

## **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 case practice regarding the subject child (the child) of the FR. The purpose of the FR was to: examine and analyze the case practice in relation to legislation, policy, and standards; promote excellence in case practice; and, identify barriers to providing adequate services.

For the purposes of the FR, Ministry records and BC Coroners Service documents were reviewed. The FR focused on the period of Ministry involvement prior to, and following the fatality of the child.

#### **B. TERM(S) OF REFERENCE**

1. During the period under review, was a thorough assessment of risk to the child conducted, which was consistent with the relevant legislation, policies, practice standards and guidelines?
2. Was an appropriate service plan developed, implemented and monitored to ensure the safety and wellbeing of the child?

#### **C. BACKGROUND SUMMARY**

The Ministry had longstanding involvement with the child's family due to child protection concerns regarding the parent's high risk behaviours. The child was not in care; however, support services and community programs were provided to the parent to resolve their issues. The parent remained engaged in services at the time of the fatality. The child was non-Aboriginal.

#### **D. FINDINGS**

1. The assessment of risk to the child was not consistent with applicable legislation, policy, and standards in effect at the time. The Ministry utilized some, but not all, of the assessment tools required by policy to ensure the safety of the child.

2. An appropriate service plan was not developed, implemented or monitored to ensure the safety and wellbeing of the child. Support services were provided; however, their effectiveness needed to be evaluated as part of the planning.

#### **E. ACTIONS TAKEN TO DATE**

1. A tracking system was created and implemented to monitor and document the completion of the assessment tools and family plans associated with ongoing protection service cases. It was presented to the Team Leaders and Management staff.
2. The involved Team Leader addressed with staff the issues regarding the documentation of assessment and planning tools, and ensured the assessments reflect the dates they were completed. This matter was also discussed at a team meeting.

#### **F. ACTION PLAN**

1. The Director of Practice leads a discussion at the local Team Leader meeting about the use of assessment and planning tools; particularly, the safety assessment form with regard to when drug use presents an imminent danger to a child.
2. The Community Services Manager assists the involved Team Leader(s) with a method for tracking families which have drug and/or pharmaceutical issues, for review during regular clinical supervision with social workers.
3. The Director of Practice reviews with the involved Ministry staff the steps required when transitioning between the Family Development Response phases, and when Social Workers should seek Team Leader consultation.

**This case review was completed in March 2016. The above Action Plan was due for full implementation by June 10, 2016.**