BRITISH COLUMBIA

Ref #: 226208
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 to examine practice in the case of the subject child (the child).

For the purpose of the File Review, Ministry records, policies, standards, guidelines, and legislation as well as BC Coroner's Service documents were reviewed. The File Review focused on a specific period of Ministry involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Was the assessment of the child's parents' ability to provide safe and 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 safety and well-being of the child?

C. BACKGROUND SUMMARY

The child's parents had a lengthy involvement with the Ministry due to concerns of parental domestic violence, and substance misuse. Services had been provided for several years with limited success before the child's birth and the child's siblings had been in the care of the Ministry for a brief period. The child was Aboriginal.

D. FINDINGS

1. The assessment of the ability of the parents to provide safe and adequate care was not consistent with legislation, policy and standards. The assessment did not adequately consider historical information and the required steps of a Family Development Response were not completed. Appropriate services were not implemented before the child was born, and an assessment of the child's safety and well-being did not take place following the child's birth.

2. There was no documented plan in place for the child and their siblings during the time period under review. Completion of the Structured Decision Making tools as

required would have provided a mechanism for ongoing evaluation of risk to the child.

E. ACTIONS TAKEN TO DATE

1. Local Service Delivery Area Child Protection Consultants reviewed and prioritized outstanding work requiring completion.
2. New child protection reports are tracked weekly and monitored by Child Protection Consultants and supervisory staff.
3. Staffing shortages are addressed by voluntary social workers from other communities and the Rapid Response Team.
4. Child Protection Consultants developed a system for mentoring and monitoring new staff.
5. The Director of Practice and Child Protection Consultants reviewed the Structured Decision Making tools with all team leaders in the Service Delivery Area.
6. Implementation of the Provincial Centralized Screening process has ensured constant assessment and screening of new reports received by the Ministry.

F. ACTION PLAN

1. The Director of Practice reviews relevant policy regarding high risk pregnancy with team leaders and staff in the Service Delivery Area.

This file review was completed in July 2016. The above Action Plan is due for full implementation in December 2016.