BRITISH COLUMBIA

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SUMMARY: DEPUTY DIRECTOR'S REVIEW of the Death of a Child in Care of the Ministry

A. BACKGROUND

The Ministry of Children and Family Development (MCFD) conducted the Deputy Director's Review (DDR), to examine the facts associated with the case and to assess whether practice met with the applicable standards that were in effect during the time period covered in the DDR.

For the purposes of the DDR ministry documents and files were reviewed.

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

There were eleven intakes reviewed in the DDR and all span a period of time from before the birth of the child to a short time after the death of the child. During this same time period, a delegated Aboriginal agency provided service to the family. The family has been served by 7 team leaders and 23 social workers in the employ of MCFD. Ministry services other than those offered and/or provided through the child welfare program area were also offered to the family.

The intakes indicate issues existed for the family that could affect how the parent functioned in their parental role. Some intakes were assessed as requiring a child protection investigation, one intake resulted in an Order for Supervision and one intake resulted in removal of the children when it was ascertained that the Order for Supervision was no longer protecting the children. The remaining intakes were assessed as requiring support services, or as requiring no further action. There were some information gaps that arose during the transfer of intake information from the district office to the delegated Aboriginal agency.

The family's ministry file was opened and closed several times, the file being re-opened when an intake report was received by the ministry.

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

B. CONCLUSIONS

In carefully reviewing the services and/or interventions provided to the family, the DDR indicates that practice standards in effect during the time period reviewed were not consistently met.

The DDR report notes that social workers made considerable efforts to work collaboratively with the parent. The social workers involved were supportive of the family in relation to the family's identified needs. The parent did follow up on some referrals for services, however, other services were offered and referrals made which were not engaged in by the parent.

The DDR report states that the death of the child cannot be linked to the practice of the involved social workers.

C. RECOMMENDATIONS

The DDR's recommendations were developed by regional staff and the Provincial Director of Child Welfare and are as follows:

1. Social workers will be informed of the recommended steps in assessing safe sleeping arrangements when completing interim approval of restricted caregivers. The Region will re-issue a regional practice advisory containing a checklist for assessing safe sleeping arrangements when completing interim approval of restricted caregivers.
2. Social workers will have access to key information about delegated aboriginal child welfare agencies in the Region. The Region will issue a regional information bulletin containing the following information about delegated aboriginal child welfare agencies in the Region: delegation level, After Hours system and use of the Social Work Information Management System (SWS/MIS).
3. The Region and Provincial Office will develop strategies to address the problems created by aboriginal agencies and district offices using different child protection information systems.
4. Aboriginal Services and the Region will conduct a joint Director's Case Review (DCR) to examine two issues arising: the placement of the children with the restricted caregiver and whether the terms of the Protocol between the Aboriginal Agency and the Region were followed during the relevant period of time covered in the DDR.