13-YEAR-OLD SETH

AN INVESTIGATIVE REVIEW

Office of the Child and Youth Advocate, Alberta

July 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 Seth. His circumstances meet the criteria for a **mandatory review**. Seth was receiving Child Intervention through a Permanent Guardianship Order 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.

Seth'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 Seth.

Respectfully,

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

ABOUT SETH AND HIS FAMILY

Seth[1] was 13 years old when he died from a suspected overdose. The Office of the Chief Medical Examiner continues to investigate his death. Seth was receiving Child Intervention through a **Permanent Guardianship Order** (**PGO**)[2] at the time of his passing.

Seth was a caring and sensitive Métis youth known for his sense of humour. He loved his family and often prioritized others' needs over his own. Seth had significant trauma and instability, and over time, he started using substances.

Seth was the oldest of Tessa and Hank's children. They had chronic instability and used substances. His three older siblings became the subjects of a PGO and were adopted before he was born. Seth and his younger sister, Demi, often lived with their grandparents, Jacob and Laura. After a period of time, Jacob obtained obtained guardianship of the children.

SUMMARY OF SETH'S EXPERIENCES WITH GOVERNMENT SYSTEMS

Seth from Birth to 10 Years Old

Shortly after Seth's birth, Child Intervention received a report about emotional injury related to Tessa and Hank's ability to meet his needs. They shared that they lived with relatives and were accessing community-based parenting supports. A safety plan was developed with them and their extended family members, and after confirming their engagement with community support workers, involvement ended.

When Seth was seven months old, Child Intervention received a report about neglect related to his parents' substance use and ability to meet their son's needs. The family had moved out of Jacob's home. Caseworkers developed a safety plan that included Hank and Tessa returning to live with Jacob, who would provide support. Intervention involvement ended, and soon after, Jacob obtained joint guardianship of Seth.

Over the next two years, Child Intervention received four reports about neglect, and emotional and physical injury. Concerns were related to Hank and Tessa's substance use, ability to meet their son's needs, and a physical altercation between relatives in the home. Each time, the concerns were not substantiated. Jacob said that he would not allow substance use in his home and would continue to ensure Seth's well-being. Hank and Tessa agreed to continue living with Jacob, and access community-based parenting supports. Intervention involvement ended. Three months later, Tessa had her daughter, Demi, and Jacob became her guardian.

Seth received routine medical care and was taken to the hospital multiple times for minor illnesses, injuries, and skin infections. Each time, he was treated and discharged home.

In elementary school, Seth had one school move; the reason is not known. In Grade 1, educators noted language delays, and he received speech and language services. He had an Individualized Program Plan (IPP) that included classroom accommodations, literacy support, and small-group activities, which continued throughout his elementary years. In Grade 3, teachers noted that Seth had difficulty managing his impulses and needed increased supervision. He was supported by a school counsellor to develop strategies.

When Seth was nine years old, Child Intervention received a report about neglect. Concerns were related to his parents' substance use, family violence, the condition of the home, and inappropriate caregivers. It was learned that Hank and Tessa had been caring for their children for several years. A safety plan was developed with Jacob that included him being the primary caregiver and supervised contact between the children and their parents. Hank and Tessa's engagement with the case team lessened, and their whereabouts became unknown. It was determined that Seth and Demi were safe in their grandfather's care, and involvement ended.

When Seth was 11 years old, Child Intervention received a report about emotional injury related to inappropriate discipline. Jacob said that he had difficulty managing the children's behaviours and that they often left home without permission. He told caseworkers that police frequently found them with Tessa and Hank, who lived in encampments and had chronic addiction concerns. Jacob entered into an **Enhancement Agreement**, and caseworkers provided a support worker to help him with parenting strategies and to connect with resources, but his engagement with the case team was poor. Involvement ended at the conclusion of the Agreement.

Seth from 12 to 13 Years Old

At 12 years old, Seth's impulsive behaviours increased. He was assessed by his pediatrician and diagnosed with attention-deficit/hyperactivity disorder (ADHD) and prescribed medication; however, he did not take it consistently. The family was referred to community-based supports and participated in counselling and youth programming.

Seth's behaviours did not improve and he was assessed by a multidisciplinary team that included a psychologist, and speech and language pathologist. It was noted that he was at risk for neurodevelopmental concerns and was diagnosed with a learning disorder,

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

conduct disorder, and adverse childhood experiences. Recommendations included monitoring his mental health and addictive tendencies, ongoing pediatric follow-up, counselling, youth mentorship, and supportive school programming.

Within months, Child Intervention received a report about neglect related to inappropriate discipline and inadequate supervision. Jacob told caseworkers that he was overwhelmed and said that the children continued to leave home without permission. Seth's assessment findings were shared with caseworkers, but recommendations were not implemented. Jacob entered into a **Custody Agreement**, and Seth and Demi were briefly placed in foster care before being moved to a kinship placement with their great aunt, Betty. Jacob's engagement with the case team lessened, and the children were **apprehended**.

In Grade 7, Seth transitioned to a new school and struggled to adjust. He shared that he missed the staff from his previous school. Educators provided support and facilitated a connection with his former teachers. Over time, as his instability increased, his attendance became sporadic, making implementing supports challenging.

At 12 years old, Seth began using substances, and his mental health declined. He was taken to the hospital, assessed, and diagnosed with an adjustment disorder. Prior to being discharged home, a safety plan was developed, and recommendations included counselling and resuming his ADHD medication; however, he refused.

Seth told caseworkers that he missed his parents, and visits between Tessa, Hank, and their children were arranged, but their engagement was poor. Over the next several months, Seth's high-risk behaviours increased, and he had several placement moves that included a shelter. Safety plans were developed, and he was provided with a cell phone to communicate with his case team. Demi continued living with Betty.

When Seth was 13 years old, he was placed in a foster home, and he became the subject of a **Permanent Guardianship Order** (**PGO**). Over the next three months, he frequently left without permission for extended periods and began spending more time with Tessa and Hank in encampments. Efforts by caseworkers and the police to locate him were often unsuccessful. Seth disengaged from supports, his substance use escalated, and he had difficulty following safety plans.

That same year, the Office of the Child and Youth Advocate was informed that Seth had been seriously injured and hospitalized following an overdose on unknown substances. He was assessed and diagnosed with substance use and mental health disorders, and began medication. He was later transitioned to a psychiatric unit for further stabilization and made a full recovery. When Seth was discharged, ongoing medication and counselling were recommended, but he refused. A safety plan was developed and he was discharged to group home staff.

Seth spent the majority of the following seven months confined under various legislations. While there, he did well with the structure and routine, and took part in addiction, mental health and education programming. Discharge recommendations included continued supports, but he refused and often returned to live with his parents in encampments.

During his last period of confinement, Seth was connected to his culture and said that he enjoyed learning about drumming and traditions. He was transitioned to a residential treatment program, and left the following day. He was reported missing to the police.

Two days later, 13-year-old Seth was found deceased in the community from a suspected overdose. The Office of the Chief Medical Examiner continues to investigate his death. Seth is deeply missed by those who knew and loved him.

TIMELINE OF SIGNIFICANT EVENTS

Birth to 11 Years Old

- **Birth – 3 Years Old**
  - Child Intervention involved 6 times
    - Grandfather obtained joint guardianship
  - Multiple hospital visits for minor illnesses
- **5 – 8 Years Old**
  - Started school
    - Speech and language supports
    - Individualized Program Plan
    - School move
    - Counselling
- **9 Years Old**
  - Child Intervention involvement
- **11 Years Old**
  - Child Intervention involvement
    - Enhancement Agreement

12 to 13 Years Old

- **12 Years Old**
  - Assessed
    - Diagnosed with attention-deficit/ hyperactivity disorder (ADHD)
    - Prescribed medication
  - Multidisciplinary team assessment
    - Learning and mental health diagnoses
  - Child Intervention involvement
    - Custody Agreement
    - Apprehended
  - Placement instability
  - Mental health concerns
  - Substance use began
- **13 Years Old**
  - Permanent Guardianship Order
    - Placement instability
  - Serious injury
    - Hospitalized following overdose
    - Assessed
    - Diagnosed with substance use and mental health disorders
    - Hospitalized in psychiatric unit
  - Confined under various legislations
  - Residential treatment

13-year-old Seth passed away

FINDINGS

Children and Family Services

In Seth's first 11 years, Child Intervention was involved 8 times because of neglect and emotional and physical injury. Concerns were related to his parents' substance use, family violence, and his caregiver's ability to meet his needs. Seth's grandfather, Jacob, was a significant support for the family and assumed a caregiving role when concerns escalated. Safety planning included Seth and his parents living with Jacob for additional support, which they often did not follow when intervention involvement ended. Seth would have benefited from a robust assessment of the effectiveness of the safety plan to appropriately meet his needs.

During Seth's adolescence, he had a multidisciplinary team assessment that identified risks related to his development, mental health, and substance use. Recommendations included ongoing monitoring and support, but were not implemented. As Seth's substance use escalated and mental health declined, case planning became crisis-driven. Although safety plans were developed to address immediate risk, he refused to follow them. The Enhancement Policy Manual indicates that young people benefit from case planning that is tailored, continuous, and informed by available assessment recommendations. This helps minimize disruptions and takes into account their unique needs, ensuring the necessary services are in place to support their well-being and development. Seth would have benefitted from ongoing reassessment and monitoring of the effectiveness of safety plans, that included considerations of his developmental well-being, and complex needs.

The Ministry of Children and Family Services has been notified that an internal review may be beneficial in Seth's circumstances to determine if further system improvements are required to strengthen adherence to policy requirements related to the concerns above.

Health and Mental Health and Addiction

In Seth's early years, he received timely medical care for minor illnesses, injuries, and skin conditions. When he was 12 years old, he was assessed and received appropriate diagnoses, pharmaceutical interventions, and prompt connections to community-based therapeutic and youth services.

During his adolescence, Seth began using substances, and his mental health declined. He was hospitalized twice for these concerns and received appropriate diagnoses and recommendations, but he often refused services. As his instability escalated, Seth was often confined under various legislations. While in these structured settings, he received coordinated supports, including addiction, mental health, and education programming.

Education

In Seth's earlier years, he received timely speech and language services when concerns were noted. He was supported through an Individualized Program Plan (IPP) that included classroom accommodations, literacy support, and small-group instruction to support his learning.

Seth had challenges when he transitioned to junior high school. Educators collaborated with his previous teachers to support this transition. Seth's instability impacted his education, and after Grade 7, he primarily completed schoolwork during periods of confinement.

THEMES TO TRACK

1. Assessment

In his first 11 years, Seth required a robust assessment of the effectiveness of the Child Intervention safety plan to appropriately meet his needs.

2. Implementation and consistency of policy and practice expectations

Policy and practice standards outlined in the Enhancement Policy Manual related to case planning were not followed.

3. Toxic drug supply

Seth began using substances at 12 years old, and died from a suspected drug overdose the following year. The Advocate remains deeply concerned about the number of young people impacted by substance use.

APPENDIX A: GLOSSARY

Apprehended

The court grants the "Director" as defined in the *Child, Youth and Family Enhancement Act* (*CYFEA*) temporary custody of the child on reasonable and probable grounds that the child needs intervention in accordance with *CYFEA*.

Custody Agreement (CA)

A voluntary agreement between guardians and the "Director" as defined in the *Child, Youth and Family Enhancement Act*. Decision-making is shared and the young person is placed outside the home.

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 lives independently.

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.

Permanent Guardianship Order (PGO)

Under this order, the "Director" as defined in the *Child, Youth and Family Enhancement Act* becomes the sole guardian of a child. The order is sought when it is believed that the child cannot be safely returned to their guardian within a specified time frame.

Secure Services

The *Child, Youth and Family Enhancement Act* allows for the confinement of a child for up to 30 days for stabilization and assessment when the child is found to be an immediate danger to themselves or others.

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