

Ministry of Children and Family Development

Child Fatality Case Review Summary Report - 2006

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 2006, 26 case reviews were completed. These included 22 deputy director's reviews (DDRs) and 4 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 22 DDRs completed in 2006

- 4 involved children in care, 2 were Aboriginal
- The categories of death were natural (1), undetermined (2) and accidental (1)

- 18 involved children who were not in care when they died but who had received services from the Ministry within the past 12 months, 9 children were Aboriginal
- the categories of death were accidental (7), undetermined (2), natural (5), homicide (1), suicide (3)

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 4 DCRs completed in 2006

- all 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), homicide (1), natural (1) and suicide (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 26 case reviews was 130
- 86 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
- 44 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 2006, there were many examples of practice that met or exceeded standards.

Examples of best practice included:

- a thorough job of working with the community
- the youth was involved and participated in the plan of care...had regular contact with his social worker and was comfortable with him
- ministry staff were actively involved with the family.
- multiple integrated case management meetings and an active care team
- when a report was accepted for investigation, all the necessary steps were taken, intakes were correctly assessed, all necessary information was documented, file reviews and prior contact checks were completed, the team leader was consulted at decision making points and collateral checks and immediate safety assessments were completed
- documentation indicated that the Aboriginal community and the Aboriginal child protection teams were involved on an ongoing and consistent basis

- guardianship planning for the child met and at times exceeded guardianship standards.
- overall guardianship planning was strong and consistent with standards
- guardianship staff is to be commended for the professional conduct and services provided.
- staff is to be complemented on the professional and caring support they provided.
- staff made strong efforts to plan in the youth's best interests. The youth's parents commented on the highly professional and respectful manner the social worker demonstrated.
- the Youth Agreement was supported by and Integrated Case Management plan.
- commend staff on the compliance to timelines for investigation completion
- the decision to designate the report for a FDR was an appropriate Section 16 response as the FDR provided an essential opportunity to develop a relationship with the mother, conduct a thorough assessment and engage the mother in services
- the inter-provincial protocol was used effectively in gathering shared child welfare involvement between BC and the other province.
- social workers were able to fulfil the critical components for the standards as well as the demands of the risk assessment model.

In addition, case reviews completed in 2006 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

- completing all required steps of child protection investigations
- informing children in care of their rights
- gathering and assessing current and historical information for designating reports, conducting investigations, risk assessments, decision making, planning interventions, identifying issues and strengths
- conducting regular reviews of files and plans of care
- conducting thorough risk assessments, including re-assessments of risk
- completing risk reduction service plans
- utilizing an integrated case management approach
- conducting thorough family assessments
- understanding the impact of violence and parental substance use on safety and well being of children
- implementing and monitoring supervision orders
- involving youth in defining problems and finding solutions

Organizational issues

- documentation
- supervisory/clinical consultation
- workload
- roles and responsibilities of intake/investigation teams and youth service teams

Interagency collaboration

- communication with, involvement of and relationship with Aboriginal agencies
- understanding services provided by community partners
- different philosophical frameworks between the Ministry and community partners
- communication and information sharing with health and mental health professionals
- relationship with contracted service providers

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 26 case reviews completed in 2006 is 127. 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. Recommendations to share the report with other program areas such as Aboriginal agency staff, mental health, regional coroner, involved physicians were also made. Finally, it was recommended to share with staff the document "Steps toward evidence based practice in supporting families with parental mental illness".

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

- reviewing practice standards pertaining to investigations, immediate safety, case documentation, supervision, assessing reports, the designation of reports, risk assessments, developing and implementing a safety plan, risk reduction service plans and developing and maintaining relationships with children in care.
- reviewing procedures to follow with the unexpected or expected death of children known to the Ministry
- incorporating best practice as it relates to family violence, chronic neglect and alcohol and drug use by the caregiver
- completing family/social histories, recording client's Aboriginal heritage, rules/procedures regarding initiating a foster home protocol investigations

- training in alternatives to care, integrated case management, monitoring supervision orders, the inter-generational effects of trauma, attachment theory, working with high risk youth with mental health diagnoses and providing child welfare responses to children with significant special needs
- practice forum to support social workers working with cases involving complex medical issues
- meeting with foster parents to review procedures related to children with illnesses requiring medical attention

With respect to file documentation, recommendations focused on:

- documenting medications for children in care, steps taken to identify and preserve a child's Aboriginal heritage
- improving documentation

From an administrative perspective, recommendations focused on:

- developing a framework for conducting case reviews for child and youth mental health cases
- reviewing resource allocations using appropriate staffing model
- developing memorandum of understanding with community partners
- evaluating the role of Ministry social workers who work out of community agency
- reviewing and affirming the principles that guide practice in cases involving the Ministry and CLBC
- updating the protocol between the ministry and Aboriginal agency/band
- reviewing computer issues with a view to suggesting improvements
- reviewing protocol for inter-regional file transfers
- developing a plan and an advisory for youth with suicidal ideations who request a Youth Agreement
- developing best practice guidelines for child protection services with young parents with youth agreements.
- improving relationships with mental health
- introducing a process to better manage cases in which complex medical issues are prevalent
- developing practice advisory re: resources used for the most commonly occurring special needs conditions