

CHILD FATALITY CASE REVIEWS
2007 SUMMARY REPORT

Ministry of Children and Family Development
March 31, 2008

A. INTRODUCTION

The objective of case reviews is to improve the delivery of services and outcomes for children/youth and their families. Case reviews also recognize positive case practice, and review case practice in relation to the legislation that governs child welfare practice in British Columbia and to the standards and policy that inform practice.

The decision to conduct a case review is made following a preliminary examination and analysis of an incident to determine if a case review is warranted. The decision is made as soon as possible and no later than 20 days following the occurrence. There are two types of case reviews: a deputy director's review (DDR) and a director's case review (DCR).

In 2007, 13 case reviews were completed. These include 3 DCRs and 10 DDRs.

B. DIRECTOR'S CASE REVIEWS (DCR)

A DCR is a comprehensive review that includes an examination of relevant documents/case files, a chronology of ministry involvement with the child/youth and their family, an analysis of information, interviews with relevant persons involved in the case, findings based on established terms of reference for the review, recommendations to address identified concerns, and a written report.

Family members, Aboriginal community members, and particular cultural community members may be offered the opportunity to be interviewed as part of the review process if necessary to address the areas outlined in the review's terms of reference.

The decision to conduct a DCR includes, yet is not limited to, the consideration of the circumstances of the occurrence and public accountability.

The expectation in 2007 was that a DCR be completed within 8 months of the decision to conduct the review.

Of the 3 DCRs completed in 2007:

- 2 involve children not in care at the time of death yet who had received services from the ministry within the 12 months prior to their death. One child was Aboriginal.
- The categories of death were undetermined (1), and accidental (1).

- One child, of Aboriginal heritage, was in ministry care at the time of their death.
- The category of death was accidental.

C. DEPUTY DIRECTOR'S REVIEWS (DDR)

DDRs are more limited in scope than a DCR and consist of an examination of relevant documents/case files and usually focus on the last five years of service provision. This review process includes a chronology and analysis of the information obtained, recommendations to address identified concerns, and a written report. There are no findings in a DDR.

A DDR could assist in determining whether a more comprehensive DCR is required.

A DDR is expected to be completed as soon as possible and within 90 days of the decision to conduct the review.

Of the 10 DDRs completed in 2007:

- 3 involved children/youth in care, 2 were Aboriginal
 - The categories of death were undetermined (2) and natural (1)
- 7 involved children/youth who were not in care when they died but who had received services from the ministry within the 12 months prior to their death, 1 child was Aboriginal
 - The categories of death in the reports were accidental (2), homicide (1), undetermined (1), and suicide (3)

D. SUMMARY OF INTAKES FROM DCRs AND DDrs

When a social worker receives a report of suspected child abuse/neglect, or a request for support services, the social worker assesses the information/request, determines the most appropriate response, and documents the report/request and the response to it on the ministry's electronic case management system as an intake.

Appropriate responses to an intake include:

- taking no further action;
- referring the family to informal and/or formal support services;
- providing a family development response;
- if the child is a youth, providing a youth service response; and,
- conducting a child protection investigation.

The total number of intakes prior to the child/youth's death from the 13 case reviews is 88. Of these intakes:

- 51 of the intakes were assessed as requiring a child protection response involving an investigation of the child's need for protection; and,
- 37 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 further action.

E. SUMMARY OF FINDINGS FROM DCRs AND ANALYSIS FROM DDRs

Case reviews involve an analysis of case practice/service delivery information specific to the identified circumstances addressed in the review in relation to potential links between case practice and outcomes for the child/youth, and compliance with legislation, standards, and policy.

Identified examples of case practice that met or exceeded standards and policy includes:

- good care provided for child/youth in care, specific to their special needs, by a ministry approved resource;
- maintaining familial and cultural relationships;
- ministry staff complied with statutory obligations under the *CFCSA*;
- standards and policy were met;
- collaborative work with family, extended family and the Aboriginal community
- child/youth placed with family members when appropriate;
- clear risk reduction plan developed;
- ministry staff met their guardianship responsibilities to child/youth according to standards;
- regular and frequent integrated case management meetings occurred;
- a range of service providers involved in delivering active support/care;
- appropriate community supports and/or referrals offered and/or made;
- though practice issues were identified, there is no indication that they are connected to the outcomes for the child/youth;
- thorough, timely, and well documented investigations;
- when a report was accepted for investigation, the necessary steps were taken, intakes were correctly assessed in a timely manner, necessary information was documented, file reviews and prior contact checks were completed, the team leader was consulted at decision making points; and,
- staff provided support and made considerable effort to engage parent(s) in appropriate services.

Reviews completed in 2007 also identified areas in which improvement is needed. These areas have been organized into themes of case practice, organizational issues, and inter-agency collaboration.

Needed improvement in case practice includes:

- completing all required steps of child protection investigations in a thorough and timely manner, obtaining collateral information and providing appropriate services as applicable;
- following protocols with community partners;
- enhancing cultural sensitivity;
- providing voluntary services;
- completing file and electronic documentation;

- gathering and assessing current and historical information for designating intake reports, conducting investigations, risk assessments, decision making, case planning , and identifying issues and strengths;
- reviewing files, plans of care, and interventions;
- conducting thorough risk assessments, including re-assessments of risk;
- completing risk reduction plans;
- following up on concerns with families throughout the case in a timely manner, and utilizing a consistent comprehensive integrated case management approach throughout the case;
- conducting thorough family assessments and addressing identified concerns;
- understanding the impact on the safety and well being of a child/youth of intergenerational protection issues, family violence, substance abuse, and verbal and physical abuse;
- recognising a child/youth's mental health issues as a risk factor;
- developing, implementing and monitoring safety plans; and,
- documenting requirements for child protection investigations.

Needed improvement in organizational issues includes:

- electronic documentation;
- supervisory/clinical consultation;
- workload; and,
- approval, training, and monitoring of caregivers.

Needed improvement in interagency collaboration includes:

- developing a relationship with Aboriginal agencies that facilitates ongoing communication; and,
- developing and implementing protocols that enhance interagency service delivery.

F. SUMMARY OF RECOMMENDATIONS FROM DCRs AND DDRs

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

The total number of recommendations within the 13 case reviews completed in 2007 is 63. The recommendations focused on five themes: reviewing information, sharing of information, training and support, file documentation, and administration.

Sharing and debriefing the report with involved staff is a consistent recommendation of the reviews. Recommendations to share the report with other program areas such as youth services and delegated Aboriginal agency staff are also made.

Another consistent recommendation of the reviews is the provision of written confirmation to a director that specific recommendations be implemented/completed by a prescribed date.

Recommendations regarding reviewing information focused on:

- reviewing with staff their responsibilities associated with their delegation and the delegation of the agency as applicable, and the protocol between the ministry and delegated Aboriginal agencies, including the transfer of files between the ministry and delegated Aboriginal agencies;
- reviewing the significance of consultation and information gathering and the documentation of each;
- ensuring quarterly reviews/audits of open intakes are completed for those open 30-60 and 90 days and shared with the regional community service manger;
- reviewing other program area review reports with staff involved;
- reviewing practice standards (including AOPSI), and AOPSI conflict of interest guidelines with relevant staff; and,
- reviewing AOPSI standards to clarify the need to articulate different processes for home studies and approval of restricted, family, and specialized care homes.

Recommendations regarding training and support, focused on:

1. Providing training in:
 - risk to children (including family violence and parental substance abuse), the development and updating of risk reduction service plans, child protection report screening, coding, assessing, investigative procedures, and section 13 criteria under which children may be found to be in need of protection);
 - the use of care agreements, comprehensive risk assessments, and integrated case management (including information sharing with other teams/service providers;
 - children in Care Standards, guardianship requirements, medically fragile children (including hospital discharge planning that addresses specific risks for infants) and high risk youth;
 - cultural awareness and planning for Aboriginal children and monitoring those plans; and,
 - protocol between delegated Aboriginal agencies and the ministry, and records management and administration for Aboriginal agencies.
2. Providing support by:
 - developing a document to support integrated case review between the ministry and delegated Aboriginal agencies and provide orientation on that document;
 - ensuring timely transfer of child protection family service files following the completion of an investigation that has found a child in need of protection;

- developing tools such as a preformatted checklist to guide processes and support consistent and thorough practice;
- distributing current research, and guidelines of community partners and other ministries as appropriate;
- clarifying the role of supervisor, and other service providers involved in a case, and identifying a case manager when working in an integrated case management process;
- providing orientation for all caregivers, including restricted, family and specialized care homes

Recommendations regarding file documentation focused on:

- file and electronic documentation of case practice including supervisory approval, and the rationale for terminating an investigative response.

Recommendations with an administrative perspective focused on:

- establishing a process of internal audit for those providing services on behalf of the ministry, and a written protocol for integrated case management; and,
- ensuring appropriate services are available.