

SUMMARY: FILE REVIEW

Of a Critical Injury of Children Known to the Director in 2017

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, ministry records were reviewed. The FR focused on a specific period of a Delegated Aboriginal Agency (the DAA) involvement prior to the critical injury of the children.

B. TERMS OF REFERENCE

1. Was the DAA's assessment of the children's safety and well-being consistent with relevant legislation, service standards and policy?
2. Was a plan developed, implemented and monitored to address the safety and well-being of the children in accordance with relevant legislation, service standards and policy?

C. BACKGROUND SUMMARY

The parents had a longstanding history of involvement with the director due to concerns of high risk and specific issues. Due to these concerns, the children's older siblings were not in their parent's care. The parents were resistant to additional services offered by the agency. The children were not in the director's care at the time of the incident. The children were Indigenous.

D. FINDINGS

1. There was no direct correlation between the children's critical injury and the agency's practice. During the time under review, the assessment of the children's safety and well-being was not consistent with legislation, services standards and policy. A child protection response was initiated within days of the high risk and specific incident; however, the children and family home were not viewed for an extended period after the reported concerns. One parent was not contacted or included in the development of the safety plan, and additional

information was not obtained to inform the assessment of the children's safety and well-being. Required assessments to determine the children's risk for future harm and inform service planning were not completed.

2. The safety plan the agency developed with a parent was not adequate to address the safety and well-being of the children. In the past, the DAA repeatedly developed similar plans after incidents of specific and high-risk behaviours, and therefore had demonstrated they were not effective in addressing the identified concerns with the family.

E. ACTIONS TAKEN TO DATE

1. The agency debriefed the incident, which led to the critical injury of the children, through healing circles and involvement with elders and the community.
2. The agency reflected upon the practice during the period under review and discussed with the staff working with the family and agency management; this included the collection of collateral information and appropriate planning with families.
3. The necessity of a Detailed Record Review as required by policy was noted and discussed with agency staff and has informed subsequent practice.

F. ACTION PLAN

1. The agency's child protection staff participate in a training sessions regarding a specific issue.

The review was completed in July 2018. The above action plan was due for full implementation in August 2018.