BRITISH COLUMBIA

Ref #: 220348
Date: June 2015

SUMMARY: FILE REVIEW
Of a Critical Injury 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 were reviewed. The FR focused on the period of Ministry involvement prior to the critical injury of the child.

B. TERM OF REFERENCE

1. 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. The child was in foster care for a substantial period while the parents addressed the child protection concerns. The parents were resistant to Ministry services and withdrew from services before fully resolving their issues. A Parental Capacity Assessment supported the child's return to parental care under a period of supervision. The child was Aboriginal and was not in care at the time of the critical injury.

D. FINDINGS

1. An appropriate service plan was not developed, implemented and monitored to address the safety needs of the child. There was a lack of 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. Reassessments of risk were not completed at regular intervals to assess whether the child's safety needs were met when there were changes in family circumstances. In particular, one child protection report regarding

the family was not entered on the system or responded to as a new incident as required by standards. The child's safety and well-being was not adequately assessed, and a comprehensive service plan was not developed monitored and revised at regular intervals to ensure the child's safety and well-being. The mechanism used as part of the safety plan was not sufficient to protect the child. Additionally, service planning was inconsistent with the guidance provided in the Best Practices Approaches.

E. ACTIONS TAKEN TO DATE

1. Section 13 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. 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 families.

2. The Director of Practice reviews with Child Protection Team Leaders that Section 13 concerns are documented as Incidents in the Integrated Case Management system.