

SUMMARY: COMPREHENSIVE REVIEW Of the Death 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 the case practice and services provided to the subject child (the child) of the CR. The purpose of the CR was to: examine and analyze the case practice in relation to the applicable legislation, policies, and standards; promote excellence in case practice; and identify barriers to providing effective services.

For the purpose of the CR, Ministry and the Delegated Aboriginal Agency (the Agency) records and BC Coroner Service documents were reviewed. Ministry and Agency staff members were interviewed. The CR focused on the period of Ministry involvement prior to and following the death of the child.

B. TERMS OF REFERENCE

1. Were the roles and responsibilities of the Ministry, the Agency and Provincial Office clearly understood, communicated and followed through with regard to transfers and case management?
2. Were the Ministry and the Agency's support, monitoring and oversight of the foster home adequate?
3. Were the Ministry and the Agency's responses, to the incidents reported, consistent with policies and standards?

C. BACKGROUND SUMMARY

The Ministry and the Agency both had longstanding involvement with the child's family due to high risk behaviours. The concerns could not be adequately resolved and the child was removed from parental care. The child was placed in an Agency foster home to reunite with a sibling. The child was Aboriginal and in care of the Ministry at the time of death.

D. FINDINGS

1. The process of transferring files between the Agency and Ministry offices lacked clarity of roles and responsibilities intended to ensure consistent service delivery.

2. Ministry and Agency screening and monitoring of the Foster Home did not meet the expectations of applicable legislation, policies and practice standards.
3. Issues with the communication and decision making processes, between the Ministry and the Agency, resulted in a lack of appropriate action to address the incident in the foster home in a timely manner.

E. ACTIONS TAKEN TO DATE

1. A Ministry Practice Advisory was issued after this case. Case Transfer Coordinators now support and oversee case transfers between the Ministry and the Agency.
2. The Ministry implemented an internal tracking system to review progress on files of individuals being served by the Agency but residing outside the Agency's jurisdiction, every 90 days.
3. The number of delegated staff increased at the Agency and an audit conducted in 2012, of the Agency's practice, indicated significant improvement to the Agency's current compliance with practice standards.
4. The Ministry created the Office of the Provincial Director of Child Welfare and Aboriginal Services to address inconsistency in decision making across the province.
5. The Ministry supported the Agency to review crib safety with all Agency foster homes in July 2014.
6. New Child Protection Policy was implemented for the Ministry and the Agency in April 2012. An Aboriginal Practice and Policy Framework was developed and implemented in April 2015.

F. ACTION PLAN

1. During Clinical Supervision, the Ministry Community Service Manager and the Agency Executive Director reviews the 2012 policy relating to case transfers with involved staff.
2. The Ministry Community Service Manager and the Agency Executive Director ensures policy relating to safe sleeping is reviewed with caregivers regularly.
3. The Ministry Community Service Manager and the Agency Executive Director develops a written plan to ensure that the necessary screening checks have occurred for new Foster Homes prior to a contract being approved.

4. The Ministry updates current policy relating to protocol investigations in Foster Homes.
5. The Ministry conducts a resource audit on Ministry and Agency files to ensure that necessary screening checks were completed for approved for foster homes.