BRITISH COLUMBIA

Ref #: 223155
Date: December 2015

SUMMARY: FILE 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 File Review (FR) to examine case practice regarding the subject youth (the youth) of the FR. The purpose of the FR was to: analyze practice in relation to legislation, policies and standards; promote excellence in assessment and planning; and identify barriers to providing adequate services.

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

B. TERMS OF REFERENCE

1. Were Child and Family Services, particularly in relation to assessment and planning, adequate to address the youth's safety and well-being in accordance with Ministry policy and standards?

2. Was the provision of child protection services conducted in a collaborative manner with the other Ministry Programs and in accordance with Ministry policy and standards (in particular, regarding identification of risk factors)?

C. BACKGROUND SUMMARY

The Ministry had extensive involvement with the youth's family due to the high risk behaviours of the parents. The youth came into the continuing custody of the Ministry when interventions with the family did not resolve the child protection concerns. The youth resided in two foster homes for a lengthy period of time before returning to the family home. The youth continued to reside with family and largely refused Ministry services to address high risk behaviours that impacted the youth's safety and well-being. For a period of time during involvement with another Ministry Program, the youth resided in a Ministry resource, as well as at the family home. The youth was Aboriginal.

D. FINDINGS

1. Child and Family Services, particularly in relation to assessment and planning, were not adequate to address the youth's safety and well-being in accordance with Ministry policies and standards. A Cultural Plan had been completed for the youth, but a current Plan of Care was not on the case record. The Ministry's long term plan for the youth was placement with extended family, but there was no indication this option was explored. Considering the youth's strong ties to family and community, a placement with extended family members may have achieved greater safety and stability.

2. The provision of child protection services was conducted in a collaborative manner with the other Ministry Programs. Provision of services was in accordance with Ministry policies and standards to the extent possible when youth engage in high risk behaviours and resist interventions. The Ministry worked collaboratively with other members of the youth's formal and informal support networks. Several supports and services were available to the youth; however, other than residing intermittently in the Ministry placement, support services were not accessed and high risk behaviours continued until death of the youth.

E. ACTIONS TAKEN TO DATE

1. The Team Leader has been documenting case practice consults in the ICM database for each high profile case.

2. A tracking mechanism was implemented for the LSA to ensure Care Plan completion and monitoring.

3. Restructuring within the SDA has resulted in this team becoming an interdisciplinary team; this restructuring has increased communication and collaboration between the various program areas.

4. A High Risk Committee was established to provide consultation regarding planning for high risk youth. The committee is comprised of Community Service Managers, Directors of Practice, and executive from another Ministry.

5. Communication with the Band involved in this case has increased since 2013 and has facilitated enhanced communication and collaboration between the Band and the Ministry, in order to provide more cohesive planning for children, youth and families; this communication continues.

BRITISH COLUMBIA

F. ACTION PLAN

1. At the scheduled monthly case practice supervision meetings with child protection workers, the team leaders in the SDA communicate the need to ensure that information discussed during consultations is recorded in the ICM database, and any direction or recommended actions provided are reviewed/followed up on at subsequent supervision meetings.

2. A mechanism is developed and implemented in the SDA to document the outcomes of Family Group Conferences on Family Service and Child Service files.

3. The team leaders in the SDA remind the child welfare workers that a copy of the referral form used to provided information regarding a child to a Ministry caregiver must be placed on the child's file.