BRITISH COLUMBIA

Ref #: 232250
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. Was the director's response to concerns related to the child's safety and well-being adequate according to policy and legislation?

2. Was a plan developed and implemented to address concerns related to the child's safety and well-being?

C. BACKGROUND SUMMARY

The director had longstanding involvement with the child's parents due to high-risk issues. The child was in care for a period of time, and then returned to the care of one of the parents. Reports continued to be received about high-risk issues. A plan was developed to address the concerns. The child is Aboriginal.

D. FINDINGS

1. The director's response to the concerns related to the child's safety and well-being was not adequate according to policy and legislation. The director did not observe the child's home environment, meet with the family to evaluate progress made towards addressing specific issues, or reassess the child's safety and well-being for an extended period. Had these steps been taken, the high-risk issues could have been alleviated. Concerns for a specific high risk issue were not addressed. The required assessment and planning was either not completed, or completed after an extended period. The child was left in this environment without the director monitoring the child's safety and well-being.

2. A safety plan was developed an extended time before the incident that led to the child's critical injury. This plan did not address the ongoing concerns for the child; it was not monitored or used to facilitate the development of a family plan. The director had an open case with the family, and a responsibility to monitor the child's safety and well-being through ongoing services. There was no direct contact with the child or the family for an extended period. The child was left in a high-risk situation, as the director did not develop or implement a plan to address the identified risks, or monitor the child's well-being in the parent's care.

E. ACTIONS TAKEN TO DATE

1. A new social worker was assigned to this case and was working collaboratively with the office that was providing courtesy work in the community where the child now resides with the child's grandparents.
2. A senior team leader in the Service Delivery Area was assigned to work alongside the current team leader, and review caseloads and files with each social worker on the team. Joint supervision was completed by the current team leader and the senior team leader with the social worker, who now has responsibility for the child's case file; resulting in ongoing mentoring and support to address the child's needs, and develop a service plan for the child.
3. Tracking tools were developed, and the use of them was implemented by the team leader to assist in the completion of required case documentation.
4. A plan was implemented to address the closure (where appropriate) of all cases where there was no outstanding concern for a child/youth's safety and well-being.
5. The Director of Operations provided monthly consultations with the team leader to ensure all open cases were monitored, and no caseloads were left unattended.

F. ACTION PLAN

Actions were not required as the findings were addressed by the actions taken to date.

The review was completed in September 2017. No action plan was required.