

## **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, policy, and standards; promote excellence in case practice; and identify barriers to providing adequate services.

For the purposes of the FR, Ministry records and BC Coroners Service documents were reviewed. The FR focused on the period of Ministry involvement prior to the death of the child.

### **B. TERM OF REFERENCE**

1. Prior to the expiry date of the Supervision Order (SO), was an appropriate service plan developed, implemented and monitored to address the safety needs of the child?

### **C. BACKGROUND SUMMARY**

The Ministry had longstanding involvement with the child's family. The parents had high risk and criminal behaviours that impacted their ability to function in their parental roles. They received and were engaged in extensive support services to improve their capacity to provide safe care to the child. The child was Aboriginal and was not in care at the time of death.

### **D. FINDINGS**

1. An appropriate service plan was not developed, implemented and monitored to address the safety needs of the child and the child's siblings. There was not compliance with applicable policy and standards for the provision of ongoing protective services. Specifically, the required assessment and planning tools were not used to inform a service plan for the family or to reassess risk to the child's safety when there were changes in family circumstances. Various services were offered to the child's parent to address high risk behaviours, but there was

no evidence that the parent engaged in those services. The Ministry continued to use the same mechanism to ensure the child's safety despite no evidence of sustainable change. Additionally, service planning was inconsistent with the guidance provided in the Best Practices Approaches.

## **E. ACTIONS TAKEN TO DATE**

1. Section 13, "When in need of protection", of the *Child, Family and Community Service Act* (CFCSA) has been amended.
2. The Best Practices policy document has been revised to include the CFCSA amendment.
3. Team Leaders and staff received training regarding the particular practice issue.
4. Team Leaders and staff received training regarding the revisions to the *Chapter 3: Child Protection Response* (Chapter 3) policies and standards. Community Service Managers and Executive Directors received an orientation session regarding the Chapter 3 policies.
5. All the Child Protection Team Leaders in the Service Delivery Area have been certified in practice supervision through the Ministry Program.
6. The Director of Practice met with Child Protection Team Leaders to identify barriers to shifting practice in the area of completing Structured Decision Making (SDM) tools. This topic is now a standing agenda item on the monthly calls between the Director of Practice and the Team Leaders.

## **F. ACTION PLAN**

1. To ensure full implementation of the SDM tools as required by policy, it is communicated to Team Leaders and Community Service Managers that Child Protection Consultant(s) support teams with the utilization and completion of SDM tools in assessment, planning and documentation of ongoing protective services for a child.
2. The Director of Practice reviews with Child Protection Team Leaders that staff consultations with Team Leaders when closing an ongoing protective service file for a family are consistent with Chapter 3 Policy.