BRITISH COLUMBIA

Ref #: 228680
Date: June 2017

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 a File Review (FR) to examine case practice regarding the subject child (the child).

For the purposes of the FR, ministry records, Delegate Aboriginal Agency (the agency) records, legislation, policies, and standards were reviewed. The FR focused on a specific period of ministry and agency involvement prior to the child's critical injury.

B. TERMS OF REFERENCE

1. Was the response to the Services Request consistent with the applicable legislation, policy and practice standards?

2. Were the services provided under the Youth Agreement consistent with the applicable legislation, policy and practice standards?

3. Was the agency's response to the child protection concerns consistent with the applicable legislation, policy and practice standards?

C. BACKGROUND SUMMARY

The ministry and the agency became involved with the child's mother during her pregnancy. The ministry provided ongoing support services to address potential risk factors that would impact the child's safety once born due to concerns of the mother's parenting capacity and high risk lifestyle. The mother was engaged with the Youth Team, prenatal services and was placed on a Youth Agreement during her pregnancy.

The child was in the mother and step-father's care at the time of the critical injury. The child is Aboriginal.

D. FINDINGS

1. The response to the Service Request was consistent with some, but not all, legislation, policy, and practice standards. Given the concerns with the child's mother at the time of pregnancy, her child services file was reopened to establish a Youth Agreement, and to provide support and preventative services. The

applicable practice directive was not adhered to; this inhibited the sharing of beneficial information with the ministry.

2. The services provided to the mother under the Youth Agreement were consistent with applicable legislation, policy, and practice standards.

3. During the period prior the child's birth, and up to the critical injury, the agency's response to the child protection concerns did not meet applicable legislation, policy and practice standards. The agency did not respond to initial information in a manner that addressed the safety and well-being of the child. The agency responded to the critical injury of the child according to applicable legislation, policy, and practice standards.

E. ACTIONS TAKEN TO DATE

1. In August 2016, a new process was established for the specific situation that presented for the child. This process involves the *Centralized Services HUB*; it was distributed to ministry staff, and posted on the ministry's internal communications site.

F. ACTION PLAN

1. The Service Delivery Area in which the critical injury occurred, distributes information about the new process to all child protection staff.
2. The Aboriginal Service Branch (ASB) distributes information about the new process to all Delegated Aboriginal Agencies working with the Centralized Services Hub. The ASB also develops and distributes written guidelines to support the new process.
3. The agency reviews the applicable practice directive for the child's circumstances with all child protection staff.
4. The agency develops and implements a tracking system for the team leaders to ensure issues are prioritized and assignment to social workers in a timely manner.

The review was completed in March 2017. The above action plan was due for full implementation in April 30, 2017.