BRITISH COLUMBIA

Ref #: 230472
Date: December 2017

SUMMARY: FILE REVIEW
Of the Death 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 death of the child.

B. TERMS OF REFERENCE

1. Was the assessment of the child's safety and well-being consistent with relevant legislation and policy?

2. Was an appropriate plan developed, implemented, and monitored to adequately address the safety and well-being of the child?

C. BACKGROUND SUMMARY

The director had previous involvement with the child's family due to high-risk behaviors. A child protection report was being assessed at the time of the child's birth due to concerns about the safety of the child's sibling living in the family home. The child was Aboriginal, and was not in care at the time of death.

D. FINDINGS

1. The assessment of the child's safety conducted by some delegates of the director was inconsistent with the relevant legislation, and policy. There were significant gaps regarding the assessment, decision-making, and risk reduction planning for the child. An assessment of the child's safety and well-being did not take place at the time of the child's birth. The assessment of other delegates of the director was generally consistent with the relevant legislation and policy; however, a specific issue not assessed.

2. Certain delegates of the director did not develop, implement, or adequately monitor a plan to address the child's safety and well-being. Other delegated

individuals developed a safety plan; however, additional supports were likely required for the family during the time of the safety plan in order to ensure the child's safety.

E. ACTIONS TAKEN TO DATE

1. The Director of Practice with Aboriginal Services Branch sent out an email outlining the updated process for placing hospital alerts.

F. ACTION PLAN

1. A practice analyst will meet with the involved staff to increase their proficiency with regard to how and when to use specific practice directives.
2. A practice analyst will meet with the involved supervisor to provide training on a structured supervision model. The training will address how to monitor case management activities, including supporting staff with completing Structured Decision-Making tools within policy and practice guidelines.
3. A practice analyst will meet with the involved staff to review specific policies, prior to training on a specific issue.
4. Training for a specific issue will be provided to the involved staff.
5. A practice consultant will meet with the involved staff to improve their competency with applying a specific practice directive.

The review was completed in July 2017. The above action plan is due for full implementation in March 2018.