BRITISH COLUMBIA

Ref #: 218544
Date: June 2016

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted the File Review (FR) to examine the case practice and services provided to the subject child (the child) of the FR.

For the purposes of the FR, Ministry records, and BC Coroners Service documents regarding the child 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 assessment of the child's parent's ability to provide adequate care for the child consistent with relevant legislation, service standards, and policy?

2. Was a plan developed, implemented and monitored to adequately address the child's safety and well-being?

C. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the child's family due to concerns of parenting capacity, high risk behaviours, and criminal behaviours. The parent received services through the community but was resistant to services. The child developed specialized needs. The child was Aboriginal and was not in care at the time of death.

D. FINDINGS

1. The assessment of the parent's ability to provide adequate care for the child was not consistent with relevant legislation, service standards and policy. Reports to the Ministry were not fully assessed to ensure the parent's ability to meet the child's needs. Ongoing assessments of the parent's ability to care for the child were not completed. There were numerous concerns about the mother's ability to provide appropriate care for the child. The child was not placed with alternative caregivers to ensure the child's needs were met.

2. A number of plans were developed but were not implemented and monitored to adequately address the child's safety and well-being. A Supervision Order was in place, but it was not implemented or monitored effectively in order to address the child's safety and well-being. Clear goals and expectations were not outlined in a plan, in order to address the concerns for the child's safety. There was information to support the necessity for the child to be placed outside of the family home, yet this did not occur. Had the child been placed in a home that could meet the child's specialized needs, the child could have been more closely monitored.

E. ACTIONS TAKEN TO DATE

There were no actions taken to date.

F. ACTION PLAN

1. a) All Team Leaders (TLs) in the Local Service Area (LSA) receive refresher training for utilizing Structured Decision Making tools.

   b) Clarity is provided to TLs in the LSA for how to respond to new reports when there is an open incident and/or case to ensure the issues are recorded, assessed and addressed.

2. The Community Service Manager of the LSA reviews with the TLs the expectations regarding:

   a) Follow through with *must-remove* clauses of Supervision Orders; and,

   b) Ensuring collateral contact information is obtained during the assessment of the report.

This case review was completed in April 2016. The above Action Plan is due for full implementation by October 31, 2016.