BRITISH COLUMBIA

Ref #: 244749
Date: December 2020

SUMMARY: FILE REVIEW
Of the Death of a Youth Known to the Director in 2019

Circumstances of the Fatality

The review examined the case files of an Indigenous youth who died. The director provided services to the youth within the 12 months prior to the youth's death.

Findings

The youth had been in care from a young age and maintained a single placement for many years before they moved to another placement; this disruption resulted in significant instability in subsequent placements. During their time in care, they had health challenges that impacted their daily functioning; however, the director and community professionals supported them with services that addressed these challenges, including accessing other Ministry of Children and Family Development programs. While the director provided the youth with information about their Indigenous culture and community, a cultural plan was not on file and the Indigenous community was not involved in development of the Care Plan.

Prior to the case review being finalized, the Service Delivery Area leadership implemented several changes to improve service to Indigenous children and youth, including the creation of a new Indigenous-focused child protection intake team and increasing the number of Indigenous Elders available to support Indigenous children and youth.

Actions

The involved Service Delivery Area leadership and the Quality Assurance team developed an action plan for the involved staff and caregivers to receive information on how youth can access specialized training and to document when youth have received this training.

The review was completed in July 2020. The above action plan was due for full implementation in October 2020.