Six-month-old who died in parental care

Ministry of Children's Services' Designated Review Findings and Recommendations

JANUARY 2020

Alberta

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Introduction

Children's Services (CS) reviews deaths of children receiving services to identify potential improvements to programs, policies and practice within child intervention (CI). The Internal Child Death and Serious Incident Review (ICDSIR) process includes input from many sources. The process may include a comprehensive examination (called a designated review), which publicly releases findings and recommendations. The goal of every review is to:

- reduce the risk of future deaths; and
- promote better outcomes for children and families.

This designated review focused on a six-month-old medically fragile child who died in parental care.

The review team analyzed CI involvement by reviewing relevant documentation and interviewing staff and professionals working with the family. The team considered the worksite and community, the level of service provided and the decisions made.

Findings

Finding #1: Adherence to child intervention safety plans reduces the risk of further harm and danger to a child.

The creation of a safety plan alone does not ensure a child is safe. A safety plan only works with accountability and communication. Family members, staff and community professionals must comply with the safety tasks. Assessing whether the parties are following the plan determines if it is working. Risk factors need to be continually assessed throughout CI involvement and safety plans adjusted accordingly.

Safety plans must be tested, reviewed and revised to be effective. Engagement with family members and community professionals supports accountability for the plan. CI supervisors and management must share accountability and support front-line staff to ensure safety plans are followed and reduce danger to the child.

Finding #2: Ongoing assessment is essential to recognizing and evaluating risk to a child.

Monitoring helps assess the risk of harm to a child. This includes assessing the family situation as risk factors change. CI should compare the child's well-being with anticipated health and developmental milestones, recognizing the vulnerability of children under the age of six. Ongoing assessment includes:

- determining the child's needs;
- assessing the family environment and dynamics; and
- assessing the family's ability to meet the child's needs.

CI professionals need support to accurately assess the risk to the child, understand staff's risk tolerance and respond to a child's vulnerability.

Finding #3: Collaboration with community professionals improves child safety, well-being and family success.

CI should work collaboratively with community professionals to support children and families. When there is a lack of community-based resources (such as family support workers, parenting programs and addictions treatment), families receive insufficient supports. Family supports and services are less effective because of insufficient working relationships with community partners.

Environmental barriers and living conditions limit CI and community professionals' ability to assess the child's risk factors. CI and other professionals cannot enter unsafe homes, which limits their ability to assess the safety and well-being of children, parents, and extended family members.

Finding #4: Collaboration with medical professionals is critical for highly vulnerable children.

Medical professionals have a critical role in safety planning for medically fragile or medically complicated children. A child's outcomes improve when physicians and community health nurses are part of safety planning. These children need special monitoring from CI. Guidelines in CI policy and practice supports on how and when to engage medical professionals could improve these children's outcomes.

Recommendations

The following are meant to build on previous recommendations in designated reviews to enhance CI services.

Recommendations for Findings #1 and #2:

A) The Statutory Director issued a directive on June 21, 2018 (after the child died but prior to this review) requiring senior management to make decisions about high-risk and vulnerable children. We recommend expanding the directive (and making it policy) to include mandatory decision-making by senior management for children under six who:

- have unexplained serious injuries;
- have caregivers/guardians who deny the injuries;
- have explained serious injuries caused by an unknown perpetrator;
- have been chronically or severely neglected; or
- are medically fragile.

B) Assessing risk in CI cases is complex and challenging. Risk assessment requires information from CI, family members, community members and community professionals. The importance of keeping children with their families has increased CI's risk tolerance in assessing whether children should enter care. The child's safety should take priority over the family's needs and community standards and preferences.

- Enhance service delivery messaging about prioritizing child safety when risk tolerance exists in case planning. Messaging will acknowledge that a child's safety, survival and well-being are the primary concerns.
- Develop practice requirements that ensure accountability methods for following safety plans.

Recommendations for Findings # 3 and #4:

A) Create CI policy for medically fragile and medically complicated children which:

- guides collaboration with medical professionals; and

- emphasizes the importance of understanding the child's medical condition, risk factors and treatment plan.

B) Create practice tools for CI to:

- identify risks for medically fragile or medically complicated children; and
- assess safety for these children with caregivers.

Conclusion

The findings and recommendations in this review support CS' ongoing work. The ministry is committed to providing the best possible services to children and their families. These recommendations position the ministry going forward to achieve positive outcomes for children and their families.

Background: Internal child death and serious incident review process.

The Statutory Director called an internal review under the authority provided by section 105.771 of the *Child, Youth and Family Enhancement Act* (CYFEA). Relevant legislative provisions are included below.

The individuals designated by the Statutory Director under section 105.771(1) commenced an ICDSIR.

The designated individuals review:

- incidents giving rise to the serious injury or death of a child that occurred while the child was receiving CI services; and
- any other incident that, in the opinion of the Statutory Director, is a serious incident and occurred in respect of a child while the child was receiving CI services.

The purpose of the ICDSIR is to identify best practices and opportunities to strengthen programs, policies and practices within CI services.

The ICDSIR process is part of the ministry's internal quality assurance processes. ICDSIR serves to:

- ensure a consistent and comprehensive examination approach following a death of a child receiving CI services;
- support the Government of Alberta's commitment to accountability, transparency and continuous improvement of the CI system;
- evaluate case information and context to make recommendations for quality improvements to CI services and professional practice; and
- share key policy and practice learnings with CS staff and stakeholders to support the continuous improvement of the CI system.

CYFEA section 105.78 provides that designated individuals are not compellable as witnesses. A designated individual must not give or be compelled to give evidence in an action in respect of any matter coming to the designated individual's knowledge in the exercise of powers and the performance of duties and functions, except in a prosecution for perjury.

The comprehensive examination is a privileged internal review. The communications arising during the comprehensive examination are privileged by CYFEA section 105.79. CYFEA provides

a statutory shield to protect as privileged the information gathered from staff and stakeholders during the comprehensive examination. The statutory privilege provides that anything said, any information supplied and any record produced during the review are privileged and not admissible in evidence in an action, except in a prosecution for perjury.

The Statutory Director reports any designated review findings and recommendations to the Minister. Subject to confidentiality and privileged information, the Minister makes the designated review findings and recommendations available to the public annually in the manner the Minister considers appropriate. The Minister must take into account privacy considerations afforded under CYFEA confidentiality and privileged information provisions. These privacy considerations contribute to the Minister's determination of appropriate reporting of designated review findings and recommendations.

Relevant legislative provisions

Child, Youth and Family Enhancement Act

Part 3.1
Quality Assurance

Definitions

105.71 In this Part, […]

(c.1) "designated individual" means an individual designated under section 105.771(1);

Review by designated individual

105.771(1) A director may, in writing, designate individuals to review:

(a) incidents giving rise to the serious injury to or death of a child that occurred while the child was receiving intervention services, and

(b) any other incident that, in the opinion of the director, is a serious incident and that occurred in respect of a child while the child was receiving intervention services.

(2) A designated individual must be:

(a) an individual employed in the public service of the Province, or

(b) an individual to whom the director has delegated authority under section 121(3).

(3) A designated individual must provide the director with a report of the designated individual's findings and recommendations, if any, arising from a review under subsection (1).

Designated individual must not give evidence

105.78 A designated individual must not give or be compelled to give evidence in an action in respect of any matter coming the designated individual's knowledge in the exercise of powers and the performance of duties and functions under this Part, except in a prosecution for perjury.

Communications privileged

105.79 The following information, records and reports are privileged and not admissible in evidence in an action, except in a prosecution for perjury:

(a) anything said, any information supplied or any record produced during a review under section 105.771(1) by a designated individual;

(b) any report referred to in section 105.771(3).

Protection from liability

105.791(1) Subject to subsection (2), no action lies or may be commenced or maintained against a designated individual in respect of anything done or omitted to be done in the exercise or intended exercise of any power under this Part or in the performance of any duty or function under this Part.

(2) Subsection (1) does not apply to a designated individual in relation to anything done or omitted to be done by the designated individual in bad faith.

Publication of statistics, findings, recommendations

105.793 Subject to sections 126 and 126.1, the Minister shall publish the following information on the Minister's department's website and shall update the information at least once a year:

[…]

(c) findings and recommendations provided to the Minister under section 105.771(5);

[…]