

## **SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Child Known to the Ministry**

### **A. INTRODUCTION**

The Ministry of Children and Family Development (the Ministry) conducted the Comprehensive Review (CR) to examine the case practice and services provided to the family of the subject child (the child) of the CR.

For the purposes of the CR, Ministry records were reviewed and Ministry staff was interviewed. BC Coroners Service documents were also reviewed. The CR focussed on the period of Ministry involvement prior to the death of the child.

### **B. TERMS OF REFERENCE**

1. Were the responses to the child protection reports consistent with Ministry legislation, policy, standards, and particular protocols?
2. Did the Ministry's service planning reflect:
  - An understanding of the family's strengths and risks;
  - Collaboration with family and service providers; and,
  - Cultural considerations necessary to meet the children's needs?

### **C. BACKGROUND SUMMARY**

The child's parents both received Ministry services as children due to longstanding child protection concerns. The Ministry was involved with the child's parents due to high risk issues and special needs that affected their ability to adequately care for their children. The parent was resistant to Ministry involvement, but obtained supports from extended family and support services from the Aboriginal Band. The child was not in care. The child was Aboriginal.

### **D. FINDINGS**

1. Responses to the child protection reports were not consistent with Ministry legislation, policy, standards and protocols. Standards require a Family Development Response (FDR) to be considered before proceeding with an Investigation Response (INV). Some aspects of the INV were compliant with

standards, but steps were not taken regarding review of prior records, interviews with children and parents, observing the child's living situation, gathering of collateral information from community professionals, and information gathering and assessment. Relying on information provided by service providers to assess parental capacity and child safety and well-being is not consistent with legislation and standards. Timeframes were not met regarding assessment of the child's immediate safety and the investigation completion. Best practice approaches and guidelines for the particular issue were not followed.

2. The Ministry's service planning did not reflect an adequate understanding of the family's strengths and risks. Collaboration with family and service providers was inadequate to address the children's safety, well-being, and cultural needs. Some Ministry actions were compliant with standards for provision of services to children and families in Aboriginal communities, including assignment of the investigation to a team dedicated to providing services to Aboriginal families. The family was engaged in culturally appropriate services with the Aboriginal Band, Delegated Aboriginal Agency, and Aboriginal Friendship Centre. However, the assessment and investigation processes did not include collaboration with all community partners and this impacted service planning.

## **E. ACTIONS TAKEN TO DATE**

1. The Executive Director of Service (EDS) developed a plan and implemented a process for a particular client group that includes: social worker consultation with the team leader; thorough assessment and planning with the clients; and maintenance of a registry of high risk cases that is reviewed by the team leader on a regular basis.
2. An audit process occurred with the teams associated with the case that resulted in a revised service delivery model with improved response times and tracking of child protection reports. A social worker has been assigned to the particular client group to ensure this population receives appropriate services.
3. The regional management structure was changed to improve efficacy and efficiency. The Community Services Manager is responsible for and on site with the co-located Aboriginal Teams.
4. The Team Leader has made all staff aware of the expectation to review the specific practice information with all parents and caregivers in the particular client group and meet with children at home on a regular basis.

## **F. ACTION PLAN**

1. The Region will develop and distribute a practice advisory on the need to ensure child protection staff do not rely solely on information from non-delegated

community professionals regarding a child's circumstances and visit the child and parent in the home. Once completed, the Office of the Provincial Director of Child Welfare will share the advisory with all EDSs.