BRITISH COLUMBIA

Ref #: 235276
Date: December 2018

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Ministry in 2017

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).

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 implement an appropriate plan based upon the youth's identified safety concerns?

2. Did the ministry adequately assess the youth's specific needs, and then offer appropriate treatment to address the presenting concerns?

C. BACKGROUND SUMMARY

The ministry had previous involvement with the youth for an extended period due to concerns regarding the youth's specific needs. Services were delivered and supports were provided by workers delegated by the director. The youth was engaged in services; however, the family did not actively engage with ministry programs. The youth was living independently near relevant resources prior to death. The youth identified as Indigenous.

D. FINDINGS

1) The ministry's response to the identified safety concerns was not adequate according to policy and legislation. A lack of ongoing assessments led to a lack of adequate safety planning and collaboration with case planning. Had adequate assessments been completed or documented according to guidelines, a formal safety plan involving multiple service streams could have been created. Planning

occurred without collaboration, which resulted in specific factors remaining unaddressed.

2) The ministry provided a thorough initial assessment, testing and specialized support; however, the modality of intervention chosen did not follow evidence-based practice. Assessments completed after the initial screen did not include a specific required assessment. By following the prescribed, evidence-based treatment practices, there would have been a greater likelihood of achieving a desired outcome for the youth.

E. ACTIONS TAKEN TO DATE

Not applicable.

F. ACTION PLAN

1. The Director of Practice reviews with the involved ministry staff, a clinical guide as a means to ensure the ministry is developing safety plans with youth at risk.
2. The Director of Practice meets with the respective ministry staff to discuss the importance of documenting the clinical progress, and use of tools for clients at risk, as well as, appropriate clinical supervision being offered to staff and subsequently documented in the electronic records.

The review was completed in August 2018. The above action plan was due for full implementation in October 2018.