BRITISH COLUMBIA

Ref #: 250549
Date: June 2021

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Director in 2020

Circumstances of the Fatality

The review examined the case files of a child who died. The child and their family were receiving services at the time of the death.

Findings

The director was aware of safety concerns related to the parent's substance misuse and did not assess and plan for concerns regarding the child's safety and well-being. The director did not view the child's home or sleeping arrangements. A care team to address the child's medical needs was not put in place and collaborative services were not implemented.

Prior to the case review being finalized the Director of Operations reviewed the case review with the involved staff to learn from the identified findings.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with the involved staff the: policy and supporting documents regarding working with expectant parents; collaborative practice protocol with the ministry and a community agency to provide collaborative services for high risk pregnant women and vulnerable children; and policy relating to safety. The review was also to be shared with the local leadership group for them to share with their teams, particularly as related to safe sleeping.

The review was completed in January 2021. The above action plan was fully implemented in February 2021.