

Ministry of Children and Family Development

Child Fatality Case Review Summary Report - 2003

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 2003, 17 case reviews were completed. These included 15 deputy director's reviews (DDRs) and 2 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 15 DDRs completed in 2003

- 3 involved children in care, 2 were Aboriginal
- The categories of death were suicide (1), accidental (2)

- 12 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, 5 children were Aboriginal
- The categories of death were natural (1), undetermined (5), suicide (1), homicide (1), accidental (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 2 DCRs completed in 2003

- 1 involved a child in care who was not Aboriginal
- The category of death was suicide (1)

- 1 involved a child who was not in care when he/she died but who had received services from the Ministry within the past 12 months, this child was Aboriginal
- The category of death was homicide (1)

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 17 case reviews was 58
- 29 of the intakes were assessed as requiring a child protection response involving either an investigation of the child's need for protection or a family development response
- 29 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 2003, there were many examples of practice that met or exceeded standards.

Examples of best practice included:

- extensive measures such as multi-disciplinary care team meetings were in place to ensure an integrated approach was taken to help youth in high risk situations.
- investigations were completed thoroughly and in a timely manner and adhered to the practice standards
- several integrated case conferences took place
- diligent efforts were made to contact and meet with the youth
- services provided met or exceeded current standards of care

In addition, case reviews completed in 2003 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 child protection reports
- conducting thorough investigations, in a timely manner
- determining the child's need for protection
- conducting thorough risk assessments, including re-assessments of risk
- completing plans of care for children in care
- involving the Aboriginal community
- assessing the risk or suicide
- utilizing and integrated case management approach when relevant

Organizational issues

- staffing levels and the availability of experienced staff
- transferring files between offices
- documentation
- supervisory consultation
- awareness of protocols

Interagency collaboration

- involvement of health professionals
- communication and planning with external agencies/contract resources
- community capacity in the area of social housing
- non-cooperation from income assistance
- community professionals not reporting child protections concerns or not cooperating with service plans

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 17 case reviews completed in 2003 is 63. 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 with other program areas such as youth justice and other involved community professionals.

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

- providing training for Aboriginal agency staff on standards for investigations and protective family service work
- familiarizing Aboriginal agency staff with interprovincial protocols, risk factors and indicators of physical, sexual and emotional abuse
- conducting forums on neglect, conduct disorder, parental substance abuse, NAS and SIDS
- reviewing practice standards pertaining to assessing reports, investigations and risk reduction service plans

With respect to file documentation, recommendations focused on:

- improving documentation of children's health information

From an administrative perspective, recommendations focused on:

- developing policies for Aboriginal agencies
- revising Aboriginal operational and practice standards and indicators
- reviewing protocols with the Health region and RCMP
- developing protocols with the Ministry of Human Resources and hospitals
- raising awareness of protocols