5-MONTH-OLD CAMILLE

AN INVESTIGATIVE REVIEW



Office of the Child and Youth Advocate, Alberta

October 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 Camille. Her circumstances meet the criteria for a **systemic review**. Camille and her family were receiving Child Intervention through an Assessment at the time 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.

Camille'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 Camille.

Respectfully,

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

ABOUT CAMILLE AND HER FAMILY

Camille[1] was four months old when she was taken to the hospital with head trauma and later passed away. The Office of the Chief Medical Examiner concluded that she died from her injuries. The police investigated, and charges were laid. Camille and her family were receiving Child Intervention Services through an **Assessment**[2] at the time of her passing.

Camille loved to be cuddled and held by her parents. She was the youngest of Manon and Luc's children. Child Intervention was involved with her older siblings because of their parents' substance use and family violence. Safety plans and counselling supports were frequently offered before involvement ended.

SUMMARY OF CAMILLE'S EXPERIENCES WITH GOVERNMENT SYSTEMS

Camille from Birth to 5 Months Old

Camille had limited systems involvement, and little is known about her circumstances. Camille was born healthy, and soon after giving birth, Manon told medical staff that she was depressed. She said that she had a support system she could rely on, and was referred to the hospital social worker, who provided her with education around the risks of postpartum depression. The next day, Camille was discharged to her parents' care, and Manon was connected to her local public health centre. She went to the initial assessment, but declined further supports.

Camille did not receive additional health services until she was one month old. She had episodes of decreased responsiveness and was taken to the hospital. She was diagnosed with brief resolved unexplained events. Although her symptoms stabilized, doctors recommended further treatment; however, Manon declined and left against medical advice. Attempts to contact the family were unsuccessful. Messages were left recommending returning to the hospital or following up with their doctor, but follow up did not occur.

A few months later, Manon and Luc separated and shared parenting time. Camille was seen at her local health clinic, and concerns were not noted for her growth and development. Days before she turned five months old, Camille was found unresponsive at her mother's home. Emergency medical services responded, performed cardiopulmonary resuscitation, and administered medication before transporting her to the hospital.

Camille was admitted to the pediatric intensive care unit. An X-ray indicated that she had a severe, life-threatening brain injury, and Camille was placed on life support.

Child Intervention and the police received a report about these concerns. Medical staff indicated that the injuries appeared to be non-accidental. Caseworkers developed a safety plan with the family, and Camille's older sister, Adel, went to live with relatives.

Manon told medical staff that Camille had been fussy, and when she picked her up, her daughter's head accidentally hit the wall. Luc shared that Camille was in his care over the weekend and he did not have any concerns about her well-being.

Caseworkers, police, and medical professionals communicated regularly about Camille's condition and treatment plan. After several tests, doctors concluded that her prognosis was poor. The family was provided spiritual support, and Manon was encouraged to access community-based therapeutic services.

Four days after she was hospitalized, five-month-old Camille was taken off life support. She passed away with her family by her side. The Office of the Chief Medical Examiner concluded that she died from blunt force head injuries. The police investigated and laid charges. Her older sister was apprehended and was placed in foster care. A memorial was held in Camille's honour, and she is deeply missed by her family and those who knew her.

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

TIMELINE OF SIGNIFICANT EVENTS

Birth to 5 Months Old

- **Birth – 5 Months Old**
  - Appointment at public health center
  - Immunization
  - Hospital visit
    - Diagnosed with brief resolved unexplained events
  - Found unresponsive at home
    - Hospitalized in the pediatric intensive care unit
  - Child Intervention involvement

5-Month-Old Camille passed away

FINDINGS

Children and Family Services

Child Intervention became involved with Camille and her family after she was found unresponsive at home and taken to the hospital. They collaborated with other professionals and her family on planning.

Health

Camille was born healthy and discharged to her parents' care, Doctors connected the family to their local public health centre. They went to the initial assessment appointment, but declined further support. The following month, Camille was taken to the hospital because of episodes of decreased responsiveness. She had timely assessments and received appropriate diagnoses and recommendations. However, her mother declined treatment, and attempts by medical staff to engage her were unsuccessful.

A few months later, Camille was taken to the hospital after she was found unresponsive in her mother's home. Medical staff shared information and collaborated with other professionals on planning and offered appropriate supports to the family to address their grief and loss.

THEMES TO TRACK

1. Collaboration and information sharing

Professionals supporting Camille and her family shared information and collaborated to inform planning.

APPENDIX A: GLOSSARY

Assessment

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.

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