

SUMMARY: FILE REVIEW

Of a Critical Injury 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 case practice regarding the subject child (the child) of the FR. The purpose of the FR was to: analyze practice in relation to legislation, policies and standards; promote excellence in assessment and planning; and identify barriers to providing adequate services.

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

B. TERMS OF REFERENCE

1. Was the assessment and response to the initial call consistent with relevant legislation, service standards and policy? Specifically, did the Family Development Response meet the standards for fully assessing and addressing the risk to the child?
2. Was a plan developed, implemented and monitored to address the risk to the child and in accordance with relevant legislation, service standards and policy?

C. BACKGROUND SUMMARY

The Ministry had minimal involvement with the child's parents. The parents and one grandparent had high risk behavior that impacted their ability to function in their parental roles. As a result of the Ministry's involvement with the family, the child was deemed not in need of protection and services were not provided to the family to address the child's safety and well-being. The child was not Aboriginal and not in care at the time of the critical injury.

D. FINDINGS

1. The Ministry's assessment of the initial call was consistent with relevant legislation based on information obtained from the child protection report. However, the FDR did not meet the standards for fully assessing and addressing

the risk to the child. When the family resisted collaboration in assessment and planning, the FDR should have been changed to a Child Protection Investigation. Subsequently, insufficient information was gathered to inform an accurate assessment of safety risks to the child and the likelihood of future maltreatment to the child was not considered. The Ministry's inadequate response contributed to the child being left at risk.

2. A plan was not developed, implemented and monitored to address the risk to the child in accordance with relevant legislation, service standards and policy. Assessment and planning tools, required by policy, were not utilized to inform critical decisions, assessments and service plans. Not completing the required assessments and planning tools contributed to the child remaining in an unsafe situation.

E. ACTIONS TAKEN TO DATE

N/A

F. ACTION PLAN

1. *The Child Safety and Family Support Policies: Chapter 3: Child Protection Response Standard 3.2(9): Changing the Response from a Family Development Response to a Child Protection Response* is reviewed with involved Ministry staff to ensure there is clarity about how this standard guides practice to ensure the safety and well-being of a child.
2. Training is provided to involved Ministry staff on the application of *Practice Guidelines for Using Structured Decision Making Tools*, to guide critical decisions, assessments and service plans according to policy.
3. The requirement for all staff, including Team Leaders who have taken on case practice, to consult with a supervisor or manager at key decision making points, in particular, when the decision has been made to close an Incident, is reinforced in writing with the Team Leaders in the SDA.