

SUMMARY: FILE REVIEW

Of the Death of a Child Known to the Ministry

A. INTRODUCTION

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

For the purpose of the FR, ministry records were reviewed. The FR focused on the period of ministry involvement prior to the child's death.

B. TERM OF REFERENCE

1. Was the assessment of the parents' ability to provide safe and adequate care to the child, consistent with relevant legislation, policy, and standards?

C. BACKGROUND SUMMARY

The ministry had assessed three child welfare reports about the family prior to the child's death, due to concerns regarding the parents' high risk behavior. The latter child protection response had concluded shortly before the child's death. The child was in the parents' care at the time of the fatality. The child was not Aboriginal.

D. FINDINGS

1. The ministry's assessment of the child's safety was not consistent with legislation, policy, and standards. Had guidelines specific to the reported concern been followed, the outcome of the ministry's response to the concern could have been more thoroughly informed. Information obtained during ministry involvement, specific to the child, was not responded to according to policy. A tool intended to assess a child's vulnerability was not completed, and another tool used to guide service planning was not used according to the guidelines. These factors contributed to the child being left in an unsafe situation when the ministry ended involvement before safety concerns were adequately addressed.

E. ACTIONS TAKEN TO DATE

1. The involved staff participated in a training workshop that was specific to the steps taken, and tools used to assess reported concerns in an effective manner.

2. A process has been implemented for the practice consultant to meet with the Local Service Area every two months to review current complex cases and identify themes, training needs, and recommendations for practice.
3. Policy relevant to a specific concern for this family was redistributed to the Local Service Area.

F. ACTION PLAN

1. Two policies, relevant to assessing specific concerns, are reviewed with the involved staff.
2. A one-day training addressing responses to specific concerns is provided to the local service area staff.
3. The practice consultant reviews the Structured Decision Making Tools with the involved staff to reinforce how the tools assist in recognizing and documenting a specific concern.

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