11-MONTH-OLD ROYCE

AN INVESTIGATIVE REVIEW

Office of the Child and Youth Advocate, Alberta

August 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 Royce. His circumstances meet the criteria for a **mandatory review**. Royce 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.

Royce'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 Royce.

Respectfully,

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

ABOUT ROYCE AND HIS FAMILY

Royce[1] was 11 months old when he was found deceased; he had been co-sleeping with a relative. The police investigated and concluded their involvement. The Office of the Chief Medical Examiner continues to investigate. Royce and his family were receiving Child Intervention through an **Enhancement Agreement** (**EA**)[2] at the time of his passing.

Royce was a happy and curious First Nation infant. His parents, Nyla and Grant, were young, and at times, their relationship was violent; they both had previous Child Intervention involvement, and Grant was receiving support through the **Transition to Adulthood Program**. There was a No-Contact Order (NCO) between them when Royce was born. He and his mother lived with his maternal grandparents, Nadia and Samuel, in their First Nation. Grant lived in the same community and had limited involvement with his son.

SUMMARY OF ROYCE'S EXPERIENCES WITH GOVERNMENT SYSTEMS

Royce from Birth to 11 Months Old

Nyla received prenatal care in her First Nation, and Royce was born healthy in an urban hospital. Health professionals provided his family with newborn education, including safe sleep protocols, and connected them with community-based resources before he was discharged home the following day.

Royce was seen by his family physician; his immunization schedule was reviewed, and his hearing, feeding, and sleep were evaluated. Early intervention nurses provided hands-on parenting support and referrals to community-based services.

At one month old, Royce was admitted to a children's hospital for breathing difficulty. He was diagnosed with a lung infection and given antibiotics and oxygen therapy. Social workers provided financial support for meals and parking. The following week, Royce was discharged to Nyla's care with a referral to community home care for his oxygen therapy. Two months later, a breathing study confirmed that he no longer required oxygen therapy, and it ended.

At times, Grant would go to Nadia and Samuel's home to visit his son. Child Intervention received a report about emotional injury related to family violence between Royce's parents. Police removed Grant from the home, and he was charged with breaching the NCO. Caseworkers connected Nyla to counselling and educational supports, spoke with the police, and developed a safety plan with her and her parents; attempts to engage Grant were unsuccessful. A conversation about safe sleep practices did not occur before intervention involvement ended.

Royce was vaccinated, treated for a skin condition, and referred to specialists for concerns about his hearing and physical development. It was determined that he did not require follow-up care for his development, and after several missed audiology appointments, his family refused services because their concerns about his hearing had lessened over time.

When Royce was eight months old, Child Intervention received a report about emotional injury. Concerns were related to family violence between Grant and Nyla, in which he was intoxicated. Grant was charged with breaching the NCO and briefly incarcerated. Caseworkers spoke to health professionals to understand Royce's medical needs and the family's circumstances. Although a safety plan was developed, safe sleep practices were not discussed with his parents. They subsequently entered into an EA.

Within the week, 11-month-old Royce was found deceased; he had been co-sleeping with a relative. The police investigated and concluded their involvement. The Office of the Chief Medical Examiner continues to investigate. A wake and funeral were held in his First Nation to honour his memory. Royce was loved by his family and friends, who continue to mourn his unexpected loss.

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

TIMELINE OF SIGNIFICANT EVENTS

Birth to 5 Years Old

- **Born healthy**
  - Family physician and early intervention
- **1 – 2 Months Old**
  - Hospitalized for breathing concerns
    - Oxygen therapy and antibiotic treatment
    - Home care and breathing study
- **3 Months Old**
  - Child Intervention involvement
- **4 – 7 Months Old**
  - Vaccinated
  - Specialist referrals
- **8 – 11 Months Old**
  - Child Intervention involvement
    - Enhancement Agreement

11-month-old Royce passed away

FINDINGS

Children and Family Services

Child Intervention first became involved with Royce when he was three months old because of emotional injury related to family violence. Caseworkers collaborated with the police, developed appropriate safety plans with the family, and connected them to community-based supports before involvement ended. Weeks later, Child Intervention received a report about similar concerns. Caseworkers consulted with other professionals supporting the family to inform interventions, and Nyla and Grant entered into an Enhancement Agreement.

During both involvements, conversations about safe sleeping practices with the parents did not occur. The Enhancement Policy Manual provides practice guidance related to assessing a child's sleeping arrangements and discussing safe sleep, which was not followed. This finding has been formally shared with the Ministry of Children and Family Services.

Health

When Royce was born, medical professionals provided newborn education, including safe sleep protocols, and connected Royce's family to community-based resources. He was regularly monitored and supported by his family doctor, and nurses from an early intervention program provided hands-on parenting support and referrals to community-based resources. Royce's family received information about vaccinations, and he had pharmaceutical support as needed. He had timely assessments and was supported by specialized medical staff as his needs evolved.

THEMES TO TRACK

1. Collaboration and information sharing

Caseworkers gathered important information from police and health professionals, which informed interventions.

2. Services and supports

Royce's family would have benefited from receiving information about safe sleep practices during Child Intervention involvements.

APPENDIX A: GLOSSARY

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 their death. A public report must be released within one year of being notified of the young person's death.

Transition to Adulthood Program (TAP)

A provincial program that provides financial supports and skill development for young adults transitioning to independence.

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