BRITISH COLUMBIA

Ref #: 227688
Date: December 2016

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Ministry

A. INTRODUCTION

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

For the purpose of the FR, Delegated Aboriginal Agency (DAA) records and documents were reviewed. The FR focused on a specific period of DAA involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Were child and family services provided prior to the child being brought into care, adequate to address their needs and in accordance with legislation, policy and practice standards?

2. Were services provided to the child and family after they were taken into the care of the DAA, carried out in accordance with legislation, policy, and practice standards?

C. BACKGROUND SUMMARY

Services to the child and family were provided by a DAA. The child was Aboriginal and eligible for registration with their Band.

Involvement with the family was brief; the DAA was involved with the family due to high risk behaviours of both parents, and their inability to care for the child. The concerns were not adequately resolved and the child came into the temporary care of the DAA, and was in DAA care at the time of death.

D. FINDINGS

1. Services provided prior to the child being brought into care were adequate to address their needs, and were in accordance with legislation, policy and practice standards.

Policy and practice standards focused on assessing and planning for the safety of the child. A safety plan was developed and when it was determined the plan was not sufficient to ensure the safety of the child, the Director had reasonable grounds to believe that a less disruptive measure was not available to protect the child; they were removed from the parents' custody.

2. The services provided to the child and family after the child was taken in to DAA care were consistent with legislation, policy and practice standards.

   The child was diagnosed with having a life threatening medical condition. A Reportable Circumstances report informed the delegate of the director in the DAA. The DAA ensured family were able to be with the child at the hospital and involved them in making decisions consenting to medical intervention. Following the child's death a Reportable Circumstances report informed the delegate of the director in the DAA.

   Consistent with policy, the DAA kept the First Nation informed and invited their collaboration with planning.

E. ACTIONS TAKEN TO DATE

Not applicable.

F. ACTION PLAN

No practice issues were identified, therefore no Action Plan has been developed.

This review was completed in August 2016.