Making the Most of Mandatory Case Reviews: An Examination of Serious Injury and Death Reviews for Youth Receiving Intervention Services in Alberta

by

Trever Walton

B.A. (Sociology and English), Mount Royal University, 2014

Project Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Policy

in the
School of Public Policy
Faculty of Arts and Social Sciences

© Trever Walton 2020
SIMON FRASER UNIVERSITY
Spring 2020

Copyright in this work rests with the author. Please ensure that any reproduction or re-use is done in accordance with the relevant national copyright legislation.

Approval

Name:	**Trever Walton**
Degree:	**Master of Public Policy**
Title:	**Making the Most of Mandatory Case Reviews: An Examination of Serious Injury and Death Reviews for Youth Receiving Intervention Services in Alberta**
Examining Committee:	**Chair:** Dominique Gross Professor
	Doug McArthur Senior Supervisor Professor
	John Richards Internal Examiner Professor
Date Defended/Approved:	March 26, 2020

Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University

or has conducted the research

c. as a co-investigator, collaborator, or research assistant in a research project approved in advance.

A copy of the approval letter has been filed with the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

Update Spring 2016

Abstract

Case Reviews for injuries and deaths of youth receiving protection services are supposed to increase accountability and improve circumstances for children and youth. However, the form that reviews take and the associated recommendations can contribute to a blame culture that undermines public trust and negatively impacts decisions made by protection workers. Balancing accountability with a focus on learning can increase the positive gains from case reviews and allow reviews to highlight effective case work that can provide context to perceived failures of child protection services. This paper examines the impact of increased case review requirements in Alberta, Canada and considers policy options for future development. Mandatory reviews in Alberta can increase opportunities to learn from tragedies. A searchable database of findings gained from case reviews could increase the value of Alberta's existing focus on industry learning, by making information more accessible to case workers and clinicians.

Keywords: Child death; Case review; Inquiry; Child Protection

Acknowledgements

There are many people I would to thank for making this project possible. First among them is my parents, Greg and Janie, for all the support and encouragement you have given me. Thank you for always pushing me to reach higher and for the years of financial and emotional support throughout my academic career.

Thank you to Christine Osgood for the time spent editing and for listening to me talk about my work. The grammatical information and moral support you provided have been invaluable.

Thanks to my advisors, Doug McArthur and John Richards for sharing your expertise. Your guidance on my research and feedback on drafts elevated the quality of my work.

And finally, thanks to the entire MPP cohort. Especially those of you who gave me feedback on my work or provided much needed distractions when I needed a break. I wish you all the best of luck in whatever comes next.

Table of Contents

Approval ii
Ethics Statement iii
Abstract iv
Acknowledgements v
Table of Contents vi
List of Tables viii
List of Figures ix
List of Acronyms x

Chapter 1. Introduction 1

Chapter 2. Background 3
2.1. Child Protection Inquiries in Canada 3
2.2. Case Reviews in Alberta 5
2.3. Case Reviews in British Columbia 9

Chapter 3. Academic Research 13
3.1. Critiques of Case Reviews 13
Blame Culture 13
Learning Dissemination 14
Public Trust 15
3.2. A Model for Recommendations 16

Chapter 4. The Policy Problem 18

Chapter 5. Methodology 19
Limitations 20

Chapter 6. Analysis 21
6.1. Alberta 21
Discussion 23
6.2. British Columbia 25
Discussion 26
6.3. Interview Findings 27
Dr. Peter Choate 27
6.4. Conclusions 28
Investigative Discretion and Accountability 28
Systems and Innovation 30
Industry Learning and Dissemination 31

Chapter 7. Policy Objectives and Evaluation Criteria 33
7.1. Policy Objectives 33
7.2. Criteria and Measures 34

Chapter 8. Policy Options **37**
8.1. Increased Investigative Discretion 37
8.2. Investigation Findings Database 38
8.3. Expanded Case Review Criteria 39

Chapter 9. Evaluation of Policy Options **41**
9.1. Increased Investigative Discretion 41
9.2. Investigation Findings Database 42
9.3. Expanded Case Review Criteria 44

Chapter 10. Recommendation **47**
Investigation Findings Database 47

Chapter 11. Conclusion **48**

References **49**

Appendix A. Reports Considered **52**
Alberta 52
British Columbia 53

Appendix B. Recommendation Assessment Criteria **54**

Appendix C. Estimated Risk of Death in Designated Services in Alberta and British Columbia **55**
Alberta 55
British Columbia 55

List of Tables

Table 1: In-mandate Deaths and Injuries in 2018-2019 10
Table 2: Alberta Case Reviews and Recommendations by Year and Type 22
Table 3: CLEAR Assessment of OCYA Recommendations by Year 22
Table 4: CLEAR Assessment of OCYA Recommendations by Type 23
Table 5: CLEAR Assessment of 2018-2019 Recommendations by Province 26
Table 6: Criteria and Measures 36
Table 7: Policy Option Assessment 46

List of Figures

Figure 1: OCYA Investigation and Reporting Process (OCYA, n.d., b) 8
Figure 2: RCY's Review and Investigation Process (RCY, 2019) 11
Figure 3: RCY's Recommendation Process (RCY, 2019) 12
Figure 4: The CLEAR method (Buckley and O'Nolan, 2013) 17
Figure 5: Recommendations Progress (OCYA, Recommendations, 2019) 25

List of Acronyms

CLEAR	An approach for developing recommendations that stands for Case for change, Learning-oriented, Evidence-based, Assign responsibility, and Review.
MCFD	Ministry of Children and Family Development – BC
OCYA	Office of the Child and Youth Advocate - Alberta
RCY	Representative for Children and Youth – BC

Chapter 1.

Introduction

The welfare of children and youth is a chief area of concern to those interested in social policy, with special attention paid to those facing increased personal risk due to marginalized identities, mental or physical disability, or histories of trauma. Most modern welfare states have a variety of organizations dedicated to providing support services to youth in need and to provide the necessary interventions to ensure their continued well-being and positive development. Oversight is provided through government ministries. These services include residential care programs for apprehended youth, as well as foster care, in-home supports, and a variety of other programs, including those focused on addiction recovery, harm reduction, and recovery from sexual exploitation. While these programs seek to reduce the harm done to children and to support their ongoing development tragedies still occur. Youth in care or receiving intervention services may experience serious injuries or loss of life. Even when the harm is self-inflicted, as in cases of drug overdose or suicide, it is important to consider whether more could have been done, or if well-meaning but misplaced interventions may have contributed to these deaths. One mechanism for answering these questions is investigative case reviews for youth who die or receive serious injuries while receiving designated services. In the province of Alberta, the responsibility for these reviews falls on the Office of the Child and Youth Advocate (OCYA), where recent criticism has led to an increase in mandatory reviews and reporting.

Academics in the field of social work offer a variety of criticisms on the review process. These criticisms include the quality of recommendations, the frequency of reviews, and even the assumptions underlying the practice. Measuring the effectiveness of death reviews in reducing risk is difficult due to the complexity of situations leading to injuries and deaths. But even focusing on resulting outputs, such as successfully implemented recommendations, there is evidence that child death reviews are not being utilized to their full potential to improve service delivery and to close gaps in youth intervention services. This paper will review the findings of academic research, as well

as examine the situation in Alberta, and compare it to other jurisdictions in order to assess existing policy approaches and consider alternatives.

Chapter 2.

Background

2.1. Child Protection Inquiries in Canada

Historically, investigations into the deaths of children in protective care were handled by law enforcement and coroner's offices but it has become increasingly common for specialized teams to take on aspects of this role. In the United States this began with the development of interagency child death review teams to better gather information from the various organizations providing social services as well as to provide the specialised knowledge to review circumstances effectively (Durfee, Gellert, Tilton-Durfee, 1992). These teams included experts from medical, health, legal, and child protective fields. This made them better equipped to navigate organizational complexities and address the lack of communication between differing agencies. Teams collaborated with law enforcement when criminal investigations were necessary and performed systemic reviews of agency actions to identify deficits, particularly around interagency communication. Canada followed a similar path with provinces developing organizations to specialize in children's welfare, but there continued to be responsibility overlaps between coroners, law enforcement, and youth welfare organizations.

Accountability for child protection services has taken a variety of forms across Canada, with some provinces utilizing internal reviews with reports submitted to the relevant minister or ombudsman, and other provinces creating agencies responsible for publicly reporting on reviews of systemic issues or specific cases (Choate, 2016). Practices for inquiry have varied through time within provinces as well, often in response to criticism over specific child protection incidents. For instance, the Manitoba children's advocate had previously utilized internal reporting, but in 2018 was empowered to publicly report on youth deaths in response to an inquiry from a death in 2013 (Dacey, 2018). The Manitoba youth advocate is expecting to require more resources, as the scope of its required work is growing considerably. A year later, in May 2019, the child advocate's office in Ontario was closed, not in response to a crisis of child deaths, but one of alleged government overspending and conservative austerity measures. While the responsibilities of the office have been turned over to the Ontario ombudsman, the

likelihood of consistent investigation and reporting to be maintained is low. While the advocate had recently implemented notification procedures to ensure that all deaths of youth in care were reported to them, this practice will not be continued. The ombudsman will not be continuing the advocacy, data collection or reporting practices of the child advocate, and will only be looking into cases that others choose to report to the ombudsman (Syed, 2019).

British Columbia has been a leader in child protection oversight and has gone through a variety of practices beginning with the Advocate for Children, Youth, and Families as well as the creation of The Children's Commission. The latter was responsible for investigating child deaths, after waiting for reports from police or coroners if they were performing their own investigations, after which the commission could perform its own in-depth investigations and make recommendations to the Ministry of Children and Family Development or other organizations as it saw fit. From the Children's Commission's inception in 1997 to its closure in 2002 it performed 769 death reviews and made 897 recommendations (Hughes, 2006). These organizations were formed after an inquiry into the death of a young boy while he was receiving services from BC's child protection system. They were eventually replaced with the Office for Children and Youth in an effort to reduce responsibility overlap and the task of child death reviews was handed to the Coroners Service, which would normally not perform the level of background investigation that had come to be expected in child death reviews. In response to inquiries into another child's death the Representative for Children and Youth (RCY) was created in 2006 under the recommendation of Ted Hughes, B.C.'s conflict-of-interest commissioner. The RCY has been responsible for child death reviews since its inception but still needs to coordinate with others as the RCY "must not inhibit the progress of other proceedings such as police investigations, MCFD [Ministry of Children and Family Development] reviews, criminal justice proceedings and inquests" (Representative for Children and Youth, n.d.).

Focusing events can be a significant factor shaping policy development in the area of youth protection. Because the welfare of children is something most people feel strongly about, perceived failures of child intervention services are often framed as public crises. The unpredictable nature of human behaviour means that while some of the risks for young people receiving intervention services can be managed through effective policy, risk can't be eliminated without encroaching on the rights of youth and

families through increased apprehensions and similarly invasive practices. Regardless of how successfully the system operates, there will always be tragedies or failures that some can point to as evidence of a broken system. This can create pressure on politicians to respond to the situation, regardless of whether the crisis is legitimate or politically manufactured. And the nature of responses can be significantly altered by who is invited to help develop them. While experts on child welfare are often embedded in the policy development process, policy makers are placed in the challenging position of balancing expert opinion against public demand for scrutiny.

2.2. Case Reviews in Alberta

In Alberta, the organization that would be come to be known as the Office of the Child and Youth Advocate (OCYA) was formed in 1989, although it did not take responsibility for investigating child deaths and related systemic issues until 2013 (OCYA, n.d., a). In 2014, a young Indigenous girl's death prompted significant attention on improving children's welfare services. One of the existing mechanisms to improve services was case reviews for children who died while receiving intervention services. The death was considered a failure of the welfare system and there was also criticism of the following investigation, as it took "the Office of the Chief Medical Examiner two years to complete its autopsy report" (Graney, 2016). This led to the formation of an all-party ministerial panel that sought to improve the child death review process. Over a twelve-month period, the panel developed two sets of recommendations and ultimately led to the provincial government passing Bill 18: The Child Protection and Accountability Act (Government of Alberta, 2019).

The legislation, which came into effect in March 2018, mandated the OCYA to investigate the death of any child that dies while, or within two years of, receiving intervention services, and to publicly report on it within one year, with the possibility to extend this timeline when it is deemed necessary (OCYA, n.d., b). The legislation also attempted to increase efficiency by providing clarity on overlapping roles, making the OCYA the primary authority to review deaths, as well as requiring relevant bodies, including police, health, and care agencies, to cooperate with the OCYA and to share relevant information during an investigation (Government of Alberta, 2017a). While these changes empower the OCYA to make more timely investigations, the added requirements on mandatory investigations for all deaths of youth receiving interventions

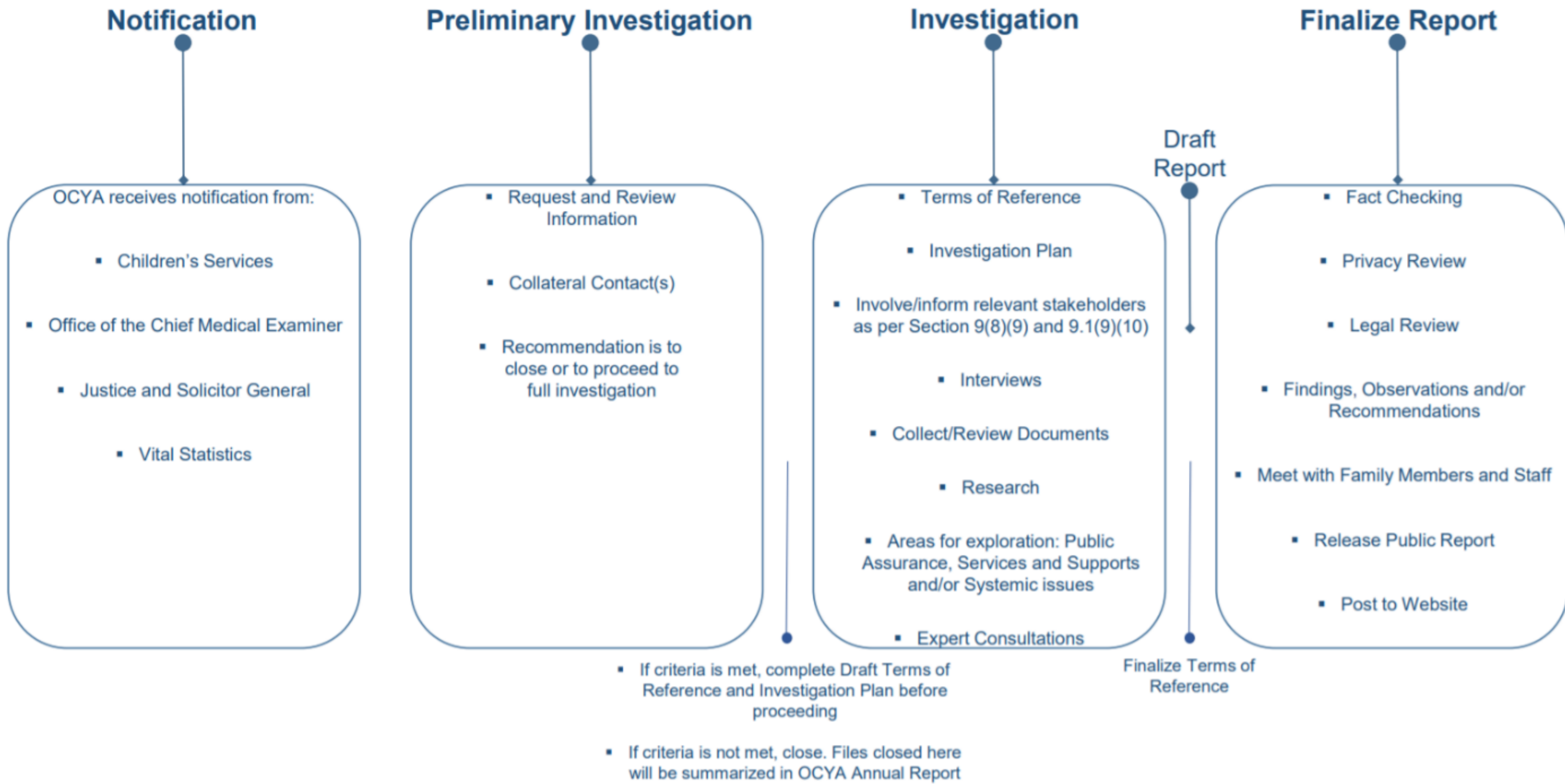
services has increased the OCYA's existing workload and $1.9 million was budgeted to cover the expenses of new investigations, increasing the OCYA budget by more than 13% (OCYA, 2019). In addition to the new requirement for mandatory reviews, the legislation requires the OCYA to include cultural experts on investigations and increase consultation with indigenous advisors (Government of Alberta, 2017b). The OCYA also works to improve the conditions for youth receiving designated services by performing systemic reviews for injuries and deaths of youth receiving intervention services, acting as an advocate for youth, both individually and systemically, and connecting youth to legal representation (OCYA, n.d., b).

From 2012 to 2017 the rate of death for children and youth receiving child intervention services in Alberta ranged from 0.05% to 0.13% (Appendix C). In the 2018/2019 period in Alberta, 15,000 children and youth received intervention services, and 42,000 were assessed (Government of Alberta, 2020b). Over a third of death notifications received by the OCYA in 2018/2019 were accidental or illness related (OCYA, 2019). The categories used by the OCYA provide a rough idea of how preventable deaths may have been, although this could be improved with additional categorization. The 'accidental' category currently includes motor vehicle accidents and drownings, as well as accidental drug overdoses. The growing national concern over addiction and the opioid crisis could warrant the inclusion of drug overdoses as its own category. 57% of notifications of deaths or injury in 2018/2019 were for Indigenous children, who also accounted for 62% of Alberta's child intervention caseload, despite being only 6.5% of Alberta's population (OCYA, 2019. Government of Alberta, 2017c). While death is an infrequent occurrence in the child intervention system, mechanisms for accountability and ongoing review are important to ensure that organizations are responding to them appropriately.

The incorporation of mandatory reviews required slight changes to the OCYA's process for identifying cases for investigation and reporting. This process begins with the OCYA receiving child welfare data, including notifications of deaths and serious injuries, from other organizations. The legislative mandate for the OCYA defines a serious injury as being "near fatal and/or resulting in life-long impairments to a young person's health" (OCYA, n.d., b). After a notification of an injury or death the OCYA conducts a preliminary investigation, after which several outcomes can occur. If the death fits the mandate required by bill 18 then further investigation will occur. Other incidents might be

closed at this stage, or could move on to a systemic review, or compiled with similar circumstances for an aggregate review (figure 1). Before the requirement for mandatory reviews it was left to the discretion of the OCYA to determine which investigations require systemic reviews. Many cases which might not have received full investigations and public reports otherwise, now fall under the requirements for mandatory review. In the 2018/2019 annual reporting period the OCYA received 21 notifications for mandatory reviews and 48 considered for systemic reviews, 11 of which were tied to injuries. Of the systemic investigation cases, 20 were closed after the preliminary investigation, and will not lead to public reports (OCYA, 2019). Investigations and the resulting reports examine the full history of the youth served, including family history, services received, interventions attempted, and other significant factors in order to assess whether the services provided were adequate to address needs and to make recommendations to appropriate entities when needed. The intent of these investigations is to improve the welfare of youth who rely on the network of youth intervention services and to reduce the likelihood of similar outcomes from occurring again. Investigations are not intended to identify legal responsibility for deaths or injuries or "find fault with specific individuals, but to recognize good practice and/or identify key issues along with meaningful findings, observations and/or recommendations, which are specific enough that progress made on recommendations can be evaluated; yet, not so prescriptive to direct the practice of Alberta government ministries" (OCYA, n.d., b). The OCYA also reports on recommendation progress every six months (OCYA, n.d., c).

Figure 1: OCYA Investigation and Reporting Process (OCYA, n.d., b)



2.3. Case Reviews in British Columbia

The wide mandate of the RCY includes a variety of programs, including child protection, adoption, youth justice, children and youth with special needs, and child and youth mental health programs (RCY, 2019). With publicly available MCFD data collected separately by each program it is difficult to estimate the number of youths within the RCY mandate, but in 2018 over 25,000 children were identified by MCFD as in need of protection (MCFD, n.d.). This puts the estimated rate of death for youth receiving reviewable services below a half percent (appendix C). In 2018/2019 the RCY reported receiving 109 death notifications (RCY, 2019). While this number is more than three times higher than Alberta's, it is misleading to make direct comparisons between these numbers due to the differing mandates of each province's youth advocate. The RCY annual report shows that in 2018/2019 nearly half of the in-mandate deaths were considered "natural" deaths. And as in Alberta, Indigenous youth are over-represented in the system, and over half of the critical injury reports and nearly a third of deaths were indigenous (RCY, 2019)

The RCY in British Columbia operates with similar governing ideologies as the OCYA, but with several notable differences. Like the OCYA, the RCY defines the focus of its reviews on "accountability and learning" (RCY, 2019). The RCY does not have the same legal stipulation the OCYA does to investigate and publicly report on each death. This gives the RCY greater discretion to determine when it is in the public's best interest to complete a full investigation. While all reports it receives of deaths and critical injuries receive some level of review, first to determine whether the incident falls within the RCY's mandate, then to determine if more significant investigations are warranted, only a few receive full investigative reviews (figure 2). The definition of injuries used by the RCY is broader than the OCYA's, which increases the number of in-mandate cases to choose from when selecting which should receive a full investigation. The RCY definition of injuries was expanded in 2015 by the ministry of child and family development to "an injury to a child that may result in the child's death or cause serious or long-term impairment of the child's health", which also includes emotional harm, and has lead to a significant increase in the number of reported incidents (RCY, 2019). In the 2018/2019 year the RCY reported 1037 in-mandate injuries compared to 11 in Alberta (table 1). While some of this variance can be explained by the RCY including a wider collection of

reviewable services in its mandate, it also reflects a significant difference in reporting definitions and practices.

The RCY's recommendation process also differs from Alberta's. It involves several stages of communication with public bodies in order to refine and improve recommendations (figure 3). Like the OCYA, the RCY provides oversight and recommendations to organizations but has no legal authority to enforce those recommendations. The RCY relies on professional collaboration and shared organizational goals in order to encourage compliance with recommendations. This also allows the RCY to adjust their recommendations based on feasibility assessments and professional expertise from the appropriate organizations.

Table 1: In-mandate Deaths and Injuries in 2018-2019

	Deaths	Injuries
Alberta	33	11
British Columbia	109	1037

Figure 2: RCY's Review and Investigation Process (RCY, 2019)

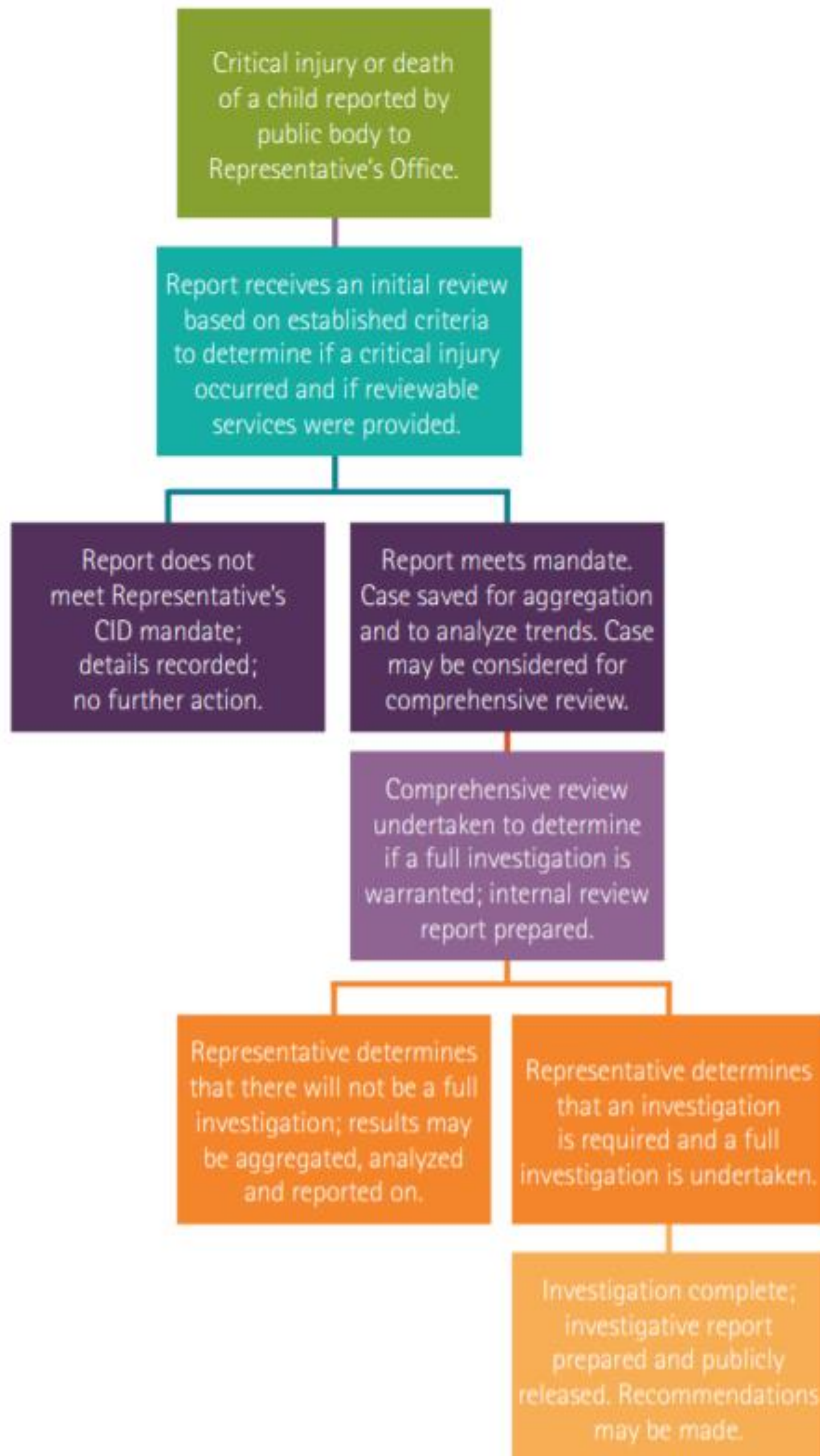


Figure 3: RCY's Recommendation Process (RCY, 2019)

Chapter 3.

Academic Research

3.1. Critiques of Case Reviews

Blame Culture

There is a significant body of research devoted to case reviews and investigations after the deaths of children receiving intervention services or other care from social services organizations and their role in developing meaningful systems development. Buckley and O'Nolan (2013) emphasized the importance of focusing on ongoing learning rather than an overabundance of prescriptive recommendations that may not always be situationally appropriate and can contribute to the unnecessary bureaucratization of services. This finding is echoed by others in the field, including Stevens and Cox (2008) who argued that an overly simplistic view of risk avoidance has contributed to a "blame culture" with findings from reviews being used to develop standards and procedures designed to correct system failures. Stevens and Cox assert that this has supported the false assumption that it is possible to develop a procedure that, if followed, can eliminate all risk. But this perspective minimizes the complexity of human behaviour and the often-unforeseeable outcomes.

Munro (2010) explored this idea further by highlighting the ways that standardisation of practices and the reduction of worker agency can negatively impact intervention work. She demonstrates the expertise required to be an effective youth worker, and that reducing practice to rules-based lists limits the ability of workers to utilize their judgement when developing treatment plans or intervention strategies. While this allows workers and organizations to claim they've done their due diligence, it absolves them of the responsibility to identify when existing procedures may not adequately protect youth who need it, and can discourage youth workers from developing creative, client driven approaches to care. And when this defensive and reactive approach is applied to death reviews it can mean the creation of additional rules, further limiting the actions of workers. Munro and Hubbard (2011) asserts the importance of a systems approach that examines the larger contexts in which deaths

occur, instead of distilling blame to single actors. Even when individual actions contribute to negative outcomes, these occur within a larger framework that can be shaped by quality of training, staffing levels, cultural awareness, or other factors. Narrowly focused and easily implemented action plans can lead to superficial change and ignore systemic issues (Brandon et al., 2012). The OCYA in Alberta appears to recognize these problems, as they state that “the Investigative Review is about learning lessons, rather than assigning blame. (OCYA, n.d., b).

Learning Dissemination

Munro (2010) points out the importance of ongoing learning to improve youth protection organizations’ ability to support youth. This goal is complicated by what Devaney, Lazenbatt and Bunting (2011) identify as the dual goals of child death reviews, agency accountability and ongoing learning from case analysis. These goals should be balanced to avoid contributing to the previously identified blame culture in ways that can limit the ability to learn from case reviews and apply that learning in meaningful ways. Devaney, Lazenbatt and Bunting point out that previous analyses of reviews have found widely varying quality of reports, overly generalized recommendations, and repeated findings that don’t seem to lead to change. One example of this is reviews frequently pointing to a lack of interagency communication that hampered their ability to identify the needs of youth served. But this lesson is learned over and over with little evidence of it changing the systems reviewed. Through significant consultation with experts, Devaney and colleagues determined that reviews offer significant gains in understanding circumstances that contribute to negative outcomes, but that more needs to be done to act on the findings of reviews. Buckley and O’Nolan’s (2013) findings support this perspective and encourage finding ways of sharing key learning points from reviews to those working in the industry.

In the United Kingdom researchers have found value in collecting and reviewing case reviews from both local and federal organizations in order to identify larger patterns in youth needs as well as identify the strengths and weaknesses in existing review processes. One of the findings from this research is the “need to distinguish between learning lessons and making recommendations” (Brandon et al., 2012). Researchers identified the value of balancing macro and micro approaches to identify individual or specific systems that contributed to outcomes as well as identification of trends and

repeated challenges for practitioners (Sidebotham et al., 2010). Another suggested way to support learning was to deliver both in-depth as well short form learning such as “short ‘fact sheets’ or briefings for practitioners, managers and policy makers” (Sidebotham et al., 2010). Additionally, it is suggested for reports to identify good practice not just focus on the worst outcomes. Identifying positive work can be a tool for learning and have an impact on public perceptions of youth intervention services.

Public Trust

Other research has explored the impact that child protection inquiries can have on public perception and child welfare workers, and the impacts that inquiries can have on case management decision making. A qualitative study of surveys and interviews of practitioners found that child deaths are the most traumatic experience faced in their work, and public inquiries and reporting can increase that trauma (Regehr et al., 2002). Inquiries increase fear and anxiety even after their conclusion, especially when attempts at accountability target workers and fail to acknowledge systemic factors, such as staffing and budgetary challenges, into their decision making. Inquiries and case reviews can shape how the media present the circumstances and negatively impact public perception. This may result in governments suspending and disciplining practitioners to demonstrate to the public that they are responding to investigation findings (Choate, 2016). Fear of this reprisal can impact case management decisions.

Dr. Peter Choate explained that case management requires balancing the risks and benefits of family preservation and child apprehension to determine the appropriate course of action. But when a child that has had multiple prior contacts with the system dies or is injured the public often views the system as incompetent for failing to act. “The more negative publicity child protection gets over a death the more prone social workers are to apprehend children. And that does not lead to better outcomes” (Choate, 2020, interview). Failure to acknowledge good work done by intervention services can increase the magnitude of public criticism which can contribute to more invasive care plans and worse outcomes for children and youth. This view is also supported by the media attention and changes in legislative requirements placed on youth advocacy organizations after the public identifies specific cases as failures of child protective services.

3.2. A Model for Recommendations

Despite these criticisms, these researchers are not advocating for the removal of oversight, or the elimination of death reviews and the resulting recommendations, but for the process to be improved to better address the needs of youth receiving intervention services. Some case review researchers created models to improve recommendations coming from child death reviews. One of these is Buckley and O'Nolan's CLEAR method (2013). The CLEAR method highlights five parts of recommendations to include to ensure that they are meaningful and actionable. The first two parts, Case for Change and Learning-Oriented, are about properly identifying the problem and the existing knowledge gaps as well demonstrating new findings that may have come from the review. The third part, Evidence-Based, is to demonstrate how the recommendation can correct the identified gaps, ideally with researched support to demonstrate the positive effect the change will create. The final two steps, Assign Responsibility and Review are to ensure that the recommendations are targeted to specific organizations or groups of organizations and include specific timelines, measures, and outcomes that can used to review progress and the impacts of the implemented recommendation. This provides a basic model that can be followed to improve the quality of recommendations.

After reviewing and assessing a sample of recommendations from child death reports Wirtz, Foster, and Lenart (2010) found that specific aspects consistently fell short of their identified best practices. One area of improvement they recommended was to state the targeted agencies responsible for implementation and sharing recommendations with them ahead of publication. This allows reviewers and agencies to assess barriers for implementation and refine recommendations collaboratively if needed. This strategy, used by the RCY in British Columbia, as part of its review and recommendation process can increase the likelihood of implementation.

Figure 4: The CLEAR method (Buckley and O'Nolan, 2013)

Case for change: A convincing case for change needs to be outlined as change may require modification of norms, perspectives and behaviours, as well as structure and policies.
Learning-oriented: Identify key learning points and any training/skill gaps that need to be addressed.
Evidence-based: Recommendations must draw on an evidence base when identifying solutions to policy and practical deficits in the report.
Assign responsibility: Each recommendation should identify the discipline, directorate, or organization with responsibility for implementation, recognising that some recommendations will require a collaborative response.
Review: Recommendations should be written in a manner that facilitates review. This can be achieved by clearly specifying desired outcomes and timelines, and any additional resources required to achieve them.

Chapter 4.

The Policy Problem

Academic research has demonstrated that a focus on blame over learning can harm the ability of case reviews to drive positive change for youth intervention services. In Alberta, perceived failures and a of lack of public trust led to legislation increasing accountability measures. While regular review can help organizations learn from and respond to negative outcomes it can also contribute to a blame culture that negatively impacts service delivery. The critiques of case reviews and the political responses to perceived failures of youth protection and advocacy organizations also highlight the challenges of developing policy in this area. Policy outcomes can be driven by public sentiment and political agendas over the opinions of relevant experts. This makes it important for organizations such as the OCYA to identify practices that allow them to address youth needs while also building public trust to increase their ability to continually improve child intervention services and outcomes for youth who receive them.

The increased mandatory investigations should be assessed to identify if expert consultation during legislation development was able to help politicians balance accountability with increased learning or if the new requirements contribute to an undue focus on blame. An understanding of the strengths and weaknesses of the current approach can be used to consider further policy changes that could help the OCYA to meet its goal of advocating on behalf of youth needs.

Chapter 5.

Methodology

To examine the effectiveness of child death reports in Alberta, several methodologies have been used. First, reports and recommendations before and after the 2018 policy change were compared to assess the immediate impacts of the change. This was done by using the CLEAR method to assess the quality of recommendations from reports. Each recommendation was assigned a score from zero to three for each of the five parts of a recommendation according to the CLEAR model. Then the scores were totaled, giving each recommendation a score out of 15. This allowed for comparisons of average scores between years as well as between different types of reports, such as investigative, aggregate, and mandatory reviews.

The scoring method is not meant to individually assess quality, as unique factors to cases give reports differing needs and focuses, some of which can be more easily fit into the CLEAR recommendations than others. But by viewing the average scores general trends can be examined. The scoring method would assign a zero if an aspect of a recommendation was missing, which did not occur in this sample. A one was given if it was below expectations, a two for meeting basic expectations, and a three for exceeding expectations. A more specific breakdown of the assessment criteria in each of the CLEAR categories can be found in Appendix B.

As well as assessments of recommendations, other factors were examined, including the number of reports produced and the number of recommendations and major findings in each report. Reports were also reviewed qualitatively to identify themes and trends and consider how well they incorporated the critiques and best practices suggested by researchers into their methodologies.

Reports and recommendations in Alberta were also compared to reports from British Columbia. Reports from British Columbia were assessed the same way as Alberta reports to identify the strengths and weaknesses between them and to look for alternative approaches.

As part of this reports research, Dr. Peter Choate, an expert working in child intervention services and a participant on the Child Intervention Panel in Alberta, was interviewed to provide additional context and insight to the findings of this work.

This analysis formed the groundwork for identifying areas for growth. This was used when developing policy options for future development and to establish criteria to assess them.

Limitations

This report does make some useful observations about case review practices in Alberta, but these findings are tempered by several limitations of this research. There is a limited sample available for assessment due to how recently the mandatory review requirements were implemented. Expanding the sample in the future to include additional years both before and after the policy change could increase the reliability of observations made. The equivalent years in BC also produced few reports, limiting the sample size available. Future research could expand the scope of the research and include more provinces and reports to examine a greater variety of approaches to case reviews.

Chapter 6.

Analysis

6.1. Alberta

The OCYA in Alberta releases a variety of reports throughout the year. In addition to investigative case reviews, it produces annual reports and special reports on other topics as deemed necessary, such as the 2019 report on youth aging out of children's services. Case reviews fall under three categories. **Mandatory reviews** are legally required for all youth that were receiving intervention services at the time of their death or up to two years before. Mandatory reviews are compiled into a single document and released every six months. **Systemic reviews** cover deaths and injuries that do not fall under the mandatory requirements and **aggregate reviews** group multiple cases to examine specific issues, such as overdose deaths. The latter two review types are released as completed. A delay in publication stopped the second batch of mandatory reviews from being included in the 2018/2019 annual report but was still included in this study to better reflect the work done in that period.

Table 2 shows the number and type of reports produced in each year, and the number of recommendations made in those reports. In the 2018/2019 period 21 case reviews were reported on, 17 of which were mandatory reviews. The OCYA in the 2018/2019 period published one aggregated report on youth overdose deaths, three full investigative reviews-- two of which were on youth deaths and one on a serious injury received from a violent assault-- and seventeen mandatory reviews. From these reports it developed 13 new recommendations, seven of which came from the mandatory reviews. In the 2017/2018 period only six reports were released. Aggregate reports produced recommendations at a higher rate than either of the other review types. In 2017/2018 100% of reports produced recommendations compared to 38% in the 2018/2019 year.

Table 2: Alberta Case Reviews and Recommendations by Year and Type

Province	Year	Type	Reports	Recommendations
Alberta	2018/2019	Systemic	3	1
		Aggregate	1	5
		Mandatory	17	7
		Total	21	13
	2017/2018	Systemic	4	10
		Aggregate	2	5
		Total	6	15

Using Buckley and O'Nolan's CLEAR framework as a model, recommendations were assessed to identify strengths and weaknesses within Alberta's reports and to determine if there was significant variation across report types. The CLEAR framework is designed to be used specifically on recommendations. 13 of the Alberta reports did not include recommendations, so could not be scored in this way, leaving 14 reports to account for the 28 recommendations scored. Each of the five elements of the CLEAR framework was assigned a score from 0 to 3, giving each recommendation a total score out of 15. Table 3 shows the yearly averages for recommendation scores and table 4 organizes the findings by report type.

Table 3: CLEAR Assessment of OCYA Recommendations by Year

Year	Number of Recommendations	Case for Change	Learning-Oriented	Evidence-Based	Assign Responsibility	Review	Total
2017/2018	15	2.7	2.5	2.5	1.7	1.3	10.7
2018/2019	13	2.4	2.3	2.1	1.8	1.5	10.1
Combined	28	2.6	2.5	2.3	1.7	1.5	10.5

While the size of the sample limits the options for statistical analysis several observations can be made. The first is that regardless of year or report type, the last two categories of assessment, 'Assigns Responsibility' and 'Reviewable', are the lowest scoring. The assessment for 'Assigns Responsibility' examined several factors. The first was that it clearly assigns the organization responsible for the recommendation, and on this ground all recommendations received at least a one. To get a higher score required reports to identify specific tasks as part of the recommendation or demonstrate available support resources or implementation models to increase the feasibility of recommendations. Therefore, a recommendation to create a review process, or develop new training tools would be scored lower than a recommendation that highlights specific

criteria to include in a review process or training models that had worked elsewhere. The 'Reviewable' category required a recommendation to state a process for review, measurable outcomes, and a timeline for implementation or review in order to achieve the highest score. Many recommendations included outcomes, but few included review processes or timelines.

Table 4: CLEAR Assessment of OCYA Recommendations by Type

Type	Number of Recommendations	Case for Change	Learning-Oriented	Evidence-Based	Assign Responsibility	Review	Total
Mandatory	7	2.3	2.3	1.9	1.9	1.6	9.9
Aggregate	10	2.7	2.5	2.6	1.6	1.3	10.7
Systemic	11	2.6	2.5	2.3	1.7	1.5	10.5
Combined	28	2.6	2.4	2.3	1.7	1.4	10.4

Another finding evident in the recommendation assessments is the difference between mandatory reviews the others. In the first three categories, mandatory reviews seem to score lower, and in the final two areas they score higher. Statistical ANOVA analysis reveals that there is less difference between the three categories of reviews than there is within categories, with no statistically significant variation between groups. The mandatory review recommendation total scores have a much greater degree of variation than the other two categories

Discussion

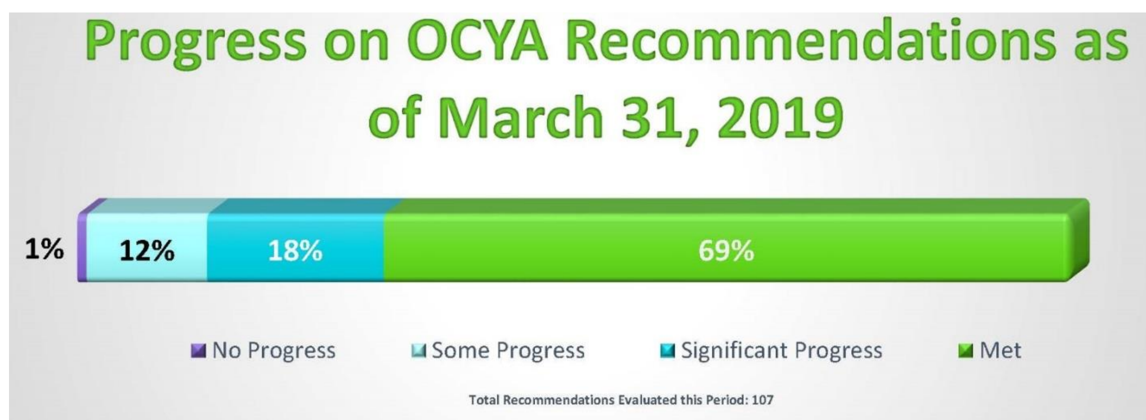
Table 2 shows that the OCYA produced a similar number of recommendations both years despite generating more than three times more reports in 2018/2019 than in 2017/2018 (21 compared to six). In the 2018/2019 year more than half of the recommendations are the result of mandatory reviews. This period also produced fewer systemic and aggregate reviews. This suggests that the OCYA has been able to use preliminary investigations to identify which case reviews are most likely to identify areas for improvement and that some cases that likely would have been selected for systemic or aggregate review now fall under mandatory reviews. This conclusion is undermined by the two systemic reports in 2018-2019 that did not produce recommendations. However, while those reports do not make new recommendations, they reference 22 past recommendations that, if fully implemented, might have prevented negative case outcomes. The number of mandatory reviews that did not lead to recommendations

indicates that the increased investigative work is not having a proportional impact on child intervention services. Further, the specific requirements for mandatory reviews might limit the ability of the OCYA to group incidents into aggregate reports. Aggregate cases produced new recommendations at the highest rate making them a valuable tool for service improvement.

Of the five areas of assessment ‘Assigns Responsibility’ and ‘Review’ appear to be the weakest scoring. This demonstrates that reports sometimes do a better job identifying and learning from service gaps than they do at developing a clear solution. This finding is not unique to Alberta. A study of American child death reports in 2010 found similar results, identifying problem assessment as the strength of the reports, with assigning responsibility and “action on recommendations” as weaknesses (Wirtz, Foster, Lenart, 2011). This might demonstrate the challenge of case reviews trying to develop universal solutions to individualized problems, rather than highlighting a weakness specific to Alberta reviews. This also highlights the value case reviews can have to learn from specific incidents even when the findings do not lead to recommendations.

The OCYA’s recommendation review practices should also be considered to provide the appropriate context. The OCYA reviews and reports on recommendation progress every six months. The OCYA’s most recent update indicated that 69% of the evaluated recommendations had been met, with 30% of them in progress (figure 5). In addition to the overall progress report, the OCYA also reports progress made by separate public bodies, allowing the public to see which ministries and organizations are making meaningful progress. This public accountability creates additional external pressure that encourages organizations to address the concerns raised by the OCYA. And while the ‘Review’ scores were lower than other categories, avoiding overspecification in recommendations allows the targeted organizations to use their expertise to refine them as necessary. While more specific recommendations could make recommendation review easier, it risks becoming overly prescriptive and pushing development paths when those working closer to the specific issue may see better ways to address the identified gaps in service.

Figure 5: Recommendations Progress (OCYA, Recommendations, 2019)



Understanding the increased variation of scores for mandatory reviews requires an examination of the types of cases within that category. Unlike the systemic and aggregate reviews, which are selected for their ability to identify areas where service delivery can be improved, the OCYA does not have the discretion to close mandatory cases after the preliminary investigation. Because of this, the mandatory reviews include cases where deaths are the result of illness or accidents that are not connected to intervention services. These are cases that would be less likely to receive public case reports without the legal requirement, but even they sometimes reveal areas for service improvement in their case histories. Recommendations from mandatory reviews respond to events from suicides and overdoses to car accidents and medical complications. This is both a strength and weakness, as it provides accountability to services that receive less attention, but it can be harder to develop strong evidence-based recommendations when examining more minute service interactions or when reviewing areas that have not received as much research attention in the past. This also explains why aggregate reviews can consistently score high on their ability to demonstrate a case for change and being learning-oriented. Aggregate reviews focus on significant trends such as overdose deaths, whereas mandatory reviews might examine the nuances of care plans for hospitalized infants.

6.2. British Columbia

In order to assess the work that the OCYA is doing in Alberta, it is important to compare it to other jurisdictions. Within Canada there is a limited pool from which to draw comparisons as many provinces do not produce public reports with the same

regularity or are only beginning to do so. The RCY in British Columbia though, like Alberta, has been performing case reviews and releasing public reports on them for some time. While the RCY and OCYA have many similarities, making direct comparisons between them can be misleading if not done carefully. The organizations have differing mandates and operational definitions, which have a significant impact on the data they collect and report on. For example, the BC RCY considers youth who have received a reviewable service within one year eligible for case reviews due to death or injury; in Alberta this is increased to two years. While the mandates and processes for the two organizations are unique, some meaningful comparisons can be made. In the 2018/2019 year the Alberta OCYA published 21 reports, four of which were not mandatory reports, whereas the BC RCY published two -- one aggregated review of overdose deaths and one case review tied to a reported injury. Despite the lower number of reports, the RCY produced 16 recommendations from these reports, compared to Alberta's 13. Scoring the recommendations with the same criteria used on the Alberta recommendations also highlights some differences. While most of the categories show similar trends, the Review category shows a much higher score in BC as well as smaller increases in the Learning Oriented and Evidence Driven categories.

Table 5: CLEAR Assessment of 2018-2019 Recommendations by Province

Province	Case for Change	Learning-Oriented	Evidence-Based	Assign Responsibility	Review	Total
Alberta	2.4	2.3	2.1	1.8	1.5	10.1
BC	2.5	2.8	2.4	1.9	2.7	12.3

Discussion

The higher scores in BC need to be examined before determining if Alberta should be adopting elements of the RCY's practice. The RCY avoids the trend seen in Alberta and the United States of lowered scores in the 'Review' or equivalent categories. The cause for the increase is the regular inclusion of implementation timelines in their recommendations. The RCY is better equipped to provide this due to their practice of consulting with targeted organizations before publishing their reports. This allows them to adjust their recommendations and build timelines based on the feedback received. This process has been suggested by researchers and helps the RCY maintain positive working relationships with other public bodies, which is important since they lack the

legal authority to force compliance with recommendations. Instead they must rely on positive reputation and organizations' shared goals in order to encourage compliance with recommendations. This would be much harder to do if the RCY chose not to take this collaborative approach. However, the RCY does not currently report on recommendation progress to the same degree that Alberta does, so it is unclear whether these timelines are consistently met. The variance in the other categories might be explained by the narrower focus of the RCY. By focusing their review efforts on specific cases, they could pick those where gaps were most evident, and the recommendations would be most impactful. This makes it easier to present a case for change and demonstrate how specific knowledge or practices could improve outcomes. This same effect is seen in the Alberta scores and the variance between the mandatory and non-mandatory reviews.

6.3. Interview Findings

Dr. Peter Choate

> The more negative publicity child protection gets over a death the more prone social workers are to apprehend children. And that does not lead to better outcomes – Dr. Peter Choate.

To better understand the processes and priorities driving case review practices in Alberta, Dr. Peter Choate was interviewed. Choate was an expert panelist on the Child Intervention Panel that led to the legislative changes requiring mandatory reviews in Alberta and is currently a professor of social work at Mount Royal University in Calgary, Alberta. He has done clinical counseling and his work has included a focus on child protection matters. His interview spanned a range of topics and some specific quotes have been integrated into the themes identified in further qualitative analysis.

One of the areas Choate highlighted was the relationship between public trust and child protection strategies. Choate points out that there is no perfect system to create accountability for child protection services, but that Alberta's approach is one of the most workable. Approaches taken in other countries, such as coroners reports, law enforcement investigations, and government review or commissions, can have very different outcomes. Some of these approaches amount to dragging child protection services "through the mud" as they attempt to lay blame for deaths. This process can

create anxiety for youth care workers and impact decisions made. Choate explains that death is such a rare event that the only systemic change likely to reduce it in a measurable way is to “elevate state interference in families” through increased apprehensions, something that indigenous and youth advocates have opposed due to the associated harm and trauma. Finding a balance between risk management and family preservation means taking some risks. Choate says, “sometimes those risks are not going to pay off. And sometimes it is going to look like a really incompetent system because [it] will have had prior contacts with the child.” Because of this it is important to consider how accountability efforts impact public trust of child protection organizations, to avoid negatively impacting protection practices.

Choate also offers insight on the public tolerance of risk for child protection services. There is a public belief that any death that occurs with the child protection system represents a failure. This belief does not reflect the reality that it will never be possible to eliminate all deaths of youth receiving intervention services. Choate points out that surgery and crossing busy traffic intersections can present a greater risk of death to children than child protection services. While society understands and tolerates a level of risk to surgery or pedestrian-automobile accidents, social conceptions of youth intervention services do not allow this same understanding of risk. Choate indicates that large scale aggregate reviews of cases can be useful to create space to discuss public risk tolerance.

6.4. Conclusions

To provide additional context to the quantitative findings in this report, the reviews from the OCYA and RCY were also examined qualitatively. This combined approach revealed several important findings that should be considered before examining policy alternatives.

Investigative Discretion and Accountability

The examination of the OCYA and the RCY recommendations revealed strengths to each approach. The RCY in BC seems to be more efficient, using the discretionary power of the representative for youth to direct investigative effort towards cases most likely to indicate areas for improvement and allow it to make the appropriate

recommendations. This appears to have some advantages to the Albertan approach of mandatory reviews, eleven of which did not produce new recommendations. Limiting the OCYA's investigative discretion could also limit its ability to group cases for aggregate reviews examining specific issues. However, the mandatory review requirements widen the areas of review and can identify service gaps that may not have been identified otherwise. This is done through the inclusion of cases, such as accidental or illness related deaths, that would have been unlikely to be selected for systemic review. The investigations span the entire case history of the youth served and recommendations can respond to findings that might not have contributed to injury or death but can still improve youth outcomes. Several recommendations in the 2018/2019 year in Alberta came from these types of cases.

Investigations can be useful to increase public accountability even when they do not produce recommendations. Many of the case reports without new recommendations reference in-progress or not yet implemented recommendations that could have helped the youth served. These reviews act as a way for the OCYA to increase pressure on service providers to implement their recommendations and better serve youth. This practice, along with the regular reporting of recommendation progress, allows the OCYA to increase public accountability for organizations providing youth intervention services. In his interview Choate explained that Alberta faces the common challenge of making child protection services a priority when there is no publicly perceived crisis. Case reviews can become a way to get youth needs onto the public agenda. The RCY does not currently report on recommendation progress so comparing implementation rates is difficult but would be a valuable area for future study.

There is still room for continued improvement in this area. The investigative and aggregate reports include in their appendices all the past recommendations that may have contributed to better case outcomes if implemented. The mandatory reviews do not do this to the same degree. Mandatory reports include several cases in the same document and have shared appendices. This improves efficiency and avoids duplicated work but an appendix for relevant past recommendations is not included in these reports perhaps due to the challenge of organization in this new format. This is only a minor critique, as the mandatory reporting format is newly developed and is likely to be refined and improved in the coming years.

Systems and Innovation

One criticism directed at case reviews in the past is their focus on identifying individual bad actors at the expense of ongoing learning and systems development, as discussed previously in the review of academic research on case reviews. However, a review of the findings and recommendations contained in the OCYA reports indicates that the Child and Youth Advocate in Alberta is aware of these criticisms and has worked to address them in its investigative and review practices. The recommendations primarily take systems-aware approaches to problem-solving while acknowledging that case outcomes are driven by a multiplicity of factors and that it takes a patchwork of systems to address the needs of youth served. The OCYA seems to recognize that case outcomes are the results of individual, societal, and organizational factors colliding with each other. Even when investigative reports do identify individually driven factors, such as staff failures, such factors are addressed by recommending changes in training, oversight, or hiring practices. This systems-aware approach to recommendations helps the OCYA avoid pitfalls in case review approaches from the past and elsewhere.

But, despite the systems approach, the very nature of systems development driven by case reviews means that recommendations are largely incremental in nature. Like the mentioned improvements in training, recommendations tend to be slight modifications to existing programs and services rather than addressing fundamental systemic challenges. There are some extremely innovative recommendations, such as one suggesting the creation of a network of subject experts that clinicians and youth workers can consult when developing care plans (OCYA, 2019b, Jaxon). But others are incremental approaches layered on top of ongoing policy development being driven by external review as well as legislative and internal program development. This difference between these approaches highlights a significant point. The CLEAR framework for recommendation development works much better for incremental changes than it does for innovative systemic changes, as it is easier to develop an evidence driven case for change and a specific review process when changes are small steps away from the status quo. Reliance on this approach could stifle the development of innovative and case-specific problem-solving approaches. The complications to case work posed by rapidly shifting policy changes can be seen in recommendations like the one to Children's Services to "ensure that there is a process for ongoing evaluation of how policy changes, assessment tools and practice frameworks are being integrated into

day-to-day casework practice" (OCYA, 2019c, Whitebird). As best practices and risk management approaches change, case workers are not always clear on how to incorporate the changes into their practice, which limits their effectiveness. But it is often easier to develop recommendations to avoid negative outcomes than it is to mandate ways to ensure positive ones. Other approaches must be considered to demonstrate how service providers can fit new practices effectively into youth's personal care plans.

Industry Learning and Dissemination

To address the challenges of effective case work it is important to recognize the value of case reviews beyond their ability to make recommendations. Examination of the OCYA public case reports reveals the collection of knowledge contained in each report, much of which is not directly connected to recommendations made. This knowledge includes research from academics and other organizations, lessons from other jurisdictions, and findings specific to cases. This is information that could be useful to practitioners developing service plans for youth facing similar circumstances. An example of this is found in one report which identified the role that good casework, including coordination of many services and a consistent relationship with a caseworker, had in identifying the unique needs of the youth served and their family in order to make the most of the services available to them (OCYA, 2019c, Osborn).

In his interview, Dr. Peter Choate explained that the case review process can be used to increase systemic learning, not just identify existing gaps:

> Alberta has begun to do this by identifying in cases where a death has occurred where there has been excellent case management. And that learning can be applied to other complex cases and we can improve the outcomes in cases where a death may not have been likely to occur, but other negative outcomes may be possible (Choate, 2020, personal interview).

This highlights the value contained within reports, beyond the recommendations they produce. Case reviews are often focused on continually decreasing the already low chance of death for youth served. But they could also play an important role in helping to increase positive outcomes. The unique needs of each youth served make it difficult to translate these findings into specific, one size-fits-all recommendations. Instead, findings could be disseminated in ways that allow identified best practices to be incorporated into service delivery when appropriate.

The 2010 American study on case reviews also included dissemination in their analysis, defining it as a measure of whether a report “specifically states who will receive the recommendation and includes not only the potential actors and recipients but also appropriate decision makers, funders, and potential supporters” (Wirtz, Foster, Lenart, 2011). Alberta case reviews are released publicly but do not otherwise state how findings and recommendations will be disseminated beyond the recommendation recipients. The OCYA does briefly summarize its findings in its annual reports, but more could be done to make them more accessible to those working with youth (OCYA, 2019).

Chapter 7.

Policy Objectives and Evaluation Criteria

7.1. Policy Objectives

Before examining specific policy options, it is important to establish the priorities for consideration and how policies can be evaluated. The dominant idea in the public is that case reviews should increase the safety of youth within the intervention services system. This is difficult to use as a priority measure for two reasons. First, as previously identified, the rate of death within intervention services is already quite low. Second, it is an outcome attributable to a variety of systemic and individual contributing factors so it is unlikely that any single policy will have a measurable impact on the death rate. But a related and more measurable objective that can be examined is that of accountability. The review process is designed to ensure that there is a process to increase accountability for service providers to persons served and their families in cases of injury and death.

Another significant policy objective to consider is improved development outcomes for youth receiving intervention services. While policy might have larger changes in this area, it also is hard to measure, as there are too many determinants driving it, complicating attempts to measure it. But changes made to the systems comprising intervention services, as well as expertise or resources available to frontline workers can be measured. It is also important to consider how policy changes will positively or negatively contribute to public trust, due to the impact this can have on future development.

Determining the appropriate place to direct policy options is another significant consideration. While this report initially sought to examine the impacts of recent legislation changes to the case reviews, making recommendations directly to legislators is a challenge. Policy windows for legislative changes to intervention services are primarily created following high profile incidents and public pressure. Politicians are unlikely to soften idealistic policy changes regardless of actual impacts or feasibility. They fear being perceived as not prioritising youth welfare. Because of this it is more

appropriate to consider policy options available to the OCYA than to direct options to the legislators and ministry defining their mandate.

7.2. Criteria and Measures

With policy priorities and a policy target identified, it is necessary to develop appropriate criteria and measures to assess these priorities. Additionally, associated governmental management objectives such as cost and administrative complexity must be included. The policy options considered will be assessed along the following seven criteria: Safety, Systems Development, Knowledge Development, Accountability, Affordability, Ease of Implementation, and Public/Media Acceptance. Each criterion has been defined and assigned an appropriate measure. These measures are estimated based on approximated assessments of policy impacts, and assigned a score of high (3), moderate (2), and low (1). The scores of all criteria can then be totaled to assign a ranking to each policy option to develop a recommendation. These criteria and measures are explained below and summarized in table five.

Safety: While this criterion will not show variance between the policy options, it is included for consideration to respond to the expected outcomes for case reviews. The measure is designed to show the risk of death for youth receiving intervention services. It uses mortality rates for youth receiving intervention services as a measure.

Development: The two development criteria are used as a proxy for improved development outcomes for youth receiving intervention services. It is expected that improved quality of the systems that comprise intervention services as well as increased knowledge and experience of those working in the field should lead to positive outcomes for youth served.

Systems Development: This is measured through the percentage of case reviews from the OCYA that result in new recommendations. This is estimated based on expected policy outcomes and compared against the status quo. This measure, like several others, is based on increases or decreases compared to the existing trend, rather than an estimate of numbers, due to the unpredictability of outcomes in youth intervention work. While increased recommendations are not a guarantee of positive systems development, the consistent quality of recommendations developed by the

OCYA and the avoidance of over recommendation allows this metric to be used in this way.

Knowledge Development: This is measured through opportunities for increasing the knowledge and expertise of youth intervention workers. It is estimated based on expected policy outcomes and is scored based on increases or decreases from the status quo due to the difficulties in quantifying this type of measure.

Accountability: This criterion is to reflect whether the OCYA is supporting efforts from youth served or their families in keeping service providers accountable to them. Increasing the number of organizations and practices that will be reviewed in investigations represents an increase in accountability. This is measured based on increases or decreases from the status quo.

Affordability: This criterion is an estimate of changes to OCYA costs based on expected changes to personnel or administration. The costs are estimates of increases or decreases, but because any policy change is going to have some initial administrative costs for implementation, the estimate is extended over five years so that implementation costs are weighed below recurring annual costs.

Ease of Implementation: This criterion reflects whether the legal mandate for the OCYA will need to be changed to implement the policy. High means that no changes are needed, moderate means minor changes, and low means significant changes are needed.

Public/Media Acceptance: This is measured through expected increases or decreases to the professional reputation of the OCYA and public trust in child protection services. This was included to reflect the impact of public opinion in driving significant legislation changes to youth intervention services.

Table 6: Criteria and Measures

Criteria	Definition	Measurement	Value
Safety	Decreased risk of death or injury to youth receiving intervention services	Percentage of youth dying while receiving intervention services	High – Less than .5%
			Med – .5% to 1%
			Low – More than 1%
Systems Development	Improvements made to intervention services systems and policies	Percentage of case reviews that result in new recommendations	High – Increased recommendations
			Med – No expected change
			Low – Decreased recommendations
Knowledge Development	Improvements in expertise or knowledge availability for those working with intervention services	Number of training and knowledge development resources for intervention workers	High – Increase in resources
			Med – No expected change
			Low – Decrease in resources
Accountability	Review of child protection services organizations and practices	The number of organizations and services likely to be reviewed each year	High – More services reviewed
			Med -No expected change
			Low - Less services reviewed
Affordability	Financial cost to OCYA	Change in operating costs (5 years)	High – Decreased costs
			Med – No significant change
			Low – Increased costs
Ease of Implementation	Ability of OCYA to implement	Level of mandate change requires to implement	High – No changes to mandate required
			Med – Minor changes to mandate
			Low – Significant changes to mandate
Public/Media Acceptance	Professional perception of protection services by the public and media	Change in public and media perception of child protection services	High – Increased positive perception
			Med – No expected change
			Low – Increased negative perception

Chapter 8.
Policy Options

This chapter outlines three policy options considered to increase the positive impact that case reviews can have on interventions services in Alberta.

8.1. Increased Investigative Discretion

The Ministerial Panel on Child Intervention recommendations didn't initially include the requirement to investigate and report on all deaths but to "review all preventable deaths of children and young adults who have received a designated service within two years of death" (Government of Alberta, 2017a). While would have left legislators with the challenge of trying to define what constituted a preventable death, it likely would have given the freedom to the OCYA to not investigate deaths related to medical complications or accidental deaths unless other factors discovered in the preliminary review warranted further investigation. Instead of finding a way to address the ambiguity around preventable deaths, the legislation exceeded 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" (Government of Alberta, 2017b). This policy option would seek to return some of that freedom back to the OCYA.

While the legislative requirements now exist, and require some level of review and reporting, the OCYA could establish a tiered system to apply to mandatory reviews. This would allow more cursory reviews and reports to be done for some cases, or for cases to be grouped together for aggregate review and reserve full investigations for cases that were more preventable and where reviews are more likely to lead to increased knowledge or meaningful recommendations. Increasing the OCYA's investigative discretion would allow for a more efficient use of resources. The policy would require the OCYA to develop criteria to assess which incidents lead to full investigations, and which could receive lighter investigations or are grouped for aggregate reports. As this process is similar to the existing process for responding to notifications it would likely only require minor adaptation to support the move to tiered investigations while still meeting the requirements of the 2018 legislation change.

Mandatory reviews have increased operating costs for the OCYA, so if their budget was decreased, they would be presented with the challenge of continuing these reviews without sacrificing other organizational priorities. A tiered approach to their mandatory reviews would allow them greater flexibility in developing organizational goals and responding to budgetary needs.

8.2. Investigation Findings Database

The OCYA investigation reports highlight valuable findings that do not always lead to recommendations. While these findings are currently reported in its annual reports, more could be done to make this knowledge accessible to those working in youth protection. This policy option would create a database, accessible from the OCYA website that summarizes and organizes these investigation findings by theme. This website could be utilized by researchers and youth care workers to improve their knowledge and better act on client needs. Researchers have pointed out that while recommendations from major case reviews can improve the quality of care, they also risk bureaucratizing youth care in ways that limit clinicians and case providers from implementing innovative therapeutic approaches and acting on their experience in ways that could be beneficial. A database of knowledge gained from case reviews could provide a balance to the recommendation process and highlight learning and information sharing as one of the primary goals of major case reviews.

Implementation of this policy option would require some additional work from the OCYA, but after the initial set-up, it should fit into their existing practices. It would require the creation of space on their website for the content, as well as the necessary updates, and for the information already developed for their case reports to be edited and organized for sharing in this way. In 2018/2019 the OCYA moved its website to an improved web hosting service and updated its servers and databases and began exploring ways to get and deliver information more efficiently (OCYA, 2019). These improvements should reduce the level of work required to develop the new database. In addition to external youth care workers the database could be a useful resource for the OCYA. Just as reports on major case reviews frequently refer to previous, in-progress, recommendations when considering new ones, future reports can cite evidence and case histories referenced in past reports, which would be made easier by making it accessible in a single place.

In the United Kingdom aggregated learning reviews are used to identify recurring challenges for youth and protection workers as well make observations about the types of care and treatment available to them (Choate, 2016). In a similar way, the collection of knowledge from case reviews can be used to more easily identify recurring themes, and areas of youth development that may not require additional recommendations but could benefit from additional knowledge and focus from youth caregivers. If the initial policy is successful it could be expanded further with the OCYA partnering with intervention services organizations to deliver update reports to highlight important new findings or to help develop training programs for staff.

8.3. Expanded Case Review Criteria

The third policy option also presents the most significant change to existing OCYA practices. While the first policy option was designed to reduce investigative work, this policy would increase it by expanding the review criteria beyond the mandatory and advocate selected case reviews to include reviews of positive youth outcomes as well. Just as positive humanist psychology determined that only focusing on negative human attributes was limiting the field, the same argument can be made to youth intervention. By examining cases of youth in need of intervention services responding positively to intervention, other care workers may be able to identify innovative approaches that could be considered in similar cases. Cases would have to be carefully selected for greatest value, perhaps through case worker suggestion. In order to have the greatest value cases would reflect a variety of services, as well as a significant change in risk assessment for the youth involved. An added benefit to reviews of this nature is the availability for subjects to be involved in the review and analysis of their own history, something that is currently only possible in the reviews that are in response to significant injuries. The participation of clients in reviews is likely to increase the knowledge gained as youth served can identify what services and clinical approaches they found most personally beneficial. Public reporting on successful intervention outcomes could also increase public trust in child protection services.

This policy option presents two significant challenges. The first is the expansion of the OCYA mandate, and the second is the additional workload it creates for the OCYA. The existing mandate requires the advocate to investigate and report on all deaths of youth receiving intervention services within in two years of their death, as well

as deaths or serious injuries in which the investigation would serve public interest. This policy change would require the mandate to be expanded to allow the advocate to investigate and report on any case in which the advocate felt there was a public benefit to doing so. This might take some time to accomplish, and it may be more feasible to start by expanding the definition of serious injury, as BC did recently, to increase the number of cases the advocate can select from for review. Additionally, the OCYA would need to determine the appropriate number of positive outcome reviews to investigate each year, as doing too many could take away resources from other reviews. This policy option would be most effective if the other two policy options were already in place, with the first policy option helping to offset the workload of this policy, and the second policy option ensuring that the learning gained from the additional reports is disseminated effectively in order to make the greatest possible use of the new findings.

Chapter 9.

Evaluation of Policy Options

This chapter will apply the criteria and measures established previously to each policy option to assess the strengths and weaknesses of each policy.

9.1. Increased Investigative Discretion

Safety: (High – 3) The average rate of death for youth receiving intervention services is quite low. Using the higher estimates, it is below a half percent. This policy is unlikely to have any impact on that number.

Systems Development: (High – 3) Mandatory reviews lead to fewer recommendations than systemic and aggregate reviews do. The focus on mandatory reviews could lead to an increase in reports that do not produce recommendations. By creating multiple tiers of mandatory reviews and including some in aggregate reviews or more condensed review processes when appropriate, the OCYA can focus on the reviews most likely to identify areas for improvement. This is expected to lead to an increase in recommendations made and implemented. However, this expectation is constrained by the limited period of review, and continued trend monitoring of mandatory reviews will indicate if the current analysis is accurate.

Knowledge Development: (Low – 1) While mandatory reviews in response to accidents or medical circumstances are less likely to lead to recommendations, the qualitative analysis of the 2018-2019 mandatory reviews did highlight two cases of infant deaths that resulted in recommendations as well as significant learning around risks and case planning. The tiered approach to mandatory reviews, by condensing some reviews, is likely to reduce the knowledge gained from case reviews, particularly those which would likely have not received full investigative reviews before the requirement for mandatory reviews.

Accountability: (Low – 1) The tiered system for mandatory reviews will decrease the level of accountability. By condensing some review processes, less organizations and situations will come under close review. This is especially true of organizations that

deal with medical circumstances as these incidents are likely to be ones that are treated with less depth as other cases.

Affordability: (High – 3) Transition to the tiered system may have some initial costs as the initial review and investigation criteria are developed, but over the long term it should reduce costs. To deal with the increased workload of mandatory reviews the OCYA budget was increased by $1.9 million. Implementing a tiered review process for mandatory reviews should reduce their expenses. The initial costs of the transition should be quite low as much of their existing and past processes for reviewing cases to determine if investigations are warranted can be utilized.

Ease of Implementation: (Moderate – 2) While the mandate does not state the level of review and reporting required for mandatory reviews and a tiered approach is not a direct violation, the legislature may see it as a failure to fully comply with the intent of the legislation. Minor changes might need to be made to the mandate to ensure that the OCYA's approach is supported by the legislature.

Public/Media Acceptance: (Low – 1) The requirement for mandatory reviews was a result of a case which has continued to gain significant media attention. A perceived slackening of practices designed to prevent a similar occurrence is likely to be reported in the media and could reduce public opinion of the OCYA and trust in child protection services.

Summary: (14) This policy option would allow the OCYA to use resources more efficiently, and to focus work on cases that are most likely to lead to new recommendations. This is done at the expense of knowledge development, with the less in-depth reviews providing less insights into the experiences of youth receiving intervention services, and less accountability and oversight

9.2. Investigation Findings Database

Safety: (High – 3) The average rate of death for youth receiving intervention services is quite low. Using the higher estimates, it is below a half percent. This policy is unlikely to have any impact on that number.

Systems Development: (Moderate – 2) This policy focuses on how findings from reviews are handled and disseminated and is unlikely to impact the number of reviews done each year, or the number that result in recommendations. While it might have more subtle impacts as to how the systems within intervention services develop, this is not reflected in the selected criteria. There is no expected measurable change from the status quo.

Knowledge Development: (High – 3) The existing approach of the OCYA results in significant investigative and research findings that can provide valuable knowledge for those working within the intervention services. However, these findings are spread through each report with no simple way for youth workers to search for it by topic or theme. Establishing a database with collected findings would provide a useful resource for youth workers to access and utilize in case planning. This results in a significant increase in knowledge available to youth workers.

Accountability: (Moderate – 2) As previously indicated, this policy option is unlikely to have any impact on the number of reviews completed by the OCYA and thus does not represent any change in accountability for intervention service providers.

Affordability: (Moderate – 2) Long run costs of this policy should be quite low. There may be some initial costs as resources are allocated to develop the database and to develop a standard practice for incorporating review findings into it, however, as these findings are already collected and reported, first in their initial reports and again briefly in the annual reports, the database may also save staff time when preparing annual reports. As the OCYA already has staff working on website and database maintenance there should be very little impact to financial costs or staff required to maintain this policy. Even with initial implementation costs, over the long term this policy should be similar to current expenses.

Ease of Implementation: (High – 3) This policy does not conflict with any elements of the OCYA's existing mandate. This policy does not change existing priorities from the mandate, and only modifies the ways that findings are reported and shared with others.

Public/Media Acceptance: (Moderate – 2) The creation of a database to collect findings from case reviews is not likely to have a significant impact on public perception

of the OCYA or protection services. Specific case reviews are likely to be of more interest to the public than collected general findings, however this resource may be a valuable resource for journalists as well as youth workers. The database could increase the attention on findings of positive case work and may be met with positive commentary from the media but is not likely significantly increase public trust.

Summary: (17) Developing a database to report on and to allow improved access to case review findings improves knowledge development without requiring any changes to the OCYA mandate. It has no significant trade offs among the other criteria, presenting a clear improvement from the status quo with only limited implementation costs.

9.3. Expanded Case Review Criteria

Safety: (High – 3) The average rate of death for youth receiving intervention services is quite low. Using the higher estimates, it is below a half percent. This policy is unlikely to have any impact on that number.

Systems Development: (Low - 1) This policy option is expected to decrease the number of reports that produce recommendations. Case reviews focused on exploring positive client outcomes are less likely to identify areas with a clear need for new recommendations. While the total number of reviews completed each year is likely to increase with this policy, the percentage that lead to recommendations will fall.

Knowledge Development: (High – 3) This policy will increase the knowledge development made by OCYA case reviews. By examining positive client outcomes, the OCYA is likely to gain new insights into youth intervention and identify practices and tools that clinicians and case workers can utilize to better support the youth they serve. While the existing reviews do lead to new findings, positive case reviews will widen the types of cases that come under review, increasing the knowledge available to youth workers.

Accountability: (High – 3) By increasing the number of reports completed, as well the types of cases selected for review, it will mean that more services and youths' experiences will receive attention from the OCYA and identify potential areas for

improvements as well as existing positive practices. This will increase accountability for youth intervention services.

Affordability: (Low – 1) Expanding case reviews to include positive outcome reviews will increase costs in several ways. The first increase, like the other policies, will be the initial implementation process of determining the criteria and process for selecting cases for review. The second will be the ongoing costs of the new reviews. When the OCYA began mandatory reviews, the budget increased by $1.9 million. The amount of further increases would depend on how many cases in the new category the OCYA decides to complete. This makes this policy a higher cost than their current expanses or any of the other considered policy options.

Ease of Implementation: (Moderate – 1) This policy would require a significant change to the existing mandate. The mandate identifies which cases the advocate has the authority to investigate, and that would need to be expanded. While small modifications, such as redefining serious injury might be more easily implemented, the larger expansion would take some time to achieve.

Public/Media Acceptance: (High – 3) Expanded case review criteria is likely to increase public trust in youth intervention services. Public case review reports of deaths can have a negative impact on public opinion on youth intervention services, particularly in cases significant enough to draw media attention. The presence of reports that can highlight positive case work could increase positive coverage and help temper criticism.

Summary: (15) Expanding case review criteria to include positive outcome reviews is likely to decrease systems development, but increase knowledge development, with youth workers having greater access to reviews of findings and practices that have contributed to successful interventions. It also will increase a measure of accountability, but decrease affordability, by increasing the OCYA workload. It will highlight positive casework which could increase public perception of the organizations that the OCYA reviews, but would require a change in mandate, which would be difficult to accomplish.

Table 7: Policy Option Assessment

Criteria	Investigative Discretion	Findings Database	Expanded Review Criteria
Safety	High 3	High 3	High 3
Systems Development	High 3	Moderate 2	Low 1
Knowledge Development	Low 1	High 3	High 3
Accountability	Low 1	Moderate 2	High 3
Affordability	High 3	Moderate 2	Low 1
Ease of Implementation	Moderate 2	High 3	Low 1
Public/Media Acceptance	Low 1	Moderate 2	High 3
Total	14	17	15

Chapter 10.

Recommendation

Investigation Findings Database

After consideration of the assessment criteria, the recommended policy option is the development of an investigation findings database. This policy option does not require any modifications to the existing mandate and can be implemented with minimal costs. It should allow the OCYA to increase the dissemination of investigations findings, increasing the positive outcomes from the work done, without any negative trade-offs. While it isn't as likely to increase public trust, it also is unlikely to encourage media criticism. Implementation of the policy option will require consideration about how best or organize and present data. Making the database searchable will allow practitioners and other interested parties to search by keywords and organize relevant reports by number of uses. This could be augmented by labeling report findings with thematic keywords so that similar findings can be linked, and practitioners can use the specified labels to find all reports with associated findings. This will allow those developing care plans for youth to more easily draw from the knowledge of others instead of relying on only their own experience.

The other considered policy options, in addition to challenges to implement under the existing mandate, had significant trade-offs for the benefits they provide. The expanded case review option required increased costs and was less likely to produce recommendations. The increased investigative discretion would reduce costs at the expense of public trust. Despite these trade-offs, the non-recommended options can still be considered for future development. After the creation of the findings database, the OCYA could make increased use of it by expanding review criteria. And while it could be difficult to get the support needed to expand the mandate, it might be possible to widen the definition of serious injuries in order to increase the number cases that can be considered for review.

Chapter 11.

Conclusion

Effective review of child protection case reviews requires the balancing of accountability and learning. This can be a challenge as public criticism can lead to an increased focus on accountability and the creation of a blame culture. This can negatively impact case decisions as youth workers seek to avoid blame for negative incidents. However, experts can steer public demands for increased accountability in ways that reduce the likelihood of poor outcomes. Analyses of Alberta case reviews demonstrate that the new legislative requirement for mandatory reviews of youth deaths has been implemented well and contributes to achievable recommendations and meaningful learning. The case reviews performed by the Office of the Child and Youth Advocate have responded to academic criticisms and show only minor areas for possible improvement.

Despite the strength of the OCYA's case reviews practices, more can be done to meet the full potential of case reviews. After consideration of several policies, increased findings dissemination is the option most likely to create meaningful improvements without negative trade-offs or criticism from the public or the provincial legislature. Increased learning dissemination can provide a balance to the increased accountability efforts and make findings accessible to youth workers and researchers. This will allow case planners to better respond to the unique needs of youth served. Future development of OCYA's mandate could expand its review criteria to include positive case outcomes as well. In her research on child death reviews Munro states "we have limited knowledge about how best to protect children. We need to learn and, so, need organizations that encourage learning" (2010). The mechanisms and tools associated with child death reviews have been well researched and significantly refined. If pointed in a new direction, youth advocates might find that there is as much to be learned from life as there is from death.

References

Buckley H, O'Nolan C. (2013). An examination of recommendations from inquiries into events in families and their interactions with State services, and their impact on policy and practice. Department of Children and Youth Affairs: Dublin.

Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., & Megson, M. (2012). New learning from serious case reviews: a two year report for 2009 – 2011, Research Report DFE-RB226. London, United Kingdom: Department of Education.

Choate, P. (2016). Child protection inquiries: what are they teaching us? A Canadian perspective. In H. Montgomer, D. Badry, D. Fuchs, & D. Kilkulwe (Eds.) *Transforming child welfare: interdisciplinary practices, field education, and research.* (pp. 61-85). Regina, SK: University of Regina Press.

Dacey, E. (2018, March 15). Manitoba children's advocate can now release reports on deaths of children in care under expanded powers. CBC. Retrieved from https://www.cbc.ca/news/canada/manitoba/manitoba-child-advocate-powers-start-today-1.4577967

Durfee, M.J., Gellert, G.A., Tilton-Durfee, D. (1992). Origins and clinical relevance of child death review teams. JAMA. 1992;267(23):3172–3175.

Devaney, J., Lazenbatt, A., & Bunting, L. (2011). Inquiring into non-accidental child deaths: reviewing the review process. British Journal of Social Work 41: 242-260.

Government of Alberta (2017a). Bill 18: The Child Protection and Accountability Act Fact Sheet. https://www.alberta.ca/assets/documents/bill-18-fact-sheet.pdf

Government of Alberta (2017b). The Child Protection Accountability Act: Impact on recommendations. Retrieved from https://www.alberta.ca/assets/documents/bill-18-mpci-recommendations.pdf

Government of Alberta, (2017c). Indigenous Community Data. Retrieved from https://www.alberta.ca/indigenous-community-data.aspx

Government of Alberta, (2019). Child Intervention Panel | Alberta.ca. Retrieved from https://www.alberta.ca/child-intervention-panel.aspx

Government of Alberta, (2020a). Deaths of children, youth and young adults receiving child intervention services. Retrieved from https://open.alberta.ca/publications/deaths-of-children-youth-or-young-adults-receiving-child-intervention-services

Government of Alberta, (2020b). Deaths, serious injuries and incidents of children receiving services. Retrieved from https://www.alberta.ca/deaths-serious-injuries-and-incidents-of-children-receiving-services.aspx

Government of Alberta, (n.d.). Child Intervention Data Tool. Retrieved from http://www.humanservices.alberta.ca/abuse-bullying/cidata/

Graney, E. (2016, November 25). NDP considers committee to investigate child welfare system failure | Edmonton Journal. Updated January 12, 2017. Retrieved from https://edmontonjournal.com/news/politics/government-considers-all-party-committee-to-investigate-child-welfare-system-failure

Hughes, T. (2006). BC children and youth review: an independent review of BC's child protection system. Submitted to the Minister of Children and Family Development

Ministry of Child and Family Development, British Columbia, (n.d.). Services to Children in Need of Protection. Retrieved from https://mcfd.gov.bc.ca/reporting/services/child-protection/services-to-children-in-need-of-protection/performance-indicators

Munro, E. (2010). Learning to Reduce Risk in Child Protection. British Journal of Social Work, 40(4), 1135-1151.

Munro, E., & Hubbard, A. (2011). A systems approach to evaluating organisational change in children's social care. British Journal of Social Work, 41, 726-743.

Office of the Child and Youth Advocate, Alberta. (2019). Annual Report 2018-2019. Retrieved from https://www.ocya.alberta.ca/wp-content/uploads/2018/11/AnnRpt_2018-19v3.pdf

Office of the Child and Youth Advocate, Alberta. (n.d.,a). Background. Office of the Child and Youth Advocate Alberta Website. Retrieved from https://www.ocya.alberta.ca/adult/about-ocya/background/

Office of the Child and Youth Advocate, Alberta. (n.d.,b). Investigations. Office of the Child and Youth Advocate Alberta Website. Retrieved from https://www.ocya.alberta.ca/adult/what-we-do/investigations/

Office of the Child and Youth Advocate, Alberta. (n.d.,c). Recommendations. Office of the Child and Youth Advocate Alberta Website. Retrieved from https://www.ocya.alberta.ca/adult/publications/recommendations/

Regehr, C., Chau, S., Leslie, B., & Howe, P. (2002). Inquiries into deaths of children in care: the impact on child welfare workers and their organization. Children and Youth Services Review: 24 (12): 885-902.

Representative for Children and Youth, British Columbia (2018). Annual Report 2017-2018.

Representative for Children and Youth, British Columbia (2019). Annual Report 2018-2019.

Representative for Children and Youth, British Columbia (n.d.). Reviewing and investigating critical injuries and deaths of children and youth. BC Representative for Children and Youth. Retrieved from https://www.rcybc.ca/about-us/mandate/reviewing-and-investigating-critical-injuries-and-deaths-children-and-youth

Sidebotham P., Brandon M., Powell C., Solebo C., Koistinen J., Ellis J. (2010). Learning from serious case reviews: Report of a research study on the methods of learning lessons nationally from serious case reviews. Research Report DFE-RR037. Department of Education: London.

Stevens, I., Cox, P. (2008). Complexity theory: developing new understandings of child protection in field settings and in residential child care. British Journal of Social Work. 38: 1320-1336.

Syed, F. (2019, April 1). Ontario child advocate wonders whether Doug Ford just made your children 'invisible again'. National Observer. Retrieved from https://www.nationalobserver.com/2019/04/01/news/ontario-child-advocate-wonders-whether-doug-ford-just-made-your-children-invisible

Wirtz SJ, Foster V, Lenart GA. (2011). Assessing and improving child death review team recommendations. Injury Prevention 17: 64–70.

Appendix A.

Reports Considered

Alberta

Office of the Child and Youth Advocate. (2017). 15-year-old Jimmy: an investigative review.

Office of the Child and Youth Advocate. (2017). 15-year-old Levi: an investigative review.

Office of the Child and Youth Advocate. (2017). 16-year-old Dillon, serious injury: an investigative review.

Office of the Child and Youth Advocate. (2017). 17-year-old Donovan: an investigative review.

Office of the Child and Youth Advocate. (2017). Beyond trauma: disrupting cycles, effecting change: an investigative review – aggregate.

Office of the Child and Youth Advocate. (2017). Three young children: an investigative review – aggregate.

Office of the Child and Youth Advocate. (2018). 14-year-old Lee, serious injury: an investigative review.

Office of the Child and Youth Advocate. (2018). 17-year-old Susan: an investigative review.

Office of the Child and Youth Advocate. (2018). 19-year-old Dakota: an investigative review.

Office of the Child and Youth Advocate. (2018). Into Focus: calling attention to youth opioid use in Alberta: an investigative review – aggregate.

Office of the Child and Youth Advocate. (2019b). Mandatory reviews into child deaths: April 1, 2018 – September 30, 2018.

Office of the Child and Youth Advocate. (2019c). Mandatory reviews into child deaths: October 1, 2018 – March 31, 2019.

British Columbia

Representative for Children and Youth. (2018). Alone and afraid: lessons learned from the ordeal of a child with special needs and his family.

Representative for Children and Youth. (2018). Time to listen: youth voices on substance abuse.

Appendix B.

Recommendation Assessment Criteria

Case for Change

0 – Not Present

1 – Identifies existing

2 – Identifies possible solutions for gap

3 – Provides in-depth explanation for how recommended changes will address gap

Learning-Oriented

0 – Not Present

1 – Identifies learning points or knowledge gaps

2 – Identifies how to improve knowledge gaps

3 – Identifies how to improve knowledge gaps and deliver knowledge to relevant persons

Evidence Driven

0 – Not Present

1 – Evidence provided for Case for Change or for Recommendations impacts

2 – Evidence provided for Case for Change and for Recommendations impacts

3 – Significant additional evidence provided

Assign Responsibility

0 – Not Present

1 – Identifies organization(s) responsible for implementation

2 – Identifies specific roles within organization for implementation

3 – Assigns specific implementation tasks to identified implementation roles or suggests ways to increase recommendation feasibility

Review

0 – Not Present

1 – Recommendation includes reviewable tasks

2 – Recommendation includes measurable outcomes

3 – Recommendation includes timelines for implementation

Appendix C.

Estimated Risk of Death in Designated Services in Alberta and British Columbia

Alberta

Table C.1: Deaths of Children and Youth Receiving Child Intervention Services, Alberta, 2012-2017

Year	Youth Receiving Services	Deaths		Assessments	Deaths	
2012/2013	18232	10	0.05%	48938	17	0.03%
2013/2014	16858	13	0.08%	49830	21	0.04%
2014/2015	15448	20	0.13%	50576	30	0.06%
2015/2016	15220	7	0.05%	51542	19	0.04%
2016/2017	16003	9	0.06%	51454	24	0.05%
Average			0.07%			0.04%

(Government of Alberta, 2020a. Government of Alberta, n.d.)

Using data from Alberta statistics, the rate of death for children and youth receiving child intervention services can be estimated. This estimate varies based on whether the assessment period before providing services to youth is included. These numbers differ from those reported by the OCYA, as the OCYA includes deaths of young adults receiving financial support as well as deaths occurring up to two years after services were last provided.

British Columbia

The estimated of death for youth receiving reviewable services in British Columbia is likely less accurate than Alberta's. The RCY mandate includes a wide array of services including adoption, children and youth with disabilities, child protection, mental health and addiction services, youth justice, and more (RCY, 2019). MCFD identified 25,100 youth in need of protection in 2017/2018 (MCFD, n.d.) The RCY reported receiving 118 notifications of deaths that year (RCY, 2018). The estimated rate of death, based on these numbers, is 0.47%. However, many of the notifications the RCY would have received would be outside the MCFD child protection statistics, so the

actual rate of death is likely to be much lower. If counts from other MCFD statistics, such as children and youth with special needs and child and youth mental health are included the estimated rate of death could be more than three times lower. However, there is likely to be significant amount of overlap between these groups, so this additive approach is likely to overcount the number of youths within the RCY mandate. This creates significant difficulty estimating the rate of death, but it is below a half percent, and likely much lower than that.