

## **SUMMARY: FILE REVIEW**

### **Of the Death of a Child Known to the Director in 2019**

#### Circumstances of the Fatality

The review examined the case files of an Indigenous child who died from an undetermined cause. The director was providing services to the child and their family at the time of the child's death.

#### Findings

Shortly before the child's death, the director obtained a supervision order returning the child to their parent's care. When the file was transferred to a new social worker, there was no indication the family was monitored for the remainder of the order. The director also received multiple reports about neglect but did not screen these to determine whether a child protection response was required. While the director completed assessment tools that identified areas of concern for the parent, these tools were not completed in collaboration with the parent.

#### Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the involved staff to receive training on the guidelines for problematic substance use and the Child Protection Response Policies, particularly around collaborating with families in completing assessment tools. Additionally, the involved staff will conduct monthly meetings with families who are being monitored through a supervision order.

**The review was completed in July 2020. The above action plan was fully implemented in July 2020.**