

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 of the FR (the child) within the applicable standards during the time period of the FR.

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.

B. TERMS OF REFERENCE

1. Was a reassessment of risk conducted by the Ministry prior to the parent's reunification with the other parent and child as per Ministry standards and policy?
2. What mechanisms were in place to monitor the family after their move and subsequent move to other communities? Were these mechanisms sufficient given the parent's history and the child's vulnerability?

C. BACKGROUND SUMMARY

The Ministry was involved with the child and family due to high risk and criminal behaviour of the parent. The child was temporarily in care until the other parent demonstrated the capacity to meet the care and safety needs of the child. The parents participated in community support services to meet the child's special needs and to address the child welfare concerns. After the parent reunified with the other parent and child and the family relocated to another community, the case was not transferred. Limited services were in place and contact between the Social Worker and the parents was infrequent. The child was not in care at the time of death.

D. FINDINGS

1. A reassessment of risk was not conducted by the Ministry prior to the parent reunifying with the other parent and the child. The lack of re-evaluation of risk and absence of service plan reviews meant fundamental aspects of child welfare

intervention were incomplete and the Ministry's statutory obligations to plan and monitor the child's safety and well-being were unmet.

2. After the family's relocation to another community, there were not sufficient mechanisms in place to monitor the family given the parent's history. The child's vulnerability and the complexities of the case merited regular supervisory consultation and approval of case plans and decisions. The family service case was not transferred to the new community and support services with effective monitoring were not in place.

E. ACTIONS TAKEN TO DATE

1. The Team received an orientation session on the particular Program Policy from the Program Consultant.
2. The Team Leaders (TL) and Community Services Managers (CSM) in the SDA, including the Team's TL and CSM, received two review sessions of Chapter 3 Policy training including the use of SDM tools. The review sessions were delivered by the Child and Family Development Consultant.

F. ACTION PLAN

1. The Executive Director of Service communicates in writing to all TLs in the SDA the expectation that SDM tools are utilized according to policy and standards and compliance is monitored during case supervision.
2. The provincial Practice Directive, Case Transfer & Joint Case Management under the Child, Family and Community Service Act is reviewed with the Team to ensure its use is understood and implemented.