BRITISH COLUMBIA

Ref #: 220429
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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 with respect to safety planning, assessment of risk, and collaborative practice with an Aboriginal agency and community professionals with respect to the subject child (the child) of the FR.

For the purpose of the FR, Ministry electronic and physical records were reviewed. The FR focused upon the initial involvement with the family and the critical injury of the child.

B. TERM(S) OF REFERENCE

1. Did the Ministry's assessment, case decisions and planning adequately address the child`s safety and well-being through:

    a. The identification of risk factors; and

    b. Consultation with involved professionals?

C. BACKGROUND SUMMARY

The Ministry had involvement with the parents as a result of the parents high risk behaviors. The parents participated in family support services with a community agency. The Ministry became involved with the child when a critical injury was sustained while in the parents' care. The parents cooperated with additional family support services. When a second critical injury occurred to the child, the child was removed from the parents' care and placed in a Ministry approved foster home.

D. FINDINGS

1. The initial investigation into the unexplained injury to the child was not fully complete. There were inconsistencies in the investigation that did not meet ministry policy. All relevant risk factors were not adequately assessed when the standardized assessment tools were competed.

2. Lack of collaborative practice with community partners surrounding the parent's behaviour at the time of the first injury prevented the Ministry from fully assessing the child's need for protection. During the subsequent service provision, the Ministry coordinated with community partners to ensure appropriate consultation and collaborative decision-making to support the child and the family. When the second critical injury occurred, and criminal behaviors were identified as a contributing factor, the Ministry ensured the child's safety and medical needs were met.

F. ACTION PLAN

1. The Executive Director of Service reviews with Ministry staff the importance of collaborating with community professionals, particularly when a suspected criminal matter has been identified during the assessment of a child's critical injury.

2. The Executive Director of Service reviews with Ministry staff the importance of accurately coding safety assessments to identify and document incidents of high risk behaviors occurring in a family home.