

SUMMARY: FILE REVIEW Of the Death of a Child Known to the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted the File Review (FR) to examine the case practice and services provided to the subject child (the child).

For the purposes of the FR, Ministry records, and BC Coroners Service documents regarding the child were reviewed. The focus of the FR was a specific period of Ministry involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Was the assessment of risk to the child (particularly in relation to the parent's capacity to parent) consistent with relevant legislation, service standards and policy?
2. Was a service plan developed, implemented and monitored to ensure the safety and well-being of the child, and to address risks (particularly capacity to parent) according to relevant legislation, service standards, and policy?

C. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the child's family due to concerns of criminal behaviour and parenting capacity. The parent worked with the Ministry and community service providers to address the identified concerns. The parent attempted to engage in services but had limited understanding of their parental responsibility for the child. The child was not Aboriginal, and was not in care at the time of death.

D. FINDINGS

1. The assessment of risk was not in accordance with relevant legislation, service standards, and policy. The protection report during the time period under review was not adequately assessed and the response was not timely. The child and the sibling were not interviewed. The assessment of the child's safety did not include the previous concerns for the child's care. A thorough assessment of the parent's ability to meet the child's needs was not conducted. A required report about an

incident regarding the child was not completed. This report could have informed a plan to address the identified concerns.

2. Planning was not developed, implemented, and monitored to address the child's safety and well-being. The assessments were inaccurate, as they did not identify the concerns. The assessment required to inform a plan to address the concerns was not completed. This affected the child's safety and well-being. The child was diagnosed with an issue. The parent's parental capacity was a concern; however, it was not assessed or considered when planning for the child. Had this assessment occurred prior to the child's death the information would have informed a plan to address the concerns for the child.

E. ACTIONS TAKEN TO DATE

1. All child protection staff in the area received training on the Screening Assessment tool, timeframes, and requirements for supervisory approval.
2. All child protection staff in the area received training on relevant policies.
3. A tracking system was developed and implemented for the area; to monitor and document the completion of required assessments and plans.

F. ACTION PLAN

No actions were required as findings were addressed by the actions taken to date.

This review was completed in August 2016.