death. Coral had specialized supports for her specific needs and was followed by a pediatrician to support her growth and development.

THEMES TO TRACK

1. Assessment

Coral required a further assessment of her family's circumstances and confirmation that the safety measures in place were adequate.

2. Safety planning

Coral may have benefited from safety planning that confirmed the support network was aware of her family's current circumstances and their roles and responsibilities.

APPENDIX A: GLOSSARY

Intake

The gathering and analysis of information to determine whether a child is in need of intervention under the *Child, Youth and Family Enhancement Act*.

Systemic Review

Under the *Child and Youth Advocate Act*, the Advocate may conduct a public review when a young person is seriously injured or dies while (or within two years of) receiving designated services (*Child, Youth and Family Enhancement Act* intakes, assessments, post-18 supports, was in open or closed custody under the *Youth Criminal Justice Act*, and/or involvement under the *Protection of Sexually Exploited Children Act*) to determine if systemic issues are present.

4-MONTH-OLD CORAL · AN INVESTIGATIVE REVIEW

NORTH OFFICE

600, 9925 109 Street NW
Edmonton AB T5K 2J8

SOUTH OFFICE

2420, 801 6 Avenue SW
Calgary AB T2P 3W3

ocya.alberta.ca · 1-800-661-3446