

CONNECTING THE EVIDENCE

Longitudinal Accountability for Alberta Fatality Inquiry Recommendations

Correspondence to the Honourable Mickey Amery
Minister of Justice and Attorney General of Alberta
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Dear Minister Mickey Amery,

You may be receiving correspondence requesting a public fatality inquiry into Parker Wells' death. I am one of the individuals encouraging Albertans to make that request, but my involvement in Parker's case is deeply personal. As an autism mother who has lived through more elopement emergencies with my own son than I can count, I understood immediately how serious his disappearance was. I learned Parker was missing at approximately 5:30 p.m. on July 16 and became involved in the community effort to get his disappearance widely circulated. Watching the search unfold, while his parents were being criticized publicly, was devastating. Parker's disappearance, the nearly two-week search and his death became a horrific community event that profoundly affected many of us who participated in trying to bring him home.

What happened to Parker also caused me to ask a larger question: when a tragedy exposes failures in a public system, what happens to the lessons identified afterward—and do those lessons actually prevent the same failures from recurring?

I am writing separately because my research into Alberta's historical fatality inquiries has raised a much broader question about the effectiveness of the fatality inquiry system itself.

I have stopped looking at these reports only as individual deaths.

I am now reviewing them longitudinally:

Death → Recommendation → Response → Implementation → Verification → Subsequent Fatality

When the inquiries are examined this way, recurring safety issues begin to appear across different years, organizations and service-delivery models.

The cases I have reviewed include:

- **Marilyn May Lane**
- **Jason Allinson**

- **Billy Beloin**
- **Stella Jane “Jennie” Nelson**
- **David Marshall Holmes**
- **Cassandra Marie-Ange Lavoie**
- **Trent Buckner**
- **Richard David Jacknife**
- **Nevaeh Madison Michaud**
- **Sharla Marie Collier**
- **Valerie Wolski**
- **Deborah Chizoba Onwu**
- **Timothy James Olenyk**
- **Phoenix Majestic Omeasoo**
- **Delonna Victoria Sullivan**
- **Mya Shiningstar-Bird**
- **Anthony James Leadly**
- **Alexandru “Alex” Radita**

These deaths are not equivalent, and I am not suggesting that an earlier recommendation necessarily would have prevented a subsequent death.

What concerns me is what becomes visible when the recommendations and circumstances are placed chronologically.

For example, **fire safety in disability residential services** appears across separate fatalities.

Marilyn May Lane died following a residential group-home fire. Her fatality inquiry raised issues including residential oversight, fire and health inspections, licensing and whether people with disabilities could actually evacuate safely.

Years later, Jason Allinson and Billy Beloin died following another Edmonton group-home fire. That inquiry again examined whether staffing reflected residents’ evacuation needs, whether nighttime evacuation drills realistically tested those needs, and whether one overnight worker could evacuate the residents during an actual emergency.

That creates an obvious systems question:

What happened to the lessons identified after the earlier death, and how were those lessons transferred across Alberta’s disability-service system?

Another sequence appears in the deaths of care workers.

Sharla Collier was killed in 2002 while providing care. Her inquiry made recommendations concerning worker assignment and safety.

Valerie Wolski was killed in 2011 while providing care. Her inquiry went back to the Collier recommendations and attempted to determine what had happened to them.

The Wolski inquiry subsequently recommended an implementation-reporting mechanism for fatality inquiry recommendations.

Then, in 2019, Deborah Onwu was killed while working alone in a care environment.

Her subsequent fatality inquiry again examined violence risk, information sharing, staffing and frontline worker safety.

Again, these cases are not identical.

But the recurrence creates a legitimate question:

When an inquiry identifies a systemic risk, who is responsible for determining every other part of Alberta's publicly funded service system where that same risk may exist?

The infant fatality inquiries raise a different concern: **timeliness**.

Phoenix Majestic Omeasoo died in 2010.

Her fatality inquiry report was not released until 2014.

Before that report was released, Delonna Sullivan, Anthony Leadly and Mya Shiningstar-Bird died in foster care in 2011 in circumstances subsequently examined alongside Phoenix's death in research assessing Alberta's fatality inquiry system.

A recommendation cannot prevent the next similar death if the next death occurs before the recommendation is even published.

Other inquiries I have reviewed raise still different recurring themes.

Jennie Nelson and David Marshall Holmes raise questions about environmental hazards, bathing safety, water-temperature controls and whether safeguards identified after one death reached other disability-service environments.

Richard Jacknife and Nevaeh Michaud raise questions concerning medical oversight, medication, monitoring and emergency response within supported residential environments.

Timothy Olenyk is particularly significant because his inquiry explicitly looked backward at previous Alberta fatality inquiries and discussed concerns expressed by Alberta judges about there being **"no way of determining whether recommendations are considered or implemented."**

That statement gets directly to the issue I am trying to understand.

Alberta has subsequently established public tracking of fatality inquiry recommendations and responses. That is an important improvement.

However:

- **Recommendation is not response.**
- **Response is not implementation.**
- **Implementation is not verification.**
- A ministry can respond to a recommendation.
- An organization can develop a policy.
- Training can be introduced.
- A risk assessment can be completed.
- A staffing requirement can exist.
- A fire evacuation plan can exist.

But ultimately the prevention value depends upon whether that safeguard reaches frontline practice and is followed when it matters.

The recent City of Calgary internal review concerning the disappearance of the vulnerable autistic child provides a current example of that distinction.

The City determined that established procedures were adequate, but they were not followed.

That finding has made the historical fatality inquiries even more relevant to me.

The systemic question is no longer simply:

“Did Alberta respond to the recommendation?”

It is:

“Can Alberta demonstrate that the safeguard identified after one person’s death was implemented, verified and carried forward wherever that same risk existed?”

This becomes particularly complicated in disability and community services because services may be delivered through different agencies, contractors, employers, funding arrangements and family-managed models.

A recommendation arising from one fatality cannot protect someone receiving services elsewhere unless there is a mechanism capable of identifying where else that recommendation applies.

I am therefore asking the Ministry of Justice to consider whether Alberta’s fatality inquiry framework needs a formal **longitudinal accountability mechanism**.

Such a mechanism could track:

Recommended → Responded → Implemented → Verified

It could also identify recurring recommendations and risks across subsequent fatalities.

For example:

If another residential fire occurs, automatically retrieve previous fatality inquiry recommendations involving residential fire safety and evacuation.

If another care worker is killed, retrieve previous recommendations involving violence risk, staffing, information sharing and worker safety.

If another vulnerable child dies in care, retrieve relevant previous recommendations involving supervision, communication, environmental hazards and emergency response.

Then ask:

What was previously recommended?

What was accepted?

What was implemented?

Where was it implemented?

How was implementation verified?

Did the later fatality expose a gap in that implementation?

This would not presume that the earlier recommendation could have prevented the subsequent death.

It would ensure that Alberta actually asks the question.

That is also one of the reasons I believe a public fatality inquiry into Parker Wells death is important.

The 911 internal review has answered part of the story.

A public fatality inquiry could examine the broader circumstances and determine whether there are systemic lessons that need to be carried forward.

But if recommendations eventually result from his death, I do not want another researcher, family member or judge years from now to have to discover them and ask:

“What ever happened to this recommendation?”

I would appreciate clarification regarding whether Alberta currently has a mechanism that performs this type of cross-inquiry recurrence analysis and independently verifies implementation of fatality inquiry recommendations.

If such a mechanism does not currently exist, I respectfully ask whether the Ministry of Justice would consider developing one.

Fatality inquiries should not exist only as individual records of how Albertans died.

Collectively, they represent decades of evidence about where our systems have failed and what Alberta has previously been told could prevent another death.

We should be connecting that evidence.

Thank you for your consideration,

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