

SUMMARY: COMPREHENSIVE REVIEW Of the Critical Injury of a Child in the Care of the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted the comprehensive review (CR) to examine practice in the case regarding the subject child (the child) of the CR.

For the purpose of the CR, Ministry files were reviewed and Ministry staff was interviewed. The CR focused on a period of time prior to the critical injury of the child.

C. TERMS OF REFERENCE

1. Were the responses to the child protection reports regarding the parent consistent with Ministry legislation, policy, standards and guidelines?
2. Upon receipt of the information that the caregiver had a new partner, were the steps taken to update the family home assessment consistent with legislation, policy, standards and guidelines?
3. What factors impeded or facilitated recommended practice for responses to child protection reports and updating of home assessments? In what way did those factors impede practice?
4. What circumstances led to the decision to approve overage placements in the foster home?
5. Was the relationship between the caregiver and the resource worker consistent with the role identified in standards and did the relationship adversely impact the resource worker's decision making and objectivity?

B. BACKGROUND

The Ministry had brief involvement with the child and family due to high risk issues that impacted the parent's capacity to adequately care for the child. An assessment of parental capacity confirmed the child welfare concerns and resulted in the removal of the child. The child was placed in an approved Ministry resource while the possibility of

a family placement was explored and permanency planning occurred. The critical injury occurred while the child was in care.

D. FINDINGS

Responses to the child protection reports were generally consistent with Ministry legislation, policy, standards and guidelines. Good practice regarding protective intervention and parental engagement was evident in case documentation. Supervisory consultation at key points of protection intakes and investigations were also evident.

There were significant delays in updating the family home assessment. The caregiver had appropriate skills, but had not yet attended mandatory foster parent training. The caregiver's new partner was residing in the foster home for a period of time before the Ministry was informed of the situation. Subsequently, there were further delays with conducting an assessment of the partner's skills and suitability. While action was taken to determine whether a criminal record existed, there was a prolonged delay in confirming information and standards requiring a Records Review Act check were not met. Once the Ministry received information that the partner was residing in the foster home, it would have been prudent to restrict the partner's unsupervised access to the children in care until the assessment update was completed.

Case recordings regarding the home study, annual reviews, monitoring, service provision, and training were comprehensive and compliant with standards; however, mandatory training requirements were not met. Competing workload demands were a significant barrier to updating the home study and reviewing the criminal record information in a timely way. The demand for residential placements and the lack of available resources impacted the availability of a suitable foster home for the child. Efforts to find alternatives to foster care and to engage the family in family-based planning were promptly initiated, but not found to be a viable alternative to foster care.

Standards required approved exception requests when more than the allowable number of children resided in the foster home. A rationale for overage placements was specified in one of the three documented exception requests; however, there was no evidence that managers approved the exceptions or that reviews of overages took place as required by the standards. While managerial approvals and reviews of overages were absent, there was ample evidence of monitoring and tracking of placement overages by the resource worker, resource supervisor, and resources team.

The CR determined there was a close professional relationship between the Resource Worker and the caregiver. The Resource Worker's contact and conduct were in accordance with the role of a resource social worker articulated in the standards. However, while maintaining a strong and supportive relationship with the foster parent, it was possible that the Resource Worker's trust in the caregiver was a factor in the delay to fully assess the new partner in the foster home.

E. ACTIONS TAKEN TO DATE

1. Since the critical injury of the child, a more formalized committee was put in place with responsibility for considering, approving and reviewing overage exceptions. Responsibility for home studies was re-integrated into existing resource teams and revisions to policies on criminal record checks were implemented.

F. ACTION PLAN

1. A template letter is developed for use in the service delivery area reminding caregivers annually of the need to inform workers of changes in households, children reaching the age of majority, and changes in criminal record profiles.
2. Managers review with supervisors and workers in the service delivery area the need to complete Criminal Record Review Act checks promptly when consolidated criminal record checks indicate a record may or may not exist.
3. When overage exceptions exist, supervisors in the service delivery area will implement a practice that the required level of worker contact with the foster parent during the overage period is specified on the exemption approval form and that monitoring activity is consistently documented on the case record.