BRITISH COLUMBIA

Ref #: 261424
Date: June 2022

Summary: Child and Family Practice Review of the Death of a Youth Known to the Director in 2021

Circumstances of the Fatality

The review examined the ministry services provided to an Indigenous youth who died. The youth and their family received services at the time of the death.

Findings

The ministry entered into an agreement for the youth's care without their parent's involvement. In that agreement, the ministry committed to offer the youth support; this did not occur. The youth subsequently moved to a home where specific concerns had been identified about their safety. No steps were documented to mitigate the safety risk to the youth. New information about the youth's specific needs was received; however, no action occurred to address these needs.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan to review with the involved staff policies regarding: Out of Care services to youth, clinical consultation to assist in case planning when involved in complex high-risk child protection cases, reassessing risk when youth return to homes where outstanding child protection concerns have not been addressed and offering support services to youth and families.

The review was completed in May 2022. The above action plan is due for full implementation in June 2022.