

## **SUMMARY: COMPREHENSIVE REVIEW Of the Death of a Youth in the Care of the Ministry**

### **A. INTRODUCTION**

The Ministry of Children and Family Development (the Ministry) conducted the Comprehensive Review (CR) to examine case practice regarding the subject youth (the youth) of the CR. The purpose of the CR was to: examine and analyze the case practice in relation to legislation, standards and policy; promote excellence in case practice; and identify barriers to providing adequate services.

For the purposes of the CR, Ministry records and BC Coroners Service documents were reviewed. Ministry staff was interviewed. The CR focused on the period of Ministry involvement prior to the death of the youth.

### **B. TERMS OF REFERENCE**

1. Were the Ministry responsibilities between service areas clearly understood, communicated and followed by the responsible services?
2. Was the Ministry coordination of services adequate to ensure the safety and well-being of the youth (integrated case planning, communication of risks and concerns, provision of support to meet the needs of the youth)?
3. Was the Ministry response to the youth's needs conducted according to policy and standard guidelines?
4. Were there any additional concerns or issues that affected the provision of services to the youth or the family?

### **C. BACKGROUND SUMMARY**

The Ministry had longstanding involvement with the youth's family due to child protection concerns regarding the parents' high risk behaviours. The concerns could not be adequately resolved and the youth was eventually removed from parental care. While in foster care, the youth continued involvement in high risk and criminal behaviours, minimally complied with Ministry Program services, and made limited improvements in circumstance. The youth was Aboriginal and in the care of the Ministry at the time of death.

## **D. FINDINGS**

1. Effective Integrated Case Management involves identifying a case manager, clarifying mandates, roles, and responsibilities of involved individuals, and coordinating discussions and information sharing amongst professionals, the caregiver, and the family. There was some evidence of planning meetings before the youth's involvement with another Program area, but subsequent planning and information sharing lacked continuity. The youth's disengagement and escalating high risk activities were reported to the other involved services. However, clarity around guardianship responsibilities was lacking and many aspects of a coordinated response and integrated plan to meet the youth's needs did not occur.
2. When multiple Program areas provide services to high risk youth, it is important that responsibilities are clear and plans are coordinated to address the youth's needs. The Guardianship Worker had the legislated mandate to support the youth's safety and well-being, but did not adequately and collaboratively lead planning to meet the youth's specific needs. Referrals and discussions occurred; however, the plan did not reflect an effective intervention strategy for the youth's high risk behaviours. The youth's behaviours and lack of engagement in service planning challenged service providers to maintain relationships and effectively support the youth's safety and well-being.
3. Ministry standards for involved Program areas governed service provision for the youth. There was no documentation of a current plan of care which would have presented an opportunity to gain clarity regarding the youth's behaviour, needs and well-being. It was apparent the foster parent did not have all of the available information to fully support the youth. The relevant standards in another Program area were met for case practice and documentation. Further steps could have been taken in conjunction with the youth's plan of care. The youth was involved in a serious incident and the required Reportable Circumstance report was not submitted to the Director. Thus, the youth's situation did not receive the oversight and support of an integrated response from Quality Assurance staff across involved Program areas.
4. There were additional concerns and issues that affected the provision of services to the youth and family. The Ministry office had staffing shortages, as well as few senior social workers to support and mentor newly hired staff. During the period under review, the youth had several social workers who, although delegated, did not have guardianship training. However, an integrated case management approach would have assisted with case continuity.

## **E. ACTIONS TAKEN TO DATE**

1. A Practice Audit was conducted and recommended increased collaboration and planning with the community, focusing on communication between foster

parents, bands and child welfare. The Team Leader and Manager developed a plan for better documentation and implementation of collaborative practice strategies. The Manager provided updates on protocols and proposed changes to services including residential services.

2. A Program area implemented a structured assessment of risk, a service planning form, a file review checklist, regional clinical supervisory guidelines for Team Leaders, and a Practice Advisory regarding file recordings.

## **F. ACTION PLAN**

1. The provincial Practice directives relevant to the case are reviewed by the teams to ensure their use is understood and implemented.
2. The Executive Director of Service communicates in writing to all the Team Leaders in the Service Delivery Area the importance of accessing local Aboriginal agencies to assist in preparing cultural plans, accessing Elders, and supporting Family Group Conferencing.
3. The Community Services Manager and Team Leaders work with staff to improve electronic and physical documentation on client files by: creating a tracking template to ensure the completeness of records; allocating time for social workers to record information; and, providing documentation training for staff.
4. The Director of Practice meets with Team Leaders and staff to: discuss the different roles and responsibilities; and, information-sharing (and documentation) rules that exist between Ministry program areas and external partners.