

Summary: Child and Family Practice Review of the Death & Critical Injuries of Children in the Care of the Director in 2021

Circumstances of the Fatality & Critical Injuries

The review examined ministry services provided to an Indigenous child who died, and their siblings who were critically injured. The children and their family were receiving guardianship and family support services at the time of the death and critical injuries.

Findings

The ministry's assessment and planning did not address the children's safety and well-being. Their placements were not screened, assessed, or approved, leaving them vulnerable to harm.

Child protection incidents were not completed in a timely manner and assessments were not completed. The ministry did not address concerns raised by community professionals about the care provided to the children. The children were not met with regularly, cultural plans were not created, and their Care Plans were not updated.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review all placement decisions for children placed outside their parental home to ensure the care providers have been assessed appropriately. The thorough and timely completion of child protection incidents will also be reviewed with the involved staff.

The involved staff would also receive training about guardianship responsibilities, including regular in-person, private meetings with children-in-care, updating Care Plans, completing cultural plans for Indigenous children-in-care, and ensuring children access appropriate medical care and support services. Further review of the involved team's cases would be completed, focusing on family service, child service and resource standards.

The review was completed in December 2021. The above action plan is due for full implementation in June 2022.