SUMMARY: FILE REVIEW
Of the Critical Injury of Children in the Care of 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 children (the children).

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 children.

B. TERM OF REFERENCE

1. Examine the child protection legislation, policy, standards and practice guidelines applicable to, and actions taken in the case by ministry staff, supervisors and legal counsel, contracted to represent the Director, under the Child, Family and Community Service Act (CFCSA), and provide prospective recommendations regarding how any errors or omissions evident in the case can best be minimized or avoided in future child protection matters;
2. In the context of the case, particular focus will be given to when a child protection matter also involves private custody and access issues between parents, particularly when there are applications, proceedings, or orders involving both the provincial court and Supreme Court of British Columbia; and,
3. Provide any recommendations that may assist in improving the ministry’s practice, policies and standards for future child protection matters.

C. BACKGROUND SUMMARY

This review examined a series of child protection complaints received by the director and the response to those complaints by child protection workers. There were separate complaints concerning the mother and father. A custody and access dispute between the parents was also a significant element of this matter. The children are not Aboriginal and were in the custody of their parents at the time of the incident.

D. FINDINGS

1. This was a high conflict marital breakdown with allegations of child sexual abuse. The circumstances associated with the investigation and subsequent decisions regarding the custody of, or access to, the children were consistently demanding.
While some minor errors took place, the work of the frontline social workers reflected consistently strong professional standards and adherence to ministry policies.

2. Greater diligence in establishing and maintaining records would be appropriate.

3. From the perspective of the children in this case, the gruelling schedule of frequent parental visits over a long period would have been unnatural, stressful, tiring and disruptive to the lives of these children, who were already subjected to the stress of placement in foster care. The need to subject the children to this ordeal correctly related to an emphasis on maintenance of family connection but the lengthy nature of this arrangement was in large part a result of the protracted court process which was certainly not in the best interests of the children.

4. A major issue in this case is the lack of sufficient documentation in the records, mentioned above, to explain why the ongoing plan to reunite the children with a parent was suddenly reversed, nor was there any record of a Risk Assessment being completed before the children were returned to the care of a parent.

**E. ACTIONS TAKEN TO DATE**

1. The director has reviewed the decision made in this case to return the children to a parent and reassessed the risk to the children.

**F. ACTION PLAN**

Action Plan not required.

The review was completed in September 2017.