



# **7-MONTH-OLD JADE**

## **AN INVESTIGATIVE REVIEW**

Office of the Child and Youth Advocate, Alberta  
**May 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 Jade. Her circumstances meet the criteria for a **systemic review**. Jade 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.

Jade'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 Jade.

Respectfully,

[Original signed by Terri Pelton]

**Terri Pelton**

Child and Youth Advocate (Alberta)

## ABOUT JADE AND HER FAMILY

Jade<sup>1</sup> was seven months old when she was found deceased in her home. The Office of the Chief Medical Examiner concluded that she died from a bacterial respiratory infection, with contributing factors that included an unsafe sleep environment. Jade and her family had received Child Intervention through an **Intake**<sup>2</sup> within two years of her passing.

Jade was an Indigenous infant who lived in her parents' First Nation. She was a part of a blended family and the youngest of Victor and Lenore's children. They used substances, had mental health challenges and, at times, their relationship was violent; they often separated and reconciled. Child Intervention was involved with Jade's siblings three times before her birth. Involvements ended with limited documentation about the services provided.

## SUMMARY OF JADE'S EXPERIENCES WITH GOVERNMENT SYSTEMS

### Jade from Birth to 7 Months Old

Jade was born healthy, and her parents received hands-on training and information about caring for newborns, including safe sleeping arrangements. They were referred to community-based health professionals before Jade was discharged from the hospital. The next day, Jade was taken to a local health centre for a rash. Doctors explained that it would resolve on its own and did not require treatment.

In Jade's first three months, Child Intervention was notified three times about Victor and Lenore's substance use, drug trafficking, and family violence. The police responded and noted that caseworkers had attended the family's home twice for these issues. It is not known how the concerns were addressed by Child Intervention, and Intakes were not completed.

Jade was taken to a local health centre for breathing issues and diagnosed with a respiratory tract infection. She was given antibiotics, and Lenore was encouraged to return if Jade's symptoms worsened.

Within months, Victor and Lenore separated. Child Intervention received a report about emotional injury related to drug trafficking and Lenore's substance use. Caseworkers and the family agreed that relatives would care for the children while Lenore went to treatment, but she did not follow through; Victor was not involved in case planning. There is little documentation to indicate how the concerns were addressed before involvement ended.

Little is known about Jade's circumstances over the next month. When she was seven months old, the police and emergency medical services responded because Jade was unresponsive and the adults in the home were intoxicated. Jade was pronounced deceased. The police investigated, and charges were not laid. Child Intervention received a report about these concerns. The family was referred to a community prevention program, and intervention involvement ended. The Office of the Chief Medical Examiner concluded that she died from a bacterial respiratory infection, with contributing factors that included an unsafe sleep environment. A funeral was held in her honour, and she is deeply missed by those who knew and loved her.

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

# TIMELINE OF SIGNIFICANT EVENTS

## Birth to 7 Months Old

- **Birth - 3 Months Old**

- Born healthy
- 2 visits to the local health centre for minor illnesses
- Child Intervention received 3 concerns about substance use, drug trafficking and family violence
  - Intakes not completed

- **4 - 7 Months Old**

- Child Intervention involved 2 times

## **7-month-old Jade passed away**

# FINDINGS

## Children and Family Services

In Jade's first three months, Child Intervention was notified three times about Victor and Lenore's substance use, drug trafficking, and family violence. The police responded and noted that caseworkers had been to the family's home twice for these issues. It is not known how the concerns were addressed, and Intakes were not completed. The Enhancement Policy Manual (EPM) outlines the considerations for determining whether a reported concern meets the legislative criteria for an Intake. It provides practice guidance for determining whether a child is in need of intervention, based on the nature of the safety concerns, the child's well-being, and existing family strengths and safety, which was not followed.

When Jade was four months old, Child Intervention received a report about drug trafficking and Lenore's substance use. Caseworkers and the family agreed that relatives would care for the children while she went to treatment, but Lenore did not follow through; Victor was not involved in case planning. There is little documentation to indicate how the safety concerns were addressed before involvement ended. The EPM outlines the requirements for recording information to maintain Child Intervention File Standards. Complete and accurate information about planning and decisions is required to support a young person's safety and well-being, which was not completed.

Children and Family Services has been notified that an internal review of Jade's circumstances may be beneficial to determine if further systems improvements are required to strengthen adherence to policy and practice standards related to the above concerns.

## Health

Prior to her discharge from the hospital, Jade's parents received training and information on caring for newborns, including safe sleep practices. Jade was taken to a local health centre twice, where she had timely assessments and was treated.

# THEMES TO TRACK

## 1. Implementation and consistency of policy and practice expectations

Policy and practice guidance outlined in the Enhancement Policy Manual related to Intakes and documentation were not followed.

# APPENDIX A: GLOSSARY

## **Intake**

A report completed when Child Intervention Services receives a community or professional concern about possible risk to a child as per 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.

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### **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