

## Ministry of Children and Family Development

### Child Fatality Case Review Summary Report - 2002

#### **A. Introduction**

The purpose of case reviews is to promote excellence in case practice, confirm and recognize positive case practice, support high quality service delivery to children and families, and to ensure compliance with the standards, policy and the legislative mandate under the *Child, Family and Community Service Act (CFCSA)*.

Case reviews are undertaken following a serious occurrence to a child. The decision to conduct a case review is made as soon as possible and no later than 20 days following the occurrence. There are two types of case reviews, with different methodologies: deputy director's review and director's case review.

During 2002, 32 case reviews were completed. These included 29 deputy director's reviews (DDRs) and 3 director's case reviews (DCRs).

#### **B. Deputy Director's Reviews (DDR)**

DDRs are limited in scope and usually consist of a file review and generally focus on the last five years of service involvement. Following a decision to conduct a DDR, the review process includes an examination of relevant case files that results in a chronology and analysis/discussion of the information. There are no findings for this type of review. A DDR is expected to be completed as soon as possible and within 90 days of the decision to begin the review. A DDR can assist the Director in determining whether a DCR is required.

##### Summary of 29 DDRs completed in 2002

- 5 involved children in care, 1 was Aboriginal
- The categories of death were accidental (1), suicide (3), natural (1)
  
- 24 involved children who were not in care when they died but who had received services from the Ministry within the last 12 months, 3 children were Aboriginal
- The categories of death were accidental (3), suicide (6), natural (7), homicide (4), undetermined (4)

#### **C. Director's Case Reviews (DCR)**

DCRs are comprehensive reviews that involve the examination of case files as well as interviews of relevant staff, caregivers and service providers. The decision to conduct a DCR is based on the severity of the occurrence, the potential link between case practice and the outcome for the child and the level of response required for public accountability. Following a decision to conduct a DCR, terms of reference are developed that define the scope of the review and confirm the processes of the review. A DCR is expected to be completed within 8 months of the decision to begin the review.

### Summary of 3 DCRs completed in 2002

- 1 involved a child in care who was Aboriginal
- The category of death was undetermined (1)
  
- 2 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, neither were Aboriginal
- The categories of death were homicide (1) and accidental (1)

*\*In one case involving a sibling group who had received services, both a DDR and a DCR were completed.*

### **D. Summary of Intakes from the Case Reviews**

When a social worker receives a report of child abuse or a request for support services, the social worker must assess the information and register it on the electronic case management system as an intake. After the assessment, the social worker may offer support services to the child and family, refer the child and family to a community agency, or investigate the child's need for protection.

- the total number of intakes from the 32 case reviews was 126
- 77 of the intakes were assessed as requiring a child protection response involving an investigation of the child's need for protection
- 49 of the intakes were assessed as requiring a non-protective response such as offering support services to the child and family, referring the child and family to a community agency or taking no action

### **E. Summary of Findings/Analysis from the Case Reviews**

Case reviews involve an analysis of case information in terms of case practice, service delivery and compliance with standards, policy and legislation.

Within the reviews completed in 2002, there were many examples of practice that met or exceeded standards.

Examples of best practice included:

- an exceptional response was provided following the child's death
- thorough comprehensive risk assessment
- frequent and conscientious contact with the family
- a number of services were provided to reduce the risk
- service provision required significant resources and creative planning
- diligence in the conduct of the investigation
- appropriate collateral contacts and referrals were made
- the social worker was clear on the child protection issues
- the social worker acted as an advocate
- the investigation was well documented and consultation points with the supervisor were clearly noted

- the youth and family received appropriate services from the Ministry
- the child had a close bond with the social worker

In addition, case reviews completed in 2002 identified areas where service delivery could be improved. For the purpose of this report these have been organized into themes of case practice, organizational issues and inter-agency collaboration.

#### Case practice

- determining appropriate responses to reports and designating files as protection or non-protection
- conducting thorough child protection investigations
- conducting thorough risk assessments, including re-assessments of risk
- determining the child's need for protection
- meeting guardianship responsibilities for children in care
- submitting reportable circumstances
- service delivery to parents with mental health issues
- utilizing integrated case management
- responding to reports regarding the care of children in foster care.

#### Organizational issues

- staffing levels and workload
- clinical supervision and documentation
- inter-regional file transfers and the delegation of social workers

#### Interagency collaboration

- integration amongst service providers
- relationships between social workers and foster parents
- coordination and sharing information between mental health and child protection, and community living services and child protection.
- reporting consistently to the police

### **F. Summary of Recommendations from the Case Reviews**

Case reviews often result in the development of recommendations to address any areas where service delivery could be improved. These recommendations are tracked and monitored for implementation.

The total number of recommendations within the 32 case reviews completed in 2002 is 114. The recommendations focused on four themes: sharing of information; reviewing information and training; file documentation; and administration.

Sharing and debriefing the report with involved staff was a recommendation made consistently. In addition, recommendations to share the report other areas such as the health authority, child development centre, coroner's office, education services branch, BC Children's Hospital, child and youth mental health and adult mental health, afterhours and any involved Aboriginal communities.

With respect to reviewing information and training, recommendations focused on:

- guardianship, integrated case management and risk assessment training
- forums on the investigative process, as well as a review of the youth service standards

With respect to file documentation, recommendations focused on:

- improving documentation and updating of children's health information

From an administrative perspective, recommendations focused on:

- developing or reviewing policy involving *Family Relations Act* matters, the use of restraints in foster homes and inter-office or inter-regional file transfers
- developing protocols with hospitals and mental health
- collaboration with Nursing Support Services
- recruitment of staff, professional development plans for staff and supervision
- integration of reportable circumstances and reviews and discussion with community partners about integrated case management