

**SUMMARY: FILE REVIEW
Of a Critical Incident of a Child Known to the Ministry**

A. INTRODUCTION

The Ministry of Children and Family Development (the Ministry) conducted a File Review (FR) to examine the case practice in the case involving the subject child (the child) of the FR.

For the purpose of the FR, Ministry electronic and physical records were reviewed. The FR focused upon the initial Ministry involvement with the family to the critical injury of the child.

B. TERM OF REFERENCE

1. Did the Ministry's response to the child protection reports and case planning concerning the child meet the applicable legislation, policies and practice standards?
2. Did the Ministry utilize the appropriate tools and clinical expertise to complete an adequate assessment of the risk of abuse to the child, as well as the mother's ability to protect the child from the abuse?

C. BACKGROUND SUMMARY

The Ministry had more than one involvement with the family due to community professionals reporting concerns for the child residing in a high-risk situation.

The subject child and their sibling were placed with alternate caregivers as a result of the investigation finding. The child's family participated in some Ministry intervention services.

D. FINDINGS

1. The Ministry's response to the child protection reports concerning the child did not meet applicable legislation, policies and practice standards. The Ministry's inadequate response contributed to the child being left at risk.

2. The Ministry did not use the appropriate standardized tools and practice directives to adequately assess the risk to the child. The Ministry did not assess the risk that the other parent presented due to criminal behaviours.

Opportunities to develop an adequate safety plan with community service providers and the family to address the identified concerns had been missed. It does not appear the service providers were aware of the parent's high risk and criminal behaviours.

Additional high risk behaviours impacting other children in the home were not identified or assessed with Ministry's standardised assessments tools. There was no plan developed to mitigate the criminal or high risk behaviours of the parents and their ability to safely care for the children.

E. ACTIONS TAKEN TO DATE

1. The Community Service Manager and the Director of Practice reviewed relevant legislation and practice concerns with the involved staff.
2. All staff in the Service Delivery Area took part in a two day training session intended to provide practice guidelines and directives when working with family's involved in high risk behaviors that impact children's safety.
3. The Ministry in the Service Delivery Area is working with community service providers to identify high risk families. This partnership has assisted in developing a team who develop and monitor safety plans involving children residing in high risk situations. This also includes monitoring any criminal issues that may impact child safety.

F. ACTION PLAN

1. The Director of Practice will further review the related practice directives, guidelines and legislation with the staff in the Service Delivery Area.
2. The Director of Practice will discuss the importance of accurately coding safety assessments and review relevant practice approaches.