Ministry of Children and Family Development

Child Fatality Case Review Summary Report - 2005

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 2005, 19 case reviews were completed. These included 17 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 17 DDRs completed in 2005

- 3 involved children in care, 1 was Aboriginal
- The categories of death were natural (1), undetermined (1) and suicide (1)

- 14 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, 10 children were Aboriginal
- the categories of death were accidental (3), undetermined (5), natural (3), homicide (1), suicide (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 2 DCRs completed in 2005

- both 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 (1) and 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 19 case reviews was 115
- 70 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
- 45 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 2005, there were many examples of practice that met or exceeded standards.

Examples of best practice included:

- services provided were coordinated and planned and utilised integrated case management meetings
- deterioration of the youths' behaviours was recognised and a safety plan was put in place
- opening/transfer recordings (not required) documented significant information gathered and actions taken
- commendations should be given for practice and work in a difficult situation
- numerous efforts were made to stabilize the youth and provide him with consistent care

In addition, case reviews completed in 2005 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 response to reports and designating files as protection or non-protection
- conducting thorough child protection investigations
- conducting thorough risk assessments, including re-assessments of risk
- completing risk reduction service plans
- utilizing an integrated case management approach
- submitting reportable circumstances

Organizational issues

- documentation
- supervisory consultation
- availability and provision of services in isolated communities

Interagency collaboration

- communication with Aboriginal agencies, CLS and child and youth mental health
- integration between MCFD and mental health.
- relationship building and conflict resolution with Aboriginal band and RCMP

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 19 case reviews completed in 2005 is 107. 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 CLBC, foster parents, community service managers, Aboriginal agency staff, child and youth mental health were also made.

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

- reviewing practice standards pertaining to investigations, risk assessments, the designation of reports, the rights of the child and permanency planning
- conducting practice forums on integrated case management, assessing family strengths and collaborative decision making, substance misuse and

the affects on family systems and planning for and engaging chronic, transient and resistant clients

- providing training on suicide intervention and working with Aboriginal agencies

With respect to file documentation, recommendations focused on:

- reviewing with staff the policy requirements regarding documentation
- improving documentation

From an administrative perspective, recommendations focused on:

- developing or reviewing protocols with RCMP, Aboriginal agencies, hospitals, child and youth mental health and other provincial jurisdictions
- developing tracking systems for team leaders for intakes and guardianship practice
- developing or reviewing policies or guidelines regarding vicious dogs
- developing or reviewing policies or guidelines regarding out of care options
- developing or reviewing policies or guidelines regarding interagency file transfer policies
- developing or reviewing policies or guidelines regarding high risk suicidal youth
- developing plans to increase cultural awareness and exploring ways to assist Aboriginal communities to develop support services