Ref #: 240354
Date: June 2020

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Director in 2018

Circumstances of the Fatality

The review examined the case files of an Indigenous child who died while in their parents' care. The director was providing services to the child and their family at the time of the death in relation to concerns of neglect and abuse.

Findings

The director received multiple concerns of neglect and abuse for this child which, on one occasion, resulted in the child coming into the care of the director for three days until further assessment and planning occurred. Child protection reports were not consistently responded to; assessment tools were completed with errors, which underestimated the child's risk; and planning with the child's family did not adequately address the safety concerns and the parents' lack of engagement with supports.

Prior to the review being finalized, the involved staff completed a two-day training related to a specific parenting issue identified in the review. Additionally, the involved leadership planned to review policy and/or best practices related to issues identified in the case review, such as working with collateral contacts and service partners, the use of structured assessment tools, case consultation with supervisors, and completing detailed record reviews.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide training to staff related to assessment and safety-planning with families experiencing intimate partner violence, as well as the importance of responding in a timely manner and engaging both parents, particularly in cases involving infants.

The review was completed in February 2020. The above action plan was due for full implementation in May 2020.