

SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Child in the Care of the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted the Comprehensive Review (CR) to examine and analyze case practice in relation to legislation, standards and policy.

The CR involved examination of Ministry records, BC Coroners Service documents, and medical service plan records. The focus of the CR was the period of Ministry involvement with the subject child of the CR (the child), the parent, and the foster parents from the child's birth until the foster home the child was placed in was closed.

B. TERMS OF REFERENCE

1. Was the child seen by the Guardianship Social Worker every three months while in care as required by policy?
2. Did the child receive a medical examination when admitted to care and during the time in care as required by policy?
3. What was the legal and placement plan for the child and was this appropriate given the circumstances?
4. Were the foster homes where the child was placed visited by a Social Worker every three months as required by policy during the period of review?
5. Were there any child protection reports or quality of care concerns expressed about any child placed, including the subject child in the foster homes during the time the subject child was placed and, if so, were the responses consistent with policy (including the protocol investigation following the child's death)?
6. Were support services and information provided to the child's mother following the child's death reasonable and appropriate according to policy and legislation?

C. BACKGROUND SUMMARY

A child welfare agency had involvement with the parent prior to the child's birth due to the mother's special needs. This child was not aboriginal. After the birth of the child, the

Ministry attempted to address the high risk issues related to the parent's parenting capacity through a supervision order (SO). A concern of high risk behaviours by the parent was received and the child was removed by the Ministry. An assessment of the parent's parental capacity occurred and recommendations were made. The parent did not initially engage in services. A second parental capacity assessment indicated the parent did not have the ability to care for the child and alternative plans needed to be made for the child's care. Although the parent engaged in services to address the concern of parental capacity and high risk behaviour, concerns remained.

A concern was received about the care provided by foster parents after the child was in the home for a period of time. This foster home was closed. The child was placed in another foster home. The second foster home had contained more foster children than allowable by policy. The child was in the care of the Ministry at the time of the child's death. Following the death of the child there was an investigation of high risk behaviours in the second foster home and the home was closed.

D. FINDINGS

1. The child was seen every three months by the Social Worker as required by policy. When the child was in the second foster home the child was not seen every month as required when the allowable number of children in a foster home is exceeded. Had the Social Worker been aware that the allowable number of children in the home was exceeded, the child's progress in the home and overall well-being would have been more closely monitored and assessed in a timely manner.
2. The child received a medical exam as required by policy at the time the child entered foster care. Medical examinations were to occur as required by a Comprehensive Plan of Care (CPOC) however a CPOC was not completed during the child's time in foster care. The foster parent was advised to make an appointment regarding the child's medical issue; however this did not occur. Had the child received a medical assessment regarding the issue the cause of the issue could have been identified.
3. Given the child's family situation, certain aspects of the legal and placement plan were appropriate. The legal plan for the child was appropriate given the circumstances. Had the placement plan been more closely monitored, formal supports could have been put in place to address the identified issue.
4. The two foster homes were visited every three months as required by policy. The second home was not seen every month while there was more than the allowable number of children in the home. The foster home did not have annual reviews as required by policy.
5. There were two concern received about the quality of care the child received while placed in the first foster home. The concerns were not addressed according to policy as the foster home was voluntarily closed. The concern with the second foster home was responded to according to policy. This response led to the second foster home being closed.

6. The mother was provided with supports following the child's death which met and exceeded the supports and information required by policy and legislation.

E. ACTIONS TAKEN TO DATE

1. After the period of review the *Care Plan* was redeveloped and training occurred throughout the province for all CYSN, Child Protection and Guardianship staff.
2. The Practice Directive: *Care Plans for Children in Care* was released after the period of review.
3. *The Good Recording Guide: Child Protection and Family Support*, was released after the period of review and the Service Delivery Area (SDA) received orientation to this guide.
4. Chapter 3: Child Protection Response was updated after the period of review, and is now referred to as Child Protection Response Policies.
5. Orientation for Child Protection staff of the Child Protection Response Policies occurred after the period of review.
6. After the period of review, the CSM strategized with the Resource TLs to support staff in the completion of the overdue annual reviews.
7. A new tracking system was developed by the SDA to track foster homes where the number of children in the home exceeds the allowable number of children according to policy. This is reviewed by the CSM and TLs during consultation every four to six weeks.
8. After the period of review, the SDA starting tracking the status of Care Plans. Reminders of overdue Care Plans are sent to the CSMs and TLs from the Executive Director of Service at least every six months.
9. After the period of review, the SDA required that foster parents who care for infants less than eighteen months of age must have specialized training.
10. After the period of review the child protection team, including guardianship workers, began using a tracking system to track contact.

F. ACTION PLAN

1. The Ministry ensures that the provincial policy for the allowable number of children in a foster home is clarified regarding expectations for monitoring, reviewing, and tracking expectations.

2. The Ministry ensures that the Provincial Policy on assessing and responding to quality of care concerns in foster homes is revised.
3. The Provincial Director of Child Welfare conducts an audit of the SDA Resource Files.
4. The Ministry ensures that the Provincial Policy regarding requirements for medical assessments for children in care is reviewed.
5. The CSMs of the SDA review with all Child Protection, CYSN and Guardianship staff the requirements and Practice Guidelines for Integrated Case Management: recording actions; next steps; roles and responsibilities; and, the distribution of plans from the Integrated Case Management meetings.
6. The CSMs review with all of the SDA TLs the Canadian Paediatric Society recommendations for children to have a well-child visit with their primary health care provider.
7. The CSM for Resources reviews with all Resource TLs the requirement to gather information regarding the care and protection of children in a timely manner, and directly from the reporter.
8. The CSM for Resources ensures the form used by the SDA is consistent with the Annual Family Care Home Review (CF1630).
9. The CSMs of the SDA:
 - a. Review the policy of recording contact between Social Workers, children in care, and foster parents with all Child Protection, CYSN and Guardianship staff.
 - b. Develop a SDA form to track and monitor Social Worker contact with children in care and foster parents for review by the TLs during clinical consultation with the SWs.

This case review was completed in December 2015. The above Action Plan was due for full implementation by May 02, 2016.