Alberta Government

The *Child Protection and Accountability Act*: Impact on recommendations from the Ministerial Panel on Child Intervention

Panel Recommendation	Status	Description
RECOMMENDATION #1: PRIMARY AUTHORITY FOR CHILD DEATH REVIEW		
Amend legislation as required to increase the mandate and authority of the Office of the Child and Youth Advocate (OCYA) as the primary body to review all preventable deaths of children and young adults who have received a designated service within two years of death.	Addressed	The proposed legislation would go above and beyond the intent of the recommendation by requiring reviews of all deaths of children under 20 years old who were receiving services or had within two years prior to their death. In the proposed legislation, all public bodies would have a mandatory, proactive obligation to share relevant information with the OCYA. The Advocate would also be required to notify family and others of the review, and engage them as appropriate.
This includes defining preventable death, and allowing the OYCA to compel production of all and any related information for the purpose of the review.	Addressed	The proposed legislation would go above and beyond the intent of the recommendation by requiring reviews of all deaths of children under 20 years old who were receiving services or had within two years prior to their death.
The Advocate, as an independent officer of the Legislature, will report to a Standing Legislative Committee with the appropriate mandate to ensure accountability, as per the Auditor General's recommendation. The committee can also compel department members to respond to questions and present information.	Addressed	The proposed legislation would address this recommendation, mandating The Advocate to report to the Speaker of the Legislature for referral to an appropriate standing committee, as per the Standing Orders of the Legislative Assembly.
Ensure the Advocate's mandate reflects a need to identify both strengths and deficits in practice and service delivery.	Addressed	The proposed legislation would empower the OCYA , giving the Advocate power to direct recommendations and observations as it sees fit.
The OCYA can use a series of approaches (i.e. aggregate-themed reviews, policy reviews) when conducting child death reviews.	Addressed	The proposed legislation would empower the Advocate with all the authority needed to develop robust, comprehensive reviews for both systemic and mandated child death reviews.
Examine other legislation that may require amendment such as: a. *Child, Youth and Family Enhancement Act (CYFEA)* to redefine scope as an internal Quality Assurance function, and remove notification and authority of the Council for Quality Assurance (CQA) to review child deaths or call for an Expert Panel Review of the same. b. *Fatalities Inquiry Act* (FIA) to eliminate the review of a preventable child death, of a child/young person	Deferred Addressed	Amendments to the *Child and Youth Family Enhancement Act (CYFEA)* will be brought forward after the Ministerial Panel has completed Phase 2 of its work, where recommendations are also likely to impact this legislation. Proposed legislation would address this recommendation in principle. The Fatality Review Board would be required to consider the cumulative impact of multiple reviews on all the

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who was receiving services at time of death or within two years of death, refine the mandate of the Office of the Chief Medical examiner (OCME) as to notify the OCYA as per expanded authority.		families involved, and consider all previous reviews and recommendations when deciding whether a fatality inquiry should proceed.
c. *Protection Against Family Violence Act* to restrict the powers of the Family Violence Death Review Committee to preclude the review of a child death.	Addressed	Proposed legislation would address recommendation in principle. These reviews would continue but the Family Violence Death Review Committee would be required to consider the OCYA's recommendations when determining whether to do a review.
RECOMMENDATION #2: ACCOUNTABILITY		
Ensure child death review recommendations follow the SMART approach in that they are specific, measurable, achievable, realistic, and time sensitive. Require that SMART recommendations be grouped into three categories: short, medium and long term to prioritize the recommendation and overall timeframe.	Addressed	The proposed legislation would include regulation-making authority to develop criteria for ensuring SMART recommendations.
Ensure clear, actionable recommendations that may include policy, program and practice changes, are developed that consider resource implications, such as training and workload pressures, as well as the implementation realities across cultures and communities; particularly as they relate to disparities on- and off-reserve.	Addressed	The proposed legislation would include regulation-making authority to develop criteria for ensuring SMART recommendations. The proposed Advisory Audit Committee would also advise the Advocate on all proposed recommendations.
Align legislation, regulation and/or policy changes with the Office of the Auditor General (OAG) accountability principles and processes used to develop and implement recommendations.	Addressed	The proposed Advisory Audit Committee would be based on the OAG's established processes. as previously recommended by the Auditor General.
The ministry that receives the recommendation has an articulated and measurable mechanism to share information with relevant front-line service delivery staff and partners.	No legislative change required	Children's Services is addressing this recommendation through policy and practice changes.
Ensure that best practice, research, and recommendations are translated into concrete, timely changes at both the management and front-line levels, and include required reporting across the service delivery system (i.e. government and contracted agencies).	No legislative change required	Children's Services is addressing this recommendation through policy and practice changes.
Ensure that all recommendations and resulting changes include a cultural lens	Addressed	The proposed legislation would require a cultural expert participate in each review and the OCYA

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to help guide implementation.		consult with Indigenous advisors.
RECOMMENDATION #3: TIMELY REVIEW PROCESS		
To ensure that the system is responsive to new learnings and respects the grieving process of families, all child death reviews, whenever possible, the internal and external reviews should be completed within a year from death unless a criminal investigation prohibits completion.	Addressed (external) Deferred (Internal)	The proposed legislation would address this recommendation in principle. It would require the OCYA to complete child death reviews within a year of notification to the Advocate's office, whenever possible. Internal death reviews would also be completed within a year. Changes to *CYFEA* will be considered after the panel has completed Phase 2 of its work, where recommendations are also likely to impact this legislation.
To ensure accountability for timeliness, the OCYA will provide an update, every six months, to the appropriate legislative committee as to the status of all active reviews.	Addressed	The proposed legislation would address this recommendation in principle. The Advocate would report to the Speaker of the Legislature for referral to an appropriate standing committee, as per the Standing Orders of the Legislative Assembly.
RECOMMENDATION #4: ACCESSIBLE, INCLUSIVE FAMILY SUPPORTS		
Develop and implement policies and procedures in external child death reviews, and related internal quality assurance process, to collect all relevant information across government and service delivery agencies, including engaging the family, community, front-line staff and Band Designate, when applicable, throughout the child death review process.	Addressed	In the proposed legislation, all public bodies would have a mandatory, proactive obligation to share relevant information with the OCYA. The Advocate would also be required to notify family and others of the review, and engage them as appropriate. Children's Services is further enhancing internal quality assurance programs and policies to address this recommendation.
These processes will be used to identify family members including foster and kinship caregivers, other caregivers and front-line staff who are impacted by the child death; immediate notification of all impacted parties; ensure safety of family and community members, particularly other children in the home; and provide a range of appropriate and culturally relevant supports for the impacted parties from pre- through to post-review.	Addressed, with further policy and practice changes to follow	In the proposed legislation, the OCYA would be required to notify family and others of the review, and engage them as appropriate. Children's Services is also further enhancing support programs and policies to address this recommendation.
These processes will also include mechanisms to support those closest to the child (family – biological, foster and kinship care, and front-line staff) to have a voice in the review process without fear of repercussions.	Addressed, with further policy and practice changes to follow	In the proposed legislation, the OCYA would be required to engage with those closest to a child as appropriate. Children's Services is also further enhancing programs and policies as needed.
Develop and maintain a resource list of	No legislative	Children's Services will develop a list and enhance

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supports and services for grieving families, caregivers and agency and frontline service delivery staff.	change required	its supports and services as needed.
OCYA will advise all families engaged in the child death review process that they have access to supports throughout the review and support connection to the same. Families may access culturally relevant supports as needed. Ensure the family has a designated individual (navigator) to support the family to navigate the system, and access care and support, as needed.	No legislative change required	Children's Services will work with the OCYA to enhance its support for families throughout the process.
RECOMMENDATION #5: INFORMATION SHARING		
Audit existing communication and technological tools, protocols and procedures that support information sharing when a child receiving intervention services dies. The audit should be completed within one year.	To be completed within a year. No legislative change required	Children's Services will audit how all the participants in the child death review process communicate and share information.
Develop recommendations to improve the timeliness of information sharing and achieve efficiencies throughout the child death review process across government services and service delivery agents.	Addressed, with further policy and practice changes to follow	In the proposed legislation, required information-sharing between law enforcement and the OCYA, among others, would ensure more timely and efficient information sharing. All public bodies would also have mandatory, proactive obligation to share relevant information with the Advocate. Information-sharing protocols will be signed with police, government and the OCYA once this legislation is passed. Children's Services is also further enhancing programs and policies to address this recommendation.
RECOMMENDATION #6: INTERNAL QUALITY ASSURANCE AND TRANSPARENCY		
Use standardized quality assurance procedures in internal reviews to enhance practice and strengthen service delivery and increase public confidence.	Deferred	Changes to *CYFEA* will be considered after the panel has completed Phase 2 of its work, where recommendations are also likely to impact this legislation.
Ensure immediate action is taken when needed to mitigate safety, address performance and make changes in service delivery.	No legislative change required	Whenever there are immediate concerns for the safety of a child, Children's Services takes immediate action to respond. Children's Services will further enhance programs and policies to address the recommendation as it relates to performance and changes to service delivery
Findings and progress of internal reviews, including identified issues and	No legislative change required	Children's Services will further enhance programs and policies to address this recommendation.

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actions taken, will be regularly reported to the public through the Ministry's annual report.		
RECOMMENDATION #7: CULTURALLY COMPETENT REVIEWS		
All reviews will be culturally sensitive to the culture of the child and/or family through the engagement of cultural representation expertise to advise the review team, and to support the review, including the drafting of the report and the development and interpretation of any resulting recommendations.	Addressed	The proposed legislation would require a cultural expert participate in each review and that the OCYA consult withIndigenous advisors.