BRITISH COLUMBIA

Ref #: 224585
Date: June 2016

SUMMARY: FILE REVIEW
Of a Critical Injury 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 of the FR (the child).

For the purpose of the FR, Ministry records were reviewed. The FR focused on the period of Ministry involvement prior to the critical injury of the child.

B. TERMS OF REFERENCE

1. Was the assessment of risk to the child (particularly in relation to a specific concern) in accordance 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 according to relevant legislation, service standards, and policy?

C. BACKGROUND SUMMARY

The Ministry was involved with the family for an extended period of time due to a substantiated child protection concern that the child was residing with his parents in a high-risk situation. The child remained in the care of one parent while the family participated in Ministry intervention services. The child was Aboriginal.

D. FINDINGS

1. The Ministry's assessment of risk (particularly in relation to a specific concern) was not consistent with relevant legislation, service standards, and policy. There were new child protection concerns reported by community members and professionals that were not documented and assessed by the Ministry as required by policy. Errors were made on the standardized assessment tools resulting in an underestimated assessment of risk. Assessment tools, including guidelines for Best Practices, were not utilized to inform critical decisions, assessment, and service plans as required by policy. Failure to document and assess new child protection concerns according to policy and utilize the standardized assessment tools as prescribed may have contributed to the child being left in an unsafe situation.

2. An initial plan had been developed and implemented prior to the period under review, but failure to monitor and enforce the plan resulted in the plan being ineffective to meet its goals. Effective planning required a full understanding of the risk posed by both parents' of the child; the social worker gathered new information relating to the child's safety during the period under review, but this information was not incorporated into a new or existing plan to address the risk of the situation. The information gathered by the social worker during the review period was not synthesized, critically analyzed, and used to determine whether planning adjustments were necessary. This may have contributed to the child being left in an unsafe environment.

E. ACTIONS TAKEN TO DATE

1. The *Child, Family and Community Services Act* (CFCSA) was amended; relevant policy documents were revised to reflect these amendments.

2. Child Welfare Policy and the Practice Guidelines for Using Structured Decision Making Tools were updated.

3. Provincial training occurred relevant to reported concerns for the subject child.

4. The Ministry in the applicable community participates in formal and regular integrated meetings related to a reported concern area.

5. The Service Delivery Area (SDA) provided refresher training to staff on policy applicable to this review.

F. ACTION PLAN

1. The *Practice Directive, Case Transfer & Joint Case Management under the CFCSA* is reviewed with the involved SDA leadership and staff.

2. The SDA provides confirmation that all involved staff have taken the refresher training; refresher training is provided to all involved staff that have not yet received the training.

This case review was completed in March 2016. The above Action Plan is due for full implementation by June 30, 2016.