BRITISH COLUMBIA

Ref #: 226609
Date: June 2017

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Ministry

A. INTRODUCTION

The Ministry of Children and Family Development (the ministry) conducted a File Review (FR) to examine case practice regarding the subject youth (the youth).

For the purpose of the FR, ministry records and BC Coroners Service documents were reviewed. The FR focused on a specific period of ministry involvement prior to the death of the youth.

B. TERMS OF REFERENCE

1. Did the ministry reassess the youth's high-risk issues and adjust safety planning appropriately?

2. Did the ministry provide an integrated and collaborative response to address the youth's high-risk issues?

C. BACKGROUND SUMMARY

The ministry had brief involvement with the family; the youth was engaged with a ministry program to address high-risk issues. The youth was not Aboriginal, and was not in care at the time of death.

D. FINDINGS

1. Although the youth met regularly with the program's practitioner, the ministry did not document if regular assessments of the youth's high-risk behaviours were conducted, nor was safety planning evident on the file. The importance of assessing the youth's risk, and seeking clinical supervision was heightened given the youth's high-risk behaviours. Regular assessments, safety planning, and supervision are required by policy in all cases; particularly for clients with frequent crises, as well as for high-risk behaviours.

2. There was minimal evidence of collaboration between the ministry, the youth's family, and community partners. Although the ministry attempted to maintain contact with the youth's parent, further collaboration with involved community partners and family members was needed. An integrated response to the youth's complex needs could have resulted in more thorough and regular

assessments of risk, more effective safety planning, and an increase in the efficacy of treatment.

E. ACTIONS TAKEN TO DATE

1. The Director of Operations met with the program's Local Service Area (LSA) Team Leaders to ensure the consistent use of the program's referral and intake tool; the process assists the practitioner to appropriately prioritize service based upon the levels of risk and the waitlist priority. Documentation of client information and supervision in the program's electronic information system was also reviewed.

2. The improvement in collaboration with community partners was partially addressed. The program's team leader for the involved LSA implemented a process which ensured that all clients' community practitioners were contacted at the time of referral for the program's services. The referral information is held for 90 days; if the client does not attend within that period, the referral does not proceed.

F. ACTION PLAN

1. The Director of Practice meets with the program's Service Delivery Area Team Leaders to review the requirements for:
    - assessment and reassessment of the high-risk behaviour;
    - documentation of risk assessments and safety planning;
    - collaboration with other involved programs; and,
    - documentation of case-based clinical supervision recommendations on the client's file.

The review was completed in March 2017. The above action plan was due for full implementation on March 31, 2017.