

## **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 examine practice at an individual case level and at a systemic level to recognize good case practice and to identify areas of practice that may require strengthening.

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

The DDR indicates brief involvement with the ministry existed for the family of the subject child (the child). During this time, the ministry opened a file for the family to provide support services.

While the ministry was involved with the family, one intake reporting concerns was received. The purpose of this intake was for the ministry to assess the family's need for further support services. While the family received services from the ministry, frequent and timely communications occurred between two ministry offices within the region and with an out-of-province child welfare authority.

The ministry had timely communications and appropriate follow-up with community partners to address concerns for the child. Community partners reported to the ministry that no concerns or low to medium concerns existed regarding the child and the child's parent.

The ministry attended the residence of the family of the child and an assessment of the family's circumstances led to an offer of specialized support services, which were accepted. A referral to a contracted service provider was made by the ministry.

The ministry's actions in relation to the child were appropriately documented on the ministry file and on the ministry's electronic documentation system.

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

### **B. CONCLUSIONS**

In carefully reviewing the service provided to the family, the DDR indicates that good social work practice was demonstrated by the ministry. Documentation on the ministry file indicates thoughtful and responsive practice by ministry social workers who attempted to provide preventative services.

The information the ministry received in the one intake was appropriately assessed as requiring an offer of further support services. The ministry followed up on the information in a timely manner and responded to the family's identified needs with an appropriate offer of further support services. The ministry and a community partner appropriately assessed the needs of the family and did not identify any immediate child protection concerns. Therefore, it is reasonable that the contracted service provider did not attempt to initiate service until two weeks after receiving the referral.

The ministry responded in a timely and appropriate manner based on the identified needs and circumstances of the family. Unfortunately, the death of the child occurred before the file could be transferred from one office to another within the region and services provided.

Upon learning of the child's death, the ministry ensured the family members were offered support and that any possible outstanding protection concerns were assessed.

The DDR report states that there is no evidence of a link between the ministry's practice and the death of the child.

### **C. RECOMMENDATIONS**

The DDR did not result in the development of any recommendations.