SUMMARY: COMPREHENSIVE REVIEW
Of the Death of a Child Known to the Director

A. INTRODUCTION

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

For the purpose of the CR, staff were interviewed. Case records, policies, standards, guidelines, and legislation were reviewed. The CR focused on a specific period of the director’s involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Was the grandparent assessed and approved as per policy to be a care provider under the Safety Plan and the Extended Family Program (EFP)?

2. Was the child’s safety and well-being monitored while the child was in the grandparent’s care?

C. BACKGROUND SUMMARY

The child’s parent was a youth when the child was conceived, and requested support services. Prior to the child’s birth, the director assessed the child’s parent’s request for service; however, the parent returned to the grandparent’s care and no further service was required. Immediately following the child’s birth the director became involved due to a high-risk issue. The child was initially placed with the grandparent as part of a safety plan. The child’s grandparent was assessed as a caregiver and although there was a history with the director related to high-risk issues, the grandparent immediately addressed identified concerns and ongoing ministry involvement was not required. The child was Aboriginal.

D. FINDINGS

1. The child’s family members participated in the development of a plan to support the child’s needs while maintaining family relationships and connection to the child’s culture. The director’s assessment and agreement of the grandparent as a...
care provider for the child under the Safety Plan and the EFP was consistent with policy and addressed the child’s specific needs. The grandparent’s home was observed, the required prior contact check, criminal record check, and reference checks were completed. When the social worker identified specific issues with the grandparent, it was determined the issues would not affect the grandparent’s ability to provide safe care for the child. The initial social worker discussed a specific detail about the care of the child with the grandparent. The grandparent was not fully informed of the ministry expectations for the issue, as the first social worker was unaware of the policy.

2. The social worker’s ability to monitor the child’s safety and well-being was restricted by barriers that existed due to staffing and training. When the child moved to a new community, those staffing barriers deterred the team leader from requesting joint case management; however, informal joint case management occurred after the social worker in the new community responded to a protection report regarding one of the grandparent’s children. When the grandparent returned to the original community, the social worker completed a home visit; however, was unaware of the requirement of policy to address a specific detail about the care of the child. Had the social worker been aware of this policy, the issue would have been addressed. The social worker appropriately gave the grandparent discretion regarding how much responsibility the parent could assume for the child’s care.

E. ACTIONS TAKEN TO DATE

1. The Provincial Director of Child Welfare requested the Practice Support branch to arrange a province-wide orientation/review of a specific policy.

F. ACTION PLAN

1. The Director of Practice demonstrated to the Team Leaders where to locate policy and practice directives on the intranet.

2. In conjunction with a community agency, annual training for all staff at the local office is offered to review a specific issue.

3. The assessment process for a specific program is reviewed to determine if changes to the process are required.

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