BRITISH COLUMBIA

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SUMMARY: DEPUTY DIRECTOR'S CASE REVIEW of the Death of a Child Known to the Ministry

A. BACKGROUND

The Ministry of Children and Family Development (MCFD) conducted the Deputy Director's Review (DDR) to assess whether the ministry fulfilled its responsibilities for providing services to children and families pursuant to the *Child Family and Community Services Act (CFCSA)* and to assess whether the relevant service standards were followed.

For the purposes of the DDR, ministry documents and files were reviewed, and information was provided by community partners.

The DDR indicates historical involvement with the ministry existed for the family of the subject child (the child). The child was Aboriginal.

The nine intakes reviewed in the DDR span a period of time up to several months before the child's death. All the intakes resulted in an investigation and consistently identified on-going risks and safety concerns that included a number of *CFCSA S*ection 13 concerns. Reports to the ministry came from various sources and they all identified similar concerns, including that the child engaged in high risk behaviors. Subsequent home visits by the ministry with the family and ministry interviews with the child identified similar concerns that were previously expressed in earlier reports made to the ministry. Attempts by the social workers to make contact with the family, or extended family, including home visits, were sometimes unsuccessful.

Referrals were made by the ministry to specialized programs for the family and individually for the child to address areas of concern. The family and the child did not follow through with services and/or did not engage in services long enough to resolve issues of concern.

The DDR's final written report is dated after January 01, 2008.

B. CONCLUSIONS

In carefully reviewing the services provided to the family the DDR indicates that historical child protection concerns were ongoing with no evidence that there had been a reduction of risk for the family or for the child. As the case progressed, concerns seemed to be focused on issues other than the safety and well being of the child.

The family's file did not contain assessments and/or outcome information that could have been beneficial when assessing risk.

A historical closing file recording did not contain a reassessment of risk and the file documentation indicated that while concerns were unsubstantiated, the *CFCSA* Section 13 child protection concerns existed. Additionally, file documentation contained evidence that key risk factors in predicting future harm were present.

As the case progressed, concerns continued and file documentation confirmed the chronic *CFCSA* Section 13 concerns were not adequately addressed in the documented service plans. Additionally, though an investigation resulted in the finding that there was a need for protection, the documented safety plan did not adequately articulate how the child would be kept safe.

A review of file documentation indicated that disclosures were made by the child which were not investigated and no rationale was provided for not pursuing an investigation in the file documentation.

The DDR found that the ministry's practice was not compliant with Child and Family Service Standard 11: *When a Child is at Immediate Risk of Harm* and Child and Family Service Standard 16: *Conducting a Child Protection Investigation* and that a possible outstanding issue of safety and well-being was not assessed.

C. RECOMMENDATIONS

The DDR report's recommendations are presented in two sets; one set developed at a meeting which included regional ministry staff, and the second set developed as an addition to the first set by the regional ministry executive. The recommendations are as follows:

SET 1:

1. The Acting Community Service Manager will review the file to ensure proper documentation is on the intake and to assure a re-assessment of risk is completed to ensure safety.
2. The Acting Community Services Manager will complete the plan initiated to hire new staff in order to deal with the large caseload numbers.
3. The Acting Community Services Manager will institute the plan to enhance the administrative ratio in order to help with the client planning, particularly in Integrated Case Management meetings.

SET 2:

1. The manager for practice development will ensure that team leader forums regularly include an exercise that examines cases on a historical basis.
2. The Regional Child Welfare Table will draft a regional response plan on how to deal with cases after the third report within a year.
3. The Community Service Manager will:
    a) ensure that the social worker and team leader involved have been debriefed; and,
    b) ensure that any identified safety issues are addressed.