BRITISH COLUMBIA

Ref #: 226932
Date: June 2017

SUMMARY: FILE REVIEW
Of the Death of a Child in the Care of the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the ministry) conducted the File Review (FR) to examine the case practice regarding the subject child (the child).

For the purpose of the FR, ministry records, policies, standards, guidelines, and legislation were reviewed. The FR focused on a specific period of ministry involvement prior to the death of the child.

B. TERM(S) OF REFERENCE

1. Did the ministry conduct a thorough assessment of risk to the child, consistent with the relevant legislation, policies, practice standards and guidelines?

2. Did the ministry implement and monitor a plan with the foster mother to ensure the child's safety and well-being?

C. BACKGROUND SUMMARY

Child and Family Service Authorities in a neighboring province had longstanding involvement with the child's mother due to concerns of neglect, domestic violence and substance use. The ministry had minimal involvement with the child or the mother. Due to concerns identified in the neighboring province the child was brought in to ministry care once it was known that the family was in British Columbia. The child had been in British Columbia for three days at the time of death. The child was not Aboriginal.

D. FINDINGS

1. The ministry met some of the relevant policy, practice standards, and guidelines regarding the assessment of risk the child: a screening assessment was completed; a child protection worker attended the home within the required period; a safety assessment was completed; the child was removed; and, a verbal safety plan appears to have been discussed with the caregiver. Ministry staff had begun the initial stages of a complex case consultation. Staff sought direction from the Executive Director of Service. There were challenges with a lack of collaboration, and timely notification from the neighboring province. The ministry was not informed of the plans for the child and the mother to move to

British Columbia until the day after they arrived. No case planning was provided. There were concerns related to the assessment of the child's safety in the home. There is no indication that the social worker assessed sleeping arrangements for the child, or that safe sleeping guidelines were reviewed with any of the adults in the home.

2. After the ministry attended the home and completed the safety assessment, there was no indication a plan was developed, implemented or monitored to address the child's safety needs within the resource. As the social worker determined that the child was not safe in the sole care of the mother, it was equally important to have a safety plan in place to mitigate the risks posed by the mother remaining in the home and being responsible for the child's care.

E. ACTIONS TAKEN TO DATE

1. None

F. ACTION PLAN

1. The Director of Practice meets with local ministry staff to review the Safe Sleeping practice directive and discuss methods to ensure the steps are consistently applied in their practice.

2. The Deputy Director of Child Welfare raises the issue of inter-provincial transfers with high-risk infants at the National Table of Child Welfare Directors.

The review was completed in December 2016. The above action plan was due for full implementation on February 28, 2017.