

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 practice and services provided in the case involving the subject child (the child) of the FR.

For the purpose of the FR, Ministry and BC Coroners Service records 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 Ministry's assessment of risk to the child, including the parent's history, consistent with legislation, policy, and service standards in effect at the time?
2. Was an appropriate service plan developed, implemented and monitored during the time period of the FR?

C. BACKGROUND SUMMARY

The Ministry had extensive involvement with the family. There were child protection concerns during both parents' previous relationships and ongoing concerns about the parents' ability to adequately care for the child. High risk issues and criminal issues existed that affected how the parents functioned in their parental role.

The primary parent met with the social worker and engaged in some of the services provided, but over time became resistant to service involvement. The other parent engaged intermittently with the social worker. Services did not adequately address the child protection concerns. The child had at one time been in the care of the Ministry, but was not in care at the time of death. The child was Aboriginal.

D. FINDINGS

1. The Ministry's assessment of risk was not consistent with legislation, policy, and service standards in effect at the time. The risk inherent in the parent's previous criminal behaviour was minimized and assessments were not completed

according to policy. The decision to place then leave the child in the parent's care was not sufficiently informed by the Structured Decision Making (SDM) tools required under Chapter 3 Policy to ensure the safety and well-being of the child. A Supervision Order was in place, but the terms of the order were not enforced. The information gathered by the Social Worker during the review period was not synthesized, critically analyzed, and used to determine whether planning adjustments were necessary.

2. An appropriate service plan was not developed, implemented and monitored. Effective planning required a full understanding of the parent's high risk and criminal behaviour. There were no SDM assessments or plans confirming that the Social Worker reflected on information gathered and developed a plan that addressed the significant risk of the situation. During the FR, a thorough review of the history and circumstances revealed that case management decisions were made without adequate information about the situation. This may have contributed to the child being left in an unsafe environment.

E. ACTIONS TO DATE

1. On-line and in-person Particular Training has been completed by all staff involved.
2. Further training in Chapter 3 and Structured Decision Making tools was been provided in the Service Delivery Area (SDA) to ensure there is a thorough understanding of how to use the tools; all staff involved in this case have completed the training.
3. A Child Welfare Alert was added to the computer system advising that the child's parent was considered a safety risk to children and, if it becomes known that they are living with children, a child protection report is to be made immediately.
4. "Chapter 3: Child Protection Response Policies" was updated. In the procedures of Standard 3.5(3) it now states: "When it is necessary for a child to be removed, conduct the removal in person by being in the physical presence of the child at the time of the removal. If distance is a factor, arrange for a local delegated child protection worker to conduct the removal."
5. To ensure a thorough and comprehensive understanding of the history, functioning and needs of a family, the team involved with this case has been restructured so that one social worker has the responsibility for a family's Family Service and Child Service files. (Previously one social worker was responsible for the Family Service file, while a second social worker was responsible for the guardianship responsibilities associated with the Child Service files.)

6. A newly appointed Team Leader has taken responsibility as the supervisor of the team and in that role has reviewed the caseloads of each social worker on the team. An extensive tracking sheet has been developed and implemented as part of ongoing case practice supervision to track the completion of required SDM tools for each family. The tracking sheet is reviewed regularly with the social workers during clinical consultation.
7. Social Workers on several teams within the jurisdiction are using checklists to ensure the SDM tools are being completed. Intake Social Workers are required to complete a prior contact check as part of the checklist.
8. Within the office there is an increased focus on Policy which includes:
 - Each social worker has a policy manual on their desk which is referred to during case consultations with their Team Leader.
 - When consideration is given to returning a child to a parent; to supervision orders set to expire; or to increasing a parent's access to a child, the required SDM tools are completed and a consultation occurs with the Team Leader.
9. The responsible CSM met with all the Team Leaders to reinforce the necessity of a thorough review of the historic records of a family and identify what a thorough review of records entails.

F. ACTION PLAN

The Executive Director of Service for the SDA will provide the Deputy Director of Child Welfare a written assessment of the impact that the actions taken to date have had on practice in the jurisdiction, including:

- The SDM and Particular training;
- The newly appointed Team Leader;
- The new service delivery model (ie generalized vs specialized caseloads);
- The new tracking sheet and checklist; and
- The CSM's meetings with the TL on the need to conduct thorough case reviews.