BRITISH COLUMBIA

Ref #: 221112
Date: June 2017

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 case practice regarding the subject child (the child).

For the purpose of the FR, ministry records and BC Coroners Service documents were reviewed. The FR focused on a specific period of ministry involvement prior to the death of the child.

B. TERM OF REFERENCE

1. Was the ministry's assessment and planning with regard to the child's safety consistent with the relevant legislation, standards and policy?

C. BACKGROUND SUMMARY

The ministry had previous involvement with the child's family due to concerns of parenting capacity. Protection services were being provided before the child's birth due a substantiated child protection concern about the safety of the child's sibling in the family home. Services had been provided with limited success before the child's birth. The child was not Aboriginal, and was not in care at the time of death.

D. FINDINGS

1. The ministry's assessment and planning with regard to the child's safety was inconsistent with the relevant legislation, policy, and service standards. There were significant gaps regarding the assessment, decision making, and risk management planning for the child. An assessment of the child's safety and well-being did not take place following the birth.

E. ACTIONS TAKEN TO DATE

1. The Director of Quality Assurance provided the Executive Director of the Service Delivery Area (SDA) with early findings of the review, to allow for an urgent response to the protection concerns.

2. The Director of Practice for the SDA met with child protection team leaders in the SDA and reviewed the ministry's child protection model (i.e., *Child Protection*

Response Policies, Practice Guidelines for Using Structured Decision Making Tools).

F. ACTION PLAN

1. The Executive Director of Service, Director of Practice and Director of Operations meet with Local Service Area (LSA) Child Protection Team Leaders to review the differences and similarities of the two child protection responses: investigations and family development responses.

2. The Director of Practice meets with LSA Ministry staff to develop strategies that ensure high-risk pregnancies, and later the infants, are responded to as high-risk.

The review was completed in December 2016. The above action plan was due for full implementation in March 2017.