BRITISH COLUMBIA

Ref #: 220321
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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 case practice regarding the subject child (the child) of the FR. The purpose of the FR was to: examine and analyze the case practice in relation to legislation, policy, and standards; as well as inform and improve future case practice.

For the purposes of the FR, Ministry records and BC Coroners Service documents were reviewed. The FR focused on the period of Ministry involvement prior to the death of the child.

B. TERMS OF REFERENCE

1. Was the informal family arrangement for the child's care adequate to ensure the child's safety and well-being and did the Ministry ensure that they would be informed if the child returned to the care of the child's parent?

2. During contacts with the child's family were adequate supports, information and services provided according to legislation, policy and standards in effect at the time?

C. BACKGROUND SUMMARY

The Ministry had longstanding involvement with the child's extended family and sporadic involvement with the child's immediate family. The parent had initial involvement with a Delegated Aboriginal Agency for support services and periodic involvement with the Ministry for high risk behaviors. The child's parent made informal arrangements for the child's grandparents to care for the child. The grandparents had high risk and criminal behaviours that impacted their ability to function in their parental roles. The grandparents engaged in community support services to address the child welfare concerns. The child was Aboriginal and was not in care at the time of death.

D. FINDINGS

The following findings summarize non compliance with applicable standards for assessment and service planning; however, this did not appear to have a causal relationship with the death of the child.

1. The informal family arrangement for the child's care was not adequate to ensure the child's safety and well-being. The vulnerability of living in a home in receipt of protective services was not adequately assessed and a service plan which included the child as a family member residing in the grandparent's home was not developed.

2. The services and supports provided to the family were inadequate to meet the needs of the child according to policy and standards. Insufficient information was gathered during child protection investigations. Assessment and planning tools, required by policy, were not utilized to inform critical decisions, assessments and service plans. Service planning was not consistent with guidelines for Best Practices. Consequently, the Ministry was not aware of the child's return to the care of the child's parent prior to the death of the child.

E. ACTIONS TAKEN TO DATE

1. Section 13, "When protection is needed", of the *Child, Family and Community Service Act* (CFCSA) has been amended.

2. The Best Practices policy document has been revised to include the *CFCSA* amendment.

3. Team Leaders and staff received training regarding a particular practice issue.

4. Team Leaders and staff received training regarding the revisions to the *Chapter 3: Child Protection Response* (Chapter 3) policies and standards. Community Service Managers and Executive Directors received an orientation session regarding the revised Chapter 3 policies.

F. ACTION PLAN

1. The operational protocol in place between the Ministry and the Delegated Aboriginal Agencies (DAAs) in the Service Delivery Areas (SDAs) is reviewed at the Joint Advisory Committee with specific focus on effective joint management of cases.

2. The importance of following the existing file transfer protocol and collaborative practice between Ministry offices when families move within and between SDA service delivery areas is communicated to Managers and Team Leaders in the SDA.

3. The importance of completing the required Structured Decision Making tools to guide decision making, inform planning, and document thorough case plans to monitor the safety and well-being of children and youth is reviewed with Team Leaders. This review includes ensuring assessments include consultations with DAAs that are providing support services for a family.