

SUMMARY: FILE REVIEW Of the Death of a Youth 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 youth (the youth) and other children in the home. The purpose of the FR was to: examine case practice in relation to legislation, policy, and standards; as well as inform and improve future case practice.

For the purpose of the FR, the Ministry's records, the Delegated Aboriginal Agency's (the Agency) records and BC Coroners Service documents were reviewed. The FR focused on the period of the Ministry and the Agency's involvement prior to the death of the youth.

B. TERMS OF REFERENCE

1. Was the Agency's assessment of the safety of the youth and children in the home consistent with applicable legislation, policy and practice standards?
2. Was collaboration and planning between the Agency and community services providers sufficient to provide necessary support to the parent, the youth and the other children in the home?

C. BACKGROUND SUMMARY

The Ministry and the Agency had some involvement following child protection reports that the children were being exposed to high risk situations and concerns regarding the parent providing adequate care. Involvement in each situation was short term.

The Agency became involved again when a child protection report was made about parental capacity to address the youth's high risk behaviours. There were community support programs involved. The child was Aboriginal and was not in care at the time of death.

D. FINDINGS

1. The Agency's assessment of the safety of the youth and children in the home was not consistent with applicable legislation, policy and practice standards. The Agency responded to the child protection report by offering support services to

the family. It would have been appropriate for a child protection assessment to have been completed and for the related Structured Decision Making (SDM) tools to have been used.

2. Although there were numerous community service providers involved, there was a lack of collaboration and planning between the Agency and the community services providers.

E. ACTIONS TAKEN TO DATE

1. The Agency and service providers developed a joint working group that meets every 2 months with the following objectives: risk prevention, mutual support across agencies, open communication and information sharing between all stakeholders/teams.
2. All delegated staff completed training on the revised Reportable Circumstance Policy.
3. All delegated staff completed training on Integrated Case Management.
4. A committee was established between the Agency, the Ministry and service providers focused on effective joint management of cases. A standing item on the agenda is the identification and review of all high risk youth.
5. The Agency meets quarterly with two other Delegated Aboriginal Agencies to review practice updates, clinical issues, and facilitate collaborative practice between the agencies.
6. The Agency meets quarterly with service providers to plan initiatives to enhance community capacity and safety.

F. ACTION PLAN

1. The importance of completing the required SDM tools to guide decision making and inform planning will be reviewed with all delegated social workers and supervisors.
2. The Agency's practice analyst will attend the Agency on a bi-monthly basis to provide formal and informal training and support to all delegated social workers with specific focus on best practices in screening, Safety Assessments and safety planning.
3. The Agency will develop a tracking system to monitor the completion of the SDM tools and Family Plans associated with open incidents and ongoing family services cases.

