Ref #: 240474
Date: June 2020

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Director in 2018

Circumstances of the Fatality

The review examined the case files for an Indigenous child who died while in their parents' care. The director was providing services to the child and their family at the time of death in relation to concerns of neglect.

Findings

The director attempted to provide voluntary support services to the family prior to the child's birth; when they were unable to contact the family, a referral was made to a local community program to attempt to reach out and offer support. Following the child's birth, the director collaborated with a local service provider to address safety concerns in relation to the state of the home and unsafe sleeping concerns for the child. While the family was supported with resources to address these concerns, the director did not attend the home to evaluate if the risks had been mitigated.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed the following action plan: discuss with the involved staff the importance of reviewing safe sleeping practices and 'The Period of PURPLE Crying' with all new parents; implement a practice in the Service Delivery Area whereby new mothers are provided digital thermometers and baby monitors, and staff or community partners support them in establishing a safe sleep surface (i.e. crib), as well as with car seat installation; and, meet with the involved staff and review the requirement to assess all child protection concerns reported and document the results in the child protection response, particularly with regard to parental substance use and intimate partner violence.

The review was completed in February 2020. The above action plan was due for full implementation in April 2020.