SOCIAL DEVELOPMENT - INTERNAL RESPONSE

A two-year-old child whose welfare was being investigated by the Woodstock child protection services unit died on April 13, 2004.

In addition to investigations by the Child Death Review Committee and the Child and Youth Advocate, Region 3 of Social Development conducted an internal review of the case and nine regional recommendations were made in July 2006.

In addition to accepting each recommendation from the regional review, Region 3 has also made organizational changes in the Woodstock/Perth child protection unit to enhance services provided to children and families.

In Woodstock, a new child protection social work position was added to recognize the challenges of rural social work practice. This new position is dedicated to child protection investigations.

Screening of referrals for all child protection investigations was moved to Fredericton to streamline service delivery throughout Region 3.

Other organizational changes include the reassignment of staff to new responsibilities maximizing their expertise and interest, as well as reassignments to priority areas such as, child protection investigations, ongoing child protection, foster homes and adoption.

Below is a summary of the nine regional recommendations:

1. If there are workload pressures, responses need to be triaged to better ensure the safety and well being of children under 5 years of age.

2. A decision to investigate a referral should not be made in isolation of previous situations. Whenever possible, subsequent referrals on a family are to be assigned to the initial investigator.

3. When a report is assigned to a child protection investigator, the child must be physically viewed by the investigator and this must occur within the assigned priority timeframe.

4. Ensure front-line social workers and supervisors attend and have access to Risk Management training and applicable Child Welfare CORE training. (Risk management is a tool that assists social workers in identifying and assessing the level of risk for abuse and neglect of children.)

5. A clinical audit of case files should be conducted to assess understanding and adherence to Child Protection Services Practice Standards and Guidelines as well as consistency in process within region.

6. Establish a regular peer review practice related to investigations to further assess consistency in service delivery.

7. In Region 3, if the parents are uncooperative and evasive, it is recommended that:

- Sharing information with other departmental staff providing services to the same families become a firmly established practice. This will assist social workers in finding and planning interventions with the families.
- *The use of Permanency Planning (development of case plans for clients based on current and future needs) be considered as a tool in this process.
- Review with staff the legal authority of social workers under the Family Service Act.
- In co-operation with Central Office, research on best practices in handling cases involving neglect, lack of supervision and recalcitrant parents both unwilling and unable to care for their children.

8. In all cases of sexual abuse, child abuse and neglect cases where criminal activity is suspected, the social worker must contact the police immediately unless exempted by the supervisor. The decision must be documented when it is decided not to contact the police.

9. It is recommended that the following training activities be provided:

- Review of "Child Protection Services Practice Standards and Guidelines".

- Risk Management and Parental Attachment training.

- Dog Bite Prevention training.