

SUMMARY: FILE REVIEW

Of the Death of a Child Known to the Director in 2019

Circumstances of the Fatality

The review examined case files for a Métis child who died while in their parents' care. The director was contacted to provide services to the child and their family at the time of death for support with an injury to the child. Prior to this incident, the director was involved with the family due to concerns of abuse.

Findings

Support services were not provided to the family related to the injury, or to the previous child safety report. In assessing the child's safety, the director interviewed the parents and completed collateral checks with a community partner and a community member. The director also requested information from another child welfare jurisdiction, that the family had previously been involved with, and learned of prior abuse concerns. The receipt of this information did not prompt the director to take further action, such as interviewing the child or developing a plan for support services, prior to concluding the child protection response.

Prior to the review being finalized, the involved staff were provided training on the completion of Structured Decision Making tools. Additionally, a decision was made in the Local Service Area that any exemptions to completing the required steps of a child protection response are to be approved by the Director of Operations.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to provide a comprehensive review of the child protection response practice cycles (with an emphasis on gathering information through meeting with all children and parents, conducting home visits, and informing police where required), and to discuss the importance of completing all the required steps to better inform decision-making.

The review was completed in September 2019. The above action plan was fully implemented in December 2019.