

SUMMARY: FILE REVIEW

Of the Death of a Child in the Care of the Ministry in 2017

A. INTRODUCTION

The Ministry of Children and Family Development (the ministry) conducted a File Review (FR) to examine the practice regarding the subject child (the child).

For the purpose of the FR, ministry records were reviewed. The focus of the FR was the period of ministry involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Was the ministry's assessment of the child's safety and well-being consistent with relevant legislation, service standards, and policy?
2. Was a plan developed, implemented and monitored to address the safety and well-being of the child in accordance with relevant legislation, service standards, and policy?

C. BACKGROUND SUMMARY

The child's mother was involved with the ministry as a child due to concerns of parental substance misuse, exposure to domestic violence, and concerns that the family home was below community standards. The father experienced instability as a child. The child was Indigenous and in the care of their parents at the time of their death.

D. FINDINGS

The assessment of the child's safety and well-being was inconsistent with relevant legislation, service standards and policy. During the period under review, the ministry received two child welfare reports concerning the safety and well-being of the child. Although a home visit occurred the day after the first report was received, and safety concerns were identified, the child was not observed nor was their safety assessed. The second report required a more immediate response given the age and vulnerability of the child; the report was responded to 4 months after it was received.

Nine months following the first child welfare report, a safety plan was developed in collaboration with the parents to address the safety risks to the child. When the parents did not follow through with the conditions of the safety plan, a consultation with a team leader determined that a supervision order would be necessary to keep the child safe. Prior to the child's death, an application for the order was not completed, nor was there a record of other planning developed to address the safety concerns. A thorough service plan would have addressed the risk to the child, and provided the intervention and monitoring required to protect the child.

E. ACTIONS TAKEN TO DATE

Not applicable.

F. ACTION PLAN

1. Policy and practice guidelines that apply to the completion of assessments that inform planning for vulnerable children are reviewed with the involved team. This includes: an assessment of the child's present circumstances, seeing the child, observing the child's home, and observing the child's sleeping arrangement. The need for a timely assessment of the safety and well-being of a vulnerable child is also reviewed.

The review was completed in November 2018. The above Action Plan is due for full implementation in December 2018.