BRITISH COLUMBIA

Ref #: 224583
Date: December 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 practice in the case of the subject child (the child).

For the purpose of the FR, Ministry records and BC Coroners Service documents were reviewed. The FR focused on a specific period of Ministry involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Was the Ministry's assessment of risk to the child's safety and well-being consistent with relevant policy and legislation?

2. Was a service plan developed, implemented, and monitored to address the safety needs of the child?

C. BACKGROUND SUMMARY

The child's parent received longstanding Ministry services as a child. The Ministry had periodic involvement with the family throughout the child's life due to the parent's high risk behaviours. At times, the parent was resistant to Ministry involvement. The child was not Aboriginal, and was not in care at the time of death.

D. FINDINGS

1. The assessment of risk to the child's safety and well-being was not entirely consistent with relevant policy and service standards. Steps required by policy to assess child protection reports were not completed. Tools that are used to assess both immediate and future risk of harm to the child were not completed in accordance with policy guidelines; this resulted in an inaccurate assessment of risk. The response to the child welfare concerns did not appear to take into consideration the child's vulnerability or an accurate representation of the parent's history. The child may have been left at risk because a thorough assessment of risk using the assessment tools as prescribed by policy was not completed.

2. A service plan was not developed, implemented, and monitored to address the safety needs of the child. Structured assessment tools not used in accordance with guidelines led to an underestimated level of risk to the child and an inaccurate determination that service planning was not required. Without the required service planning, the child was left in an unsafe situation.

E. ACTIONS TAKEN TO DATE

1. The two-day Domestic Violence Training occurred on multiple occasions; training was provided to the involved staff of the Service Delivery Area (SDA).

2. Provincial Centralized Screening became operational province wide with the following responsibilities: gathering information and completing the Initial Record Review (IRR), completing the *Screening Assessment*, and forwarding protection responses to the local community office for action.

3. Child Protection staff in the involved SDA received additional orientation on Domestic Violence guidelines.

4. The *Practice Guidelines for Using Structured Decision Making Tools* were updated to reflect changes related to the duties of Centralized Screening, and further guidelines have been provided to identify domestic violence concerns at the screening stage.

5. *Child Protection Response Policies* were updated to reflect changes related to the duties of Centralized Screening. A Prior Contact Check now consists of an Initial Record Review that is completed by Centralized Screening, and a Detailed Record Review that is completed by the assigned social worker. The requirements of each review are outlined, and the office responsible for each review is identified.

F. ACTION PLAN

1. Training is provided to reinforce:
    - how to complete a Detailed Record Review (DRR), and the importance of using a DRR to inform practice;
    - the steps required to complete a child protection response; and,
    - the importance of completing the SDM tools according to guidelines and using the results to guide decision-making and planning.

This review was completed in September 2016. The above Action Plan was due for full implementation in October 2016.