BRITISH COLUMBIA

Ref #: 238512
Date: December 2019

SUMMARY: COMPREHENSIVE REVIEW
Of the Death of a Child Known to the Director in 2018 and Of a Critical Injury of a Child Known to the Director in 2018

Circumstances of the Fatality & Critical Injury

This review examined the case files and discussions with involved staff for two siblings, one who died and one who was critically injured. The director was providing services to the children and their family at the time of the fatality and critical injury in relation to the parents' ability to care for their children's needs while one parent experienced a health issue.

Findings

One of the parents was diagnosed with a health issue shortly after the birth of the youngest child and contacted the ministry for support. The ministry collaborated with the family to develop a plan that addressed the identified issues. The implementation of this plan was delayed as a community-based service provider suggested an alternative option to the parents. The ministry continued to support the family while they considered which plan best met their needs. The youngest child died during this waiting period.

Following the death of the youngest child, the ministry worked collaboratively with the family, community agencies and a ministry program to assess and develop a plan for the older child's immediate safety and well-being. The family used the safety plan when one of the parents was out of the home. The ministry made repeated attempts to update the plan with input from the parent's community supports to address the oldest child's safety prior to the parent returning to the home. The ministry then worked directly with both parents to develop a plan to address safety concerns before the parent returned to the home. This plan provided the parents with information and guidance that they used when an issue occurred that could have affected their child's safety and well-being.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan with the involved staff, which included: reviewing existing policy and protocols for in-home respite options, reviewing policy and protocols for working with community partners, and encouraging staff to access supports when critical incidents occur. Additionally, community partners were invited to a learning event for information sharing.

The review was completed in September 2019. The above action plan was fully implemented in October 2019.