BRITISH COLUMBIA

Ref #: 229577
Date: December 2017

SUMMARY: FILE REVIEW
Of a Critical Injury of a Child Known to the Director

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).

For the purpose of the FR, case records were reviewed. The FR focused on a specific period of the director's involvement prior to the critical injury of the child.

B. TERMS OF REFERENCE

1. Were the services provided under the *Child, Family and Community Service Act* consistent with applicable legislation, policy and standards?

2. Was the communication and collaboration with the community professionals sufficient to ensure the safety and well-being of the child?

C. BACKGROUND SUMMARY

One parent had child welfare involvement with an older child in a different province. The director was not involved with the child prior to the time period under review. The child was in the care of their parents at the time of the injury. The child was Aboriginal.

D. FINDINGS

1. The services provided by some of the director's delegates were partially consistent with applicable legislation, policy, and standards. The services provided by other delegates of the director were consistent with applicable legislation, policy, and standards.

   The director appropriately determined that the first report of a parent's high-risk issue required a child protection response. The safety plan was not formalized with the parents, which left the child's safety and well-being at risk. A team leader requested that information be obtained about prior child protection concerns from the province where the child's sibling resided. There was no indication this occurred. Two further child protection reports were received

regarding a parent's high-risk issue. There was no indication that safety planning occurred to address the parent's high-risk issues.

The director provided the majority of service to the child. The voluntary support the child's family received exceeded the requirements of policy. These services provided the family with support and helped the child to be visible in the community.

A different agency/office delayed forwarding information from a child protection report therefore the original assessment was incomplete. Neither agency/office requested further information and clarification of the concerns from the original caller. Given the information that was available, an appropriate decision was made that the safety concerns were addressed and no further services were required.

2. The communication and collaboration with the community professionals was evident when there was a high-risk issue with the child, and the director had the parent bring the child to a community professional. The director spoke with the community professional to confirm there were no issues noted.

   After the child's critical injury, according to a specific community professional, a number of reports of the child at high risk were required; this did not occur. Had the concerns for the child's safety been reported, action could have been taken to address the child's safety and well-being.

E. ACTIONS TAKEN TO DATE

1. The child protection manager reviewed with the lead professional at a specific community agency, the concern that the community professionals who saw the child for high-risk concerns did not report them as child protection concerns.
2. Orientation training of a team involved in this case occurred regarding the use of safety plans according to Chapter 3 policy.

F. ACTION PLAN

1. Clarification is provided to all child protection teams at the agency of the need to obtain further information when a child protection report is vague and requires further clarification and assessment.
2. Policy 3.1 *Assessing the Report and Determining the most Appropriate Response* is revised to address the development of interim Safety Plans, including those made by specific social work teams.
3. A specific team of the local Service Delivery Area receives orientation to the revisions regarding immediate safety plans.

4. The process of how to make an interprovincial request for child welfare information is clarified and reviewed with the Team Leaders and staff of the Local Service Area.
5. The use of guidelines to facilitate the completion of the Safety Assessment and Vulnerability Assessment is reviewed with the involved staff.
6. The development of Safety Plans and the importance of accountability for written Safety Plans to be signed by the parents and social worker is reviewed with the involved staff.

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