Alberta Human Services

Implementation Oversight Committee Recommendations: Status Update

As of December 2016

Recommendation	Status
Source: IOC Letter to Minister of Human Services, April 2014	
The Office of the Chief Medical Examiner (OCME) and Alberta Justice are currently undergoing a review the Fatality Inquiries Act. The creation of a multidisciplinary Child Death Review Committee within the Office of the Chief Medical Examiner to investigate the deaths of all children in Alberta is being considered as part of this review. We strongly support the creation of this committee.	Ongoing
We would also recommend the government consider giving the OCME direct access to the Government of Alberta Intervention Services Information System so the OCME can proactively and more easily search for system involvement as part of their routine investigation of child death. The OCME already has the authority to access this information, but does so reactively and must go through official channels to access it. By giving them direct access to the database, the government would streamline information sharing in support of the OCME's prevention mandate.	Ongoing
We recommend the department, in partnership with the Council for Quality Assurance and the Office of the Child and Youth Advocate develop a fulsome internal child death and serious incident review process and publish the final process to the Human Services website. Serious incidents should be defined to include: serious injuries, physical or sexual abuse of a child in care and serious incidents involving suicidal or other serious risk taking behaviors. Specific definitions of serious incident should be developed by the department in partnership with the Council for Quality Assurance and the Office of the Child and Youth Advocate.	Completed
To ensure an open and frank disclosure of information as part of this internal review process, we recommend child intervention workers and reviewers be extended the same 'statutory shield' protection as exists for investigations by the Office of the Chief Medical Examiner and Office of the Child and Youth Advocate.	Completed
All internal child death and serious incident review reports should be made available to the Advocate and the Council for Quality Assurance upon completion.	Completed
That internal review process should be designed, ready to be implemented and published no later than September 30, 2014.	Completed

The Council for Quality Assurance plays a lead role, in consultation with the Department of Human Services and the Office of the Child and Youth Advocate in developing an integrated system of quality assurance and continuous improvement. In the death review process, the Council for Quality Assurance can play a critical role in ensuring the department learns from every incident and quality of service improves to prevent further incidents.	Completed
We believe the Council should not conduct its own separate review of death and serious injury but rather ensure there is a rigorous internal investigative process, provide independent expert advice to the internal review process and the Minister, participate in the Child Death Review Committee where required, and monitor the quality of the internal review process and the implementation of recommendations. If they feel an internal investigative review is insufficient or the process is flawed, the Council should be empowered to require revision. Given the critical role the Council plays in quality improvement we feel the Council should report directly to the Minister.	Completed
We recommend the Advocate be empowered to investigate the death of any child who dies within one year of leaving care or receiving child intervention services.	Completed
We therefore recommend removing the blanket publication ban on reporting the names of children in care or receiving services if a child dies in care or while receiving child intervention services. We believe Alberta Human Services should not release the names of children and families receiving child intervention services but those families and youth should be free to identify themselves.	Completed
Alberta Human Services and the Council for Quality Assurance have begun a process to catalogue recommendations to the Child Intervention System going back 15 years to 1999 and to develop a system for tracking the implementation of these recommendations. As the IOC is a temporary advisory committee, and implementation of recommendations is clearly a quality assurance and performance improvement activity, we recommend the Council for Quality Assurance be formally charged with tracking and publically reporting on implementation of recommendations.	Completed
We recommend the government consider the creation of an Alberta Centre for Child Welfare Development in partnership with an appropriate post-secondary institution that: • Provides a comprehensive child welfare education including a Bachelor of Social Work with a child welfare focus, a route into a tailored Masters of Social Work to help educate senior managers in child welfare leadership and supervision, and a range of child welfare professional development opportunities; • Drives collaborative research on child welfare practice in	In progress

partnership with Alberta Human Services; and • Provides complementary supports to the child welfare system, such as promotion of child welfare as a career path, and programming for children formerly in care. The Alberta Centre for Child Welfare Development should be accessible to Albertans in all areas of the province and should connect and collaborate with post-secondary institutions under Campus Alberta.	
Source: IOC Letter to Minister of Human Services, August 2014	
Ensure the Child Intervention System gets the full benefit of external reviews through a thorough review of the intent and feasibility of the recommendations prior to their acceptance. The department develop a process to review and discuss proposed recommendations with the recommending body before committing to implement. The purpose of this discussion would be to clarify the intent and feasibility of recommendations which can help ensure that, once accepted, departmental action plans address the identified issues. An approach similar to this is regularly used by the Alberta's Auditor General. For fully independent review bodies such as the Office of the Child and Youth Advocate, the department could consider some form of Memorandum of Understanding to outline how these bodies could work with the department to achieve clear, implementable recommendations.	Completed
Ensure the Child Intervention System gets the full benefit of external reviews through a thorough review of the intent and feasibility of the recommendations prior to their acceptance. In cases where this type of advanced dialogue is not workable, develop a process to discuss the published recommendations with the recommender and develop a clear implementation plan that meets the recommendations' intent. This will require that the Minister allow the department adequate time to consider each review and discuss with the recommending body before responding or accepting the recommendation.	Completed
Engage the judiciary and the Office of the Child and Youth Advocate in the development of clear and precise recommendations to support improvement to the system and improved outcomes for vulnerable Albertans. Outreach to judges and the Office of the Child and Youth Advocate to establish guidelines for developing recommendations that are clear and precise to support more ready implementation and audit. The SMART criteria (Specific, Measureable, Achievable, Realistic and Timely) may be a useful model or approach.	Ongoing
Develop a detailed plan for the execution of each recommendation. For each recommendation accepted by government, the department	Completed

should develop an auditable action plan that has at minimum: • A clear outcome for each recommendation; • Clearly articulated actions that will be undertaken; • Assigned responsibility for those actions; • Timeline for completion; • Regular review and scheduled audit.	
Implementation of a comprehensive strategy that supports: • Enhanced system performance; • A benchmark of Alberta's performance; and • Improves public confidence. To support the assessment of Child Intervention System performance and ongoing performance improvement we're recommending a four point System Performance Data Strategy. The four points of (the) proposed System Performance Data Strategy are: - Public reporting of program data and system outcomes; - Benchmarking Alberta's performance; - Review of existing cross-ministerial administrative data on children leaving the Child Intervention System; - Longitudinal study tracking the experiences of current children following their inclusion in the Child Intervention System.	Ongoing
Source: IOC Letter to Minister of Human Services, February 2015	
We recommend the government set measurable and time-bound goals for the reduction of injury and deaths to children in care or receiving services, benchmarked against other child intervention systems around the world. Benchmarking also needs to put deaths in the child intervention system within the context of the broader population (i.e. are the rates or nature of fatalities somehow different to those experienced by other children in Alberta?). We can and should set the standard and have the ultimate goal of no preventable deaths among children in provincial care or receiving services.	Ongoing
We recommend that the ministry complete comprehensive reviews of all deaths and serious injuries for two years, including those deaths that occurred in 2014. The ministry and the CQA should complete a joint evaluation of those reviews to establish criteria for the decision on when the Director should order a Statutory Review and when a scaled-down review is warranted. The scope of the internal death review process should consider all interactions with Government of Alberta systems.	Completed
We recommend the government review the use of the ex parte provision during the upcoming review of the Child, Youth and Family Enhancement Act.	Ongoing
We recommend that government efforts to reduce poverty prioritize specific, targeted initiatives to reduce poverty among Aboriginal people living in urban centres. Targeted efforts should begin with a focus on	Ongoing

urban Aboriginal families and youth currently in contact with the child intervention system, including those about to age out of care and those who recently have. Strategies should be reviewed against key risk factors for child intervention involvement, including unaffordable or no housing, poverty, addiction, domestic violence, and a history of foster care.	
We recommend the Government of Alberta formally recognize and endorse Jordan's Principle.	Ongoing
We recommend the Government of Alberta support the establishment of a National Inquiry into Missing and Murdered Indigenous Women.	Completed
We recommend that the CQA be led by an Executive Director or CEO with staff hired and led independently of the ministry. Considering the evolution and mandate of the CQA, a review of the membership of the CQA might be in order. The purpose of the review would be to ensure that the appropriate skills, experience, and expertise are present within the membership to complete the work required.	Ongoing