

SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Child Known to the Director and Of a Critical Injury of a Child Known to the Director

A. INTRODUCTION

The Ministry of Children and Family Development (the ministry) conducted the Comprehensive Review (CR) to examine case practice regarding two subject children (the children).

For the purpose of the CR, case records were reviewed, as well as information obtained through interviews with the involved staff. The CR focused on a specific period of the director's involvement prior to the death of one of the subject children, and the critical injury of the other subject child.

B. TERMS OF REFERENCE

1. Did the director's response to concerns for the children's safety meet the applicable legislation, policy, and practice standards?
2. Did the director take the appropriate steps to approve and monitor the placement for the children?

C. BACKGROUND SUMMARY

The children were residing with their parent in a high-risk situation. The children were placed in the interim custody of a relative due to a substantiated child protection concern. The parent was engaged with services in the community, and working towards a reunification with the children. The children were Aboriginal.

D. FINDINGS

1. The director's assessment of the children's safety while in their parent's care, met most of the relevant legislation and policies; gaps that existed did not influence the outcome for the children. However, during the assessment, the director facilitated the children's move to the home of relatives on two different occasions, and the director's response to ensure the children's safety while in the

care of these individuals was inadequate and inconsistent with policy. A complete assessment of the caregivers and their respective homes did not occur.

2. The director did not take the appropriate steps to approve and monitor the placement for the children. The assessment of the caregiver missed critical steps, which meant information vital to assessing and planning for the children's safety in that home was not available; information that was available was not adequately considered. Omissions in reviewing file information at key stages, as well as gaps in communication among the involved staff, contributed to these errors going unaddressed while the children continued to reside with the caregiver. While some monitoring of the placement occurred, it was hindered by the fact the social workers did not have the information that a complete assessment would have provided. In addition, when indicators suggested the caregiver was struggling to meet their responsibilities in caring for the children, further assessment and planning did not occur.

E. ACTIONS TAKEN TO DATE

1. Centralized Screening was implemented province wide. The office is responsible for receiving child protection reports and requests for service for the province, and completing an Initial Record Review and initial *Screening Assessment* tool to determine whether a protection response is required.
2. The Centralized Services Hub was implemented province wide. The Hub is responsible for screening Out-of-Care care providers, which includes the detailed records review, criminal records checks, references, and creation of the applicable case file. The Hub provides a comprehensive summary of the screening results to the responsible office, a recommended outcome, as well as a set of standardized templates/tools to guide the out-of-care assessment process.
3. The local service area created and staffed three Out-of-Care social worker positions; a fourth position is imminent. The social workers provide direct and extensive support and advocacy to the care provider(s), and connect them to community supports; as well, they support the family's social worker in monitoring the placement and mitigating any concerns with regard to the placement.
4. The Provincial Director of Child Welfare requested the Practice Support branch to arrange a province-wide training/review of a specific policy.
5. The Provincial Director of Child Welfare requested the Provincial Practice branch lead a review of specific policy, to examine its effectiveness.

F. ACTION PLAN

1. The involved staff will receive training on a specific policy ensuring that the results of the Out-of-Care care provider's assessment are shared with the parent(s), in accordance with policy.
2. The involved staff will receive refresher training on determining a child's Aboriginal ancestry, developing a *Safety Plan*, assessing a specific issue, reviewing the section 70 rights, and interpreting the relevance of Prior Contact Check and criminal record check results.

The review was completed in November 2017. The above action plan was due for full implementation in November 2017.