9-MONTH-OLD KYLE

AN INVESTIGATIVE REVIEW

Office of the Child and Youth Advocate, Alberta

May 2026

LEGISLATIVE AUTHORITY

Under my authority and duty as identified in Section 9.1 of the *Child and Youth Advocate Act* (*CYAA*), the following is an individual investigative review regarding Kyle. His circumstances meet the criteria for a **mandatory review**. Kyle and his family were receiving Child Intervention through an Enhancement Agreement at the time of his 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.

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.

Kyle's experiences were unique, and he left a lasting impression on those who knew and loved him. My heartfelt condolences go out to his family and those who cared about Kyle.

Respectfully,

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

ABOUT KYLE AND HIS FAMILY

Kyle[1] was nine months old when he was found unresponsive in the bathtub. Emergency medical services (EMS) responded, and he was taken to the hospital, where he was pronounced deceased. The Office of the Chief Medical Examiner continues to investigate his death. At the time of his passing, Kyle and his family were receiving Child Intervention through an **Enhancement Agreement** (**EA**).[2]

Kyle was an adorable and active First Nation infant. He was part of a blended family and was Megan and Brandon's only child together. His parents had a volatile relationship, and they often separated and reconciled.

SUMMARY OF KYLE'S EXPERIENCES WITH GOVERNMENT SYSTEMS

Kyle from Birth to 9 Months Old

Child Intervention received a report shortly before Kyle was born related to concerns for physical injury regarding his older siblings. Caseworkers and the police responded, and charges were not laid. A safety plan was developed with Megan's mother, Collette, and sister, Kayla, who agreed not to leave the children unsupervised with their parents.

Kyle was born three weeks prematurely and was healthy. He did not require further hospitalization and was discharged to his parents' care with a referral for an infant hearing screening with a pediatric audiologist; he was not taken to the appointment. Kyle was added to the Child Intervention **Assessment**. Caseworkers received additional concerns about inadequate supervision and physical discipline related to his older siblings. Megan and Brandon entered into an EA, the safety plan remained in place, and a family support worker was provided to improve their parenting skills and access community-based programs.

Two weeks later, the police responded to an incident of family violence; Brandon was arrested, and a No-Contact Order (NCO) was put in place. Caseworkers learned that Kyle and his siblings had been left alone with their parents, and there were concerns about Brandon's substance use. Collette said that the level of supervision in the safety plan was unsustainable. Shortly after, Megan and her mother, along with the children, moved into a housing program that provided support for housing stability. Family members agreed to supervise visits for Brandon with the children.

Over the next two months, Megan met with a family support worker. Involvement ended at the conclusion of the EA. During this time, it does not appear that Kyle received routine infant health services.

Over the next two months, Child Intervention received concerns twice for Kyle and his siblings related to emotional injury. Brandon had breached the NCO and went to Megan's home. The police responded following both incidents of family violence. Megan was under the influence of alcohol; however, there was a sober relative who agreed to take care of the children. Brandon was arrested for breaching the NCO. Child Intervention determined the concerns did not meet the threshold to generate an **Intake**.

Approximately one month later, Child Intervention received a report about emotional injury related to family violence and Brandon's alcohol use. Brandon and Megan had reconciled, and the police charged him for physically assaulting her. An Emergency Protection Order was obtained, and the NCO remained in place. Megan shared that she recognized the impacts family violence had on her children; however, she also wanted to maintain her relationship with Brandon. Megan entered into an EA and was given information about how to access counselling and parenting supports.

Two weeks later, nine-month-old Kyle was found unresponsive in the bathtub. EMS responded, and he was taken to the hospital, where he was pronounced deceased. The Office of the Chief Medical Examiner continues to investigate his death. A funeral was held in his honour, and he is deeply missed by those who knew and loved him.

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

TIMELINE OF SIGNIFICANT EVENTS

Birth to 9 Months Old

- **Birth – 3 Months Old**
  - Child Intervention involvement
    - Safety plan
    - Enhancement Agreement
- **4 – 9 Months Old**
  - Child Intervention received 2 concerns; Intakes not completed
  - Child Intervention involvement
    - Enhancement Agreement

9-month-old Kyle passed away

FINDINGS

Children and Family Services

Child Intervention received a report about physical injury related to Kyle's older siblings shortly before he was born, and he was added to the intervention Assessment after his birth. A safety plan was developed with his parents' support network to supervise Megan and Brandon's contact with their children; however, the network was unable to sustain the level of supervision requested. The plan concluded when their living circumstances changed. The Enhancement Policy Manual outlines that safety plans must be regularly reviewed and adjusted to ensure they continue to address the family's circumstances. Kyle and his siblings would have benefited from timely revisions of the safety plan.

Supports and services were provided through Enhancement Agreements (EA). Kyle received appropriate services through the first EA. Within one month of its conclusion, Child Intervention received concerns about Megan and Brandon's alcohol use, family violence, and Brandon's repeated breaches of a No-Contact Order. Despite these persistent concerns, an Intake was not completed. The Enhancement Policy Manual provides guidance that, when receiving information from the community, consideration must be given to the frequency, severity, and impact on the child to determine whether an Intake should be generated.

The Ministry of Children and Family Services has been notified that an internal review of Kyle's circumstances may be beneficial to determine if improvements are required to strengthen adherence to policy and practices standards related to safety planning and completing an Intake.

Health

Kyle was born three weeks prematurely and received appropriate health services and referrals.

THEMES TO TRACK

1. Safety planning

The safety plan was not sustainable and required timely review and adjustment to be effective for Kyle and his family.

2. Implementation and consistency of policy and practice expectations

Kyle would have benefited from adherence to policy and practices standards outlined in the Enhancement Policy Manual related to safety planning and completing an Intake.

APPENDIX A: GLOSSARY

Assessment

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

Enhancement Agreement (EA)

A voluntary agreement under the *Child, Youth and Family Enhancement Act* to provide services and support to a family or a young person who is 16 or 17 years old. It is intended to address protection concerns while the child remains with a guardian or livesindependently.

Intake

A report completed when a community member or professional reports a concern aboutpossible risk to a child as per the *Child, Youth and Family Enhancement Act*.

Mandatory Review

Under the *Child and Youth Advocate Act*, the Advocate must conduct a Mandatory Review when a young person dies who had an agreement or order under the *Child, Youth and Family Enhancement Act* at the time of or within two years of their death. A public report must be released within one year of being notified of the young person's death.

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