

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Director & Critical Injury of a
Child Known to the Director
in 2019

Circumstances of the Fatality and Critical Injury

The review examined the case files of two Indigenous children who were siblings. One child died and the other was critically injured. The director was providing guardianship services to one child at the time of their death and was providing services to the other child and their family at the time of their critical injury.

Findings

One of the siblings had been in care prior to the incident but was returned to the parents' care. Planning occurred to support the return of the child; however, information from community partners working with the family was not gathered to inform assessment or planning for either child. When additional concerns of neglect arose, the director did not complete the required steps of a child protection response. Upon learning the children had been critically injured while with their parents, they were brought into the care of the director and medical treatment was obtained. One of the children subsequently died from their injuries.

Actions

The involved Service Delivery Areas and the Quality Assurance team developed an action plan to review policy that guides assessments, collaboration with other service providers, and gathering collateral information. Additionally, a plan was developed to review how to identify and invite key stakeholders to Family Group Conferences. The involved staff were to review the practice directive on Case Transfer and Joint Case Management.

The review was completed in September 2020. The above action plan was fully implemented in October 2020.