



**Children's Services
Deputy Minister's Office
12th floor Sterling Place
9940-106 Street NW
Edmonton, Alberta T5K 2N2**

October 29, 2018

AR 3994

**Ms. Jennifer Fuchinsky
Fatality Inquiry Coordinator
Justice and Solicitor General
Legal Services Division
9th Floor, Peace Hills Trust Tower
10011 - 109 Street
Edmonton AB T5J 3S8**

Dear Ms. Fuchinsky:

Thank you for providing a copy of Honourable Judge Bart Rosborough's report from the public fatality inquiry into the death of T.S, a youth in care at the time of her passing. The death of any child or youth is devastating, and our thoughts remain with the family and community who continue to mourn the loss of this child.

Fatality inquiries provide a valuable opportunity for an external review of tragic incidents involving Albertans. Children's Services continues to evolve to serve the needs of vulnerable Albertans and values the input from our ministry partners and stakeholders. They offer insight into how the child intervention and health systems can be enhanced to support better outcomes for children, youth and families.

Please see the attached table for Children's Services' response to the recommendations and the rationale for this response.

Thank you for the opportunity to respond. If you require anything further, please contact my office.

Sincerely,

Original signed by

**Darlene Bouwsema
Deputy Minister**

Attachment

Ministry of Children’s Services’ Response to the Public Fatality Inquiry – T.S.

Recommendation	Ministry Response	Actions Planned or Underway
<p>5. Emergency Contact – “Earlier in this report I referred to contact made to the Crisis Unit relating to comments attributed to T.S. about self-harm, etc. I am satisfied that at least some of the information conveyed was false and other aspects exaggerated.</p> <p>“However, that conclusion was arrived at quite some time after the original report. Other reports (albeit of a similar nature) may require immediate action. 'On-call' workers at DFNA's are likely in the best position to determine whether immediate action is warranted in these situations. Accordingly, I recommend that a Crisis Unit be required to notify an 'on-call' worker at a DFNA regarding any report of a possible suicide risk and that they be instructed to err on the side of contact.”</p>	<p>The Ministry of Children’s Services accepts this recommendation.</p>	<p>Children’s Services’ top priority is the safety and well-being of children and youth. Currently, the north and south Alberta Child Intervention Services units accept reports of concerns for children and youth in the province after-hours. They assess the information and alert the service delivery area to any incident, including risk of suicide, which may require the attendance of an after-hours worker.</p> <p>Children’s Services will review and clarify the process that north and south units use in contacting Delegated First Nation Agencies (DFNA) and regions when there is a possible suicide risk.</p> <p>As part of this work, Children’s Services will reinforce the need to have, and share, clear and accurate information regarding how and when to contact DFNAs in these situations. This includes having a system in place with up-to-date information regarding who is on-call for the DFNAs and regions, and how to reach them so that appropriate action can be taken.</p>
<p>6. Supporting Survivors – <i>In Toward a Better Tomorrow</i>, reference is made to the fact that the</p>	<p>The Ministry of Children’s Services accepts the intent of the recommendation.</p>	<p>Every death of a young person is a tragedy. Children’s Services’ policies and practice already enable front-line</p>

tragedy of a suicide extends beyond the deceased, noting (at p.50):

“Those interventions that are made after a suicide, largely taking the form of support for those left behind. Some research suggests that at least six people close to the individual who died will be left in a state of grief and loss. Losing someone close to suicide commonly results in intense emotional trauma, shock, grief and guilt; and, both physical and mental health can be negatively impacted. Information and support are important in helping the bereaved. When a youth has a relative who has attempted suicide or died by suicide, there needs to be deliberate, proactive supports to help the young person. Suicidal behaviour by family members is positively associated with the suicidal behaviour of young people, which needs to be considered when working with particularly vulnerable youth. Exposure to peer suicide may also increase the suicide risk and supports are required.

“Following a suicide in those communities suffering from a disproportionately high rate of Aboriginal youth suicide, the DFNA in that area should determine whether there is a kinship connection between the deceased and any children-in-care. Proactive support for those

workers to proactively support bereaved loved ones, including children and their caregivers.

However, one youth lost to suicide is one too many. We are working shoulder-to-shoulder across government, with Alberta Health Services, municipalities, agencies and communities to take immediate action to prevent youth suicide.

Children's Services, in collaboration with other ministries and stakeholders, has created *Voices for Hope: The Alberta Youth Suicide Prevention Plan*. This provincial strategy will be released in the coming months and will guide government in increasing targeted, culturally appropriate access to suicide prevention, intervention and postvention services and supports for youth, families and those impacted by the tragedy of suicide in Alberta.

The actions in *A Stronger, Safer Tomorrow* will also provide increased funding for youth suicide prevention programs and more responsive, culturally appropriate and accessible services for children youth and families – regardless of where they live in Alberta.

<p>identified in this process (typically, bereaved children and their caregivers) should be provided by the DFNA to prevent future suicides.”</p>		
<p>7. Performance Measures – “I appreciate that the factors precipitating Aboriginal youth suicide are many and varied. Failure to reduce the disproportionately high rate of Aboriginal youth suicide may not signal failure of any or all of the Ministry’s measures. Nevertheless, any increase in that rate (or even static numbers) over the course of a 3-year Business Plan should invite scrutiny: reconsideration of existing strategies and a search for new strategies.</p> <p>“Accordingly, I recommend that the Ministry of Children’s Services amend its Department of Children’s Services Business Plan: 2018-21 to add the annual number of Aboriginal youth suicides as a performance measure for Outcome Two: Resilient Families and Communities and that it report on those numbers in each Annual Report.”</p>	<p>The Ministry of Children’s Services accepts the intent of this recommendation.</p>	<p>Children’s Services is committed to accountability and transparency. The ministry agrees that a measure of youth suicide enables scrutiny when the measure changes; however, the business plan does not enable the type of monitoring intended by this recommendation.</p> <p>Children’s Services will make changes to the public monthly reporting to support this recommendation. The monthly public reporting currently includes the type of intervention, racial status, gender and age group. This will be changed to include the manner of death, and identified as Indigenous and non-Indigenous. The report will show the numbers of suicides for children in care and enable the scrutiny intended by this recommendation.</p> <p>Alberta Health Services also publicly reports on the total number of suicides in Alberta each year.</p>