Alberta Justice and Solicitor General

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COPY

Darlene Bouwsema
Deputy Minister of Children's Services
12th Floor, Sterling Place
9940 – 106 Street
Edmonton AB T5K 2N2

Dear Darlene Bouwsema:

Subject: Mackenzy Woolfsmith – Public Fatality Inquiry
Response to Recommendations

Please find enclosed the Honourable Judge Joshua B. Hawkes' report to the Minister of Justice and Solicitor General. This report will be publicly released on January 14, 2019.

The following recommendations may impact Alberta Children's Services:

[63] Pursuant to section 53(2) of the *Fatality Inquiries Act,* Judge Hawkes made the following recommendations that may assist in the prevention of similar deaths:

a. The legislative framework governing the provision of child care in Alberta should be comprehensively reviewed to address and reduce risk to infants and children in all forms of child care (licensed and unlicensed). [1, 2, 107, 108]

b. A specific focus of that legislative review should be to shift the focus from solely regulating the size of unlicensed daycare to a focus on reducing risk and increasing protective factors in all forms of child care. Academic research, the experience of other jurisdictions and the tragedy in this case all illustrate and support the need for risk focused regulation of child care. [107, 108, 109, 110, 112]

c. Significant operational and staffing changes must accompany any legislative changes to ensure that timely and effective investigations regarding risk in all child care settings. Operational changes include adding the necessary I.T. capacity to track serious incidents

and the providers who are involved in such incidents. [3, 4, 5, 11, 12, 14, 15, 16, 17, 18, 39, 40, 42, 79, 80, 108, 109, 111]

d. The 2014 report of the Auditor General of Ontario regarding the inspection and review of licensed child care in that jurisdiction revealed that legislative change, while necessary, is insufficient to create an effective enforcement regime. The objective of that report was to determine if the responsible Ministry had effective management and oversight practices to ensure effective regulation of this sector. The report noted that more than 29,000 "serious occurrences" were reported to the Ministry over a five year period from 2009-14. The Auditor General made nine specific recommendations relating to enforcement and oversight. [1, 2, 3, 4, 5, 6, 8, 9, 10]. Those recommendations should be considered, both in the current legislative framework to ensure that adequate oversight and enforcement actually occurs with licensed facilities and providers in Alberta, and in the context of examining the revised "risk focused" legislative review I have recommended.

e. The new enforcement culture should be a proactive, rather than a reactive, complaint driven process. [8, 9, 10]. Mechanisms to track ongoing investigations and to audit or review investigations are essential components of such a culture. Other elements of an effective enforcement regime are described in these recommendations from the Ombudsman Report. [21, 22, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 44, 47, 48, 50, 51, 58, 59, 60, 62, 63, 64, 67, 68, 73, 74, 77, 78]

f. Information sharing regarding critical incidents where significant injury or the risk of significant injury occurs in a licensed or unlicensed day care is essential. Specific investigation and information sharing protocols should be examined regarding critical incidents. In particular, the rights of parents or guardians to information regarding critical incidents should take precedence over the privacy rights or commercial interests of child care providers or workers regarding essential information in those reports. The related recommendation from the Ombudsman Report is recommendation 55.

g. All witnesses who were asked about the report form and requirements currently in place for licensed daycares in Alberta agreed that they do not strike the appropriate balance between protecting the privacy of child care workers and providers and providing detailed and meaningful information to regulators, parents and guardians regarding these incidents,

h. The *Children First Act,* (S.A. 2013, c.12.5), and its associated regulation, *Disclosure of Information Regulation,* (A.R. 231/2013), must be examined and revised where necessary to ensure that information regarding critical incidents can be shared and disclosed appropriately.

i. Effective enforcement also requires that the legislation provide for an appropriate range of remedial powers and sanctions, applicable to all forms of child care providers. These must include the power to immediately close unsafe daycares, issue remedial orders and monitor compliance, and to restrict or prohibit individuals from providing child care services. [75, 76, 79, 80, 104]. All of the witnesses in this inquiry agreed that the

legislative authority and operational capacity to identify, restrict, and prohibit individuals from providing child care services was essential.

j. Providing child care is demanding work that is often stressful. That stress can be amplified by the number and age of children and is also exacerbated when that care is provided in an isolated setting without other adults present for support. Tools for self-assessment, and for support should be readily available and accessible. Mandatory support and assistance should be considered for all involved in reported critical incidents.

[64] Mackenzy's death at the hands of her trusted caregiver was a shocking tragedy and terrible loss for her parents and family. It is hoped that the recommendations in this report will give rise to a careful re-examination of the legislative, policy, and operational framework that governs child care in Alberta. As the facts in this case demonstrate, the risks to the very young and vulnerable are real. Other jurisdictions have carefully reviewed all forms of child care from a risk based perspective. That review led to legislative change.

[65] Judge Hawkes strongly recommends such a review in Alberta in order to reduce the likelihood of a recurrence of events like these.

I ask that you please advise the following:

1. Whether Alberta Children's Services accepts, accepts in principle, does not accept, or has a different response to each recommendation;

2. A brief explanation of why that decision was made; and

3. If Alberta Children's Services intends to accept the recommendation, or to implement different measures, what steps will be taken in that regard.

A response to this enquiry is not mandatory. However, be advised that this letter and any response received will be publicly released and posted on the Open Government Portal:

https://open.alberta.ca/dataset/responses-to-public-fatality-inquiry-recommendations

If a response has not been received by May 14, 2019, that information will also be made publicly available.

Thank you for your cooperation in this matter.

Yours truly,

Jennifer Fuchinsky
Fatality Inquiry Coordinator
Enclosure