CALLING FOR CHANGE

Investigative Reviews Report

2025-2026

ocya OFFICE OF THE CHILD AND YOUTH ADVOCATE ALBERTA

November 2026

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LEGISLATIVE AUTHORITY

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate's authority is defined in the *Child and Youth Advocate Act* (*CYAA*).

The role of the Advocate is to advance the rights, interests, and viewpoints of children receiving designated services [those identified under the *Child, Youth and Family Enhancement Act* (*CYFEA*), the *Protection of Sexually Exploited Children Act* (*PSECA*), or the youth justice system].

Under Section 9 of the *CYAA*, the Advocate has the mandate to review the circumstances of a young person who passed away or was seriously injured while receiving designated services, or passed away within 2 years of receiving services through *CYFEA*. 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.

We publicly report on the circumstances of children and youth for whom we receive notifications and release completed individual investigative reviews by posting each on our website. This reporting provides additional transparency and public accountability regarding investigative reviews so that each young person's circumstance is reflected in a consistent manner.

Each review includes information about the services and supports that the young person received, along with findings and themes. Annually, a larger public report, *Calling for Change: Investigative Reviews Report*, is released. It explores prevalent themes in the completed reviews and contains recommendations to improve services and supports for children and youth.

MESSAGE FROM THE CHILD AND YOUTH ADVOCATE

In 2025-2026, we completed and released 82 individual investigative reviews related to the circumstances of 69 children and youth who passed away and 13 who were seriously injured. The loss of a young person is heartbreaking, and life after a serious injury can bring profound and lasting challenges. I keep these children, their families, and the dedicated professionals supporting them in my thoughts as they navigate their grief and healing.

This report was strengthened by the generosity, knowledge, and guidance of many people. I am especially grateful to Cultural Educator Colleen Mustus, whose insight and encouragement were instrumental throughout this work. I also want to send my sincerest thanks to Colleen and Elder Daryl Brass Jr. for inviting us to learn through ceremony and teachings that broadened our understanding of Indigenous ways of knowing and helped ground this report in a deeper and more meaningful context.

I am indebted to the young people, community organizations, and professionals who entrusted us with their stories, experiences, and perspectives. Their openness and willingness to contribute have shaped both our findings and recommendations.

Finally, I want to recognize the frontline professionals who walk alongside vulnerable children, youth, and families. The challenges you face are significant, yet you continue to show up with compassion, resilience, and dedication. Your efforts have a lasting impact on the lives of those you support.

This report explores a persistent theme that emerged across the reviews: the adequacy of assessment within child-serving systems. It considers how young people's needs, strengths, risks, supports, and changing circumstances are understood; how assessment information is used to inform planning and decision-making; and the impact when this does not occur consistently.

Assessment has been a recurring issue identified in previous reports. While child-serving ministries generally have policies, procedures, and practice guidance in place, concerns about the quality and consistency of assessments remain. These findings suggest that improvement efforts must extend beyond frameworks and focus on the supervision, oversight, and professional development that support frontline decision-making. Strengthening these areas is critical to promoting consistent, responsive, and well-informed decisions for young people.

I hope the recommendations contained in this report serve as a catalyst for meaningful change, inspiring action that leads to safer, more responsive systems and improved outcomes for children and youth.

Respectfully,

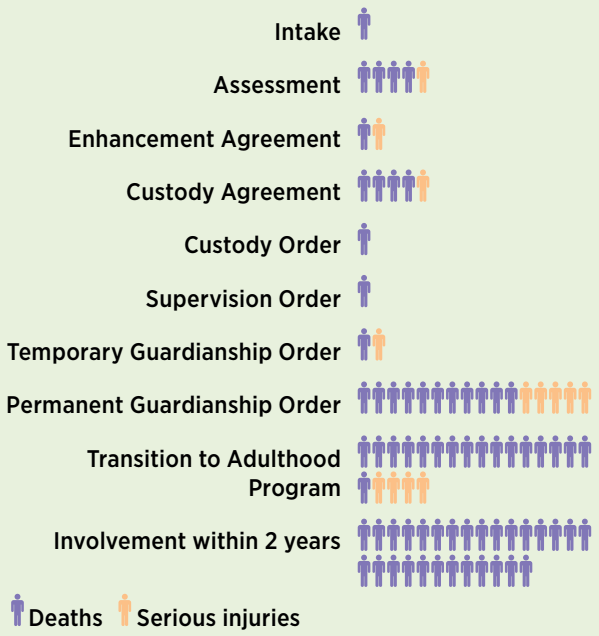
[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

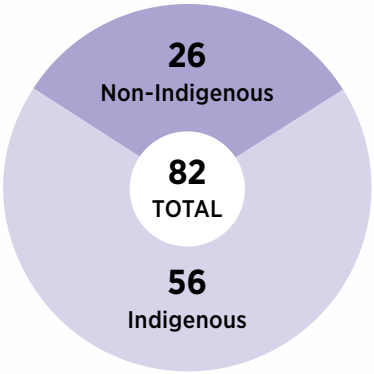
EXECUTIVE SUMMARY

Between April 1, 2025, and March 31, 2026, the Office of the Child and Youth Advocate (OCYA) released 82 individual investigative reviews regarding the circumstances of 69 young people who passed away and 13 who were seriously injured. These children and youth were receiving designated services at the time of their death or serious injury or had received child intervention services within two years of their passing. They ranged in age from 8 days old to 21 years old. Each was a unique young person who mattered deeply to their families, communities, caregivers, and the professionals who supported them.

Bar graph of Child Intervention status at time of death/serious injury



In June 2025, through the passing of the *Red Tape Reduction Act*, the mandate of the Child and Youth Advocate was amended; reducing the maximum age for reviews of death to 19 years old from 23 years old. Seventeen (21%) of the reviews completed and released this reporting period were about these young adults. Most had challenges with trauma, mental health, substance use, housing instability, unmet basic needs, and faced barriers to accessing adult services. The Advocate is very concerned that this legislative change will both limit public understanding of the experiences of emerging adults and the information available to inform evidence-based improvements for these young people who continue to face significant risks after involvement with child-serving systems ends or changes.

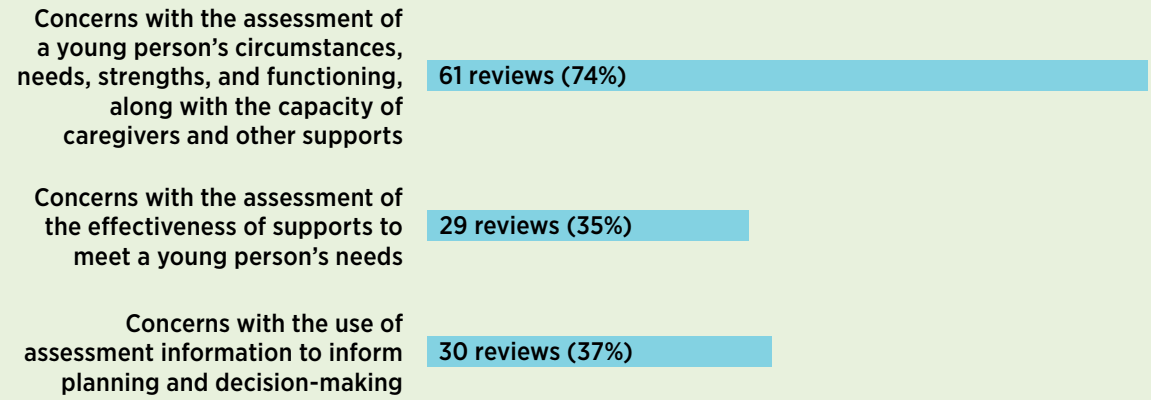


The over-involvement of systems in the lives of First Nation, Métis and Inuit families remains a longstanding concern. Since 2012, the Child and Youth Advocate has made 29 recommendations addressing systemic issues affecting Indigenous young people. Despite this, the circumstances reviewed this year show that meaningful and sustained action is still required.

The reviews in 2025-2026 continue to highlight the interconnected impacts of substance use, mental health concerns, early adversity, trauma, disruptions in relationships, and barriers to services on the lives of children and youth. Thirty-five (43%) young people died or were seriously injured from accidental drug- and/or alcohol-related causes. This included infants and children who ingested substances in their home, as well as those whose substance use escalated over time. Eight (10%) died by suicide, and forty-two (51%) had suicidal ideation.

The most prevalent theme that emerged across the 82 young people was the adequacy of assessment by child-serving systems. Often, assessments did not meaningfully capture a young person's functioning, changing needs, risk factors, cultural identity, caregiver capacity, or the appropriateness and accessibility of supports. This affected the ability of systems to respond early and effectively. At times, concerns were addressed as isolated incidents rather than as part of a pattern, and supports were not consistently adjusted as a young person's needs evolved. This made them more vulnerable to declining mental health and escalating substance use, placement disruptions, justice involvement, and housing instability. In some instances where assessment information informed planning, responses were not coordinated, often reactive, and focused on crisis rather than prevention.

For the purpose of this report, *assessment* is defined as the ongoing process of understanding a young person's needs and identifying the supports required as circumstances change.



*Some young people's circumstances were reflected in more than one of these areas.

At times, professionals worked collaboratively, reassessed changing needs, involved caregivers and natural supports, and used information from multiple systems to guide planning. This underscores the importance of thorough, responsive, and culturally informed assessments that better meet the needs of young people and align with their strengths, relationships, and circumstances.

While child-serving ministries have assessment policies, procedures, and practice guidance, we continue to see concerns about the quality and consistency of assessments in our reviews. This suggests that addressing assessment challenges requires looking beyond tools and processes to the supports that influence frontline practice, including supervision, oversight, and professional development. To improve the circumstances of young people receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act*, or the youth justice system, **the Child and Youth Advocate is making three recommendations**:

This report is informed by the experiences and insights shared by young people, community members, and professionals from across the province. Elders and Cultural Educators offered ceremony and guidance throughout the process, grounding the work in respect and Indigenous ways of knowing.

RECOMMENDATION 1

The Ministries of Assisted Living and Social Services; Children and Family Services; Education and Childcare; Justice; Public Safety and Emergency Services; Primary and Preventative Health Services; Hospital and Surgical Health Services; Mental Health and Addiction; and Arts, Culture and Status of Women should each establish minimum supervision standards for frontline staff, including clear expectations for how often supervision occurs, what should be documented, and how staff are supported in their practice and decision-making.

FURTHER COMMENTS:

- Minimum standards should promote consistency while allowing for more frequent or focused supervision based on staff experience, case complexity, emerging concerns, or significant changes in a young person's circumstances.
- Supervision should be a regular and intentional part of practice, supporting reflection, professional growth, critical thinking, and sound decision-making.
- Documentation of supervision should provide a clear record of discussions, decisions, direction provided, and required follow-up actions to support accountability, continuity of service, quality assurance, and informed decision-making.

RECOMMENDATION 2

The Ministries of Assisted Living and Social Services; Children and Family Services; Education and Childcare; Justice; Public Safety and Emergency Services; Primary and Preventative Health Services; Hospital and Surgical Health Services; Mental Health and Addiction; and Arts, Culture and Status of Women should each establish a process to regularly review and assess supervision practices to determine whether supervision is occurring in accordance with established standards and effectively supporting frontline practice.

FURTHER COMMENTS:

- Review and assessment of supervision practices should be a regular part of organizational practice and support continuous improvement.
- Reviews should assess whether established standards for the frequency, quality, and documentation of supervision are being met.
- Considerations in the review should include whether supervision is effectively supporting staff practice, including critical thinking, decision-making, and responses to complex or emerging concerns.
- The process should draw on relevant sources of information such as supervision records, quality assurance activities, and staff feedback.
- Where gaps or areas for improvement are identified, ministries should have processes to address them and assess whether changes have resulted in improved supervision practices.

RECOMMENDATION 3

The Ministries of Assisted Living and Social Services; Children and Family Services; Education and Childcare; Justice; Public Safety and Emergency Services; Primary and Preventative Health Services; Hospital and Surgical Health Services; Mental Health and Addiction; and Arts, Culture and Status of Women should each establish requirements for the training and ongoing professional development of staff who supervise, guide, or approve frontline decisions, to ensure they have the knowledge and skills needed to provide effective oversight and support sound decision-making.

FURTHER COMMENTS:

- Staff should receive role-specific training when they first assume responsibilities for supervising, guiding, or approving frontline decisions.
- Each respective ministry should establish expectations for ongoing professional development to support the maintenance and strengthening of supervisory knowledge and skills over time.
- Training and professional development should reflect supervisory responsibilities and strengthen skills in areas such as critical thinking, reflective practice, assessment, decision-making, and the application of relevant legislation, policy, and practice frameworks.
- Learning opportunities should be regularly reviewed and updated to reflect changes in legislation, policy, research, and practice.
- Ongoing development should include the sharing of knowledge, experience, and effective practices among staff with supervisory responsibilities.

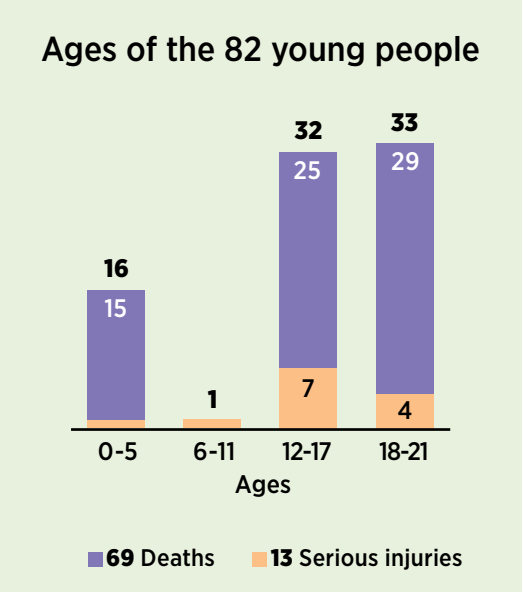
LEARNING FROM THE EXPERIENCES OF THE 82 YOUNG PEOPLE

An overview of the young people

All Individual Investigative Reviews can be found at: ocya.alberta.ca

Between April 1, 2025, and March 31, 2026, the Office of the Child and Youth Advocate (OCYA) completed and publicly released 82 individual investigative reviews[i] regarding the circumstances of 69 young people who passed away and 13 who were seriously injured. They were receiving child intervention services either at the time of their death or injury, or had received services within two years of their passing. Each review involved a unique young person whose life mattered. For those who died, their loss continues to be felt by those who loved and cared for them; for those who were seriously injured, their experiences continue to impact them and those around them.

Ramona was the youngest child to pass away. She was born prematurely and had timely medical assessments of her functioning and needs. Health professionals shared information with caseworkers to inform planning. Her prognosis did not improve, and Ramona passed away at eight days old from health complications.



Orion was an emerging adult and the oldest to pass away. In his first four years, his family moved between three provinces and had Child Intervention involvement. He became the subject of a **Permanent Guardianship Order** (**PGO**)[ii] at nine years old. Orion began using substances at 12 years old; he was suspended from school, left his placements without permission, had challenges with his mental health, and became involved with the youth justice system. He had timely mental health assessments and received multiple diagnoses, which were shared with his case team. Although he was referred to community-based supports, at times, he had to complete tasks and navigate services on his own. When he was unable to do so, he was offered help but often refused. His circumstances deteriorated, and he died by suicide at 21 years old.

Thirty-three (40%) reviews were about youth who were 18 years of age or older. Many faced challenges related to substance use, mental health, housing instability, unmet basic needs, and difficulty accessing adult services. These challenges began earlier in life and continued into adulthood. In June 2025, through the passing of the *Red Tape Reduction Act*, the mandate of the Child and Youth Advocate was amended; reducing the maximum age for reviews of death to 19 years old from 23 years old. This is deeply concerning as an independent review body will no longer routinely examine these deaths or report publicly on the experiences of these emerging adults. Tala and Laniyah were among the 17 (21%) young people whose circumstances we would not have reviewed had they passed away after the legislative change.

i A list of the 82 individual investigative reviews completed is provided in Appendix 1.

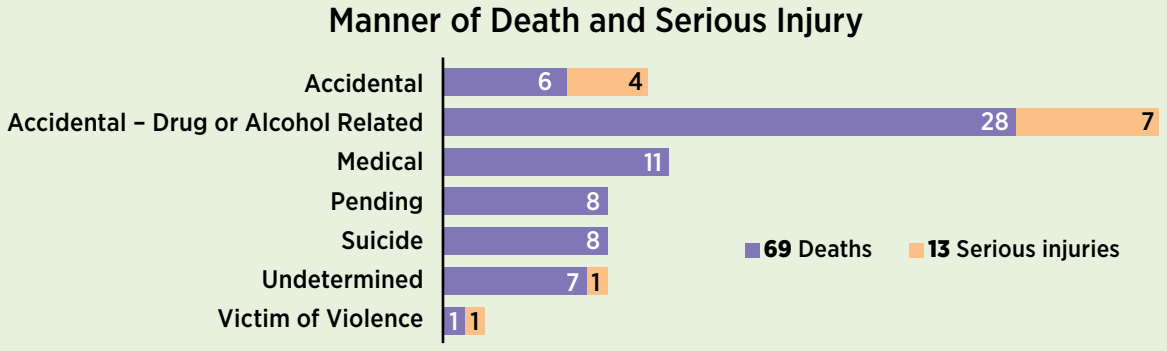
ii Bolded terms are defined in Appendix 2.

Tala was a young First Nation woman who became the subject of a PGO when she was three years old. She was exposed to family violence and neglect, and had placement instability. Tala had complex mental health, behavioural, and developmental needs. After recommended cultural, disability, and financial supports were delayed, she entered into a **Support and Financial Assistance Agreement** (**SFAA**) and received services from the **Transition to Adulthood Program** (**TAP**). Caseworkers consulted with her Band, developed plans to help her access addiction and mental health services, and had her assessed to determine her eligibility for adult disability services. They tried to maintain contact with Tala, but her circumstances made it challenging for her to engage with supports. Tala passed away at 21 years old; the Office of the Chief Medical Examiner (OCME) continues to investigate her death.

Child Intervention was involved with **Laniyah** and her family throughout her childhood because of her parents' substance use, family violence, neglect, abandonment, and physical injury. She became the subject of a PGO at six years old. In adolescence, trauma, grief, and loss impacted her mental health, and she began to use substances. As Laniyah's needs became more complex, child intervention, health, and justice professionals shared information and collaborated on planning, but her circumstances remained unstable. Laniyah was 21 years old when she died from drug toxicity.

Eleven (13%) of the reviews completed involved children and youth who died from a medical condition.

When **Cindy** was 14 months old, Child Intervention was briefly involved for concerns related to physical injury. Her family was referred to community-based supports before involvement ended. Six months later, Cindy was hospitalized with a viral respiratory infection. Health care professionals provided her family with emotional support, helped with the cost of parking, and wrote letters of support to her parents' employers outlining their need to be with their daughter at the hospital. Her condition deteriorated, and at 20 months old, Cindy passed away.



Florence was diagnosed with a brain tumour at 10 years old and died from medical complications when she was 16 years old. Throughout her illness, she received timely and coordinated health services, including being supported by specialists and receiving treatment outside of Canada. As her condition worsened, health care professionals provided comprehensive medical support, coordinated travel for treatment, arranged culturally informed care, and helped her family access financial resources to reduce barriers. Jordan's Principle was used to ensure continuity of care; and, health, education, and disability service providers collaborated on planning to address Florence's evolving needs and support her family.

Eight (10%) young people died by suicide and forty-two (51%) had suicidal ideation. This highlights the profound impact that mental health challenges have on young people. We recognize the significant work underway to strengthen mental health services across the province,[iii] and look forward to the full implementation of initiatives so that young people can access the supports they need when they need them.

Ansel was the youngest at nine years old to have suicidal ideation and self-harm. He was apprehended shortly after birth because of his parents' substance use and neglect; he became the subject of a PGO at two years old. As his emotional and behavioural needs increased, he had placement instability. He received pediatric, addiction, and therapeutic services, and had specialized educational programming and individualized program plans. Despite repeated assessments and adjustments to address his evolving needs, his circumstances remained unstable, and services increasingly became crisis-driven. At 14 years old, Ansel was seriously injured following a drug overdose.

Keaton was the youngest to die by suicide at 14 years old. He and his family had repeated Child Intervention involvement because of his parents' substance use, family violence, neglect, and physical injury. He was apprehended at eight years old and later became the subject of a PGO. As he grew older, he had multiple placement disruptions and increasing mental health concerns; he was connected to therapeutic supports. By 13 years old, Keaton had suicidal thoughts; however, suicide risk assessments and safety planning were not completed.

Of the 82 young people, 35 (43%) passed away or were seriously injured because of substance use.

Lincoln was exposed to his parents' substance use, family violence, neglect, and physical injury. At 11 years old, he began to self-harm, and the following year, he started using substances. His circumstances deteriorated; his mental health worsened, he stayed at youth shelters, and became involved with the youth justice system. Caseworkers, placement staff, mental health and addiction professionals, and justice staff coordinated planning and tried to implement supports, but were unsuccessful. As he transitioned to adulthood, service providers continued to struggle to meet his complex needs. Lincoln died at 21 years old from methamphetamine toxicity.

Substance-related deaths and serious injuries were not limited to adolescents. The reviews included young children who ingested substances in their homes, which highlights the serious and life-altering consequences this can have on a child.

Elton was nine months old when he ingested substances and was seriously injured. Child Intervention was involved with his family because of his parents' substance use. Caseworkers referred them to addiction services, but they had limited engagement. Elton was placed in kinship care. While in respite care with relatives, Elton was found unresponsive. Emergency medical services responded and administered Narcan. He was admitted to a pediatric intensive care unit, where testing confirmed he had ingested multiple substances, including methamphetamine and morphine. He was subsequently discharged and placed in foster care.

iii https://www.ocya.alberta.ca/recommendations/

Dawson was the youngest to die from substance-related causes at 12 months old. His parents had justice system involvement, and he was exposed to their substance use. By the time he was eight months old, Child Intervention had been involved with his family twice. His parents worked with service providers to address their addiction, and both involvements ended after safety plans were developed in consultation with his parents, relatives, caseworkers and other professionals supporting his family. Four months after intervention involvement ended, Dawson was found unresponsive. The OCME concluded that he died from accidental fentanyl and methamphetamine toxicity.

Twenty-five (30%) young people were prenatally exposed to substances. Fifteen (18%) were diagnosed with fetal alcohol spectrum or related disorders. Timely assessments, diagnoses, and ongoing support can help youth and caregivers understand and manage the impact of prenatal substance exposure.

Tatum had a chaotic upbringing that included exposure to his mother's substance use, mental health concerns, and family violence. After his mother passed away when he was 10 years old, he went to live with his father. Two years later, Tatum was diagnosed with fetal alcohol spectrum disorder (FASD). He was connected to a community-based FASD program and Family Support for Children with Disabilities (FSCD), but he lived in a small community where service providers were limited. As he got older, Tatum struggled with his mental health, began using substances, and was sexually exploited. He was connected to community-based addiction services, given information on harm reduction strategies, and confined under various legislations as his substance use escalated. Despite these interventions, his circumstances remained unstable, and he died from drug toxicity at 15 years old.

> Prenatal substance exposure has been associated with an increased risk of long-term cognitive delays, speech and language impairments, difficulties with self-regulation and executive functioning, poorer academic achievement, and elevated rates of behavioural and mental health disorders.
>
> **Eiden et al., 2023.**

Drew was prenatally exposed to substances, and Child Intervention was involved throughout his childhood because of his parents' substance use, family violence, and neglect. Although prenatal alcohol exposure was identified when he was young, he did not have a timely assessment because of limited information sharing between professionals. Drew had ongoing mental health and behavioural challenges and was supported by caseworkers, educators, therapists, and doctors, but his circumstances remained unchanged. At 13 years old, he was assessed and received several diagnoses but not FASD. Drew died by suicide at 19 years old.

Fifty-six (68%) Indigenous children and youth were the subject of our reviews. We continue to see an over-involvement of systems in the lives of First Nation, Métis, and Inuit people. This highlights the ongoing impacts of colonial policies, systemic inequities, and the disruption of family, community, culture, and connections.

Elowyn was a First Nation youth who became the subject of a PGO at three years old. Educators completed appropriate assessments and she took part in cultural activities in school and community. By eight years old, she moved with her caregiver to another province. Caseworkers arranged for courtesy workers to support her connections with her family, community and culture. Despite these efforts, there were long periods without contact with her mother, and her First Nation was not consistently involved in decisions about her care. Elowyn was 17 years old when she died from a suspected suicide.

Progress on the OCYA's Indigenous-related recommendations can be found at:

ocya.alberta.ca/recommendations/

- **15** were closed as met
- **13** were closed, with some or significant progress
- **1** remains ongoing with some progress

Systems working with Indigenous children and youth should recognize that identity is shaped not only by the individual, but also by family, community, culture, and connection to the land. These connections are deeply rooted and exist on physical, emotional, mental, and spiritual levels. For many Indigenous children and youth, connection extends beyond family members to include their traditional territory, the land, waters, plants, animals, and all that has sustained their families and communities across generations. Together, these relationships form an important part of their identity, sense of belonging, and well-being.

Colleen Mustus, Cultural Educator

There were intentional efforts by service providers to maintain a young person's connections with their family, community, and culture towards fostering a positive sense of identity and belonging.

Rupert was a young First Nation man who became the subject of a PGO at one year old. Throughout his childhood, Child Intervention and Supports for Permanency (SFP) caseworkers, caregivers, relatives, and educators collaborated on planning to maintain his relationships with his family and community. He and his siblings were cared for by kinship caregivers, who later became their guardians. Family meetings helped guide important decisions about his care and safety, and supported his ongoing connections to the people and relationships that were important to him. Rupert was 19 years old when he died from meningitis and septic shock.

Meaningful engagement with families, communities, Elders, and Indigenous knowledge-holders can strengthen understanding and support more culturally responsive decision-making.

Colleen Mustus, Cultural Educator

The Advocate has raised concerns about the over-involvement of systems in Indigenous lives in several reports and has made 29 recommendations to improve outcomes. Across Canada, Indigenous communities are working with governments to advance self-determination. In 2020, *An Act respecting First Nations, Inuit and Métis children, youth and families* came into force, affirming the rights of Indigenous peoples to exercise jurisdiction over child and family services.

Since then, Nations in Alberta have been developing their own approaches to supporting children, youth, and families, based on their laws, cultures, priorities, and traditions. We will continue to support these efforts and advocate for services that meet their needs and reflect their viewpoints.

Adequacy of assessment - prevalent theme

We have defined assessment as the ongoing process of understanding a young person's needs and identifying the supports they require as their circumstances change. Effective assessment is not a single event; rather, it is a continuous process to respond to a young person's evolving needs.

One way the OCYA highlights practice that requires attention or identifies exemplary work is to notify the relevant ministry.

This year, ministries were notified of 28 assessment-related findings, including 23 where there were concerns and 5 highlighting exemplary practice.

After reviewing the circumstances of 82 young people, the adequacy of assessment emerged as a common theme. There were many instances in which assessments did not fully capture the complexity of a young person's situation nor their evolving needs, and services and supports were not adapted or coordinated to meet them. Similar concerns were noted in our 2024-2025 *Calling for Change* report,[1] suggesting that assessment-related challenges continue to affect planning, decision-making, and support for young people.

Assessment is a critical component of service delivery. It helps practitioners understand a young person's circumstances, strengths, needs, and risks, and provides the foundation for planning and decision-making. When assessments are incomplete or do not meaningfully inform practice, opportunities to identify concerns, respond to changing needs, and provide appropriate supports are often missed.

Three areas of assessment-related concerns were identified:

1. **Assessment of a young person's circumstances, needs, strengths, and functioning, along with the capacity of caregivers and other supports.**

For 61(74%) of the young people, assessments did not fully reflect their circumstances, evolving needs, or the capacity of caregivers and other supports. At times, the concerns persisted or escalated while planning and supports remained unchanged.

OCYA Youth Council members have shared that they have experienced occasions when service providers made decisions without their input or an explanation. Sometimes important assessments were missed, and it limited their access to needed resources and supports.

Ellora moved to Alberta with her family when she was nine years old. She had a mild intellectual disability, significant learning needs, and did not attend school regularly. Child Intervention was involved numerous times with her family because of her mother's substance use, housing instability, and capacity to care for her daughter. Involvements ended after safety plans were developed. As Ellora got older, she began to use substances, was sexually exploited and assaulted, and became involved with the youth justice system. These concerns were not consistently assessed together to understand their cumulative impact on her well-being and functioning, nor used to identify her support needs. Ellora died from drug toxicity at 15 years old.

Tonia was involved with Child Intervention 9 times before she was 15 years old. Concerns were related to her parents' substance use, family violence, and neglect, along with her declining mental health and poor school attendance. These concerns were often addressed as separate events rather than as interconnected factors that impacted her safety and well-being. Assessments did not consistently consider her caregivers' capacity to provide care, nor were they informed by her evolving circumstances. Tonia was 17 years old when she was seriously injured after a burn on her hand became infected.

There were examples of strong practice in which professionals took time to understand the young person's functioning, development, cultural identity, caregiver strengths, and risk factors. These children and youth benefited from coordinated and ongoing evaluations of their needs, which strengthened decision-making.

Zain's caseworkers, teachers and health care professionals shared information to gain a fulsome understanding of his functioning and behavioural and emotional needs. He had timely assessments that identified a learning disorder and challenges with executive functioning, and he was diagnosed with attention-deficit/hyperactivity disorder (ADHD). Service providers assessed his caregiver's capacity and identified strengths that could be built upon to meet his changing needs. Information was shared across systems and informed school- and community-based supports. Zain was 13 years old when he died from injuries sustained in an accident.

2. Assessment of the effectiveness of supports to meet a young person's needs.

We found that for 29 (35%) of the young people, available supports and services were not always accessible or responsive to their needs. As their circumstances changed, supports were often not adapted. Many had ongoing placement instability, justice involvement, and other negative outcomes.

Hayden had cognitive challenges and he and his family were supported by child intervention, mental health and addiction, education and community-based supports. As his substance use escalated and his needs became more complex, there was limited assessment of whether services were appropriate, effective, or accessible. When existing supports, including respite care, school programming, recreation, and community-based services did not reduce safety concerns, alternative approaches were not consistently explored. Hayden was 20 years old when he died from drug toxicity.

Dominic had declining mental health, housing instability, and challenges engaging with service providers. Although he was connected to community-based, educational, mental health, housing, and probation services, there was limited assessment of whether these supports were appropriate, effective, or accessible. As concerns persisted, services were not consistently adjusted to address barriers that affected his ability to access support. Dominic was 19 years old when he died from drug toxicity.

There were examples of circumstances in which ministries and community partners worked together to respond to a young person's changing circumstances. As their needs increased or new concerns emerged, supports, planning, and services were adjusted to better address them.

Tyler's circumstances were regularly reassessed by caseworkers, health care providers and community-based services staff. These assessments helped identify factors affecting his safety and well-being, including substance use, housing instability, physical and mental health concerns, and challenges engaging with services. The information was used to connect Tyler with a range of supports, including medical care, addiction counselling, outreach services, housing supports, safety planning, and referrals for adult disability-related services. Tyler was 20 years old when he passed away from drug toxicity.

3. Use of assessment information to inform planning and decision-making.

For 30 (37%) of these young people, we noted that although assessments were completed, the information was not consistently reflected in planning and decision-making. In some circumstances, planning focused on the immediate concerns rather than the young person's broader needs and circumstances. Information was not shared between service providers to inform holistic supports, services were often fragmented, and their needs were frequently not fully addressed.

Zidane's substance use and mental health challenges escalated; he struggled with his relationships, disengaged from school, and became involved with the youth justice system. Supports focused on the presenting concerns, and although he was supported by caseworkers, educators, and justice professionals, there was limited information sharing and coordination to inform planning. Zidane's circumstances continued to deteriorate, and when he was 17 years old, he died from drug toxicity.

Taya struggled with substance use and mental health concerns, had poor school attendance, placement instability, and possible FASD. Although these issues were identified by caseworkers, educators, and health care staff, there was limited information sharing and collaboration on planning to address her holistic needs. Services were often crisis-driven, and Taya's circumstances remained unstable. At 15 years old, she died by suicide.

There were some examples of strong practice in which professionals shared information, worked together, and coordinated planning to better understand a young person's needs. This collaborative approach helped identify appropriate services and supports and strengthened the overall response to the young person's circumstances.

Dove's physical and mental health, behavioural, cognitive, safety, education and transition to adulthood needs were assessed regularly. Professionals from child intervention, health, education, justice, and disability services shared information, collaborated, and coordinated planning to understand her strengths and challenges and provide tailored supports. Although Dove continued to experience significant instability and risk, assessment information informed responsive services that evolved to meet her changing needs. Dove was 20 years old when she died from undetermined causes.

While examples of strong practice demonstrate what is possible when assessment information is used to inform planning, decision-making, and supports that respond to a young person's changing circumstances, assessment-related concerns continue to be prevalent across our reviews.

Since 2013, the Advocate has made 34 recommendations related to assessment, most of which have been met. Child-serving ministries also have legislation, policies, standards, training, and practice guidance intended to support frontline decision-making. Despite these efforts, assessment-related concerns persist, suggesting that the challenge is not simply whether requirements and resources exist, but how consistently they are understood and applied in practice.

This led us to consider what additional factors support the effective application of assessment information in frontline practice and decision-making. Based on research, stakeholder input, and our review of information from child-serving ministries, we identified two areas where practice could be strengthened:

- decision-making oversight for frontline service delivery staff; and
- strengthening capacity for practice oversight.

Together, these areas can support more consistent decision-making, strengthen service continuity, and help ensure important information is carried forward over time.

FROM LEARNING TO ACTION

Decision-making oversight for frontline service delivery staff

When a child or youth is involved with multiple systems, effective oversight of frontline decision-making is critical.[2] Frontline service delivery staff must assess complex and evolving circumstances, integrate information from multiple sources, and determine how that information should inform planning and service delivery. Oversight supports this process by providing opportunities for reflection, critical analysis, and guidance in applying professional judgment.[3] Without effective oversight, assessment information may not be fully considered in decision-making, increasing the risk that a young person's needs are not adequately addressed.

> "Poor oversight contributes to missed steps, inconsistencies in practice, and reduced quality of care."
>
> "There is an increased risk of harm to children and families when gaps in oversight occur."
>
> **Stakeholders**

> While professional expertise is important, it cannot replace the lived experiences, cultural knowledge, and histories of First Nations children and communities. Decisions should be guided by humility, cultural understanding, and respect for identity, belonging, and connection, with recognition of the lasting impacts of separation from family, community, culture, and land.
>
> **Colleen Mustus - Cultural Educator**

Supervisors play an important role in providing this oversight.[4] They help ensure that significant decisions are documented, reviewed, and guided by relevant policies and procedures.[5] Effective supervision also provides opportunities for staff to reflect on their practice, build skills, and strengthen their ability to respond to complex situations.[6] This supports frontline staff to apply policies and practice guidance consistently and make decisions that support young people's well-being.

Clear and consistent supervision includes regular and protected time to conduct it, defined roles and responsibilities, and consistent documentation and reporting processes.[7,8] It should extend beyond administrative requirements to support reflection, learning, professional development, and accountability, while giving staff the guidance they need to manage complex work.[9,10] When these processes are inconsistent, gaps in guidance, consultation, follow-up, escalation, and coordination may go unrecognized. This is particularly concerning in complex, high-risk, or time-sensitive situations where effective oversight is critical.

To meaningfully support frontline practice, there must be clear expectations for how supervision occurs. Expectations related to frequency, documentation requirements, and the key areas to be discussed can help ensure staff have regular opportunities to reflect on practice, consider assessment information, and receive guidance to support decision-making.[11,12] Documentation can also strengthen organizational accountability by helping identify whether supervision is occurring as intended and where additional support or attention may be needed.

Across child-serving systems, stakeholders identified similar concerns. Those responsible for guiding, supervising, and approving frontline decisions emphasized the need for clearer expectations, stronger preparation and training, and more consistent supervisory processes to help support informed decision-making to better support young people.

> "Although there are requirements around who needs to be part of decision-making and when it needs to occur, the actual decision-making process varies based on individual processes, and it's not done or documented in a consistent way."
>
> **Stakeholder**

These observations were consistent with our review of information provided by child-serving ministries[iv] and publicly available materials. While supervision and other forms of practice oversight occur across child-serving systems, expectations related to frequency, documentation, and areas of focus were not consistently evident in the information reviewed.

The Advocate is making two recommendations to establish consistent expectations for supervision and strengthen the quality, consistency, and accountability of frontline practice across child-serving systems.

RECOMMENDATION 1

The Ministries of Assisted Living and Social Services; Children and Family Services; Education and Childcare; Justice; Public Safety and Emergency Services; Primary and Preventative Health Services; Hospital and Surgical Health Services; Mental Health and Addiction; and Arts, Culture and Status of Women should each establish minimum supervision standards for frontline staff, including clear expectations for how often supervision occurs, what should be documented, and how staff are supported in their practice and decision-making.

FURTHER COMMENTS

- Minimum standards should promote consistency while allowing for more frequent or focused supervision based on staff experience, case complexity, emerging concerns, or significant changes in a young person's circumstances.
- Supervision should be a regular and intentional part of practice, supporting reflection, professional growth, critical thinking, and sound decision-making.
- Documentation of supervision should provide a clear record of discussions, decisions, direction provided, and required follow-up actions to support accountability, continuity of service, quality assurance, and informed decision-making.

EXPECTED OUTCOMES

- Regular supervision strengthens practice and supports reliable service delivery to young people.
- Decision-making about young people and their families is strengthened and occurs in a timely manner through regular discussion and collaboration between frontline staff and their supervisors.
- Supervision documentation provides an up-to-date record of decisions, direction, and required follow-up, supporting continuity of service and appropriate care.
- Young people benefit from more consistent oversight of the services, decisions, and supports that affect them.

iv A summary of internal information provided by child-serving ministries is provided in Appendix 5.

RECOMMENDATION 2

The Ministries of Assisted Living and Social Services; Children and Family Services; Education and Childcare; Justice; Public Safety and Emergency Services; Primary and Preventative Health Services; Hospital and Surgical Health Services; Mental Health and Addiction; and Arts, Culture and Status of Women should each establish a process to regularly review and assess supervision practices to determine whether supervision is occurring in accordance with established standards and effectively supporting frontline practice.

FURTHER COMMENTS

- Review and assessment of supervision practices should be a regular part of organizational practice and support continuous improvement.
- Reviews should assess whether established standards for the frequency, quality, and documentation of supervision are being met.
- Considerations in the review should include whether supervision is effectively supporting staff practice, including critical thinking, decision-making, and responses to complex or emerging concerns.
- The process should draw on relevant sources of information such as supervision records, quality assurance activities, and staff feedback.
- Where gaps or areas for improvement are identified, ministries should have processes to address them and assess whether changes have resulted in improved supervision practices.

EXPECTED OUTCOMES

- Ministries have reliable information about whether supervision standards are being met and whether supervision is effectively supporting frontline practice.
- Gaps in supervision are identified and addressed in a timely manner, strengthening accountability and the quality of support provided to frontline staff.
- Frontline staff receive effective supervision that strengthens their practice and supports informed and timely decision-making about the needs of young people and their families.
- Young people, including those with complex or changing needs, benefit from stronger oversight and better-informed decisions about the services and supports they receive.

Strengthening capacity for practice oversight

Child-serving systems rely on leaders who provide oversight, guidance, and approval of frontline decisions to support consistent practice and informed decision-making. This requires specialized knowledge and skills, including the ability to interpret assessment information, apply policy and practice guidance, support professional judgment, and guide practitioners through complex situations.[13,14] As experienced staff move between roles or leave organizations, systems must have ways to develop and maintain this expertise to support continuity and consistency in practice.

Supervisors play an important role in supporting frontline employees. Through coaching, consultation, and guidance, they help staff apply policies, procedures, and practice standards consistently and make informed decisions.[15] They also support the transfer of knowledge and experience by helping practitioners learn from past practice, navigate complex situations, and build professional judgment. When knowledge and expertise are not effectively maintained, organizations risk losing valuable practice experience and leadership capacity.

Developing capacity for practice oversight requires more than professional or clinical experience. The knowledge and skills needed to effectively guide and support frontline decision-makers should be strengthened through formal training and ongoing professional development.[16,17] Ongoing learning helps those providing oversight strengthen their skills and supports the continuity of effective practices when workers or leadership change.

The Alberta Public Service (APS) recognized the importance of strengthening leadership and supervisory capacity in its 2011–2014 APS Workforce Plan.[v] The plan identified supervisory and leadership development as workforce priorities, recognizing their role in building organizational capacity and supporting effective service delivery. However, the plan did not provide specific details about how these priorities would be achieved, and publicly available progress updates have not been provided since 2015.

Across ministries, stakeholders who guide, supervise, or approve frontline decisions identified concerns about the consistency and availability of training and professional development. While some training is provided when they begin supervisory roles, ongoing development is often limited, not mandatory, and does not always address the complexities of frontline decision-making. Stakeholders identified the need for more consistent support to strengthen supervisors' skills in providing oversight, consultation, and guidance to frontline decision-makers.

These observations were consistent with our review of information provided by child-serving ministries and publicly available materials. We found a range of training and supports for supervisors, including role-specific training, e-learning, coaching, communities of practice, consultation, and mentorship. However, the availability of these supports varies across ministries, and some systems do not have formal training requirements for oversight roles. Expectations for ongoing development of supervisory knowledge and skills are also not consistent.

The Advocate is making the following recommendation to support the ongoing development of staff who supervise, guide, or approve frontline decisions and strengthen their ability to provide effective oversight and support informed decision-making.

v 2011-2014 Alberta Public Service Workforce Plan.

RECOMMENDATION 3

The Ministries of Assisted Living and Social Services; Children and Family Services; Education and Childcare; Justice; Public Safety and Emergency Services; Primary and Preventative Health Services; Hospital and Surgical Health Services; Mental Health and Addiction; and Arts, Culture and Status of Women should each establish requirements for the training and ongoing professional development of staff who supervise, guide, or approve frontline decisions, to ensure they have the knowledge and skills needed to provide effective oversight and support sound decision-making.

FURTHER COMMENTS

- Staff should receive role-specific training when they first assume responsibilities for supervising, guiding, or approving frontline decisions.
- Each respective ministry should establish expectations for ongoing professional development to support the maintenance and strengthening of supervisory knowledge and skills over time.
- Training and professional development should reflect supervisory responsibilities and strengthen skills in areas such as critical thinking, reflective practice, assessment, decision-making, and the application of relevant legislation, policy, and practice frameworks.
- Learning opportunities should be regularly reviewed and updated to reflect changes in legislation, policy, research, and practice.
- Ongoing development should include the sharing of knowledge, experience, and effective practices among staff with supervisory responsibilities.

EXPECTED OUTCOMES

- Staff should receive role specific training when they first assume responsibilities for supervising, guiding, or approving frontline decisions.
- Responsible or Child-serving ministries should establish expectations for ongoing professional development to support the maintenance and strengthening of supervisory knowledge and skills over time.
- Training and professional development should reflect supervisory responsibilities and strengthen skills in areas such as critical thinking, reflective practice, assessment, decision-making, and the application of relevant legislation, policy, and practice frameworks.
- Learning opportunities should be regularly reviewed and updated to reflect changes in legislation, policy, research, and practice.
- Ongoing development should include the sharing of knowledge, experience, and effective practices among staff with supervisory responsibilities.

CLOSING REMARKS

Calling for Change outlines the experiences of 82 children and youth whose circumstances were reviewed this year. My thoughts are with the 69 children and youth who passed away, the 13 who survived serious injuries, and their families, caregivers, communities, and professionals who continue to be affected by these profound losses and life-altering events.

This report emphasized the importance of supervisors having the knowledge, skills, and abilities to support frontline staff in making informed, timely, and accountable decisions and in turning assessment information into effective action. It also highlights the critical role supervisors have in retaining and sharing organizational knowledge, supporting staff development, maintaining continuity during transitions, and promoting consistent practice across child-serving systems.

This year's report also brings forward several areas of concern. Recent legislative changes mean that my office is no longer notified of the deaths of young adults over 19 years old, which removes the opportunity for an independent review of their experiences with child-serving systems. This raises important questions about how their circumstances and the services they received will be understood and learned from going forward.

Beyond these concerns, the report highlighted several troubling issues that continue to impact young people and their families. These included the over-involvement of systems in the lives of Indigenous children and youth, reflecting longstanding systemic challenges; the ongoing impacts of substance use; and the number of youth who experienced suicidal ideation or died by suicide. I am also deeply concerned about the prevalence of prenatal substance exposure and the significant long-term impact it can have on children's development and overall well-being. This issue requires greater attention and understanding, and I intend to explore it further in my next special report.

It is important to recognize the significant work underway across child-serving ministries to respond to many of these challenges. I look forward to seeing how systems continue to strengthen their ability to respond to the changing needs of children, youth, and young adults.

As I reflect on the experiences of these 82 children and youth, I am also encouraged by the many examples of dedicated family members, caregivers, community partners, and professionals who worked tirelessly to support them. Their commitment demonstrates what is possible when services are collaborative, responsive, culturally meaningful, and centred on the unique needs of young people. And, it is important to recognize that in spite of all the right interventions at the right time, sometimes tragedies happen.

I am hopeful that the recommendations contained in this report will lead to stronger assessment practices, improved decision-making oversight, and more consistent and responsive services. Ultimately, these changes can help improve outcomes for Alberta's most vulnerable children and youth, helping support their safety, well-being, and long-term success.

[Original signed by Terri Pelton]

Terri Pelton
Child and Youth Advocate (Alberta)

APPENDICES

Appendix 1: The 82 Young People

In 2025-2026, the Office of the Child and Youth Advocate released individual investigative reviews of 69 young people who passed away and 13 who were seriously injured.

Each individual investigative review report can be found at:
www.ocya.alberta.ca/individual-investigative-reviews

Death Serious Injury

Pseudonym	Date Released	Manner of Death/Serious Injury
8-day-old Ramona	December 2025	Medical death
5-week-old Asher	April 2025	Victim of violence
4-month-old Coral	March 2026	Undetermined
4-month-old Daphne	February 2026	Undetermined
5-month-old Garrett	November 2025	Undetermined
8-month-old Kyren	November 2025	Pending OCME investigation
8-month-old Miko	July 2025	Undetermined
9-month-old Elton	January 2026	Serious Injury - Accidental (drug or alcohol related)
9-month-old Mavis	September 2025	Medical death
11-month-old Hira	March 2026	Pending OCME investigation (suspected accidental)
11-month-old Mason	December 2025	Undetermined
12-month-old Dawson	June 2025	Accidental death (drug or alcohol related)
20-month-old Cindy	September 2025	Medical death
2-year-old Hani	February 2026	Medical death
3-year-old Aveline	November 2025	Pending OCME investigation (suspected medical)
4-year-old Payson	July 2025	Accidental death
6-year-old Spencer	March 2026	Serious Injury - Accidental
12-year-old Bart	October 2025	Medical death
13-year-old Rahim	April 2025	Pending OCME investigation
13-year-old Wilder	February 2026	Medical death
13-year-old Zain	May 2025	Pending OCME investigation (suspected accidental)
14-year-old Aliza	June 2025	Serious Injury - Accidental (drug or alcohol related)
14-year-old Ansel	July 2025	Serious Injury - Accidental (drug or alcohol related)
14-year-old Keaton	July 2025	Suicide

Pseudonym	Date Released	Manner of Death/Serious Injury
15-year-old Casey	June 2025	Suicide
15-year-old Ellora	May 2025	Accidental death (drug or alcohol related)
15-year-old Kylie	October 2025	Accidental death (drug or alcohol related)
15-year-old Tatum	May 2025	Accidental death (drug or alcohol related)
15-year-old Taya	June 2025	Suicide
16-year-old Charlotte	April 2025	Accidental death (drug or alcohol related)
16-year-old Damon	August 2025	Pending OCME investigation
16-year-old Eleanor	February 2026	Accidental death (drug or alcohol related)
16-year-old Florence	February 2026	Medical death
16-year-old Lydia	November 2025	Pending OCME investigation
16-year-old Nate	March 2026	Accidental death (drug or alcohol related)
16-year-old Ruby	September 2025	Suicide
16-year-old Veronica	January 2026	Serious Injury - Accidental (drug or alcohol related)
17-year-old Cohan	March 2026	Accidental death (drug or alcohol related)
17-year-old Damian	December 2025	Serious Injury - Accidental (drug or alcohol related)
17-year-old Elowyn	July 2025	Suspected suicide (death occurred out of province)
17-year-old Ena	December 2025	Pending OCME investigation (suspected accidental)
17-year-old Jayden	April 2025	Serious Injury - Victim of violence
17-year-old Karlie	October 2025	Accidental death (drug or alcohol related)
17-year-old Marcie	October 2025	Accidental death (drug or alcohol related)
17-year-old Raven	August 2025	Serious Injury - Accidental (drug or alcohol related)
17-year-old Robbie	May 2025	Accidental death (drug or alcohol related)
17-year-old Sabrina	March 2026	Pending OCME investigation
17-year-old Tonia	January 2026	Serious Injury - Undetermined
17-year-old Zidane	September 2025	Accidental death (drug or alcohol related)
18-year-old Cameron	July 2025	Suicide
18-year-old Dorian	October 2025	Accidental death (drug or alcohol related)
18-year-old Lucian	March 2026	Medical death
18-year-old Luke	February 2026	Serious Injury - Accidental

Pseudonym	Date Released	Manner of Death/Serious Injury
18-year-old Winnie	February 2026	Serious Injury - Accidental
19-year-old Dominic	July 2025	Accidental death (drug or alcohol related)
19-year-old Drew	May 2025	Suicide
19-year-old Elden	October 2025	Accidental death (drug or alcohol related)
19-year-old Eloise	February 2026	Accidental death (drug or alcohol related)
19-year-old Hudson	February 2026	Accidental death (drug or alcohol related)
19-year-old Jemal	July 2025	Accidental death
19-year-old Luna	October 2025	Pending OCME investigation
19-year-old Ren	December 2025	Medical death
19-year-old Rupert	March 2026	Medical death
19-year-old Vera	December 2025	Accidental death (drug or alcohol related)
19-year-old Zachary	May 2025	Undetermined
20-year-old Aurora	September 2025	Accidental death (drug or alcohol related)
20-year-old Calvin	April 2025	Accidental death (drug or alcohol related)
20-year-old Dove	January 2026	Undetermined
20-year-old Hayden	April 2025	Accidental death (drug or alcohol related)
20-year-old Kendall	July 2025	Pending OCME investigation
20-year-old Lillian	July 2025	Serious Injury - Suspected Accidental (drug or alcohol related)
20-year-old Tyler	July 2025	Accidental death (drug or alcohol related)
21-year-old Coraline	January 2026	Accidental death
21-year-old Forest	November 2025	Serious Injury - Accidental
21-year-old Knox	July 2025	Accidental death (drug or alcohol related)
21-year-old Laniyah	July 2025	Accidental death (drug or alcohol related)
21-year-old Lena	November 2025	Accidental death (drug or alcohol related)
21-year-old Lincoln	July 2025	Accidental death (drug or alcohol related)
21-year-old Orion	August 2025	Suicide
21-year-old Selene	January 2026	Accidental death (drug or alcohol related)
21-year-old Tala	August 2025	Pending OCME investigation
21-year-old Zander	May 2025	Accidental death (drug or alcohol related)

Appendix 2: 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*.

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.

Custody Order (CO)

The court grants the "Director" as defined in the *Child, Youth and Family Enhancement Act* temporary custody of the child until legal status can be determined. The child is placed in an approved placement.

Enhancement Agreement (EA) / With Youth (EAY)

A voluntary agreement between a family (or a young person who is 16 or 17 years old) and the "Director, as defined under the *Child, Youth and Family Enhancement Act* to provide services and support. It is intended to address protection concerns while the child remains with a guardian or lives independently.

Intake

A report completed when Child Intervention receives a community or professional concern about possible risk to a child as per the *Child, Youth and Family Enhancement Act*.

Permanent Guardianship Order (PGO)

The court grants the "Director" as defined in the *Child, Youth and Family Enhancement Act* sole guardianship 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.

Supervision Order (SO)

The court grants the "Director" as defined in the *Child, Youth and Family Enhancement Act* mandatory supervision of a young person. Guardians retain custody.

Support and Financial Assistance Agreement (SFAA)

A former voluntary agreement whereby services and financial assistance were provided under the *Child, Youth and Family Enhancement Act* to a young person between 18 to 22 years old.

Temporary Guardianship Order (TGO)

The court grants the "Director" as defined in the *Child, Youth and Family Enhancement Act* custody and guardianship of a child for a specific period. The child is in the care of Child Intervention, and guardianship is shared with the parent/ legal guardian.

Transition to Adulthood Program (TAP)

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

Appendix 3: Endnotes

1. Office of the Child and Youth Advocate, 2025
2. Manitoba Centre for Health Policy, 2020
3. Kelley & Haskins, 2021
4. Beddoe et al., 2022
5. Kim & Park, 2026
6. O'Neill et al., 2022
7. Kim & Park, 2026
8. Rothwell et al., 2021
9. O'Neill et al., 2022
10. Moe et al., 2025
11. Kim & Park, 2026
12. Rothwell et al., 2021
13. Moe et al., 2025
14. Holmes et al., 2021
15. Holmes et al., 2021
16. Sewell et al., 2021
17. Holmes et al., 2021

Appendix 4: Youth and stakeholder consultation questions

This report was informed by consultations with the OCYA Youth Council and alumni members, as well as stakeholders in leadership roles from child-serving ministries across the province. The following questions were asked:

Youth consultation questions

1. **When professionals assessed your needs, did you feel that they accurately captured your functioning, circumstances, and changing needs over time?**
   - Did they adjust the plan based on what they learned?
2. **During times that professionals assessed you, what was your experience of the process?**
   - Was it explained?
   - Were results shared?
   - Was your voice included?
3. **When decisions were made about you, do you feel that professionals understood your circumstances? Why or why not?**
   - Did professionals explain how they made decisions about you? (What factors did they consider? I.e., talked to a supervisor/manager)
4. **If you could trade places with the professionals who assessed your needs, was there anything that would have been done differently?**

Stakeholder consultation questions

Cross-ministry leaders

1. **How does your organization provide oversight to monitor, direct, evaluate and maintain the work of its employees (outside of policy, procedures, tools and practice guidance)?**
   - What is your understanding of your responsibility to provide oversight and guide decision-making by frontline staff?
   - Is there a methodology that is used within your organization to provide this oversight and guidance?
     - Is that methodology standardized? If so, what does it look like?
   - Do you receive training to provide decision-making oversight and guidance to frontline staff?
     - If so, do you feel that training is adequate?
   - Who provides oversight and guidance to you for your decision-making?
2. **What, if any, barriers have you encountered in providing effective oversight and guidance to frontline staff?**

3. **Do you feel you are supported to provide meaningful oversight and guidance? Why or why not?**
4. **What, if any, factors prevent you from providing meaningful oversight and guidance?**
5. **What are the implications of poor oversight and guidance in decision-making?**

HR Questions

1. **What does your organization do to recruit and retain staff?**
   - Do you have processes for this? If yes, what are they?
2. **What strategies does your organization use to build, maintain, and transfer organizational knowledge?**
   - Do you have processes for this? If yes, what are they?
3. **What are your considerations when you hire staff?**
4. **How are decisions made when placing staff in a team or unit to ensure there is a balance of experienced and new staff?**
5. **What, if any, staffing challenges does your organization face?**
6. **How does your organization retain experienced staff?**
7. **Are there trends in workforce demographics that influence staffing?**

Appendix 5: Summary of internal ministry information

Ministry of Justice	
Information requested	**Response**
Oversight and support for frontline staff	Information was not provided on requirements, standardized approaches, or processes to provide oversight and support.
Recruitment and retention	Information was not provided for recruitment and retention.
Staff placement and knowledge transfer	Information was not provided regarding staff placement considerations or organizational knowledge transfer.

Ministry of Public Safety and Emergency Services	
Information requested	**Response**
Oversight and support for frontline staff	Oversight and support are guided by established policies and supervisory practices, including coaching conversations, casework discussions, observation of staff interactions, file reviews, regular case discussions, and one-on-one meetings. Training includes role-based preparation, competency-aligned learning, progressive responsibility, and leadership development, supported by shared oversight forums, structured review processes, and leadership engagement.
Recruitment and retention	Recruitment and selection occur in accordance with the *Public Service Act* and Alberta Public Service (APS) principles, considering knowledge, ability, experience, and relevant attributes, through partnership between managers and human resource professionals. Retention is supported through internal transfers, preference for in-service applicants, specialization opportunities, mentoring, career development, and service recognition programs.
Staff placement and knowledge transfer	Staff placement decisions are based on knowledge, abilities, and experience, with consideration of transfer requests, workload, staffing levels, resource complements, learning needs, experience levels, and oversight capacity to support effective supervision and development. Knowledge transfer is supported through training, shadowing senior staff, one-on-one meetings, team meetings, coaching calls, and shared digital platforms.

Ministry of Primary and Preventative Health Services	
Information requested	**Response**
Oversight and support for frontline staff	Primary and Preventative Health Services (PPHS): Oversight is provided through system stewardship, governance, accountability mechanisms, and escalation pathways. Primary Care Alberta (PCA): Oversight is provided through clinical leadership structures, regional management, peer consultation, and quality and patient safety frameworks with access to clinical leads and escalation pathways. Health Shared Services (HSS): There is no formal requirement; oversight is supported through regulatory, organizational, and legislative frameworks, supported by orientation, professional development, clinical leadership, and real-time consultation and collaboration mechanisms.
Recruitment and retention	PPHS: Recruitment follows Government of Alberta and Public Service Commission processes, with additional outreach through social media and email, while retention supports career progression into senior management and non-management roles. PCA: Recruitment and retention are based on clinical qualifications, workforce and regional needs, equity and inclusion, team-based care, and workload sustainability, supported by career progression, leadership pathways, flexible work, and professional development. HSS: Recruitment and retention are led by healthcare organizations and programs, focusing on clinical competence, experience, and interpersonal skills, with retention supported through professional development, mentorship, career pathways, student placements, recruitment initiatives, and supportive work environments.
Staff placement and knowledge transfer	PPHS: Organizational knowledge is supported through orientation, onboarding, standard operating procedures, growth opportunities, and succession planning. PCA: Staff placement considers service delivery models, patient population need, balance of experience and learning, clinical oversight, mentorship, and geographic access, while knowledge is supported through standard operating procedures, onboarding, communities of practice, quality improvement, and documentation and information sharing platforms. HSS: Staff placement is based on patient/client needs, staff competence and experience, learning needs, and available supervision, while knowledge is supported through orientation, mentorship, clinical guidelines, continuous learning, shared decision-making, and succession planning.

Ministry of Hospital and Surgical Health Services	
Information requested	**Response**
Oversight and support for frontline staff	Oversight and decision-making support is provided through a shared and tiered accountability model involving executive leadership, program and zone leadership, directors and managers, and professional practice and clinical leadership. Frontline staff are supported through supervision, clinical consultation, and practice oversight, with feedback gathered through supervision, team meetings, engagement surveys, professional practice forums, quality improvement initiatives, and informal feedback channels. Emerging gaps are identified through performance management, incident reviews, accreditation findings, staff feedback, changes in clinical standards or patient acuity, and training compliance data, and are escalated through leadership and governance structures.
Recruitment and retention	Information was not provided for recruitment and retention.
Staff placement and knowledge transfer	Utilization of formal and informal succession planning mechanisms, including talent reviews, leadership development, identification of critical roles, acting assignments, mentoring, cross-training, and collaboration with professional practice. Staff providing oversight and support receive enhanced onboarding and transition-to-practice programs, coaching and education support, standardized education platforms, and leadership development opportunities. Workforce planning and placement decisions are informed by vacancy and turnover rates, retention data, workforce distribution, and alignment of staff competencies with service delivery needs. Organizational knowledge is supported through mentorship and preceptorship models, onboarding and transition-to-practice programs, communities of practice, interdisciplinary learning, digital education platforms, and leadership development initiatives.

Ministry of Mental Health and Addiction - Recovery Alberta	
Information requested	**Response**
Oversight and support for frontline staff	Oversight and support are provided through structured clinical supervision and collaborative practice, including regular group and one-on-one supervision, case conferences, on-demand consultation, caseload monitoring, multidisciplinary discussions, complex case escalation protocols, and professional practice councils. While there is no formal standardized training program, support includes monthly communities of practice, peer networks, provincial supervisor councils, and system-wide training when new processes or procedures are introduced.
Recruitment and retention	Recruitment and retention focus on qualifications, onboarding, and professional development, including hiring candidates with relevant mental health experience and active professional registration, structured orientation and onboarding with role clarity and early check-ins, ongoing clinical supervision and leadership support, continuing education, and specialized training. Retention is supported through professional development opportunities, mentorship roles, structured salary progression, and recognition programs.
Staff placement and knowledge transfer	Staff placement balances experience, learning, and service delivery needs through a mix of senior and junior staff, on-site supervision, mentorship, team-based learning, workload balancing, and rotation based on experience, clinical specialization, and service needs. Knowledge transfer is supported through observation opportunities, communities of practice, and formal workflows and documentation.

Ministry of Assisted Living and Social Services	
Information requested	**Response**
Oversight and support for frontline staff	Supervisory oversight and frontline decision-making support are delivered through delegated authorities, mandatory training, quality management practices, file reviews, coaching, mentoring, and regular one-on-one supervision. Disability Services (DS) including Persons with Developmental Disabilities and Family Support for Children with Disabilities: Delegation authorities define roles, responsibilities, competencies, and accountability requirements for delegated staff. Supervisors oversee program delivery to ensure alignment with legislation, regulations, and policy. In response to recommendations from the Office of the Auditor General's FSCD audit, the ministry implemented standardized delegation resources, including a training accountability framework, mandatory statutory oversight and accountability training, and a centralized repository to monitor completion of delegation requirements. Employment and Financial Services (EFS): Oversight is supported through quality management practices, including file audits, review of client interactions, standardized evaluation tools, documented feedback, coaching, and regular supervision meetings. Office of the Public Guardian and Trustee (OPGT): Oversight and support are provided through delegation of authority frameworks, training, peer mentorship, supervisor support, regular one-on-one and quarterly performance meetings, skill checklists, and ongoing review of delegated responsibilities to support progress, accountability, and decision-making. Public Service Commission (PSC): Oversight and support are embedded in the APS leadership accountabilities, policies, and performance management frameworks, supported by corporate guidance, leadership competencies, training, coaching, feedback, and escalation structures.
Recruitment and retention	Knowledge transfer is supported through coaching conversations, mentoring, job shadowing, buddy systems, cross-training, communities of practice, and supervisory oversight. Organizational knowledge is maintained and shared through centralized repositories, shared documentation platforms, policy and operational procedure training, planned transition activities, and succession planning. DS: Retention is supported through supervisory support, quality management practices, learning and development, stable work environments, and recognition of experience. Knowledge is built and transferred through delegation training, policy reviews, supervisory oversight and coaching, development opportunities and centralized resources.

Ministry of Assisted Living and Social Services	
Information requested	**Response**
Recruitment and retention	EFS: Retention strategies include regular guidance, coaching and feedback, standardized review processes, balanced workloads, learning and development. Knowledge transfer is supported through supervisory coaching, mentoring, job shadowing, cross-training, documentation practices, centralized repositories, and communities of practice to support continuity, consistency, and informed decision-making. OPGT: Retention is supported through the People Plan, focusing on meaningful opportunities, skill development, and recognition. Knowledge is maintained and transferred through staff committees for policy and training development and shared documentation platforms, including SharePoint. PSC: Retention is supported through learning and development opportunities, career progression, competitive compensation, recognition and performance feedback frameworks, temporary assignments, well-being and psychological safety supports, and flexible workforce arrangements. Knowledge is supported through corporate learning platforms, succession planning, mentorship, job shadowing, and documentation standards.
Staff placement and knowledge transfer	Supervisory staff are supported through standardized APS supervisory training, role-specific onboarding, leadership development, and ongoing learning opportunities to strengthen supervisory competencies and support effective oversight of frontline staff. DS: Supervisory staff receive standardized, role-specific training upon commencement in their roles. Practice supervision training was implemented to strengthen supervisor oversight, support critical thinking, and promote consistent application of legislation, policies, and procedures. Additional supports include quarterly communities of practice, performance agreement tracking, and system improvements to support consistent service delivery. EFS: Supervisory staff are supported through APS-wide training, including foundations for supervisors, performance management, crucial conversations, and communication strategies for de-escalation. Additional role-dependent supports include branch-specific training, quality management working groups, peer learning opportunities, mentoring, and leadership support. While some supervisory training is standardized, additional training and supports vary based on branch and operational requirements. OPGT: Placement decisions consider staff-to-supervisor ratios, experience, skills, and experiential background to support effective oversight, staff development, and client service. PSC: Decisions balance service delivery, supervisory experience, and development opportunities, considering leadership readiness, prior experience, operational risk, workload, mentoring availability, career development, and succession planning, with merit-based recruitment and support for lateral transfers.

Ministry of Education and Childcare	
Information requested	**Response**
Oversight and support for frontline staff	Education and Childcare (ECC) does not have a requirement to provide oversight and support to frontline staff, as responsibility for frontline staff in schools rests with individual school authorities. Accordingly, there is no standardized oversight approach or related training within ECC.
Recruitment and retention	Recruitment focuses on candidates having a clear understanding of their roles, while retention is supported through positive work environments, professional development, opportunities to build on strengths, train others, and develop new skills, and an employee engagement plan that promotes career growth, leadership development, and a supportive workplace culture.
Staff placement and knowledge transfer	ECC staff placement is based on applicable skills, knowledge, and experience for specific roles, while responsibility for frontline staff in schools lies with individual school authorities, and organizational knowledge is supported through internal communities of practice across branches, sectors, and divisions.

Ministry of Children and Family Services	
Information requested	**Response**
Oversight and support for frontline staff	Oversight and support are provided through established relationships, guiding judgment, and decision-making in line with legislation and policy. Practice is guided by the Enhancement Policy Manual and Practice Strategies for Lifelong Connections, with required third-person consults at key decisions. Intake meetings, safety analysis meetings, the *Child, Youth and Family Enhancement Act* delegated advisors, and ongoing development support consistent, reflective, quality decision-making.
Recruitment and retention	Recruitment uses multiple approaches, with candidates assessed against minimum recruitment standards. New hires receive training, mentorship, and supervision, while retention is supported through compensation, professional development, career growth, workplace supports, and recognition programs.
Staff placement and knowledge transfer	Worksites assign files based on operational needs, staff experience and competency, learning needs, supervisory capacity, and service demand. Complex cases go to experienced staff; new staff are gradually onboarded with training and supervision. Knowledge transfer is supported through mentorship, supervision, the intranet, training, and ongoing learning initiatives.

Appendix 6: Terms of reference

Authority

Alberta's Child and Youth Advocate (the "Advocate") is an independent officer reporting directly to the Legislature of Alberta. The Advocate derives her authority from the Child and Youth Advocate Act (CYAA). The role of the Advocate is to represent the rights, interests and viewpoints of young people receiving services through the *Child, Youth and Family Enhancement Act*, the *Protection of Sexually Exploited Children Act*, or the youth justice system.

The CYAA sections 9.1 and 9(2)(d) require the Advocate to review the death or serious injury of any child who was receiving a designated service (child intervention or youth justice) at the time of their death or injury or had received child intervention services within two years of their death.

Objectives of an investigative review and consolidated report

To review the experiences of young people who passed away or were injured, and those of their families, with child-serving systems.

To identify findings related to relevant protocols, policies and procedures, standards and legislation in each completed and publicly released investigative review.

To track themes identified in each completed and publicly released investigative review.

Annually, to analyze the themes in each completed investigative review and prepare a larger consolidated public report that explores those prevalent themes and makes recommendations.

Scope/limitations

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, meaningful findings, and advocate for system improvements that will enhance the overall safety and well-being of young people who receive designated services.

Methodology

The review process will include:

- Analysis of the findings and themes in each completed and publicly released investigative review
- Review of relevant research
- Review of documentation and reports
- Review of policy and casework practice
- Personal interviews
- Consultation with experts and other stakeholders
- Other factors that may arise for consideration

Consultation

Consultation with relevant stakeholders and subject matter experts will occur, either through individual or group consultation or by convening a committee—to be determined by the Advocate and the Deputy Advocate of Indirect Advocacy Services. The purpose of consultation is to inform the report's findings and recommendations.

Reporting

The Child and Youth Advocate will release an annual public consolidated report.

Appendix 7: Bibliography

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CALLING FOR CHANGE

Investigative Reviews Report

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