BRITISH COLUMBIA

Ref #: 218080
Date: June 2014

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) of the FR. The purpose of the FR was to examine and analyze the case practice in relation to legislation, standards and policy; inform case practice at an individual case level and at a systemic level; identify barriers to providing an adequate level of service; and promote excellence in case practice.

The FR involved examination of Ministry records and BC Coroners Service documents. The focus of the FR was the period of Ministry involvement with the child, the parent, the extended family caregiver, and care provider until the death of the child.

B. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the child's family. The parent's high risk behaviours and special needs affected the parent's capacity to provide for the safety and well-being of the child. The child was in an out-of-care placement with extended family members and was not in the care of the Ministry at the time of death. During the time period under review, concerns were brought to the attention of the Ministry about the environment in which the child lived. The child was Aboriginal.

C. FINDINGS

The FR identified concerns related to documentation, formal assessment and lack of referral to appropriate Ministry services to address the concerns for the child and family. Issues relating to communication between the Family Service Worker (FSW) and the Resource Social Worker (RSW) were identified. The FSW was not fully aware of the factors impacting the capacity of involved individuals to provide care for the child.

The examination of practice with respect to the out-of-care placement revealed several areas of concern. First, there was no documentation of an assessment of the caregivers' ability to care for the child on a full-time basis. Second, the appropriate checks required as per policy before completing an agreement with a caregiver was not documented. Finally, the FSW was unaware of arrangements for the child's care made by the caregiver and did not approve the plan until shortly before the child's death.

While the FR revealed that the child welfare practice did not contribute to the child's death, several areas of practice were highlighted:

- The specific policy be expanded to include a visiting requirement between the Social Worker and children;
- Staff exercise due diligence when placing children outside the family home;
- Communication be improved between child protection, resources and a particular oversight organization;
- Information sharing be established so child protection workers have access to a particular oversight organization's files so that information can be used as part of Prior Contact Checks, if required; and,
- Proper monitoring and tracking of Assessment of Capacity for approved caregivers be implemented.

D. ACTION PLAN

1. The Executive Director of Service or Community Services Manager (CSM) to review with staff all resources which also provide a community service. These resources will be identified and the current circumstances will be updated regarding monitoring requirements.

2. Training regarding a specific policy to be provided to all relevant staff.

3. The CSM to review with staff the expectations for communication between child protection social workers and resource social workers when safety planning for children involves Ministry approved caregivers.

4. The specific standard is reviewed with the Provincial Director of Child Welfare to determine if there is a need to include a visiting requirement between the social worker and the children placed to ensure basic needs for safety and well-being are being met.

5. Review prior contact check procedures when caregivers may also be providing a specific community service.

6. Monthly meetings with a particular oversight organization.