

## **SUMMARY: DIRECTOR'S CASE REVIEW of an Incident Involving a Child Known to the Ministry**

### **A. BACKGROUND**

The Ministry of Children and Family Development (MCFD) conducted the Director's Case Review (DCR) to examine the facts associated with the case and determine whether or not the ministry fulfilled its mandate under the *Child, Family and Community Service Act (CFCSA)* and met the expectations of policy, and practice standards.

The terms of reference were to:

- Determine if the ministry's response to child protection reports and requests for service were appropriate and consistent with legislation, policy and standards.
- Determine if the ministry's assessment of the strengths, risks and needs of those involved was adequate and consistent with legislation, policy and standards.
- Determine if the ministry's intervention adequately addressed the needs and risks of their clients.
- Determine if there were any systemic barriers to quality service delivery.

For the purposes of the review, interviews were conducted and ministry documents were reviewed.

The DCR reports that historical involvement with the ministry existed. The historical file was reopened and closed twice, and the family of the parent of the child who is the subject of the review was offered many services during the times the file was open.

The DCR states a ministry intake office received a report about the family of the child who was the subject of the review and a ministry file was opened. An assessment of the family circumstances revealed the file was under the jurisdiction of another office and the intake was forwarded to that office. The receiving office immediately conducted a safety assessment, which included contact with the service provider actively involved with the family. No concerns were raised by the service provider or identified by the social worker who conducted the assessment.

An action alert was attached to the file to ensure the social worker would be contacted if there was a change in family circumstances. The social worker was in contact with the family, persons close to the family, and engaged service providers to ensure a support system was in place.

When circumstances changed for the family, a recommendation of an intensive service for the family was made to the ministry. In consultation with service providers directly involved with the family, and who believed that though concerns existed the family was doing well and did not require the intensive service recommended, the ministry did not provide the intense service recommended and subsequently established a case plan that was supported by service providers in specialized program areas who were working with and supporting the family.

Through monitoring of the case plan and support system, which included contact with the engaged service providers and the parent, the social worker confirmed the family was doing well and a further assessment was to be requested.

The family's file was prepared for transfer to an Aboriginal team. The transfer was refused because the family had not lived in their current home for a long enough period of time. Services continued for the family.

A change in social workers occurred, followed shortly afterward by the end to a specialized service for the family – a request was made to have this service reinstated. The social worker followed up on a child welfare report during this time and did not identify child protection concerns. The social worker also completed a Comprehensive Risk Assessment and a subsequent integrated case management meeting which included the parent, extended family member, and a current service provider.

The family's file was transferred to an Aboriginal team. This transfer was supported by a file transfer meeting, which included the family's social worker from the Aboriginal team, the previous social worker, and a current service provider. A service plan was established.

The newly assigned social worker from the Aboriginal team visited the family, followed up on intake reports, and conducted an investigation of an intake report that resulted in the determination that the report was unsubstantiated. The parent had not engaged in services they were referred to and a referral for another service was made. Subsequent services and supports were provided to the family.

Further concerns were followed up on by the social worker. The social worker was subsequently away from the office and did not have contact with the family for a period of time. The social worker did have contact with other service providers involved with the family during that same time period to monitor the family's functioning and no concerns were communicated to the social worker. The family's file with the ministry remained open.

The ministry received an intake call from a hospital social worker advising of the incident that precipitated the DCR. The ministry received two intakes following the incident outlining concerns relating to a time period before the incident occurred.

The DCR's final written report is dated within the first six months of 2008.

## **B. FINDINGS**

In carefully reviewing the services provided to the subject child and parent, the DCR findings indicated the following:

1. The ministry's response to child protection reports and requests for services were for the most part not appropriate and consistent with legislation, policy and standards;
2. The ministry's assessment of strengths, risks, and needs of the parent was inadequate and not consistent with legislation, policy and standards;
3. The service network put in place by the ministry was adequate for the issues it addressed - other issues facing the family were not addressed and therefore, the family's total needs were not adequately addressed by the ministry's interventions; and,
4. Quality service delivery was affected by the following systemic issues:
  - a. regional reorganization;
  - b. file transfer processes;
  - c. reporting responsibilities; and,
  - d. unclear mandate for Aboriginal services.

## **C. RECOMMENDATIONS**

The DCR's recommendations were developed by representatives of the regions involved and are encapsulated as follows:

1. The director of child welfare will engage in a discussion with their counterpart in a partner organization to develop a protocol.
2. The director of child welfare will review at a Leadership Forum the guidelines on file transfers with team leaders, and will ask at the forum that team leaders review the same guidelines with their team members.
3. The director of child welfare will: review with team leaders at a Leadership Forum the need for social workers to make lists of tasks on cases for others to monitor while they are on vacation; and will strategize with managers at a Regional Leadership Team meeting on how to ensure continuity of coverage of cases when the social worker is away.
4. The manager for service quality will strategize on how to improve working relations with other service providers.
5. The director of child welfare will strategize with the regional leadership team on how to ensure that Risk Decision #5's and Risk Decision # 6's of the B.C. Risk Assessment Model are updated.
6. The director of child welfare will discuss with the regional executive the need to provide supports to teams in order for them to meet file transfer guidelines during times of organizational change.
7. The community service manager for Aboriginal services will clarify with the regional executive director and/or the director of operations which agencies Aboriginal children and families are eligible to receive services from and communicate this information to all managers in the region.