BRITISH COLUMBIA

Ref #: 218143
Date: June 2014

SUMMARY: FILE REVIEW
Of the Death of a Child Known to the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted the File Review (FR) to examine the case practice with respect to the Ministry's involvement with the subject child (the child) of the FR within the applicable standards.

For the time period of the FR, Ministry records and BC Coroners Service documents were reviewed. The FR did not include interviews with Ministry staff. The focus of the FR was the time period leading up to the death of the child.

C. TERMS OF REFERENCE

1. Did the Ministry's reunification planning reflect a thorough assessment of the parent's strengths, risks, and ability to care for the child?
2. Did the Ministry's reunification planning reflect a thorough assessment of the child's needs, including any specific issues that could be related to the child's death?
3. Did the Ministry's reunification planning reflect a comprehensive plan that outlined services and monitoring of the reunification?

B. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the child's family. The parents had high risk issues that impacted their ability to function in their parental roles. They received and engaged in extensive support services to improve their capacity to provide safe, nurturing care to their children. The child was Aboriginal, had special needs, and was in care for a long period of time before returning to the parents' care. The child was not in care at the time of death.

D. FINDINGS

Case records indicate that the child's family was effectively engaged with the Ministry and well supported by extensive services in their community. The findings below identify

a lack of compliance with applicable standards for assessment and planning; however, this lack of compliance did not appear to have a causal relationship with the outcome for the child.

1. The Ministry's reunification planning did not meet requirements for documenting family assessments under Chapter 3 Policy and Standards. Although the Ministry possessed a broad understanding of the parents' strengths and challenges and facilitated referrals to appropriate community service providers, and received reports regarding their progress, there was no thorough assessment of the parents' abilities and capacities to meet the significant demands of caring for the child and the child's siblings.

2. The Ministry's reunification planning did not reflect a thorough documented assessment of the child's needs, including any specific issues that could be related to the child's death. Case documentation confirmed that the Ministry received thorough assessments conducted by community service providers, and kept apprised of the child's progress. There was no documented plan of care and cultural plan, therefore the Ministry and the parents lacked measurable goals to address the child's special needs.

3. The Ministry's reunification planning did not reflect the comprehensive Family Plan, formal review, and details of service provision and monitoring that were required before the child's reunification with the family. No Family Plan was completed, though case documentation did demonstrate support services were in place to support the child's return home and some elements of the reunification plan were in the Supervision Order. A Family Plan could have provided clearer direction regarding the child's special care needs and ongoing family supports.

E. ACTIONS TAKEN TO DATE

1. The Child and Family Development Consultant met with the Community Services Manager and Team Leaders on a regular basis to review the Chapter 3 Policies and Standards and establish Chapter 3 compliance as an integral part of staff consultation and supervision.

2. A new Care Plan tool was implemented provincially, including the relevant SDA. Training to support the implementation of the new Care Plan tool was delivered to staff, including the team involved in this case.

F. ACTION PLAN

The Actions Taken to Date as documented above address identified practice issues for this case, therefore no further actions will be developed.