

## **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 Coroner's Service documents were also reviewed. The CR focused on the period of Ministry involvement prior to the death of the child.

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

1. Were the assessments and responses to the Service Request and Child Protection Reports consistent with Ministry legislation, policy, standards, protocols and recommended practice?
2. What factors, if any affected the completion of assessments and subsequent responses and/or decisions regarding the Ministry's provision of service (including case planning) to the child and the family?

### **C. BACKGROUND SUMMARY**

The child's parents both received Ministry services as children. The Ministry had historical involvement with the child's parents due to high risk issues and special needs that affected their ability to care for their children. One parent received support from the Aboriginal Band and Community Services. The child was Aboriginal.

### **D. FINDINGS**

1. The assessments of and responses to the service request and protection reports regarding the child's family were partially consistent with Ministry legislation, policy, standards, protocols, and recommended practice. The Ministry completed the necessary steps for non-protection responses to the reports. If the Ministry's history of the parents had been fully reviewed, it would have led to a child protection response because of the vulnerability of the child and the special

needs and high risk issues of one of the child's parents. Due to the perceived absence of child protection concerns, the Social Worker did not meet with the family and a Community Professional as the Community Professional requested. The case met the criteria for further consultations; however, these consultations did not occur. The concerns were not explored, no plan was developed, and supports for the child and the family did not occur.

2. There were a number of factors that affected the completion of assessments, the subsequent responses, and service provision for the child and the family. There was a high turnover of Social Workers and Team Leaders working with the family. This likely affected continuity of case management and supervision and effectiveness of service planning. The consultations with Team Leaders, although occurring as required, did not identify the need for more thorough prior contact checks, Screening Assessments, and protective interventions through the lens of a specific type of case. The incidents were closed without either full assessment of the concerns or provision of support services.

The information ICM provides to the Best Practice Portal does not always obtain fulsome information about Aboriginal families. It appeared this issue contributed to a false negative result for the prior contact search regarding the family.

During the period of review, there was training for Social Workers and Team Leaders regarding the changes to Child Protection policies, tools, and computer systems. This led to increased workload pressures for all Social Workers and, in this case, affected the thoroughness of the work.

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

1. After the period of review, a Provincial Protocol Agreement was put in place between the Ministry and another Ministry.
2. In partnership with another Ministry, an orientation package has been developed for future training for the Provincial Protocol Agreement.
3. Child Protection Workers and Team Leaders received training regarding the implementation of policies and standards, assessment tools and the new database.
4. The Local Service Area (LSA) established a full time Social Worker to address specific concerns.
5. The Child Protection Consultant met with the Team Leaders in the LSA to review child protection policies and ensure understanding and consistent approach.
6. The Social Workers and Team Leaders were provided with a review of the updates to Child Protection Response Policies.

7. In the LSA, the assessment of a certain issue focuses on vulnerabilities not just child protection concerns.

## **F. ACTION PLAN**

1. The ICM system is revised to ensure that the primary contact in ICM is successfully identified in the Best Practice (BP) portal when a prior contact check is conducted in BP. The BP system is revised to preselect all aliases that migrate from ICM.
2. The issue above regarding the interface between ICM and BP (and the resolution of the issues) is discussed with the Executive Directors of Service and the Executive Directors of the Delegate Aboriginal Agencies.
3. The Community Service Manager (CSM) for the Local Service Area (LSA) reviews with all Team Leaders in the LSA the expectation to conduct and complete consultations according to policy and standards.