

Ministry of Children and Family Development

Child Fatality Case Review Summary Report - 2004

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 2004, 5 case reviews were completed. These included 4 deputy director's reviews (DDRs) and 1 director's case review (DCR).

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 4 DDRs completed in 2004

- None involved children in care
- 4 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, 1 child was Aboriginal
- The categories of death were accidental (2), undetermined (2)

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 1 DCR completed in 2004

- it involved a child in care who was not Aboriginal
- the category of death was natural (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 5 case reviews was 26
- 11 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
- 15 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 2004, there were many examples of practice that met or exceeded standards.

Examples of best practice included:

- guardianship planning fully met or exceeded Ministry standards and policy
- positive steps were taken to ensure that planning for the youth adequately addressed his health needs
- many steps were taken to ensure guardianship services were available to the youth when he transferred to another region

In addition, case reviews completed in 2004 identified areas where service delivery could be improved. For the purpose of this report these have been organized into themes of case practice and organizational issues.

Case practice

- conducting thorough intakes and investigations, including safety planning
- conducting thorough risk assessments
- completing risk reduction service plans and comprehensive plans of care
- considering culture in practice

Organizational issues

- clinical supervision
- transferring files between regions
- workload and staffing levels
- organisation of file documentation

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 5 case reviews completed in 2004 is 19. 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.

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

- reviewing practice areas such as supervision orders, risk assessments and re-assessments of risk, risk reduction service plans and integrated case management
- reviewing practice standards pertaining to transferring files and ending services
- providing training on suicide prevention

With respect to documentation, recommendations focused on:

- filing relevant case notes in files

From an administrative perspective, recommendations focused on:

- reviewing the case transfer file process and protocol
- developing standardized formats for documentation of service provision by contacted service providers